Supplementing Medicare: An Overview

When people become eligible for Medicare, they may have other insurance and want to know if and how the other insurance may work with Medicare. If they don't have other insurance, many want to explore options for paying the Medicare out-of-pocket costs. This fact sheet discusses some common insurance people have when they become eligible and options they have to pay their out-of-pocket costs.

Common types of health care coverage people may have when they become eligible for Medicare include:

- Employer Group Health Coverage
- Retiree Plans
- COBRA
- TriCare for Life
- Veterans Affairs Benefits
- Medi-Cal (Medicaid in California)

Options that help Medicare beneficiaries pay out-of-pocket costs include:

- Medicare Savings Programs
- Medigap Policies (Medicare Supplement Insurance)
- Medicare Advantage Plans (HMOs, PPOs, SNPs)

See our Medicare Topics sections for more information on each of these options at cahealthadvocates.org.

1. Employer Group Health Coverage

If You Are 65 Years or Older

If you are 65 years or older, and you or your spouse works, you may have health care coverage from the employer. If the employer has *20 or more employees* (or 100 or more if you have Medicare due to a disabling condition), the employer must, under federal law, offer you the same coverage that is offered to the other employees. If you choose to have both the employer's group health plan and Medicare, the employer plan is primary under federal law (paying first), and Medicare is secondary (paying after the employer plan). You or your spouse must be actively working for this situation to apply.

Note: You can delay taking Medicare Part B in this situation without penalty as long as you enroll in Medicare within 8 months of leaving employment. See our fact sheet B-004, Coverage While You or Your Spouse Works, or our website section under Topics called Other Health Insurance.

If have Medicare and your employer has fewer than 20 employees, your employer is ***not*** required to offer you the same health insurance coverage that is offered to other employees In this situation Medicare is primary and the employer coverage is secondary.

If You Are Younger Than 65

If you are younger than 65 years and become eligible for Medicare due to a disability, you may have group health benefits through your own or a family member's employment. If the employer has *100 or more employees*, the employer must under federal law offer you the same coverage as other employees. If you choose to have both the employer's health plan and Medicare, under federal law the employer's plan pays first and Medicare pays after the employer plan. You or your family member must be actively working for this situation to apply.

Note: You can delay taking Medicare Part B in this situation without penalty as long as you enroll in Medicare within 8 months of leaving employment.

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If the employer has fewer than 100 employees, the employer is ***not*** required to offer you the same coverage as other employees. Medicare is primary and the employer coverage is secondary. For more information about employer-sponsored coverage and Medicare, see our Topics section on Other Health Insurance and visit the page "Coverage While You or Your Spouse Works" at cahealthadvocates.org.

Coverage If You Are Younger Than 65 and Have Permanent Kidney Failure

If you have Medicare due to kidney failure, also known as End Stage Renal Disease (ESRD), and are also covered by an employer group health plan or COBRA, that plan or COBRA is required to pay first (be your primary payer) during the first 30 months of your Medicare eligibility. This is true regardless of the size of the group.

For more information, contact your local Health Insurance Counseling and Advocacy Program (HICAP) – their number is listed in the footer.

2. Retiree Plans

Some people receive health insurance as a retirement benefit from their or their spouse's former employer or union. Benefits and costs vary widely from plan to plan. Some plans cover costs that are not covered by Medicare, such as dental and vision benefits. Others have large deductibles that must be met before any benefits can be paid. Some retiree health plans act like Medigap plans, covering Medicare deductibles and cost-sharing (see #8 below for more information on Medigaps), while other retiree health plans are offered through Medicare Advantage Organizations or non-Medicare managed care plans.

Employers can change the benefits, cost-sharing or premiums for these plans, or drop the plan at will. Retirees can also lose their benefits if a former employer files for bankruptcy.
For more information, see our Topics section on Other Health Insurance and visit the page "Retiree Plans."

3. COBRA & CalCOBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is federal law that requires an employer (with 20 or more employees) to extend the employer's group health coverage to an eligible employee or family member for a period of time after certain events, such as job loss, divorce or death. If you elect COBRA, you are responsible for the premium (plus a 2% administration fee). CalCOBRA is California law that applies federal COBRA to smaller employers that have 2-19 employees. CalCOBRA does not apply to anyone with Medicare.

If you become eligible for Medicare while you have COBRA coverage, your COBRA coverage will usually end. However, if you already have Medicare and later become eligible for COBRA, you may elect COBRA, and Medicare would be primary to COBRA. If you have Medicare, you have other options to supplement Medicare besides COBRA. If you have Medicare due to ESRD and you elect COBRA, the coverage under COBRA is primary for the first 30 months. For more information, see our fact sheet "Medicare and People with End Stage Renal Disease," or contact your local HICAP for assistance.

Note: If you delayed enrollment in Medicare Part B when you first became eligible for Medicare because you had employer coverage, you should sign up for Part B when your employment or the health coverage ends. You have an 8-month Special Enrollment Period (SEP) once you are no longer working to enroll in Medicare Part B. If you miss this window to enroll, you will incur a late enrollment penalty, be restricted as to when you can enroll and have a delay in benefits.

Conflict between COBRA and Medicare

If you sign up for Medicare Part B after the SEP, you may have to pay the late enrollment penalty and your benefits will be delayed. However, if you sign up for Medicare ***after*** you've elected COBRA, your COBRA benefits can end. This is a conflict in federal law for which there is currently no solution.

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Note that a person who has or could have had coverage under Medicare is not eligible for CalCOBRA under state law.

For more information, see our Topics section on Other Health Insurance and visit the page "COBRA & CalCOBRA Insurance."

4. TriCare For Life (TFL)

TriCare is a program that provides health care coverage to all uniformed service personnel, retirees, their spouses, survivors, and other qualified dependents. TriCare for Life (TFL) is the program for TriCare members who become eligible for Medicare. When a TriCare member becomes eligible for Medicare, he/she must enroll in Medicare Parts A and B, and TFL acts as supplemental coverage and provides creditable prescription drug coverage (as good as or better than the standard Medicare Part D plan). There are no additional premiums other than the Part B Medicare premium or copayments for services covered by Medicare and/or TFL. For more information, see our Topics section on Other Health Insurance and visit the page "TriCare for Life." You can also call TFL at 1-866-773-0404 or visit their website at tricare4u.com.

5. Veterans Affairs (VA) Benefits

Veterans of any age, except for those who have been dishonorably discharged, may apply for health care called the Medical Benefits Package at the Department of Veterans Affairs. VA facilities and providers offer inpatient care (hospital and skilled nursing care), primary care, diagnostic and laboratory services, mental health and substance abuse treatment, home health care, respite care, hospice care, adult day health care, dental care, and eyeglasses. The VA prescription drug benefit is creditable (as good as or better than the standard Medicare Part D plan). The VA also covers some urgent and limited services outside VA facilities.

The VA encourages enrolled veterans to obtain or retain any other health insurance they may have, including Medicare. Veterans may use other health care coverage in addition to their VA health care benefits. The VA Medical Benefits Package and Medicare are independent programs and do not coordinate. To enroll in the Medical Benefits Package, apply at any VA health care facility or veterans' benefit office, or mail in a completed application form.

For more information, see our Topics section on Other Health Insurance and visit the page "Veterans Affairs Benefits." You can also call 1-800-827-1000 or 1-877-222-VETS (8387) or visit the VA website va.gov/health-care.

6. Medi-Cal (California's Medicaid program)

When a California resident aged 65 years or older applies for Medi-Cal, his/her assets and income are considered as well as other eligibility criteria that are unique to Medi-Cal's various programs.

Medicare beneficiaries who also qualify for Medi-Cal are commonly referred to as "Medi-Medis" or "dual-eligibles."

If you have Medicare and qualify for full Medi-Cal benefits, Medi-Cal covers your Medicare Part B premium and your Medicare coinsurance and deductibles, if you have no other insurance. You must go to providers that accept both Medicare and Medi-Cal.

Medi-Cal also covers some services Medicare doesn't, such as home and community based services, long-term nursing home care, some hearing aid costs, some ambulance services and some prescription drugs not covered by Medicare.

If you are receiving full Medi-Cal benefits without a monthly share of cost, you don't need a Medigap policy, and it is illegal for companies to sell you one. For more information, see our Topics section on Low-Income Help.

7. Medicare Savings Programs

Medicare Savings Programs help people with low incomes and assets pay for Medicare costs.

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Three of the programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualified Individual) pay the Medicare Part B monthly premium. The Qualified Medicare Beneficiary program also covers the Medicare deductibles and coinsurance, and the Medicare Part A premium for those who do not qualify for premium-free Part A. These programs have varying income and asset requirements. For more information, see our Topics section on Low-Income Help.

8. Medigap Policies (Medicare Supplement Insurance)

Medicare supplement insurance or Medigap policies are sold by commercial insurance companies. There are 10 standardized plans labeled A through N (plans A, B, C, D, F, G, K, L, M and N) that pay for part, or all, of Medicare's cost-sharing and deductibles. Some also cover foreign travel emergency medical care. Two plans, Plans F and G, have a high deductible option.

Once you buy a Medigap policy, the company cannot change the benefits covered by the plan, and cannot cancel the policy unless you fail to pay the premium. The company can however, at its discretion, increase the premium. For more information, see our Topics section on Medigap.

9. Medicare Advantage Plans

Medicare Advantage plans are Part C of the Medicare program and are another way, besides Original fee-for-service Medicare, for you to receive Medicare benefits. The Medicare program contracts with commercial insurance companies and health plans and pays them a monthly fee for each beneficiary enrolled in a Medicare Advantage plan.

To join a Medicare Advantage plan, you must be eligible for or enrolled in Medicare Parts A *and* B and continue to pay the Part B premium. If you enroll in a Medicare Advantage plan, the rules of Original fee-for-service Medicare are replaced by the rules of the plan; you get your Medicare benefits through the Medicare Advantage plan, according to that plan's terms and conditions. Medicare Advantage plans must cover all Medicare Parts A and B services, except the hospice benefit. Some plans offer additional benefits not covered by Original Medicare, such as dental or vision. Plans may provide some non-medical supportive services to people who are chronically ill and qualify for those benefits.

Medicare Advantage plans are required to accept any Medicare beneficiary who applies, so long as the applicant is eligible for or enrolled in both Medicare Parts A and B, live in the plan's service area and does not have end stage renal disease (ESRD). Medicare Advantage plans may not require health screening or impose waiting periods for pre-existing conditions.

There are different types of Medicare Advantage plans: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Special Needs Plans (SNPs). Some Medicare Advantage plans include prescription drug benefits that are as good as or better than the standard Medicare Part D coverage and are known as MA-PDs (Medicare Advantage Prescription Drug plans). Other Medicare Advantage plans do not include prescription drug benefits (other than certain drugs that are covered under Part B), and are known as MA-only plans.

For more information on Medicare Advantage plans, including how the different types of plans work, please see our Topics section on Medicare Advantage.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call **1-800-434-0222** to make an appointment at the HICAP office nearest you.

Note: Online access to all CHA fact sheets on Medicare and related topics is available for an annual subscription. See cahealthadvocates.org/fact-sheets/.

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