

MODULE 2: MEDICARE OVERVIEW

Objectives

Below are the topics covered in Module 2, Medicare Overview. HIICAP counselors will attain an expertise in each of these areas, which will give them the tools to assist their clients with Medicare issues.

Contained toward the end of the Medicare Overview module are helpful reference phone numbers and Web sites and the HIICAP study guide questions and answers.

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- Federal government health insurance that covers people age 65 or older, people under 65 but are disabled, and people with end-stage renal disease (ESRD)
- People can get their Medicare benefits in one of two ways
 - Original Medicare or Original Medicare with Supplement
 - Medicare Advantage (HMO, PPO, PFFS)

How is Medicare organized?

- The Centers for Medicare & Medicaid Services (CMS) oversees Medicare
 - Manages Original Medicare
 - Manages private health insurance companies that administer Medicare Advantage Plans
- Medicare supplements (Medigap policies) are managed by a state's Department of Insurance

Who is eligible for Medicare?

- People age 65 or older
- Some people with disabilities under age 65
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant)

Enrollment

65 and over

- If someone is 65 or over, but not eligible to collect Social Security benefits or Railroad Retirement benefits, they will have to actively enroll into Medicare by contacting Social Security. People who do not qualify to collect Social Security or Railroad Retirement benefits may have to pay higher Medicare Part A premiums.
- If they are collecting Social Security or Railroad Retirement benefits before they turn 65, they will be automatically enrolled into Medicare when they turn 65.
- If they are eligible to collect, but are not yet collecting Social Security or Railroad Retirement benefits, they will have to actively enroll into Medicare by contacting Social Security.

Under 65 but disabled

- Disabled individuals who are under 65 and have been receiving Social Security Disability (SSDI) benefits or Railroad Disability Annuity benefits will be automatically enrolled in Medicare beginning the 25th month of receiving benefits.

Exception: People who are under 65 and disabled due to amyotrophic lateral sclerosis (ALS) a.k.a. Lou Gehrig's disease become Medicare eligible starting the first month they receive Social Security Disability (SSDI) benefits or Railroad Disability Annuity benefits.

Note: For people eligible for Medicare Part A and/or Part B because of ESRD who are on dialysis, Medicare coverage usually starts the first day of the fourth month of dialysis treatments.

Applying for Medicare

- Need to actively apply if not receiving Social Security benefits or Railroad Retirement Benefits
- Initial Enrollment Period (IEP)
- General Enrollment Period (GEP)
 - Late Enrollment Penalty (LEP) for those who do not apply when first eligible

Delaying Enrollment in Medicare

- Older adults receiving employer group health benefits through their employer or their spouse's employer
- Disabled individuals receiving employer group health benefits through their employer, a spouse or family member's employer
- Special Enrollment Period (SEP)
- Equitable Relief
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MEDICARE: WHAT IS IT?

Medicare is a federal government health insurance program for people age 65 and older and for certain disabled people under age 65. Medicare usually is the first payer of health care costs for those who are enrolled.

Medicare was enacted into law in 1965 as **Title XVIII** of the Social Security Act and became effective July 1, 1966. The program was the first large federal health insurance program enacted by the United States government. Today, Medicare is the largest public health insurance program in the country, covering over 50 million eligible older adults and disabled persons. Over the years the program has changed, covering additional services and new categories of beneficiaries.

Original Medicare has two parts: Hospital Insurance (**Part A**) and Medical Insurance (**Part B**). Hospital Insurance (Part A) pays for inpatient hospital care, limited post-hospital care in a skilled nursing facility, home health care, and hospice care. Medical Insurance (Part B) pays for physician services, outpatient hospital services, ambulance services, durable medical equipment, and home health care (if not covered under Part A). The alternative way to receive Medicare benefits is through **Medicare Advantage** Health Plans, which are private plans that are contracted with the

federal government to provide the same benefits as Original Medicare. Medicare Advantage plans are allowed to impose different rules, restrictions and cost sharing.

The Medicare card acts like any other health insurance card. The Medicare card shows the person with Medicare's name, Medicare claim number (identification number), and the part(s) of Medicare in which he or she is enrolled. Beneficiaries should contact the Social Security Administration (SSA) to sign-up for Medicare and to receive their card (or to replace a lost or stolen Medicare card) by calling toll free at 1-800-772-1213 or 1-800-MEDICARE or online at <http://www.ssa.gov>. If the person with Medicare gets benefits from the **Railroad Retirement Board (RRB)**, he or she may contact the RRB toll-free at 1-877-772-5772 or online at <http://www.rrb.gov/> or go to their local RRB office to request a replacement Medicare card.

HOW IS MEDICARE ORGANIZED?

The **Centers for Medicare & Medicaid Services (CMS)** is the federal agency that administers **Medicare, Medicaid, and Child Health Insurance** programs. CMS provides health insurance for over 97 million Americans through these programs. Medicare, the nation's largest health insurance program, covers over 50 million people. Medicare provides health insurance to eligible people age 65 and over, those who have permanent kidney failure and certain people with disabilities. In addition to providing health insurance, CMS also performs a number of quality-focused activities, including development of coverage policies and assessment of the quality of Medicare Advantage plans.

Medicare beneficiaries have the option of accessing benefits through Original Medicare or a Medicare Advantage health plan. The majority of Medicare beneficiaries in New York State receive their benefits through the fee-for-service delivery system, Original Medicare, though there is an increasing number that are choosing Medicare Advantage plans.

All of the types of Medicare coverage options including Medicare Advantage plans are listed below. However, not every type of Medicare Advantage plan listed below may be available in your client's county:

- Original Medicare
- Original Medicare with a Supplemental Insurance Policy (Medigap, Employer group health plans)
- Medicare Advantage Health Plans
 - Health Maintenance Organization (HMO)
 - HMO with Point of Service Option (HMO-POS)
 - Preferred Provider Organizations (PPO)
 - Private Fee-for-Service Plans (PFFS)
 - Medicare Medical Savings Account (MSA)
 - Medicare Special Needs Plan (SNP)

These health plan options are explained in Module 5, *Medicare Advantage Health Plan Options*

CMS contracts with insurance companies who handle coverage determinations and payments for health services under the Original Medicare Program. National Government Services is the Part A and Part B Medicare Administrative Contractor (MAC) for the state of New York. As such, National Government Services is responsible for processing the Medicare Part A and Medicare Part

B claims for services performed throughout the state of New York, with the exception of claims for Durable Medical Equipment (DME).

National Heritage Insurance Company (NHIC, Corp.) is the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for New York. Palmetto GBA handles all Medicare claims for railroad retirees.

WHAT DOES MEDICARE COST-SHARING MEAN?

Medicare will pay for covered health care services and supplies that are considered “reasonable and necessary” for the beneficiary. Medicare uses reasonable and necessary to explain whether services are considered safe, effective, and medically necessary for someone. Medicare pays a portion of a beneficiary’s total health care costs and the beneficiary (or their supplemental insurance plan) is responsible for the remaining cost. The remaining costs are called cost sharing. These costs include:

1. **Deductibles** - fixed amounts the person with Medicare must pay before Medicare begins to pay;
2. **Coinsurance** – a percentage of the cost of a service that the person with Medicare is responsible for. For Part B services, the coinsurance is 20 percent of the Medicare approved amount;
3. **Excess charges** - a limited amount above the Medicare-approved amount charged by doctors and other health care providers who do not accept assignment;
4. **Noncovered services** - health care costs that Medicare does not cover at all.

The gaps in Medicare coverage can be paid either by a secondary insurance plan or by the Medicare beneficiary. Only by understanding what the gaps in Medicare coverage are can an individual begin to explore the possible ways to pay for those costs. (Refer to Modules 3 and 4 for more information).

WHO IS ELIGIBLE FOR MEDICARE?

These are the guidelines:

- Collecting Social Security retirement or Railroad Board benefits; or
- U.S. citizens or permanent U.S. residents who have lived in the U.S. continuously for five years before applying for Medicare ; AND
- Are age 65 or older; or
- Are receiving Social Security Disability (SSD) income for 24 months (except for people with ALS who qualify for Medicare as of the month they begin to receive SSD benefits); or
- Have ESRD or have had a kidney transplant and meet specific criteria.

While most people with Medicare do not have to pay a premium for Part A, there is a Part B monthly premium. It is usually deducted from the person with Medicare’s Social Security, Railroad Retirement, or Civil Service Retirement check. When the premium is not deducted from these benefits, beneficiaries pay the premiums directly to Medicare.

If beneficiaries have questions about their eligibility for Medicare Part A, Part B, or if they want to apply for Medicare, they should call the Social Security Administration (SSA). When beneficiaries contact SSA, they should take note of the date and time of the call, the name of the Social Security representative, and any information they are told. The toll-free telephone number is 1-800-772-1213. The TTY/TDD number for the hearing and speech impaired is 1-800-325-0778. They can also call 1-800-MEDICARE if they have questions about Medicare.

If Not Eligible for Social Security, Can a Person Still Enroll in Medicare?

If a person is not eligible for Social Security benefits, he or she may buy Medicare coverage. To purchase Medicare, an individual must be a United States citizen or a U.S. permanent resident that has resided in this country for five consecutive years before applying for Medicare. In this case, the person with Medicare will pay separate monthly premiums for Part A and Part B. (Refer to Modules 3 and 4). The Omnibus Reconciliation Act of 1993 (OBRA 93) reduces the Part A premium for individuals with thirty credits or more of work covered by Social Security (about 7.5 years) but not enough credits (40 quarters, or 10 years) to qualify for Social Security benefits.

Note: When an individual earns a specified amount of money (\$1,160 in 2013), SSA credits them as earning a qualifying “quarter of coverage.” An individual can earn up to four quarters of coverage each year, regardless of when they work during the year.

Full Retirement Age Increasing

Social Security refers to age 65 as “full retirement age” for people born before 1938. People born prior to 1938 received their full Social Security benefit without any age reduction if they took it at age 65 or later. Because of longer life expectancies, the Social Security law was changed in 1983 to increase full retirement age in gradual steps until it reaches age 67. The change started in 2003, and it affects people born in 1938 and later. People born in 1938 and later who start receiving their Social Security benefit before the month and year in the chart shown below will have their benefit reduced because they will get it before reaching “full retirement age.”



Caution: The age for Medicare eligibility is NOT changing. It remains at age 65.

<u>Year of Birth</u>	<u>Full Retirement Age</u>
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Note: Persons born on January 1 of any year should refer to the previous year.

ENROLLMENT

There are two ways that a person can enroll in Medicare: by being automatically enrolled, or by actively applying. HIICAP counselors can help clients nearing retirement by explaining the Medicare enrollment rules. Here’s how they work:

Automatic Enrollment

If a person is not yet 65 and is receiving Social Security or Railroad Retirement benefits, he or she does not have to apply for Medicare. Enrollment will be automatic in both Part A and Part B and the Medicare card is mailed approximately three months before the person's 65th birthday.

If a person is disabled, he or she will be automatically enrolled in Medicare Part A and Part B beginning the 25th month of receiving Social Security Disability benefits. The Medicare card will be mailed approximately three months before he or she is entitled to Medicare. (Contact Social Security if the Medicare card is not received.)

Individuals under the age of 65 who have ALS (Lou Gehrig's disease) will get Medicare benefits the first month they get disability benefits from Social Security or the Railroad Retirement Board.

When an eligible person enrolls in Medicare based on ESRD and is on dialysis, Medicare coverage usually starts the first day of the fourth month of dialysis treatments. When a person has ESRD and receives a kidney transplant, Medicare coverage generally begins the month that he or she is admitted to a hospital for the transplant.



Caution: The notice that comes with the Medicare card asks that the person with Medicare send it back only if he or she does **not** want Medicare Part B. Part B is a critically important piece of your client's total health insurance coverage. **Someone with Medicare should not refuse Part B unless enrolled in insurance from the current employment of his or her spouse and sometimes his or her family member.** It is also critical for the Medicare eligible individual to check with his or her plan to determine if it is primary or secondary to Medicare. This will be discussed in more detail below.

In most cases, the monthly premium for Medicare Part B is 25% of its actual value. This means that most beneficiaries will pay 25% of the cost of the premium, while the federal government will subsidize 75% of its cost; besides being necessary, Part B is a very good buy.

Note: **The Part B premium is higher if an individual has an adjusted gross income of more than \$85,000 (single) or \$170,000 (couple). See Module 4 for details.**

Inability to pay for Medicare should not be a reason to reject Medicare coverage. If a person with Medicare finds the Part B monthly premium too costly, he or she may qualify for a state-operated program which will pay the Medicare Part B premium and may pay Medicare deductibles and coinsurances as well. **(Refer to Module 9 for information on the Medicare Savings Programs and how they work with Medicare.)**

APPLYING FOR MEDICARE

If a person is not receiving Social Security or Railroad Retirement Benefits and is turning 65, they can enroll during the seven-month **Initial Enrollment Period (IEP)** that begins three months before the month they turn 65,* the month of the person's birth date, and continues for three months afterward. In order to avoid a delay in the start of Part B coverage, it is advisable for your clients to apply in the three months before their 65th birthday. Filing for Part B in the month a person reaches age 65 or in the last three months of their IEP will result in a delay in the start of their Part B coverage. This could result in lapses in needed coverage. To apply, contact the Social Security Administration at 1-800-772-1213 or, if a person or spouse worked for the railroad, the Railroad Retirement Board at 1-877-772-5772.

Example: Mrs. Rockford turned 65 on May 25th, 2013. If she applies:

February, March or April of 2013	her coverage will begin	May 1, 2013
May, 2013	her coverage will begin	June 1, 2013
June, 2013	her coverage will begin	August, 2013
July, 2013	her coverage will begin	October, 2013
August, 2013	her coverage will begin	November, 2013

* **Exception** – If a person’s birthday is on the first of the month, Social Security considers them to have reached age 65 in the month prior to the month when they celebrate their birthday. In this case the 4th month of the IEP is the preceding month. If the person wants Medicare Part B in the month they celebrate their 65th birthday they must sign up for it in the preceding month.

If a person does not enroll during this seven-month IEP, they will have to wait until the next **General Enrollment Period (GEP)** to sign up for Part B. (If the person or their spouse is *currently working*, they may qualify for the **Part B Special Enrollment Period (SEP)**, which is discussed in greater detail below.) The GEP is held January 1 to March 31 of each year. When a person enrolls during this period, their Part B coverage does not start until the following July.



Caution: Don’t put off enrolling in Medicare. If a person fails to enroll during his or her IEP and does not have primary coverage (e.g., employer group plan), he or she will be at risk of experiencing lapses in coverage. The person will also be assessed a 10% premium penalty for every full 12 month period that he or she should have enrolled in Medicare Part B but did not. For example, if a Medicare eligible individual did not have coverage that is primary to Medicare, and failed to enroll in Part B for three full years, he or she will be assessed a 30% monthly premium penalty.

DELAYING ENROLLMENT IN MEDICARE

As a rule, Medicare eligible individuals should only delay enrollment into Medicare Part B if they have coverage through an employer group health plan based on current employment (their own, their spouse’s, or in some cases, their family member’s). They also should only delay enrollment in Part B if this insurance is considered primary to Medicare. COBRA coverage and retiree insurance are group health plans based on **former employment**. They are not based on current employment and do not allow delayed enrollment into Medicare. The rules regarding delaying enrollment into Medicare are outlined in the section below.

Note: Since Medicare Part A is usually free, HIICAP counselors in most cases should advise their clients to enroll in Part A, regardless of any other coverage they may have. However, enrollment in Medicare Part A may affect coverage through COBRA and other forms of employer-based insurance plans. It is always a good idea to verify with the employer that Medicare Part A enrollment will not affect their eligibility for other types of coverage.

There are no strict enrollment periods for people with premium-free Part A who failed to enroll in Medicare Part A during their IEP. A Medicare-eligible individual can elect to enroll in premium-free Part A at any time of the year, and coverage can be retroactive for up to six months. However, the enrollment rules for Medicare Part B are strict. Medicare eligible individuals can only enroll in Part B during specific enrollment periods as outlined in this chapter. Rules governing enrollment into premium Part A (Part A for people who do not qualify for premium-free Part A) are the same as the enrollment rules for Part B.

Because enrollment rules for premium Part A and for Part B are strict, it is essential to understand when clients can delay enrollment. A mistaken delay in enrollment could mean that your client will have to wait for the next enrollment period to obtain Medicare coverage. For some, this wait can have serious consequences, as they may be without essential coverage during times of serious medical need. A delay in enrollment also could lead to a monthly premium penalty as described above.

A Note about Primary Insurance

Primary insurance is insurance that is mandated to pay first on health claims. Secondary insurance often acts as a supplement to primary coverage and will pay only after the primary insurance has paid or has been billed.



Caution: If Medicare is mandated to be the primary insurer and the Medicare eligible individual is not enrolled in Medicare, secondary insurance (Consolidated Omnibus Budget Reconciliation Act [COBRA], retiree coverage and others) can refuse to pay as primary. This means that the Medicare eligible individual will not have primary coverage until he or she enrolls in Medicare. Without primary coverage, the individual essentially has no health coverage. If the secondary insurer mistakenly paid as primary because they were unaware that the insured was Medicare-eligible, the secondary insurer can take back all payments made during the time that Medicare should have been primary.

Delaying Enrollment: Medicare beneficiaries aged 65 +

Working seniors: Employers with more than 20 Employees

One of the few times a 65+ Medicare eligible individual can delay enrollment in Medicare without consequence is when the person is covered by a group health plan from his or her or the spouse's **current** employment, and that employer has 20 or more employees. Employer group health plans based on **current** employment from companies with 20 or more employees are primary to Medicare. Therefore, the Medicare eligible individual can delay enrollment into Medicare until he or she loses the group health plan based on **CURRENT** employment. As stated above, COBRA and retiree coverage are **NOT** considered group health plans based on current employment. Therefore, people on COBRA or retiree coverage should enroll in Medicare as soon as they are eligible to avoid lapses in coverage and premium penalties.

Case Example 1: Phil is about to turn 65. He currently works for ABC shipping company, which employs 200 employees. Both he and his wife Sarah are covered under the company's employer group health plan. Phil and Sarah can delay enrollment into Medicare as long as they are covered under Phil's employer group health plan based on his **current** employment at ABC shipping company.

Case Example 2: Phil retires and is considering whether or not to take COBRA coverage. At this point, he no longer has a group health plan based on **current** employment, and should enroll in Medicare as soon as possible in order to avoid lapses in coverage and premium penalties. Phil and Sarah are entitled to the SEP that will allow them to enroll into Medicare as soon as they lost his current employer coverage from ABC shipping company. (For a full discussion of the SEP see the following.)

Working Seniors: Employers with Fewer Than 20 Employees

In most situations, if a Medicare eligible individual is covered by a group health plan based on current employment and the company has fewer than 20 employees, Medicare is the primary insurer. Medicare will pay first on any medical claims and the group health plan could act as secondary insurance and pay after Medicare has paid on claims. It might be helpful for a client to keep their group health plan if they can afford it even though Medicare is their primary insurance because the group health plan can supplement Medicare and might even cover services that Medicare does not cover, such as routine vision and dental services. When an individual who is covered by a group health plan based on current employment becomes eligible for Medicare he or she should usually enroll in Medicare if the company has fewer than 20 employees.

If the Medicare-eligible individual does not enroll in Medicare, his or her group health plan may stop paying primary. In effect, this person will not have primary coverage and in some cases will have no health coverage at all.

If a Medicare-eligible individual is covered by a group health plan based on current employment from a company with fewer than 20 employees and his or her employer group health plan appears to be providing him or her with primary health coverage, the insurer may not yet know or realize that he or she is eligible for Medicare. Unless this policy specifically states that it will provide primary health coverage to Medicare-eligible individuals, the plan can stop primary coverage at any time, and in some cases can even recover anything they paid out while the claimant was eligible for Medicare but not enrolled. **Please note** that in order for a group health plan with less than 20 employees to provide coverage that is primary to Medicare, the plan must notify CMS and get special permission from the insurance company that they work with. Beneficiaries thinking of delaying Medicare enrollment should ask their employer for written confirmation that their group health plan has received these special permissions before delaying Part B.

Example: Susan, aged 64, currently works for a small law firm with 10 employees. She and her husband have excellent group coverage from the firm. Next year, Susan will be eligible for Medicare. She will continue to work at the firm. She isn't sure if she should enroll in Medicare.

Since Susan's company employs fewer than 20 employees, she should enroll in Medicare during her IEP in order to avoid lapses in primary health insurance coverage. In addition, when her husband becomes Medicare eligible, he should also enroll in Medicare as soon as possible. If Susan fails to enroll in Medicare, it is possible that her employer group health plan will not provide her with primary health coverage, since they are supposed to be paying secondary to Medicare. This is because Medicare is primary to employer group health plans with fewer than 20 employees.

Susan can call her plan to determine if the insurer will pay primary to Medicare when she and her husband become eligible. If the plan can send her something in writing stating that it will pay primary to Medicare, she can delay enrollment.

Susan will have an SEP to enroll into Medicare Part B for the entire time she is currently working and for some time afterward. For more information on the Part B SEP, see below.

Delaying Enrollment: Disabled Medicare Beneficiaries

Working People with Disabilities: Employers with 100 or More Employees

One of the few times disabled Medicare-eligible individuals can delay enrollment in Medicare without consequence is when the beneficiary is covered by a group health plan from their own or their spouse's or their family member's **current** employer. That employer must have 100 or more employees*. Employer group health insurance based on **current** employment from companies with 100 or more employees is considered primary to Medicare for people with disabilities. The employer group health plan pays first on medical claims and Medicare pays second. A disabled Medicare-eligible individual can delay enrollment into Medicare until he or she loses the group health plan based on **current** employment.



Caution: As stated above, COBRA and retiree health insurance are not considered coverage based on **current** employment. They are employer plans based on former employment. COBRA and retiree health insurance do not allow delayed enrollment in Medicare Part B.

Example: Sam became disabled in 2004 and was eligible for Medicare in 2006. Since 2003 he has had excellent coverage from his wife's employer insurance. She currently works for Verizon. Since Sam is covered by his wife's employer insurance based on her **current** employment, and since her company employs more than 100 employees, Sam can delay enrolling into Medicare without consequence.

Working People with Disabilities: Employers with Fewer than 100 Employees

If disabled Medicare beneficiaries are covered by a group health plan based on their own, their spouse's or their family member's **current** employment and the company employs fewer than 100 people, Medicare is generally primary. Medicare will pay first on any health claims and the group health plan will act as supplemental insurance and might cover services Medicare does not cover such as routine vision and dental services. Therefore, when a disabled individual who is covered by a group health plan based on current employment becomes eligible for Medicare he or she should usually enroll in Medicare if the company has fewer than 100 employees.

If a Medicare eligible individual does not enroll in Medicare, his or her Group Health Plan can stop paying primary once he or she becomes eligible for Medicare. If the employer Group Health Plan appears to be providing primary health coverage, the insurer may not know or realize that he or she is eligible for Medicare. Unless the policy specifically states that it will provide **primary** health coverage to Medicare eligible individuals, the plan can stop primary coverage at any time. In some cases the plan can even recover payments on claims paid while the individual was eligible for Medicare and was not enrolled. See the section on SEPs for more information about this.

Example: John is disabled and is covered by his wife Sue's employer insurance. Sue works for a gas station that employs 15 people. John will become eligible for Medicare in a few months. He is happy with Sue's insurance and would prefer not to enroll in Medicare. If John does not enroll in Medicare, he will not have primary insurance. Since John is insured through Sue's group health plan based on current employment, and since she works for a company with fewer than 100 employees, John should enroll in Medicare as soon as he becomes eligible.

Special Enrollment Period (SEP)

An SEP allows beneficiaries to enroll in Medicare Part B outside of their IEP and the GEP. If they meet the eligibility criteria, their Medicare coverage will either be effective on the first of the month

that they enroll, or on the first of the following month, depending on their specific situation. This Part B SEP does not allow beneficiaries to enroll in Part B retroactively.

To be eligible for an SEP to enroll into Part B beneficiaries must meet all of the following criteria:

- They must be eligible for Medicare due to age or disability (*If they are eligible due to ESRD, they are not entitled to a Part B SEP.*)
- When they **first became eligible** for Medicare they were enrolled in either Medicare Part B or an employer group health plan based on their **current** employment or the **current** employment of a spouse or other family member. (*If they did not have any health coverage or had only retiree coverage or COBRA when they first became eligible for Medicare, they are not entitled to an SEP.*)
- They must have been continuously covered by a group health plan based on their **current** employment or the current employment of a spouse or other family member from the time they became eligible for Medicare until now, with no more than **eight consecutive months of lapses in coverage**. (A lapse in coverage is defined as not having employer group health coverage based on **current employment** for any period of time after someone becomes eligible for Medicare.) For example, if they had no insurance, this is considered a lapse. In addition, if they had COBRA or retiree coverage at any time since they became eligible for Medicare until now – this is also considered a lapse in coverage. If their lapse in coverage exceeded eight consecutive months, then they are not eligible for an SEP.

*If the person enrolls in Part B during a month in their IEP (the seven months surrounding the month they are age 65) in which they also qualify for an SEP, the IEP enrollment rules take precedence over the rules for SEP enrollments.

How to Obtain a SEP

If you believe your client is eligible for an SEP, contact SSA by phone and request that he or she be enrolled into Medicare using the SEP. SSA will send the client an application for enrollment form (CMS 40B) as well as a Request for Employment information form (CMS L564). Once the client has filled out the information, he or she can submit it to the local Social Security office with a cover letter, indicating that he or she is requesting enrollment into Medicare by way of the SEP. Since this is considered an initial enrollment request, SSA is required to respond in writing. If the request is denied, the client will receive a written explanation and will be given an opportunity to appeal the denial.

Equitable Relief

If your client is not eligible for an SEP to enroll in Medicare, he or she can request equitable relief. Equitable relief is a process employed by someone who believes that his or her failure to enroll in Medicare was “unintentional, inadvertent or erroneous” AND was the result of “error, misrepresentation or inaction of a federal employee or any person authorized by the federal government to act in its behalf.”

For example, if a client did not enroll in Part B because a Social Security representative told him or her that it was not necessary to enroll, the person may have grounds for equitable relief.

Equitable relief is an administrative process created under federal law that allows people with Medicare to request relief from the Social Security Administration (SSA) in the form of:

- Immediate or retroactive enrollment into Medicare Part B, and/or
- The elimination of a Part B premium penalty.

To obtain equitable relief, the client must write a formal letter to Social Security, explaining that he or she received misinformation from a federal employee (someone at 800-Medicare, Social Security, or someone acting on the federal government's behalf such as a Medicare private health plan). The letter should include as many details as possible, including how the person was misled or misinformed, when this took place, and whom he or she spoke with. In addition, the client should describe the outcome of the conversation. The person must also state whether he or she would like to be enrolled in Part B prospectively or retroactively, and whether he or she would like the late enrollment penalty to be eliminated. There are no set timeframes in which SSA must respond to a request for equitable relief. To follow up on an equitable relief request, the client must contact SSA.

Using the MSP to Enroll in Medicare Part B

Any client that has failed to enroll in Medicare and now finds themselves without coverage should be considered for a Medicare Savings Program (MSP). A person does not need to have Part B in order to apply for a Medicare Savings Program, though there is often confusion about this at local Department of Social Services offices. By enrolling into an MSP, beneficiaries are automatically enrolled into Medicare Part B. MSPs also eliminate any premium penalties they may have incurred for not enrolling into Part B when they were first eligible. Additionally, if someone is enrolled in an MSP, they automatically receive Extra Help, also known as Low Income Subsidy (LIS), the federal benefit that helps pay for prescription drug coverage.

CONCLUSION

Whether or Not to Enroll in Medicare Part B

HIICAP counselors assisting individuals reaching age 65 or who are over age 65 and deciding whether or not to enroll in Medicare Part B should consider the following questions:

1. Is your client or their spouse currently working?
2. Is your client covered under their spouse's or their own employer group health plan based on **current employment**?
3. Does this employer have 20 or more employees?
4. If the group health plan from the employer has fewer than 20 employees, will the employer group health plan continue to offer your client primary coverage when they become eligible for Medicare? Can your client get this in writing?

If the answer is **yes** to these questions, your client can delay enrollment into Part B as long as the employer group health plan remains primary. The client should also contact the employer benefits manager to obtain specific information about how the employer group health benefits will coordinate with Medicare drug coverage. In addition, the person should obtain a written notice from the employer regarding the employer drug coverage and whether this coverage is just as good as Medicare coverage or creditable coverage.

Sources of Assistance

NYS OFA HIICAP Hotline **1-800-701-0501**

Coordination of Benefits Contractor (COBC) **1-800-999-1118**
TTY 1-800-318-8782

Call the COBC with any changes in insurance coverage or any questions about who pays first.

Centers for Medicare & Medicaid Services (CMS) **1-212-616-2205**
NYS Region 2 Office

26 Federal Plaza, Room 3811

New York, NY 10278

<http://www.cms.gov>

<http://www.medicare.gov>

1-800-MEDICAR(E) **1-800-633-4227**

Call for questions about Medicare coverage, claims, or how Medicare works with your clients' other insurance. Available in English and Spanish via touch-tone or voice automated service.

Social Security Hotline **1-800-772-1213**

Call for Medicare eligibility and enrollment information, lost Medicare card replacement and general Social Security issues.

Additional Resources

Publications:

- *Getting Medicare before you get your Full Social Security Retirement Benefits*, CMS Publication #11038, March 2008
- *Medicare & You 2013*, CMS Publication #10050, November 2012
 - <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>
- *Medicare Basics: A Guide for Families and Friends of People with Medicare*, CMS Publication #11034, May 2011
 - <http://www.medicare.gov/Publications/Pubs/pdf/11034.pdf>
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*, CMS Publication #10128, April 2012
- *Get Your Medicare Questions Answered*, CMS Publication #11386, April 2013
 - <http://www.medicare.gov/Publications/Pubs/pdf/11386.pdf>
- *Coordination of Benefits*, CMS Publication 11546, November 2012
 - <http://www.medicare.gov/Pubs/pdf/11546.pdf>
- *Welcome to Medicare*, CMS Publication 11095, November 2012
 - <http://www.medicare.gov/Publications/Pubs/pdf/11095.pdf>

STUDY GUIDE MODULE 2: MEDICARE OVERVIEW



Read your *HIICAP Notebook*. As you read this section, look for information that is especially important to someone about to turn 65.

- I. History and Operation of the Medicare Program
- II. Medicare Eligibility
- III. Medicare Enrollment
- IV. Medicare Definitions
- V. Medicare for Working Seniors

Use the information from your *HIICAP Notebook* and *Medicare & You* handbook for the following lessons regarding Medicare.



1. MEDICARE PROGRAM OPERATION

- Medicare is a _____ health insurance program that became effective in _____.
- The _____ enacts Medicare laws.
- _____ administers the Medicare program and enforces Medicare laws.
- Medicare Part A and Medicare Part B claims processing and payments are handled by private insurance companies called _____.



2. MEDICARE COST-SHARING

- Medicare is a cost-sharing program. Medicare pays for only a _____ of a person with Medicare's total health care costs.
- Medicare beneficiaries are responsible for paying _____, _____, _____, and _____.
- Part A helps to pay for _____, _____, _____, and _____.
- Part B helps to pay for _____, _____, _____, and _____.



3. MEDICARE ELIGIBILITY AND ENROLLMENT

- Who is eligible for Medicare?
 - a. _____
 - b. _____
 - c. _____
- How do seniors enroll in Medicare?
- Medicare enrollment can be automatic. That means

- Or seniors may enroll in Medicare in one of three enrollment periods. Name these three enrollment periods and describe how they work.
 - a. _____
 - b. _____
 - c. _____



Group Activity

- Mrs. Charles is retired and began collecting Social Security checks at age 62. She will turn 65 next October. How will she enroll in Medicare?
- Mr. Barry does not plan to retire until he is 70 years old. He is covered by his large employer group health plan. When should he enroll in Medicare Part B?
- Ms. Davidson is retired and refused Part B of Medicare last year when she became eligible. When can she enroll? What will her monthly premium be?



Group Activity: If you already have a Medicare card, take it out so that you and others can examine it. On a chalkboard or flip chart, one of your group members may record the information that you find on the Medicare card.



In Summary: Consider what you have learned in this *Medicare Overview* module.

- Medicare is the starting point of my health insurance after age 65.
- Medicare pays for many of my health care costs, but I share those costs.
- Signing up for Medicare on time is my responsibility.
- Medicare Part B medical insurance has a monthly cost but it's a very reasonable one for the protection it offers me.

ANSWER KEY MODULE 2: MEDICARE OVERVIEW ANSWERS



Read your *HIICAP Notebook*. As you read this section, look for information that is especially important to someone about to turn 65. *Medicare's two parts A and B, Medicare eligibility, Medicare enrollment.*

Use the information from your *HIICAP Notebook* and *Medicare & You* handbook for the following lessons regarding Medicare.



1. MEDICARE PROGRAM OPERATION

- Medicare is a federal health insurance program that became effective in 1966.
- The U.S. Congress enacts Medicare laws.
- CMS administers the Medicare program and enforces Medicare laws.
- Medicare Part A and Medicare Part B claims processing and payments are handled by private insurance companies called Medicare Administrative Contractors (MAC).



2. MEDICARE COST-SHARING

- Medicare is a cost-sharing program. Medicare pays for only a portion of a person with Medicare's total health care costs.
- Medicare beneficiaries are responsible for paying premiums, deductibles, copayments, and noncovered costs.
- Part A helps to pay for inpatient hospital, skilled nursing facility care, home health care, and hospice care.
- Part B helps to pay for doctor services, outpatient hospital care, diagnostic tests, and medical supplies and equipment and home health care services not covered by Part A.



3. MEDICARE ELIGIBILITY AND ENROLLMENT

- Who is eligible for Medicare?
 - a. age 65 and older who meet U.S. residency requirements
 - b. eligible disabled persons
 - c. eligible persons with end-stage renal disease (ESRD)
- How do seniors enroll in Medicare? Medicare enrollment can be automatic. That means that persons receive a Medicare card by mail three months before their 65th birthday if they are already receiving Social Security or Social Security disability insurance (SSDI) checks. Persons who receive Railroad Retirement benefits before their 65th birthday will also be automatically enrolled in Medicare.
- Or seniors may enroll in Medicare in one of three enrollment periods. Name these three enrollment periods and describe how they work.
 - a. Initial enrollment period: 7 months surrounding their 65th birthday
 - b. General enrollment period: January/February/March for coverage effective July that same year
 - c. Special enrollment period: 8 months after they retire or stop actively working if covered past age 65 under employer group health plan



Group Activity:

- Mrs. Charles is retired and began collecting Social Security checks at age 62. She will turn 65 next October. How will she enroll in Medicare? Enrollment will be automatic because Mrs. Charles is already collecting Social Security benefits.
- Mr. Barry does not plan to retire until he is 70 years old. He is covered by his large employer group health plan based on “current” employment. When should he enroll in Medicare Part B? He can enroll in Part B any time he is still enrolled in the group health plan based on “current” employment or up to 8 months after “current” employment ends. This is called the Special Enrollment Period (SEP). There is no penalty for enrolling during this SEP. If Mr. Barry enrolls in Medicare Part B while still enrolled in his employer plan or during the first full month when not enrolled in this plan, his Medicare Part B coverage will begin either (1) the first day of the month of enrollment or (2) at his option, the first day of any of the following three months.
- Ms. Davidson is retired and refused Part B of Medicare last year when she became eligible. When can she enroll? What will her monthly premium be? Assuming she is not covered under a spouse who is currently working, she may not enroll until the next General Enrollment Period: January-March of each year. Her coverage will not be effective until July 1, and she will pay a 10 percent penalty for each full year of late enrollment (e.g., if she did not enroll for three years, she will pay the current Medicare Part B premium plus a 30 percent penalty).



Group Activity: If you already have a Medicare card, take it out so that you and others can examine it. On a chalkboard or flip chart, one of your group members may record the information that you find on the Medicare card.

Name, Medicare claim number, Part A coverage, Part B coverage, effective date



In Summary: Consider what you have learned in this Medicare Overview module.

- Medicare is the starting point of my health insurance after age 65.
- Medicare pays for many of my health care costs, but I share those costs.
- Signing up for Medicare on time is my responsibility.

Medicare Part B medical insurance has a monthly cost but it’s a very reasonable one for the protection it offers me.