

## MODULE 16: MEDICARE AND THE HEALTH INSURANCE MARKETPLACES

### **Objective**

This module will educate HIICAP counselors about how Medicare is affected (and not affected) by the health insurance Marketplaces.

### **What is the Affordable Care Act (ACA)?**

The Patient Protection and Affordable Care Act (ACA) or “Obamacare” was signed into law in March 2010. The ACA is considered the most significant overhaul of the US healthcare system since the passage of Medicare and Medicaid in 1965.

### **Who implements the ACA?**

The U.S. Department of Health and Human Services is responsible for implementing the ACA provisions, administering new and revised programs, and overseeing the funding.

The IRS is responsible for overseeing the tax provisions within the law (including the individual mandate and tax credits for individuals and small businesses that are eligible for financial assistance with paying their premiums).

Some states created and operate Health Insurance Exchanges or Marketplaces, which are online marketplaces where individuals and small businesses can purchase health plans. Additionally, states determined whether or not they expanded Medicaid eligibility. In New York State, the Department of Health assumed the responsibility of New York’s Health Insurance Marketplace, known as New York State of Health. Additionally, New York expanded Medicaid eligibility.

### **What is the Individual Mandate?**

The individual mandate requires that most Americans obtain minimum essential health insurance or risk paying a tax penalty. The individual mandate went into effect on January 1, 2014. If a person does not have health insurance, a tax penalty will be applied for each month that they did not have health insurance or an exemption from the mandate.

### **What’s the penalty if a person does not have health insurance?**

Penalties are pro-rated for months without coverage. The fee in 2016 is 2% of your yearly income with a minimum of \$325 per adult for the year or \$162.50 per child, or \$925 per family, whichever is higher. The 2% is based on an individual’s income minus their tax filing threshold (for example: \$10,150 for an individual or \$13,050 for the head of household). This penalty will increase every year. In 2016 it is 2.5% for your yearly income or \$695 per person, whichever is higher.

**What types of health insurance plans count as the Minimum Essential Coverage for the individual mandate?**

- Medicare Part A and Medicare Advantage Plans;
- Medicaid
- Children’s Health Insurance Program (known as Child Health Plus in New York State);
- A plan purchased through the health insurance marketplace;
- A plan purchased outside of the marketplace through a private insurance company;
- Employer-based coverage, including COBRA and retiree coverage;
- CHAMPVA and VA Healthcare (programs through the Veteran’s Administration);
- TRICARE and TRICARE for Life;
- Health insurance for Peace Corps volunteers;
- Health insurance provided by colleges and universities for students;
- Coverage under the Non-appropriated Fund Health Benefit Program;
- Most foreign health insurance that provides coverage in the United States.

**Who may qualify for an exemption from the penalty for the individual mandate?**

You may qualify for an exemption if...

- You’re uninsured for less than 3 months of the year.
- Your cheapest option for insurance is not “affordable” (the lowest-priced coverage available to you would cost more than 8.05% of your household income).
- You don’t have to file a tax return because your income is too low.
- You’re a member of a federally recognized tribe or eligible for services through an Indian Health Services provider.
- You’re a member of a recognized health care sharing ministry.
- You’re a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare.
- You’re incarcerated, and not awaiting the disposition of charges against you.
- You’re not lawfully present in the U.S.
- You experienced a hardship that makes you qualifies you for an exemption

**Tax Credit and the Cost Sharing Reductions**

Premium Tax Credits are a new federal tax credit that is available for people who purchase their health insurance through the health insurance marketplace. These “premium tax credits” act as a subsidy and are available immediately upon enrollment to put towards the purchase price of health rather than at tax time. Premium Tax Credits are also refundable, so in the alternative, the individual/family can choose to have the lump sum of the credit applied when they file their taxes.

Individuals and families who purchase their insurance through the health insurance marketplace are eligible for tax credits if their income is between 100% and 400% of the federal poverty level. Premium Tax Credits are also available to lawfully residing immigrants with incomes below 100% of the federal poverty level and who are not eligible for Medicaid because of their immigration status. In New York State, most immigrants who are Permanently Residing Under Color of Law are eligible for Medicaid or the Essential Plan if their income is under 138% of the federal poverty level.

An individual or family can only apply the premium tax credits to one of the four metal tier plans and may not apply them to a catastrophic coverage plan.

### **What are the Health Insurance Marketplaces?**

The Health Insurance Marketplaces, also called health exchanges offer private health plans to individuals and small businesses (businesses with less than 50 employees) to facilitate the purchase of health insurance in accordance with the ACA. Some states have set up their own health insurance marketplace, while others use the marketplace set up by the federal government ([www.healthcare.gov](http://www.healthcare.gov)).

The New York State Marketplace is known as the New York State of Health and can be accessed at <http://nystateofhealth.ny.gov>.

Through the Marketplace, New Yorkers can compare health insurance options and enroll in health insurance coverage through a website, over the phone, in-person or by mail. People who have Medicare will not be able to get Medicare coverage in the Marketplace. Medicare Advantage, Part D, and Medigap plans will not be sold in the Marketplace. As a result of the implementation of the ACA in 2014, the cost of insurance plans in New York has decreased by an average of 53%. During the enrollment process, an individual and/or their family may apply for either Medicaid, Child Health Plus or for premium tax credits and cost-sharing assistance to help them purchase of private health insurance. On the marketplace, you are able to compare plans.

### **Marketplace eligibility**

In order to participate in the Marketplace, individuals must:

- Live in the Marketplace service area;
- Be a U.S. citizen or
- Be a lawfully present non-citizen; and
- Not be incarcerated.

*It is illegal for a representative of the Health Insurance Marketplaces to sell an individual with any part of Medicare (Part A and/or Part B) a Marketplace plan.*

### **Enrollment Deadlines**

The open enrollment period for 2017 is November 1, 2016 to January 31, 2017. An individual or family may not apply for health insurance outside of the open enrollment periods unless they qualify for a special enrollment period (most major life events). However, open enrollment only applies to Qualified Health Plans. Individuals and families can apply for Medicaid, the Essential Plan, and Child Health Plus at any time of the year without restriction.

### **Enrollment Assistance**

Individuals and Families can get assistance with completing their application:

#### **Navigators:**

Navigators are trained and certified to educate and provide enrollment assistance to individuals and small businesses about the health insurance options available to them through the Marketplace. They speak over 40 different languages and are available weekdays, evenings, and even on weekends. Navigators are available in convenient community-based locations in every county and all help is free. To find a Navigator, you can visit the New York State of Health website:

[https://nystateofhealth.ny.gov/agent/hx\\_brokerSearch?fromPage=INDIVIDUAL](https://nystateofhealth.ny.gov/agent/hx_brokerSearch?fromPage=INDIVIDUAL) or you can call Community Service Society: 1-888-614-5400

#### **Brokers:**

Brokers are licensed professionals that have been certified by the Marketplace to provide enrollment assistance to individuals and small businesses about the health insurance options available through the Marketplace. Help applying for coverage and enrolling in a plan is free.

**Certified Application Counselors:** Certified Application Counselors (CACs) are also trained to provide enrollment assistance to individuals applying for coverage through the Marketplace. CACs may work for entities such as hospitals, clinics, providers or health plans. Call 1-855-355-5777 for more information about CACs.

### **Qualified Health Plans**

A Qualified Health Plan (QHP) is a health insurance plan sold in the Marketplace that covers Essential Health Benefits. At the very least, Essential Health Benefits include ambulatory patient services; prescription drugs; emergency services, rehabilitative and habilitate services/devices; hospitalization; laboratory services; maternity and newborn care; preventive and wellness

services; chronic disease management; mental health and substance abuse services; and pediatric services.

The Affordable Care Act requires most people to have health insurance that meets a certain standard, called “minimum essential coverage.” QHPs sold in the exchange qualify as minimum essential coverage. There are 5 types of Qualified Health Plans available: Platinum, Gold, Silver, Bronze, and Catastrophic. All plans cover the same essential health benefits but vary in price and cost-sharing.

Metal Tiers:



**Platinum:** Your health plan pays about 90% of your costs on average. You pay about 10%.

**Gold:** Your health plan pays about 80% of your costs on average. You pay about 20%.

**Silver:** Your health plan pays about 70% of your costs on average. You pay about 30%.

**Bronze:** Your health plan pays 60% on average. You pay

about 40%.

**Catastrophic:** For people under 30

Medicare Part A qualifies as minimum essential coverage, so Medicare beneficiaries with Part A are not subject to tax penalties for failing to meet this requirement. Medicare Part B without Part A does not meet the minimum essential coverage requirement.

There are two types of QHPs,

- Individual QHPs, or plans that individuals can buy for themselves and/or their families and
- QHPs sold through the Small Business Health Options Program (SHOP). SHOP plans make it possible for small businesses owners to provide health insurance for their employees.

To avoid confusion we will refer to individual QHPs as “QHPs” and QHPs sold through the SHOP as “SHOP plans.”

**QHPs for people who already have Medicare**

Any person with any part of Medicare (Part A or Part B) cannot be sold a QHP.

This means that if a beneficiary has Medicare Part A but did not take Medicare Part B and are now facing a gap in coverage, you should explore other options with that client:

- Are they eligible for Equitable Relief?

- Equitable Relief is a formal request to Social Security. Equitable Relief is used to help people who delayed enrollment into Part B based on false or misleading information they received from a representative of the federal government. A representative of the federal government could be a Social Security representative or Medicare representative. If you think a client qualifies for Equitable Relief please read more about requesting Equitable Relief in Module 2.
- Are they eligible for a Medicare Savings Program (MSP)?
  - The Medicare Savings program (MSP), which helps pay Part B premiums, can also help enroll beneficiaries into Medicare Part B outside of the usual enrollment periods. The MSP is run by the state Medicaid office. Whether a beneficiary qualifies for an MSP depends on her or his income. See Module 9 for information on how to screen clients for the MSP.

Beneficiaries are allowed to drop all of their Medicare benefits to purchase a QHP, but this is generally **not a good idea**.

1. People who disenroll from Medicare Parts A and B can purchase a QHP through the Marketplaces. However, most people with Medicare qualify for free Medicare Part A and it's a bad idea for them to drop Medicare or turn it down.
  - a. **In order to disenroll from Part A, people who owe no premium must withdraw their initial application – this means they are removed from Medicare back to when they first enrolled and must pay Medicare back for any benefits already paid.** This means they have to reimburse Social Security for any care that Part A has paid for – including hospitalizations, SNF stays and homecare, if applicable. People without Part A are not allowed to collect Social Security retirement benefits, and so to withdraw from Part A a person also has to pay back any Social Security retirement checks they have received.
  - b. People who are eligible for premium free Part A do not qualify to receive tax credits to help pay QHP premiums.
2. Beneficiaries will most likely have a Medicare Part B premium penalty and gaps in coverage if they decide to reenroll into Medicare in the future.

As a reminder, Medigap policies, Medicare Advantage plans and stand-alone Part D plans are not sold through the Marketplaces.

**Note:** Individuals who do not qualify for premium free Medicare Part A and must pay a Part A premium are eligible for tax credits to help pay QHP premiums. These individuals could potentially purchase QHP if they do not have any part of Medicare and income is above 138% FPL. If income is below 100% FPL, individuals may be eligible for Medicare Part A Buy-in program.

### **Transitioning from a QHP to Medicare**

People with QHPs should enroll into Medicare when they become eligible. Beneficiaries should terminate their QHPs when their Medicare benefit begins.

There are several reasons it is not a good idea to keep a QHP and delay enrollment in Medicare:

1. Most beneficiaries are not eligible for any tax credits to help pay for QHP premiums, and full QHP premiums are more costly than Medicare, Medigap or Part D premiums.
2. They will likely have gaps in coverage and have to pay premium penalties if they enroll in Medicare late.
3. QHPs may stop paying altogether for the cost of care of recipients eligible for Medicare who have elected to delay Medicare enrollment. However, if a QHP enrollee signs up for Medicare at any point during their Initial Enrollment Period (IEP), their QHP should continue to pay primary until their Medicare coverage goes into effect.
4. While beneficiaries are allowed to keep their QHPs after they enroll into Medicare, it is typically not a good idea to do so. QHPs will pay second to Medicare, if at all. As listed above, beneficiaries are typically not eligible for tax credits, so they will pay the full price for their QHP, even when the QHP is secondary to Medicare and paying only a small portion of the cost. A better alternative for most beneficiaries enrolling in Medicare is to choose Medigap policies, Medicare Advantage plans and/or stand-alone Part D plans that work with Medicare.

Here are the steps beneficiaries should take when they become eligible for Medicare:

1. Enroll in Medicare Parts A and B as soon as they are eligible.
2. Drop their QHP coverage. Individuals should notify their state Marketplace or Navigator, if they have one, at least 14 days before they want their coverage to end.
3. After they enroll in Medicare, consider how they will get their Medicare coverage. Beneficiaries have a choice between Original Medicare and a Medicare Advantage plan. Please see Modules 5, 6 and 7 for more on Medicare choices.

Be aware that if beneficiaries take Medicare late, they will likely pay higher Medicare premiums for the rest of their lives. They may also have to wait for their Medicare coverage to start.

QHPs may not let beneficiaries know when they become eligible for Medicare. Clients should know to enroll in Medicare during their Initial Enrollment Period (IEP). For individuals who become eligible for Medicare due to age, the IEP is the seven month period that includes the three months before their 65<sup>th</sup> birthday month, the month they turn 65 and the three months after their 65<sup>th</sup> birthday. Most individuals who are Medicare eligible due to disability will be automatically enrolled into Medicare Parts A and B the 25<sup>th</sup> month they receive SSDI payments. Beneficiaries should also enroll into a Medicare prescription drug (Part D) plan during their Initial Enrollment Period for Part D. For more on Medicare Part D enrollment, please see Module 6.

### **Exceptions to these rules**

Two groups of Medicare-eligible people may wish to keep a QHP and delay Medicare, as some of the above rules apply differently to them. These beneficiaries should carefully consider the pros and cons of a QHP versus Medicare.

- **The beneficiary who must pay for Medicare Part A**

Although most people do not need to pay a premium for Medicare Part A, some people do not qualify for premium-free Part A and must pay high premiums for this coverage. If your client must pay for Part A, they should consider whether or not a QHP may offer a better deal than Medicare.

Depending on their income, beneficiaries with premium Part A may qualify for tax credits to purchase QHPs through the Marketplace. However, they cannot have any part of Medicare when they purchase a QHP. This means clients must disenroll from any parts of Medicare that they are enrolled in to purchase a QHP. If they return to Medicare coverage later, they will pay premium penalties for the time they had a QHP instead of Medicare. In addition, the times that they can sign up for Medicare will be limited, and they will likely experience gaps in coverage if their QHP coverage ends before their Medicare coverage begins. As a reminder, individuals who do not qualify for premium free Part A are at risk of incurring a Part A Late Enrollment Penalty and a delay in Part A coverage in addition to the Part B Late Enrollment Penalty and delay in Part B coverage. While a QHP premium may be cheaper in the short term, if the person ever wishes to return to Medicare coverage, the premium penalties may be significant.

- **The beneficiary is under 65 and eligible for Medicare due to End-Stage Renal Disease (ESRD)**

If a client is under 65 and has End-Stage Renal Disease (ESRD), also known as kidney failure, he or she can choose a QHP instead of Medicare and may be able to keep premium subsidies. **Be aware that if your client already has ESRD Medicare then she/he typically should not disenroll to take a QHP. Disenrolling from Part A requires people to pay back all the benefits they've used in addition to any Social Security Disability or Social Security Retirement benefits they receive.** If one already has a QHP, one can keep it or the person can disenroll from the QHP and enroll in Medicare. The choice made depends on a number of factors.

- People under 65 with ESRD may qualify for tax credits to purchase a QHP through the Marketplace if they do not enroll in Medicare. This could be a good choice because they may have substantial cost sharing if they enroll in Medicare instead. People with ESRD are generally excluded from enrolling into Medicare Advantage plans. In New York, people with ESRD can purchase Medigap Plans to supplement Original Medicare, but this is not true in every state.
- QHPs tend to have limited provider networks, while Original Medicare allows individuals to see any Medicare participating provider.
- People with ESRD who do not have any part of Medicare can choose to keep their QHP coverage and delay enrollment into Medicare (both Part A and Part B). However, if they have a kidney transplant and want Medicare Part B to cover their immunosuppressant drug costs in the future, they must have Medicare Part A at the time of the transplant. If they do not have Medicare Part A at the time of their transplant (or retroactive back to the time of the transplant) then when they enroll into Medicare later their immunosuppressant medications will be covered by Medicare Part D instead of Part B. Part D costs can be higher than Part B costs. Part D plans can also have additional restrictions, such as in-network pharmacies that beneficiaries must go to for medicines.

- Even if beneficiaries do not enroll in Medicare when they are eligible due to ESRD, it is important to counsel them to enroll into Medicare when they turn 65, or if they apply for and receive Social Security Disability Insurance benefits for 24 months. When they become eligible for Medicare at age 65 or after 24 months of SSDI they will no longer qualify for tax credits to help pay QHP premiums. If they do not enroll into Medicare during their later IEP, they may pay premium penalties and experience gaps in coverage when they later want to enroll in Medicare.

For people with ESRD and for people who must pay a premium for Part A, the calculation might be different if they qualify for assistance with Medicare costs. Always check to see if your client's income qualifies them for assistance with Medicare premiums and costs. This assistance, in the form of a Medicare Savings Program and/or the Extra Help drug subsidy, will likely provide them with more comprehensive and lower-cost coverage than a QHP would provide. Specifically, persons with premium Part A should always be screened for eligibility for the Part A buy-in. For more on the Part A buy-in please read more on QMB eligibility in Module 9.

### **Medicare and the Small Business Health Options Program (SHOP)**

The SHOP is the Small Business Health Options Program within the Marketplace, where small businesses and their employees can search for and purchase health insurance. Currently employers with 50 or fewer employees may participate in the SHOP. In 2016, all states must allow employers with up to 100 employees to participate in the SHOP. To participate in the SHOP, small business employers must also:

- Offer, at minimum, all full-time employees coverage in a Qualified Health Plan (QHP) through SHOP; and
- Offer coverage to eligible employees through the appropriate SHOP.

The way a SHOP plan works with Medicare is the same as the way other current employer insurance works with Medicare. For more information on how current employer insurance works with Medicare please see Module 2. Please find a short description of how SHOP plans coordinate with Medicare below.

People insured by a SHOP plan who become eligible for Medicare due to age need to decide whether or not to take Part B coverage when they first turn 65. All people with SHOP coverage can delay Part B without penalty. However, certain people should never do this. An individual who becomes eligible for Medicare due to age should take Medicare Parts A and B if the employer offering the SHOP plan has less than 20 employees. Medicare will pay first, and the SHOP plan pays second on their health claims. If these individuals fail to enroll in Part B, their SHOP plan may provide little or no coverage. On the other hand, if the employer has 20 or more employees, individuals may want to consider delaying Part B. In this case, the SHOP plan pays first and Medicare pays second on health claims. A SHOP plan for an employer with 20 or more employees cannot reduce its coverage if an employee or his/ her spouse who is over 65 fails to enroll in Part B.

People who are under 65, insured by a SHOP plan, and become eligible for Medicare due to a disability should enroll in Medicare Part B when they first qualify, even though most can delay enrollment without a penalty. Only employers with less than 100 employees may offer SHOP

coverage. Medicare always pays first for individuals who get Medicare due to disability if the employer offering coverage has less than 100 employees. If people with disabilities fail to enroll in Part B, their SHOP plan may provide little or no coverage.

Beneficiaries should delay Part D only if their SHOP plan offers creditable drug coverage. Creditable coverage is drug coverage that is at least as good as Medicare's basic drug benefit. SHOP plans may or may not offer creditable drug coverage. Clients should look for a yearly notice from their insurer that states whether or not their SHOP drug coverage is creditable for Part D. If they don't receive this notice, they should ask for it from their employer. People with creditable coverage from a SHOP plan can delay Part D without penalty for as long as they have creditable coverage. Beneficiaries should enroll in Part D within 63 days of losing creditable coverage to avoid penalties and gaps in coverage.

### **What is the Employer Mandate?**

The Employer Mandate counts employees as "full-time equivalents" (FTEs). This term means that while a full-time employee (defined as 30 hours or more a week) counts as 1 employee, 2 half-time employees also count as one employee. This rule prevents employers from reducing hours to avoid liability under the Employer Mandate.

The Employer Mandate requires some businesses to offer affordable health insurance to their full-time employees. Within the Mandate, there are 3 groups, each with their own rules.

- In 2016, large employers (defined as 100+ FTEs in 2014) must offer affordable health insurance to full-time employees or face penalties.
- In 2016, mid-sized employers (defined as 50+ FTEs in 2015) must offer affordable health insurance to full-time employees or face penalties.
- Small businesses never have to offer health insurance to any employees.

### **Annual Enrollment Period**

The annual enrollment period begins 90 days before the end of the plan year and will last at least 30 days. During this time, the employer can renew the plan, make changes to the plan offering, or change to a new plan.

To compare plans and complete the enrollment process in New York, go to:

[www.nystateofhealth.ny.gov/employer](http://www.nystateofhealth.ny.gov/employer)

Employers can have assistance with completing their application:

- **Navigators** are certified and trained to educate and provide enrollment assistance to individuals and small businesses about the health insurance options available through the Marketplace. They speak over 40 different languages and are available weekdays, evenings, and even on weekends. Navigators are available in convenient community-based locations in every county and all help is free.

- To find a Navigator, you can visit the New York State of Health website:
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- Or you can call Community Service Society: 1-888-614-5400\
- "**Certified brokers**" are licensed professionals that have been certified by the Marketplace to provide enrollment assistance to individuals and small businesses about the health insurance options available through the Marketplace. Help applying for coverage and enrolling in a plan is free.