Technical Advisory

Timely information for the dynamic world of employee benefits

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What is Medicare?

For those who are about to turn 65 and retirement is in sight, questions about healthcare coverage often arise. What kind of coverage is available? How do I sign up? What's the cost? You may hear the same questions from any person of any age, but for those who are about to turn 65, the options are more limited and the cost may be more prohibitive. One option available for those who turn 65 is Medicare.

What is Medicare?

Medicare is the nation's largest healthcare program, covering approximately 39 million Americans. The program is federally funded and covers:

1) People age 65 or older who are entitled to benefits under either the Social Security or Railroad Retirement systems, or have worked a sufficient period of time in federal, state, or local government employment.
2) Some people with disabilities under age 65.
3) People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

When am I eligible?

If you already received benefits through Social Security or the Railroad Retirement Board for 24 months, then you are automatically entitled to Medicare coverage starting the first day of the month that you turn age 65. For those who are not receiving benefits but are eligible, Medicare cards are mailed about 3 months prior to one's 65th birthday. No paperwork is required to enroll in the plan.

What does Medicare have to offer?

Medicare is made up of two parts. Medicare Part A (hospital coverage) is free for those who qualify. Part B (medical coverage) is optional and requires the payment of a monthly premium.

Medicare Part A:

Part A comes automatically and is free for most people once they turn 65. There is not a premium because the person or their spouse paid Medicare taxes while they were working. Medicare Part A is hospital insurance and helps pay for the following:

1) Hospital Stays - Semi-private room, meals, general nursing and other hospital services and supplies (this includes care in critical access hospital).
2) Skilled Nursing Facility - To get coverage for a skilled nursing facility, one must have been in the hospital for at least three days and one's stay in the facility must be requested by the doctor involved.
3) Home Healthcare - To receive coverage for home healthcare, a patient must be home bound and receiving skilled care. Again, the doctor involved must make a written request to the approved home healthcare provider.
4) Hospice Care - In order to receive coverage for hospice care, you must be diagnosed with a terminal disease with a life expectancy of less than six months.
5) Blood - The first three pints of blood you receive at a hospital or skilled nursing facility during a covered stay.

Medicare Part B:

Where Medicare Part A covers hospital costs, the optional Part B covers everyday medical services. There is a cost if you opt for Part B. As of January 2001, the monthly premium for Medicare Part B is $50. The premium is deducted each

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What is Medicare?

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month from your Social Security, Railroad Retirement, or Civil Service Retirement check. If you do not receive any of these payments, then Medicare sends you a bill for the premium every three months. For the monthly premium, you receive coverage for:

1) Doctors' Services - Outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees, and durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers). Second surgical opinions, outpatient physical and occupational therapy, and outpatient mental healthcare are also covered.
2) Clinical Laboratory Service - Blood tests, urinalysis, etc.
3) Home Healthcare - To receive coverage for Home Healthcare, the patient must be home bound and receiving skilled care. The doctor involved must make a written request to the approved home healthcare provider (for those who are not eligible for Part A but have purchased Part B).

Part B is optional. The enrollment period begins three months before you turn 65 and lasts for seven months. If you decide not to select Part B, you must check the "refusal" box located on the back of the form that you receive with the card. Then you should mail both the card and the form back to the Social Security Administration. You should then receive a new card showing that you have elected Part A only.

If you do not select Part B during the initial enrollment period, you will have to wait for the next general enrollment period to enroll. General enrollment periods are from Jan. 1 and March 31, each year. If you choose to sign up during a general enrollment, your coverage will not take effect until July 1 of that year and you may be subject to a 10% rate increase for each year following your initial eligibility. The exception to this policy is if you or your spouse is working and had group coverage during the initial enrollment period: when you are no longer on the group plan, you can enroll in the Medicare plan during a special enrollment period. You have eight months after the end of your employment to sign up for Part B.

the more you investigate, the more you'll see there are options available

If I have Medicare does that cover everything?

Medicare does not cover everything. Prescription drugs, in particular, are not covered on the Medicare plan. Medicare Supplemental plans help bridge the gap. Supplemental plans help cover the out-of-pocket costs left over on Medicare. Costs such as deductibles for Parts A and B, foreign travel and prescription drugs can be covered depending on the supplemental plan that is chosen. There are ten plans available (A-J). Each plan option incrementally increases in coverage and in cost. The most popular of the plans are H-J because they include limited coverage for prescription drugs.

Medicare, although it is not the end-all/be-all, can play an important role in providing health coverage for the years after retirement.

To get more information about Medicare, contact your representative at Kibble & Prentice or visit www.medicare.gov.

PacMed Clinic Closures

Effective September 30, 2001, PacMed Clinics closed six of their twelve clinics. PacMed is a large, multi-specialty group with clinics in various Seattle neighborhoods.

The decision to close the clinics was a major part of PacMed's financial strategy to achieve positive cash flow by year-end. The six clinics provided care for about 20% of PacMed's total patients. Many of the members disrupted by this decision will be transferred to the six remaining PacMed Clinics or other community providers.

Following this termination, there will be a total of 185 PacMed physicians.

Virginia Mason Obstetrics Practice Closing

Virginia Mason Medical Center has decided to shut down its obstetrics practice after November 30th of this year. Virginia Mason officials point to the flattening birthrate in Seattle as the main reason for the move.

The number of babies born in Seattle has declined over the last few years. In 1994, the birth rate in Seattle was 24.4 babies per 1,000. That number fell to 20.9 in 1999. The 2000 census showed that only 2% of Seattle residents are babies, the second lowest percentage among large cities in the country[1].

The decision marks the end of 80 years of Virginia Mason delivering babies in Seattle. Approximately 266 pregnant patients will be affected by the closure. Clinics in Federal Way and Port Angeles will not be affected by the decision.

[1] *Seattle-Post Intelligencer* (8/11/01), Carole Smith

Think you know FMLA? Test your knowledge! Take an FMLA quiz!

1. Under the FMLA (Family Medical Leave Act) regulations, what is the maximum number of days an employer may retroactively designate leave as FMLA leave?

   In most situations, the employer cannot count leave as FMLA leave retroactively. Remember, the employee must be notified in writing that an absence is being designated as FMLA leave. If the employer was not aware of the reason for the leave, leave may be designated as FMLA leave retroactively only while the leave is in progress or within two business days of the employee's return to work.

2. It is an employer's policy to discontinue nonmedical benefits during an FMLA leave. An employee returns from an FMLA leave on August 31. How long does an employer have to reinstate an employee's nonmedical benefits that were discontinued during FMLA leave?

   The employer must provide equivalent benefits to the employee upon return from unpaid FMLA leave. To do so, it may be necessary that premiums be paid continuously to avoid a lapse of coverage. (Note: An employee who returns to work for at least 30 calendar days is considered to have "returned" to work. An employee who transfers directly from taking FMLA leave to retirement, or who retires during the first 30 days after the employee returns to work, is deemed to have returned to work.)

3. A company requires employees to contribute a portion of their medical premiums to maintain their benefits during FMLA leave. How long must an employee have to make up a delinquent payment?

   45 days -- if the employee's premium payment is more than 30 days late and the employer has given the employee written notice at least 15 days in advance advising that coverage will cease if payment is not received.

4. An employee decides not to return to work after taking FMLA leave. What happens to his or her medical benefits?

   An employer's obligation to maintain health benefits under FMLA stops if and when an employee informs the employer of an intent not to return to work at the end of the leave period, or if the employee fails to return to work when the FMLA leave entitlement is exhausted. In some circumstances, the employer may recover premiums it paid to maintain health insurance coverage for an employee who fails to return to work from FMLA leave.

5. An employee has requested FMLA leave according to company policy. How many days does the employer have to provide the employee with written notice that designates the leave as FMLA?

   The employer notice should be provided to the employee within ***one or two business days*** *after receiving the employee's notice of need for leave and include the following: the leave will be counted against the employee's annual FMLA leave entitlement; any requirements for the employee to furnish medical certification and the consequences of failing to do so; the employee's right to elect to use accrued paid leave for unpaid FMLA leave and whether the employer will require the use of paid leave, and the conditions related to using paid leave; any requirement for the employee to make co-premium payments for maintaining group health insurance and the arrangement for making such payments; any requirement to present a fitness-for-duty certification before being restored to his or her job; rights to job restoration upon return from leave; employee's potential liability for reimbursement of health insurance premiums paid by the employer during the leave if the employee fails to return to work after taking FMLA leave; and whether the employee qualifies as a "key" employee and the circumstances under which the employee may not be restored to his or her job following leave.*

6. What is the maximum number of days an employee has to provide medical certification to justify the need for leave for his or her own serious health condition (assuming no mitigating circumstances exist)?

   An employer may require the need for leave for a serious health condition of the employee or the employee's immediate family member be supported by a certification issued by a health care provider. The employer must allow the employee at least ***15 calendar days*** *to obtain the medical certification.*

7. What is the maximum number of days an employee may take for maternity?

   An eligible employee is entitled to a total of 12 weeks of FMLA leave in a 12-month period. If the employee has to use some of that leave for another reason, including a difficult pregnancy, it may be counted as part of the 12-week FMLA leave entitlement.

Stay tuned for a discussion of the interplay between FMLA and state medical leave laws in our next issue.

The complete text of Federal FMLA can be found in the Code of Federal Regulations, Title 29, Chapter V, Part 825.

The Bipartisan Patient Protection Act

The House of Representatives passed "The Bipartisan Patient Protection Act" or Patients Bill of Rights on August 2, 2001. The Senate passed a different version of this same bill in June.

Many provisions of the bill passed by the House are similar to the bill passed by the Senate in June. Both versions of the bill state that an external review requires a qualified person to review the claim without deference to the decision made by the insurance carrier, or the insurance carrier's definition of appropriate or necessary care.

Failure to comply with the external review decision could result in penalties of $1,000 per day, a single penalty of $10,000 for not commencing treatment in accordance with the decision of the reviewer, and a single penalty of $50,000 for repeated refusal to comply with the decision of an external reviewer. Designated decision makers may be liable if they fail to exercise ordinary care, and the delay of benefits is the sole cause of injury and/or death. Employers are excluded when a designated decision maker is appointed (i.e., health insurer or TPA).

In order for the Patients Bill of Rights to become a law, compromises must be made between the two versions of the proposed legislation. The major differences are: both bills requires exhaustion of external review before seeking court-ordered remedies, but the House bill allows immediate relief for the cost of any needed services prior to the exhaustion of the review process. In addition, both bills allow an individual to pursue action in a State court if the reviewer does not reach a decision within 31 days or 72 hours for an expedited review.

Under the Senate bill, unlimited economic and non-economic damages may be brought, but punitive damages would be limited to $5,000,000. The bill passed by the House does not set a limit in economic damages, but limits non-economic damages to $1,500,000 with punitive damages being limited to $1,500,000. Both bills limit the definition of a class action suit to the participants of a health plan, but the Senate bill allows for civil actions beginning January 1, 2002, whereas the House bill allows class action lawsuits beginning August 2, 2002.

The House bill includes several provisions to increase access to uninsured individuals by expanding Medical Savings Accounts, increasing deductions for health care costs for the self-employed and providing small business tax credits for small businesses. In addition, the bill would allow the establishment of non-profit health benefit purchasing coalitions and provide money to States to study methods of increasing access to health care. The Senate bill does not include any provisions to help increase access to healthcare.

A committee will now be appointed to work out the differences between the two versions of the bill. If both Houses of Congress and the President agree on the final version, the bill could become law by the end of this year. The final version of the bill would apply to group health plans beginning October 1, 2002, with collectively bargained plans being granted an extra year to comply.

A complete version of "The Bipartisan Patient Protection Act" can be found at http://thomas.loc.gov/cgi-bin/bdquery/z?d107:h.r.02563:. If you have questions regarding "The Bipartisan Patient Protection Act," please contact the Kibble & Prentice Tech Team. *(See page 5 for contact information.)*

COBRA Corner

Q: How does Medicare entitlement or eligibility affect COBRA?

A: First, it is important to understand the difference between *Medicare entitlement* and *Medicare eligibility*. A person is typically eligible for Medicare when he or she reaches Social Security normal retirement age (currently age 65) and is eligible to receive Social Security benefits. A person becomes entitled to Medicare when he or she applies for Social Security benefits or receives hospital insurance benefits under part A of Medicare. COBRA benefits are affected by Medicare entitlement, not Medicare eligibility.

If an employee is entitled to Medicare prior to enrolling for COBRA benefits, then the following applies:

Affected COBRA beneficiaries may elect COBRA for the longer of either 36 months from the date of Medicare entitlement or 18 months from date of the qualifying event (e.g., termination of employment).

If a former employee enrolled on COBRA becomes Medicare entitled, then the following applies:

Affected COBRA beneficiaries may extend their coverage up to 36 months from the initial qualifying event.

Medicare entitlement is rarely a qualifying event. However, Medicare entitlement after electing COBRA typically results in COBRA benefits being terminated for the individual (dependents may qualify for extended benefits).

Important New Benefit for Female Employees

On September 5, 2001, Insurance Commissioner Mike Kreidler signed a contraceptive rule, providing access to contraceptive coverage to over 200,000 Washington women.

Last year's ruling by the Equal Employment Opportunity Commissioner (EEOC) followed by the more recent decision in the Erickson vs. Bartell case laid the legal groundwork for defining what constitutes sex discrimination in insurance coverage.

The contraceptive rule requires all plans regulated by the Office of the Insurance Commissioner that offer a prescription drug benefit to cover prescription contraceptives and devices. It also ensures coverage for the medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of contraceptives. The new rule takes effect January 1, 2002, with coverage required for plans renewed on or after that date.

Please contact Kibble & Prentice for more information on how this new rule will affect your benefits.

Ideas??

If you have questions or ideas for future issues of the Technical Advisory we would like to hear from you! Please call or e-mail us at techteam@kpcom.com.

TIMELY INFORMATION FOR THE DYNAMIC WORLD OF EMPLOYEE BENEFITS

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Contact the Tech Team

Would you like to obtain future copies of this newsletter by e-mail? If so, send us your name, phone number and e-mail address and we will add you to our e-mail list in time for the next mailing!

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