



FROM THE DESK OF

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Medicare for Railroad Families

The federal Medicare program provides hospital and medical insurance protection for railroad workers and their families, just as it does for workers under social security. Medicare has the following parts:

- **Medicare Part A** (hospital insurance) helps pay for inpatient care in hospitals and skilled nursing facilities (following a hospital stay), some home health care services, and hospice care. Part A is financed through payroll taxes paid by employees and employers.
- **Medicare Part B** (medical insurance) helps pay for medically-necessary services like doctors' services, outpatient care, and other medical services and supplies not covered by hospital insurance. It also helps cover some preventive services. Part B is financed by premiums paid by participants and by federal general revenue funds.
- **Medicare Part C** (Medicare Advantage Plans) is another way to get Medicare benefits rather than through the Original Medicare Plan, the traditional fee-for-service Medicare plan. Medicare Part C combines Part A, Part B, and, sometimes, Part D (prescription drug) coverage. These plans are managed by private insurance companies approved by Medicare.
- **Medicare Part D** (Medicare prescription drug coverage) offers voluntary insurance coverage for prescription drugs through Medicare prescription drug plans and other health plan options.

The following questions and answers provide basic information on Medicare eligibility and coverage, as well as other information on the Medicare program.

1. Who is eligible for Medicare?

All railroad retirement annuitants age 65 or over and other persons who are directly or potentially eligible for railroad retirement annuities are covered by the program. Although the age requirements for some unreduced railroad retirement annuities have risen, just like the social security requirements, annuitants are still eligible for Medicare at age 65.

Coverage before age 65 is available for disabled employee annuitants who have been entitled to monthly annuities based on total disability for at least 24 months and have a disability insured status under social security law. There is no 24-month waiting period for those who have ALS (Amyotrophic Lateral Sclerosis), also known as Lou Gehrig's disease.

If a person is entitled to monthly railroad retirement payments based on an occupational disability, **and** has been granted a disability freeze, they are eligible for Medicare starting with the 30th month after the freeze date or, if later, the 25th month after they became entitled to monthly payments. If

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a person is receiving payments due to occupational disability and has **not** been granted a disability freeze, they are generally eligible for Medicare at age 65. (The standards for a disability freeze determination follow social security law and are comparable to the medical criteria a person must meet to be granted a total disability.)

Under certain conditions, spouses, divorced spouses, surviving divorced spouses, widow(er)s, or a dependent parent may be eligible for Medicare based on an employee's work record when the spouse, etc., turns age 65. Also, disabled widow(er)s under age 65, disabled surviving divorced spouses under age 65, and disabled children may be eligible for Medicare, usually after a 24-month waiting period.

Medicare coverage at any age based on permanent kidney failure requiring dialysis or receipt of a kidney transplant is also available to employee annuitants, employees who have not retired but meet certain minimum service requirements, spouses, and dependent children. The Social Security Administration has jurisdiction of Medicare in these cases; consequently, a social security office should be contacted for information on coverage for kidney disease. More information can be found via the following link, <https://www.medicare.gov/publications/11360-medicare-dialysis-kidney-transplant.pdf>, to the Centers for Medicare and Medicaid Services publication 11360, "Medicare's Coverage of Kidney Dialysis & Kidney Transplant Benefits."

2. How do persons enroll in Medicare?

If a retired employee, or a family member, is receiving a railroad retirement annuity, they will receive information about the Medicare program a few months before becoming eligible for coverage. Enrollment for both Medicare Part A and Part B is *generally* automatic and coverage begins when the person reaches age 65. For annuitants who are totally disabled, both Medicare Part A and Part B start automatically with the 30th month after the annuitant became disabled or, if later, the 25th month after the annuitant became entitled to monthly payments. Even though enrollment is automatic, an individual may decline Part B; this does not prevent them from applying for Part B later. However, Part B premiums may be higher if enrollment is delayed. (See Question 5 for more information on delayed enrollment.)

If an individual is eligible for, but not receiving an annuity, they should contact the nearest Railroad Retirement Board (RRB) office before turning age 65 and apply for both Part A and Part B. (This does **not** mean that the individual must retire, if working.) The best time to apply is during the 3 months before the month age 65 is attained. Individuals will then have both Part A and Part B protection beginning with the month age 65 is reached. If the individual does not enroll for Part B in the 3 months before attaining age 65, they can enroll in the month age 65 is reached, or during the 3 months that follow, but there will be a delay of 1 month before Part B is effective. If an individual is still working and does not enroll in Part B, they may be able to enroll in a special enrollment period. (See Question 5 for more details on the special enrollment period.) Anyone who does not enroll for Part B during this initial enrollment period has the option to sign up in any general enrollment period (January 1 – March 31 each year). Coverage for such individuals begins the month after the month of enrollment and, as mentioned, there may be higher premiums incurred by the delay.

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3. Are there costs associated with Medicare Part A (hospital insurance)?

Yes. While individuals don't have to pay a premium to receive Medicare Part A, recipients of Part A benefits are billed by the hospital for a deductible amount (\$1,632 in 2024; \$1,676 in 2025), as well as any coinsurance and noncovered services amounts due. The remainder of the bill from the hospital, as well as bills for services in skilled nursing facilities or home health visits, is sent to Medicare to pay its share.

4. What are the costs associated with Medicare Part B (medical insurance)?

Anyone eligible can enroll in Medicare medical insurance (Part B) by paying a monthly premium. The standard premium is \$174.70 in 2024 (\$185 in 2025). The standard premium amount applies to new enrollees in the program and certain beneficiaries who pay higher premiums based on their modified adjusted gross income.

Monthly premiums for some beneficiaries are greater, depending on a beneficiary's (or married couple's) modified adjusted gross income. The income-related Part B premiums for 2024 range from \$244.60 to \$594, depending on how much a beneficiary's modified adjusted gross income exceeds \$103,000 (\$206,000 for a married couple). The income-related Part B premiums for 2025 will range from \$259 to \$628.90, depending on the extent to which a beneficiary's modified adjusted gross income exceeds \$106,000 (\$212,000 for a married couple). Whether in 2024 or 2025, the highest premium rate is paid only by beneficiaries with modified adjusted gross incomes of over \$500,000 (\$750,000 for a married couple).

There is also an annual deductible of \$240 in 2024 (\$257 in 2025) for Part B services. After meeting this amount, Medicare generally pays 80 percent of covered services for the rest of the year.

Palmetto GBA, a subsidiary of Blue Cross and Blue Shield, generally processes claims for Part B benefits filed on behalf of railroad retirement annuitants in the Original Medicare Plan (the traditional fee-for-service Medicare plan). An individual in the Original Medicare Plan should have their hospital, doctor, or other health care provider submit Part B claims directly to:

**Palmetto GBA
Railroad Medicare Part B Office
P.O. Box 10066
Augusta, GA 30999-0001**

Persons with **questions about Part B claims** under the Original Medicare Plan can contact Palmetto GBA at the address above, online at [Palmettogba.com/palmetto/rrb/nsf](https://palmettogba.com/palmetto/rrb/nsf), or by calling toll free at **1-800-833-4455**.

5. Can Medicare Part B premiums increase due to delayed enrollment?

Yes. Part B premiums are increased 10 percent for each 12-month period someone could have been, but was not, enrolled. Persons age 65 or older who are covered under a group health plan, either from their own or their spouse's **current** employment, have a **special enrollment period** in which to sign up for Medicare Part B. This means that they may delay enrolling in Medicare Part B without having to wait for a general enrollment period and paying the 10-percent premium surcharge for late

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enrollment. The special enrollment period rules allow them to:

- enroll in Medicare Part B anytime while they are covered under the group health plan based on current employment; **or**
- enroll in Medicare Part B during the 8-month period that begins the month after their group health coverage ends or employment ends, whichever comes first.

Special enrollment period rules do **not** apply if employment or employer-provided group health plan coverage ends during their initial enrollment period.

If they do not enroll by the end of the 8-month period, they will have to wait until the next general enrollment period, which begins January 1 of the next year.

People who receive disability benefits and are covered under a group health plan, from either their own or a family member's current employment, also have a special enrollment period and premium rights that are similar to those for workers age 65 or older.

Persons deciding when to enroll in Medicare Part B must consider how it will affect their eligibility for supplemental health insurance policies such as prescription drug coverage and Medigap insurance. Prescription drug coverage and Medigap insurance are explained in the answers to Questions 7 through 9.

6. Do Medicare beneficiaries have choices available for receiving health care services?

Yes. Under the Original Medicare Plan, the fee-for-service Medicare plan that is available nationwide, a beneficiary can see any doctor or provider who accepts Medicare from qualified railroad retirement beneficiaries and is accepting new Medicare patients. Those enrolled in the Original Medicare Plan who want prescription drug coverage must join a Medicare prescription drug plan as described in Question 7 unless they already have drug coverage from a current or former employer or union that is at least as good as the standard Medicare prescription drug coverage.

However, a beneficiary may opt to choose a Medicare Advantage Plan (Part C) instead. These plans are managed by Medicare-approved private insurance companies. Medicare Advantage Plans combine Medicare Part A and Part B coverage, and are available in most areas of the country. An individual must have Medicare Part A and Part B to join a Medicare Advantage Plan, and must live in the plan's service area. Medicare Advantage Plan choices include regional preferred provider organizations (PPOs), health maintenance organizations (HMOs), private fee-for-service plans and others. A PPO is a plan under which a beneficiary uses doctors, hospitals, and providers belonging to a network; beneficiaries can use doctors, hospitals, and providers outside the network for an additional cost. Under a Medicare Advantage Plan, a beneficiary may pay lower copayments and receive extra benefits. Most plans also include Medicare prescription drug coverage (Part D).

7. How does Medicare Part D (Medicare prescription drug coverage) work?

Medicare contracts with private companies to offer beneficiaries voluntary prescription drug coverage through a variety of options, with different covered prescriptions and different costs. Beneficiaries pay a monthly premium (averaging about \$34.70 in 2024 or \$36.78 in 2025), a yearly

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deductible (up to \$545 in 2024 or up to \$590 in 2025), and part of the cost of prescriptions. Those with limited income and resources may qualify for help in paying some prescription drug costs.

Depending on a beneficiary's (or married couple's) modified adjusted gross income, the Affordable Care Act requires some Part D beneficiaries to pay a monthly adjustment amount in addition to their premium. The Part D income-related monthly adjustment amounts in 2024 are \$12.90, \$33.30, \$53.80, \$74.20, or \$81, depending on the extent to which a beneficiary's modified adjusted gross income exceeds \$103,000 (\$206,000 for a married couple). In 2025, the adjustment amounts will be \$13.70, \$35.30, \$57, \$78.60, and \$85.80 depending on the extent to which a beneficiary's modified adjusted gross income exceeds \$106,000 (\$212,000 for a married couple). Whether in 2024 or 2025, the highest amount is only paid by beneficiaries whose incomes are over \$500,000 (\$750,000 for a married couple).

In most cases, there is no automatic enrollment to get a Medicare prescription drug plan. (Individuals enrolled in Medicare Advantage Plans will generally get their prescription drug coverage through their plan.) To enroll, individuals must have Medicare Part A and live in the prescription drug benefit plan's service area. Beneficiaries can join during the period that starts 3 months before the month their Medicare coverage starts and ends 3 months after that month. **There may be a higher premium if an individual does not join a Medicare drug plan when first eligible.** A beneficiary can generally join or change plans once each year during an enrollment period from October 15 through December 7. Drug coverage would then begin January 1 of the following year.

8. Can persons who have prescription drug coverage from other insurance keep it?

Yes. Persons who have prescription drug coverage from other insurance, such as provided by an employer or union, can keep that coverage. If that coverage offers the same or better benefits than a Medicare prescription drug plan, individuals will not have to pay a higher premium if they join a Medicare prescription drug plan later. In many cases, an individual's other insurance provider will send them a notice that tells them if its plan covers as much or more than a Medicare prescription drug plan. If a person does not receive a notice, they should contact the other provider to see how its coverage compares.

9. What is Medigap insurance?

Many private insurance companies sell insurance, known as Medigap, that helps pay for services not covered by the Original Medicare Plan. Policies may cover deductibles, coinsurance, copayments, health care outside the United States, and more. Generally, individuals need Medicare Part A and Part B to enroll, and a monthly premium is charged. When someone first enrolls in Medicare Part B at age 65 or older, he or she has a **one-time** 6-month Medigap open enrollment period. During this period, an insurance company cannot deny coverage, place conditions on a policy, or charge more for a policy because of past or present health problems.

Individuals age 65 or older with health coverage through an employer or union that is based on their or their spouse's current employment may want to wait to enroll in Medicare Part B and delay their Medigap open enrollment period.

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10. Where can people get more information about the Medicare program?

Individuals with general questions about Medicare coverage for railroad retirement annuitants can call an RRB field office toll-free at 1-877-772-5772. Information is also available by visiting **RRB.gov**, clicking on **FAQ**, and then selecting **Medicare**. Individuals can also send a secure message to their local RRB field office by accessing **Field Office Locator** at RRB.gov and clicking on the link at the bottom of their local office's page.

More **detailed information on Medicare's benefits, costs, and health care options** is available from the Center for Medicare & Medicaid Services (CMS) publication *Medicare & You*, which is mailed to Medicare beneficiary households each fall and to new Medicare beneficiaries when they become eligible for coverage. *Medicare & You* and other publications are also available by visiting **Medicare's website, Medicare.gov**, or by calling the **Medicare toll-free number, 1-800-MEDICARE (1-800-633-4227)**.

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