Q & A MEDICARE
The PAHO Forms mentioned in this Q&A can be found on the AFSM website

THE PROGRAM

Why does Staff Health Insurance want us to register for Medicare?

The World Health Organization Staff Health Insurance (SHI) is a self-insured fund, meaning there must be a balance between the cost of benefits received from SHI and the income (premiums and earnings) of SHI. Because SHI is worldwide and the USA is a high cost area, members living in the USA continually use a bigger share of SHI funds in comparison with other WHO countries that have lower health costs. Some of that is covered by the extra tier of premiums applied to working staff in the Region, and SHI, is constantly looking to contain expenses and implement cost containment measures. In addition, the actuarial accounting demonstrates under the accepted international accounting system, a deficit in the required reserve equal to 30 years of expected costs. This increases the pressure on SHI to look for ways and means to obtain the cost/income balance and preserve our level of benefits.

In the US, Medicare, a government subsidized insurance program for those over 65 and others, sets fees for health-related services including hospitalization. Because of its large volume, it can negotiate sizable savings. Other international organizations such as the UN, OAS, IDB, World Bank, and IMF have recognized that potential and have provided a Medicare subsidy a number of years ago.

SHI commissioned actuarial studies on our present population and these have shown important savings from having all eligible persons enrolled in Medicare. This is true now, even including the fact that SHI will have to assume the penalties for those between age 65 and 75 for not having enrolled when they became eligible. In the future, since all newly eligible former staff will be able to enroll at age 65, the savings will be even greater.

Why is it obligatory to enroll for those under 75?

As you know, insurance systems work because the risk is spread over a large number and not everyone is going to need attention at the same time. Each person who enrolls in Medicare will contribute to both SHI savings and ultimately, to maintaining our benefit level. Therefore, it is in everyone's interest that all eligible persons who can, do enroll. It is a good example of one of the principles of the SHI: Solidarity.

Note: The mandate for eligible SHI participants is to be enrolled in both Part A and Part B.

What is the SHI Subsidy Program?

Former staff members, their dependents and other eligible family members participating in the SHI, and enrolled in the United States Medicare Part A and Part B will receive – **through a corresponding payment to the former staff member concerned - a subsidy equal to 100 per cent of their contribution towards participation in the Medicare Part A and Part B**, subject to the conditions set forth in WHO/SHI Medicare reimbursement Form and related Guidelines, Application for Reimbursement of Medicare Premiums. *(Reference SHI Rule C.27)*

This subsidy includes both the penalties incurred and the income related monthly adjustment amount (IRMAA)fees. Upon SHI's receipt of the necessary documents the subsidy will be paid once a year in anticipation of the yearly costs. Documents will need to be resubmitted each year since the amount for

Part B varies. Everyone is encouraged to submit the forms when they become available from Social Security. Please note that to receive this year's subsidy, t**he deadline for acceptance at SHI is August 31, 2019.**

Note: Because the reimbursement is annual in anticipation of the entire yearly cost, it is strongly suggested that those participants who are on a 3-month billing cycle, create a separate account for this deposit so that there is no confusion as to the purpose of these funds.

How does Medicare work?

Medicare is composed of several sections. Part A covers hospitalization and Part B covers doctors' and other services. Part C contains different Medicare approved private insurance company plans like Health Maintenance Organizations (HMOs) and Part D is for prescription drug coverage.

In the case of the SHI subsidy plan, only what is known as "Original Medicare", Parts A and B, are included. Neither a designed plan in Part C nor Part D, prescription drug benefits are covered. AFSM does not recommend Part D as our pharmacy plan coverage is much better.

When you have Medicare coverage, Medicare becomes your primary insurer, meaning that the bills will go first to Medicare and then to any other insurances you have.

Medicare negotiates rates for services with the providers throughout the USA, and fixes these prices by area of residence since fees vary from place to place. Providers who accept Medicare agree to charge **only** the negotiated price for those services. For example, a recent office visit in the Washington DC area was billed at $134.55, the Medicare negotiated price was $85.31. Medicare pays 80% of the negotiated price and then remits your claim to any other insurance you may have.

Medicare coverage is only for USA services. It cannot be used for expenses incurred in any other country. The WHO insurance will be used if you should travel outside the USA. When traveling outside the USA, take both your Aetna card and the blue PAHO/WHO card which should be used in case of emergencies.

What happens to my SHI Coverage?

You maintain your SHI coverage (presently managed by Aetna in the US).

Within the USA, SHI becomes your secondary insurance. This means that only after Medicare has processed the bill, can Aetna or any other insurance enter the scene. Claims must be sent first to Medicare. By law, other insurances cannot process a claim first if they know the person is covered by Medicare, and therefore they will deny the claim unless they have received it from Medicare. When Aetna receives the Medicare processed claim, they will then pay the remaining 20% of the Medicare negotiated price for these services.

In order to coordinate this, PAHO SHI needs to notify Aetna of your enrollment in Medicare. This will ensure that the billing route goes from your provider to Medicare and then is automatically sent to Aetna. In an effort to make sure that all enrolled in Medicare are covered, **PAHO SHI is requesting that if you have not done so since the Feb 1 announcement, you fill out the Aetna Medicare Direct document and send it medicare@paho.org.**

Note: For those already in Medicare, you may have filled out a form known as "Coordination of Benefits" or the Aetna Medicare Direct document when you registered for Medicare. Even if you have previously filled out either of these, please resend.

Who is eligible for the WHO Medicare subsidy?

- Any former staff, dependents and other eligible family members participating in the SHI who are already registered in Medicare

- Former staff who meet the following criteria but are not yet registered in Medicare
  - those persons who are insured under the WHO Staff Health Insurance and are 65 yrs of age and had not completed 75 years as of 1January 2019.
  - a US citizen whose primary residence is in the USA
  - a lawful permanent resident who has lived in the USA for 5 continuous years

Notes:

Former staff who have not yet reached 65 years of age become eligible and will need to register in the 7 months surrounding their 65th birthday. (eligibility begins 3 months prior to the 65th birthday and extends through that month and 3 more)

Members and/or dependents who have primary coverage under other insurances and who receive or are eligible to receive Medicare premium reimbursements with that insurance are not entitled to this benefit.

What happens if I am over 75 years of age?

If you had completed 75 years of age as of 1 January 2019 and you and/or your spouse are already enrolled in Medicare Parts A and/or B, you will receive a subsidy equivalent to 100% toward your contributions, upon completing the form "Medicare Reimbursement Form."

If you are over 75 years of age, and are not enrolled in Medicare, you don't need to enroll. Your SHI coverage will continue to be your primary plan and you will be reimbursed at the same level (80%), as long as you use in-network providers. *Reference Rule C.7*

Notes:

- **The age exemption is individual. That is, if the former staff is over 75 but the spouse or other dependent is not and meets the criteria above, the spouse and/or other dependent must enroll.**

- If you are over 75 and wish to be included in the Medicare subsidy program, write an email to WHO SHI (shihq@who.int) and request that they consider your enrollment. If you choose to do this, we highly encourage you to have the specific information on your costs from Social Security to present with your request.

MEDICARE ENROLLMENT

What do I do if I am already enrolled in Medicare part A and Part B?

Send in the required forms for reimbursement and wait for your subsidy to appear!

What do I do if I am eligible and need to register for Medicare Part A and/or part B coverage?

You must make an appointment with your local Social Security Administration Office (1-800-772-1213) and register for Medicare, Parts A and B.

When you go for your appointment you should bring your report of income taxes for 2017 (the cost for Part B is income related from your income of two years past), proof of citizenship or residence, Social Security information, mailing address, and if applicable, date of marriage and or, previous marriages lasting more than 10 years, (the latter is important, one green card holder, divorced for 20 years, found that, since she had been married to a taxpayer for 10 years, she gets Part A for free!)

Note*:* Open enrollment for those who have never enrolled in Medicare is from January to March each year so time is of the essence. If you have already enrolled in Part B and only have to add Part A, you may do it at any time during this year, however, remember the sooner enrolled, the sooner the benefits.

If I register for Medicare now, coverage will start in July 2019, how do I process my insurance claims until then?

Until Medicare coverage starts you will continue to submit to Aetna only.

What happens if I am eligible and decide not to enroll?

As of January1 2020, former staff members and participating family members who are eligible to participate in Medicare Part A and Part B but decide not to enroll, will have their SHI claims /medical expenses in USA dealt with as if they were enrolled. As an example, a specialist's visit billed at US$300 would be reimbursed as follows:

Scenarios	Amount billed $	Medicare approved rate $	Amount paid to provider $	Amount you owe $
Current situation	300	N/A	AETNA: 240 (80%)	60 (20%)
Participant enrolled in Medicare Part B	300	100	Medicare: 80 (80%) AETNA: 20 (remaining cost)	0
Participant eligible but has chosen not to enroll in Medicare	300	100	Medicare: 0 AETNA: 100	200 (not credited towards catastrophic)

How do I pay for Medicare?

Once registered,

- if you are receiving Social Security financial benefits because you have paid into taxes (FICA) in the US for 40 quarters (10 years) your Medicare fees for Part B will be deducted each month from your Social Security payments.

- If you have not paid Social Security taxes, you will be billed quarterly for Medicare charges and you will have to authorize a payment mechanism (check or credit card.)

ADDITIONAL USEFUL INFORMATION

What happens if my provider does not accept Medicare?

There may be times when the provider of your choice does not accept Medicare. These are called **Opt-out providers**.

Since Aetna, by law, cannot process the claim without Medicare clearance for those enrolled in Medicare. The SHI participant is responsible for obtaining the provider's official documentation that he/she has rejected participation with Medicare, and sending it to Aetna. This allows them to accept your claims without having to pass through Medicare. The document is called an **opt out letter** and is valid for two years. Some participants have found, however, that it is preferable to send a copy with each claim to prevent confusion.

In this situation, there are two methods of submitting claims for reimbursement:

- You pay the **opt-out provider** directly. The provider's office will complete a claim form on your behalf and submit it to Aetna for a reimbursement that will be mailed directly to you.
- You pay the **opt-out provider** directly. The Provider's office does not submit claims, and you must submit the claim yourself directly to Aetna with the opt out letter and you will be reimbursed by mail.

Note: If you are submitting for yourself, the letter can be obtained from your provider's office. If your provider submits on your behalf then they will attach the letter for your convenience.

Aetna will reimburse according to the SHI Rules in place, and whether or not the provider, although opted out of Medicare, belongs to the Aetna network. Normally, the reimbursement level for opt out providers will be 200% of the Medicare approved rate with no credit for catastrophic limits. (*Reference: Rule C.7*) There may be some providers, however, who have opted out of Medicare but are within network with Aetna and their reimbursement level will be at the network cost with the 20% credited to catastrophic. See example below.

Scenarios	Amount billed $	Approved rates	Amount paid to provider $	Amount you owe $
Current situation	300	N/A	AETNA: 240 (80%)	60 (20%)
Provider opted out of both Medicare and Aetna networks	300	Medicare approved rate $100	Medicare: 0 AETNA: 200 (200% of the Medicare approved rate)	100 not credited towards catastrophic
Provider opted out of Medicare but participating in the Aetna network	300	(AETNA network reimbursement base: $260)	AETNA: 208(80%)	52(20%) credited towards catastrophic

What if Medicare does not cover charges for something that is covered by the SHI?

If possible, have the provider send the bill to Medicare even if they anticipate a denial. Medicare may sometimes reject a claim but will then automatically forward it to Aetna where the claim will be covered if it is part of SHI coverage.

Note: Exceptions to this rule are fixed price limits such as dental and glasses. They can be sent directly to Aetna.

What to do if a provider refuses to send a bill to Medicare because they know in advance that it will be refused by them

This presents problems because Aetna will not act upon a claim unless or until it has been processed by Medicare. Medicare Form 1490S https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1490S-ENGLISH.pdf will allow you to submit the claim directly to Medicare however, there is a 60 day period for them to act so it is best to avoid this situation if possible.

What happens if a member dies after receiving a reimbursement of the Medicare premium for the full year?

SHI will request reimbursement of the excess from the survivors.

RESOURCES

Centers for Medicare & Medicaid Services (http://www.cms.gov)

Medicare Costs (https://www.medicare.gov)

Medicare and you 2019 https://www.medicare.gov/medicare-and-you Also available at the AFSM website (**https://www.afsmpaho.com**) in the documents section