MODULE 2: MEDICARE ELIGIBILITY AND ENROLLMENT

Objectives

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

Near the end of the Medicare Eligibility and Enrollment module are helpful reference phone numbers, websites, and the HIICAP study guide questions and answers.

TABLE OF CONTENTS

Medicare: What is it?

- Health insurance managed by the federal government that covers people age 65 or older, people under 65 who have certain disabilities, and people with End-Stage Renal Disease (ESRD)
- People can get their Medicare benefits in one of two ways
    - Original Medicare with or without a supplemental insurance plan
    - Medicare Advantage (HMO, PPO, PFFS)

How is Medicare organized?

- The Centers for Medicare & Medicaid Services (CMS):
    - Manages Original Medicare
    - Manages private health insurance companies that administer Medicare Advantage Plans
- Medicare supplemental insurance plans (Medigap policies) are regulated by a state's Department of Insurance (Department of Financial Services in New York State)

Who is eligible for Medicare?

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

Enrollment

65 or older

- Individuals collecting Social Security or Railroad Retirement benefits before they turn 65 will be automatically enrolled into Medicare when they turn 65.
- Individuals who are eligible to collect but are not yet collecting Social Security or Railroad Retirement benefits will have to actively enroll into Medicare by contacting Social Security Administration (SSA).
- Individuals who are 65 or over, but are **not eligible** to collect Social Security benefits or Railroad Retirement benefits, will have to actively enroll into Medicare by contacting SSA.
    - Note: Part A is free for most people.
    - In general, individuals may be eligible for "premium free" Medicare Part A if they or their spouse have at least 40 calendar quarters (10 years) of work in any job at which they paid Social Security taxes in the U.S.; or are eligible for

Railroad Retirement benefits; or were a federal employee after December 31, 1982 or a state or local employee after March 31, 1986.

- People who do not qualify to collect Social Security or Railroad Retirement benefits may have to pay Medicare Part A premiums.

Under 65 and disabled

- Individuals with disabilities 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 due to ESRD who are on dialysis, the day Medicare coverage starts depends on how the beneficiary receives treatment. At the latest, coverage will start on the first day of the fourth month of dialysis treatments. For more information regarding ESRD and Medicare enrollment see the Additional Resources section of this module. (Page 2-16)

Applying for Medicare

- Need to actively apply for Medicare if not receiving Social Security benefits or Railroad Retirement Benefits during the:
  - Initial Enrollment Period (IEP)
  - Special Enrollment Period (SEP)
  - General Enrollment Period (GEP)
- Late Enrollment Penalty (LEP) for those who do not apply when first eligible and are not eligible for an SEP

Delaying Enrollment in Medicare

- Individuals eligible for an SEP to delay Medicare enrollment are:
  - Older adults receiving employer group health benefits through their employer or their spouse's employer (based on current employment)
  - Individuals eligible due to a disability receiving employer group health benefits through their employer, a spouse, or in certain circumstances a family member's employer (based on current employment)

People who mistakenly delayed enrolment may be entitled to

- Equitable Relief, if they were given misinformation by a representative of the federal government
- Use a Medicare Savings Program (MSP) to enroll in Medicare outside of an enrollment period, as long as they meet the MSP income limits. MSPs also help pay Part B premiums.

MEDICARE: WHAT IS IT?

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

Medicare was enacted 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 almost 60 million eligible older adults and persons with disabilities. 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).

Alternatively, beneficiaries can receive Medicare benefits through Medicare Advantage Plans. These are private plans that contract 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 Medicare beneficiary's name, Medicare claim number (identification number), and the part(s) of Medicare in which the beneficiary is enrolled.

New Medicare Cards

- **Between April 2018 and April 2019, all people with Medicare were automatically mailed a new Medicare card containing a new unique 11- character identifier (which does not contain a Social Security number). Medicare has finished mailing new Medicare cards to all beneficiaries. If a beneficiary did not receive their new card, they should call 1-800-MEDICARE and speak to a representative.**

- For detailed information about the new Medicare cards refer to: https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

Individuals 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). People can contact SSA by calling their toll free national hotline at 1-800-772-1213, or by visiting SSA's website, http://www.ssa.gov. If the person with Medicare gets benefits from the **Railroad Retirement Board (RRB),** that person may contact the RRB toll-free at 1-877-772-5772 or online at http://www.rrb.gov/. Beneficiaries may also 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. Medicare provides health insurance to eligible people age 65 and over, certain people with disabilities, and those who have permanent kidney failure. 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 receiving benefits through Original Medicare or a Medicare Advantage 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 of beneficiaries who are choosing Medicare Advantage Plans.

Most types of Medicare coverage options, including Medicare Advantage Plans, are listed below. However, not every type of Medicare Advantage Plan may be available in your client's county:

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

These health plan options are explained in Module 5, ***Medicare Advantage Plan Options.*** https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod5.pdf

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 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).

Noridian is the DME 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 the terms 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 the beneficiary's supplemental insurance plan) is responsible for the remaining cost. The remaining costs are called cost-sharing. These costs include:

1. **Deductibles -** fixed amounts people with Medicare must pay before Medicare begins to pay;
2. **Coinsurance charges –** percentage of the cost of a service that people with Medicare are responsible for. For most Part B services, the coinsurance is 20% of the Medicare-approved amount;
3. **Copayments –** fixed amount that people with Medicare are responsible for whenever they receive a service;

4. **Excess charges -** limited amount above the Medicare-approved amount charged by doctors and other health care providers who do not accept assignment but have not formally opted out of Medicare. A provider who does not accept assignment does not accept the Medicare-approved amount for services as full payment. In New York State, an additional 5% of the Medicare-approved amount is the most physicians can charge (for most services);
5. **Non-covered 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. Individuals can begin to explore the possible ways to pay for these services and costs after they understand what the gaps in Medicare coverage are. (Refer to Modules 3 and 4 for more information. https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod3.pdf https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod4.pdf)

Individuals may also receive additional coverage and payment assistance if they are eligible for certain benefits which offset the cost of one's Medicare. These benefits include the Medicare Savings Program, Extra Help, and Medicaid. There is more information about these benefits in Modules 6, 9, and 17. https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod6.pdf https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod9.pdf https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod17.pdf

WHO IS ELIGIBLE FOR MEDICARE?

To be eligible for Medicare, one must be:

- Collecting or eligible for Social Security retirement or Railroad Board benefits AND age 65 or older; OR
- A U.S. citizen or permanent U.S. resident who has lived in the U.S. continuously for five years before applying for Medicare AND
    - Is age 65 or older;
    - Has received Social Security Disability Insurance (SSDI) income or a railroad disability annuity check for 24 months (except for people with ALS who qualify for Medicare the month they begin to receive SSDI or railroad disability annuity); or
    - Has ESRD or has had a kidney transplant and meets specific criteria.

While most people with Medicare do not have to pay a premium for Part A, most do pay a premium for Part B each month. It is usually deducted from the beneficiary's Social Security, Railroad Retirement, or Civil Service Retirement check. When the premium is not deducted from these benefits, beneficiaries likely pay the premiums directly to Medicare. (In some cases, a beneficiary may be enrolled in a Medicare Savings Program and the state will pay the Medicare Part B premium instead of the beneficiary.) The premium is billed quarterly or the beneficiary can elect to have the premium deducted monthly from a checking/savings account. The authorization agreement form to do this can be found using the following link. https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/sf5510english.pdf.

If beneficiaries have questions about their eligibility for Medicare Part A, Part B, or if they want to apply for Medicare, they should contact SSA. When beneficiaries contact SSA, they should take note of the date and time of the call, the name of the representative, and any information they are told. The toll-free telephone number is 1-800-772-1213. The TTY/TDD number for individuals with hearing and/or speech difficulties is 1-800-325-0778. Individuals may also be able to apply for Medicare online at www.ssa.gov. Individuals 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, that person may still enroll in Medicare, but must usually pay a premium for Part A. To enroll in 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 Budget 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 ($1,360 in 2019), and pays federal taxes on that income, 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. Due to longer life expectancies, 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.

Year of Birth	Full Retirement Age
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 becoming Medicare-eligible due to age (is turning 65) and is already receiving Social Security or Railroad Retirement benefits, she or he does not have to apply for Medicare. Enrollment in both Part A and Part B will be automatic, and the person's Medicare card will be mailed to them approximately three months before their 65th birthday.

If a person is becoming eligible for Medicare because they have received 24 months of Social Security Disability Insurance they 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 she or he is entitled to Medicare. A person should contact Social Security if she or he does not receive a Medicare card.

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 she or he is admitted to a hospital for the transplant.

Caution: The notice that comes with the Medicare card asks the person with Medicare to send it back only if she or he does **not** want Medicare Part B. Part B is a critically important piece of one's total health insurance coverage**. A Medicare-eligible beneficiary who wants to refuse Part B should first speak to a representative at their current insurance plan or their employer human resources department to find out how that insurance will work with Medicare.** It is critical for the Medicare-eligible individual to check with their plan to determine if it is primary or secondary to Medicare. This will be discussed in more detail below. The person should also be sure to speak to Social Security to confirm that their current employment-based coverage will give them an SEP to avoid late-enrollment penalties and to ensure that they can enroll in Part B at a later date. They should take notes of the conversation and record the name of the person they speak to.

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 through the premium and the federal government will subsidize 75% of the cost of care.

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.**
https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod4.pdf

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, she or he 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**.)
https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod9.pdf

APPLYING FOR MEDICARE

Individuals who are not receiving Social Security or Railroad Retirement Benefits and are turning 65 can enroll during the seven-month **Initial Enrollment Period (IEP)**. The IEP includes the three months before the month they turn 65*, the month of their birth date, and the three months

afterward. In order to avoid a delay in the start of Part B coverage, it is advisable for individuals to apply during the three months before their 65th birthday. Filing for Part B during the month a person reaches age 65 or in the last three months of one's IEP will result in a delay in the start of one's 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, 2019. If she applies:

February, March or April of 2019	her coverage will begin	May 1, 2019
May, 2019	her coverage will begin	June 1, 2019
June, 2019	her coverage will begin	August, 2019
July, 2019	her coverage will begin	October, 2019
August, 2019	her coverage will begin	November, 2019

* **Exception** – For individuals who have birthdays on the first of the month, Social Security considers them to have reached age 65 in the month prior to the month of their birthday. In this case, the 4th month of the IEP is the preceding month. If people in this situation want Medicare Part B in the month they celebrate their 65th birthday they must sign up for it by the preceding month. If an individual with a birthday on the first of the month is not aware of this rule and tries to enroll during their perceived seventh month of the IEP, although this would technically be the eighth month of the IEP, Social Security will still allow them to enroll. For example, if Mrs. Rockford in the aforementioned example was born on May 1st and tried to enroll in August of 2019, although Social Security considers her to have reached age 65 in April, they would still allow her to enroll.

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

Caution: One should not put off enrolling in Medicare. If a person fails to enroll during their IEP and does not have primary coverage (e.g., employer group plan), they may be at risk of experiencing lapses in coverage. **If a person does not qualify for the Part B SEP, they will also likely be assessed a 10% premium penalty for every full 12-month period that they could have enrolled in Medicare Part B but did not.** For example, if a Medicare-eligible individual failed to enroll in Part B for three full years, that individual will be assessed a 30% monthly premium penalty. If one is not eligible for premium free Part A, then one may also face a Part A late enrollment penalty as well.

DELAYING ENROLLMENT IN MEDICARE

Typically, Medicare-eligible individuals should only delay enrollment into Medicare Part B if they will be eligible for an SEP, meaning they will be able to enroll in Part B outside of the General Enrollment Period and will not be subject to any late-enrollment penalties. To be eligible for an SEP a person must 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), and to have had such coverage, or Part B, since their initial eligibility for Medicare.

COBRA coverage and retiree insurance are group health plans based on **former employment**. They are not based on current employment and do not give access to an SEP for Part B. 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, such as the ability to contribute to Health Savings Accounts (HSAs). 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 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 generally the same as the enrollment rules for Part B.

Since 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 may have to wait for the next enrolment period. 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 required 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 the primary insurer and the Medicare-eligible individual is not enrolled in Medicare, secondary insurance (COBRA, retiree coverage and others) can refuse to pay as primary. This means that the Medicare-eligible individual will not have primary coverage until enrolling in Medicare. Without primary coverage, the individual essentially has no health insurance coverage for Part B-covered services. 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 age 65 +

Employers with 20 or more employees

An age 65+Medicare-eligible individual can delay enrollment in Medicare without adverse consequence when the person is covered by a group health plan from their or their 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. In other words, the plan pays before Medicare pays.

Remember, Medicare-eligible individuals can delay enrollment into Medicare until they lose group health plan coverage 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.

- If later on Phil retires, he may consider whether or not to take COBRA coverage. When he retires, he no longer has a group health plan based on **current** employment, and should enroll in Medicare Part B as soon as possible in order to avoid lapses in coverage and premium penalties. Phil and Sarah are entitled to the Special Enrollment Period (SEP) that will allow them to enroll into Medicare as soon as they lose his current employer coverage from ABC shipping company. (For a full discussion of the SEP see the following.)

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 the 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, she or he should usually enroll in Medicare if the company has fewer than 20 employees.

If the Medicare-eligible individual does not enroll in Medicare, their 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 their employer group health plan appears to be providing them with primary health coverage, the insurer may not yet know or realize that the person is eligible for Medicare. Unless the insurance 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 employer 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.

NOTE: Most Medicare-eligible individuals with any insurance based on current employment can use an SEP to enroll into Medicare. This means that if a person with insurance from a company has fewer than 20 employees accidentally delays Medicare enrollment, they can enroll later without

penalty. However, people with Medicare as their primary coverage **should not** delay Medicare enrollment.

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: Medicare beneficiaries eligible due to receiving Social Security Disability

Working people with disabilities: Employers with 100 or more employees

One of the few times individuals eligible for Medicare due to a disability can delay enrollment in Medicare without consequence is when the beneficiary is covered by a group health plan from their own or a spouse's or a 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 primary to Medicare for people with disabilities. The employer group health plan pays first on medical claims and Medicare pays second. Individuals eligible for Medicare due to a disability can delay enrollment into Medicare until they lose 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 a beneficiary to delay enrollment in Medicare Part B.

Example: Sam became disabled in 2014 and was eligible for Medicare in 2016. Since 2013 he has had excellent coverage from his wife's employer insurance. She currently works for XYZ Phone Company, which has 130 employees. 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 beneficiaries eligible for Medicare due to a disability 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

while the group health plan will act as secondary insurance and might cover services Medicare does not cover such as routine vision and dental services. Therefore, individuals eligible for Medicare due to a disability typically should enroll if their current coverage is from a group health plan with fewer than 100 employees.

If a Medicare-eligible individual does not enroll in Medicare, their group health plan can stop paying primary once the beneficiary should be enrolled in Medicare. If the employer group health plan appears to be providing primary health coverage, the insurer may not know or realize that the person 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.

NOTE: Medicare-eligible individuals with any current employer insurance can use their SEP to enroll into Medicare, even if their employer has fewer than 100 employees. This is true unless the insurance is through a family member whose company has fewer than 100 employees (*see below for additional details). However, people with Medicare as their primary coverage **should not** delay Medicare enrollment.

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)

If eligible, an individual can enroll in Part B any time he/she is still enrolled in a group health plan based on "current" employment or up to 8 months following the month "current" employment ends. This is called the Special Enrollment Period (SEP). There is no penalty for enrolling during this SEP.

The Part B 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. The 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 and/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 lapse of coverage more than **eight**

consecutive months. (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.

*Individuals who are eligible for Medicare due to a disability may be covered under a family member's group health plan. **These individuals are only eligible for the Part B SEP if the employer has over 100 employees.** If the individual is covered by a group health plan with less than 100 employees, then the individual cannot utilize the Part B SEP. Note that these rules only apply for those eligible due to disability when they are covered by a family member's current employer coverage, and do not apply if the person is covered by their own or their spouse's current employer coverage.

If the person enrolls in Part B during a month in their IEP (the seven-month period during which they can enroll in Medicare for the first time) in which they also qualify for an SEP, the IEP enrollment rules take precedence over the rules for SEP enrollments.

How to obtain an SEP

If you believe your client is eligible for an SEP, contact SSA by phone and request that your client be enrolled into Medicare using the SEP. SSA will send the client an application for enrollment form (CMS 40B) http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS40B-E.pdf as well as a Request for Employment information form (CMS L564) http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-L564E.pdf. Your client can fill out and submit the form to their local Social Security office with a cover letter, indicating that they are 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, that client may request equitable relief. As stated within Social Security's Program Operations Manual System (POMS), equitable relief is a process employed by someone who believes that their 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 her or him 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 they received misinformation from a federal employee (someone at 1-800-MEDICARE, Social Security, or someone acting on the federal government's behalf such as a Medicare Advantage Plan). The letter should include as many details as possible, including how the person was mislead

or misinformed, when this took place, and whom the person spoke with. In addition, the client should describe the outcome of the conversation. The person must also state whether they would like to be enrolled in Part B prospectively or retroactively, and whether they 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. By enrolling into an MSP, beneficiaries are automatically enrolled into Medicare Part B. This process should be automatic, and the individual should not have to request Part B enrollment. MSPs also eliminate any premium penalties one may have incurred for not enrolling into Part B when 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. For more information on MSPs, please refer to Module 9. https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod9.pdf

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 all of these questions, your client can delay enrollment into Part B without penalties or gaps in coverage. 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.

HIICAP counselors assisting individuals eligible for Medicare due to disability who are deciding whether or not to enroll in Medicare Part B should consider the following questions:

5. Is your client, their spouse, or their family member currently working?
6. Is your client covered under their spouse's, their family member's, or their own employer group health plan based on **current employment**?
7. Does this employer have 100 or more employees?
8. If the group health plan from the employer has fewer than 100 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 all of these questions, your client can delay enrollment into Part B without penalties or gaps in coverage. As a reminder, individuals covered under family member's current employer plans are ineligible for the Part B SEP if the employer's plan is less than 100 employees.

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**

Benefits Coordination & Recovery Center (BCRC) **1-855-798-2627**
TTY 1-855-797-2627

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

1-800-MEDICARE **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.

http://www.medicare.gov

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

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

Additional Resources

Publications:

- *Medicare & You* , CMS Publication #10050
  - https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf
- *A Quick Look at Medicare,* Publication # 11514
  - https://www.medicare.gov/Pubs/pdf/11514-A-Quick-Look-at-Medicare.pdf
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*, CMS Publication #10128
  - https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf
- *Where to Get Your Medicare Questions Answered*, CMS Publication #02246
  - https://www.medicare.gov/Pubs/pdf/02246-Where-Get-Medicare-Questions-Answered.pdf
- *Coordination of Benefits*, CMS Publication #11546
  - https://www.medicare.gov/Pubs/pdf/11546-coordination-of-benefits.pdf
- *Enrolling in Medicare Part A & Part B*, CMS Publication #11036
  - https://www.medicare.gov/Pubs/pdf/11036-Enrolling-Medicare-Part-A-Part-B.pdf
- *Welcome to Medicare*, CMS Publication #11095
  - https://www.medicare.gov/Pubs/pdf/11095-Welcome-to-Medicare.pdf

STUDY GUIDE MODULE 2: MEDICARE ELIGIBILITY AND ENROLLMENT

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 individuals turning 65 enroll in Medicare?
- Medicare enrollment can be automatic. That means

  _____
- Or individuals turning 65 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 retired three years ago and is single. She refused Part B of Medicare last year when she became eligible. When can she enroll? What counseling strategies could you use to assist with her Part B enrollment? What will her potential monthly premium be?

In Summary: Consider what you have learned in this *Medicare Eligibility and Enrollment* module.

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

ANSWER KEY MODULE 2: MEDICARE ELIGIBILITY AND ENROLLMENT 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 *people with disabilities*
  c. eligible persons with *end-stage renal disease (ESRD)*
- How do individuals turning 65 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 individuals turning 65 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 month 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 following the month "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 retired three years ago and is single. She refused Part B of Medicare last year when she became eligible. When can she enroll? What counseling strategies could you use to assist with her Part B enrollment? What will her potential monthly premium be? *Ms. Davidson 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). Ms. Davidson should consider if she is eligible for Equitable Relief or the Medicare Savings Program (MSP). If eligible for Equitable Relief or the MSP, Ms. Davidson may be able to get Part B before July and/or avoid the late enrollment penalty.*

In Summary: Consider what you have learned in this Medicare Eligibility and Enrollment module.

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