Medicare Enrollment & Options

COUNCIL FOR AFFORDABLE HEALTH COVERAGE

ELIGIBILITY

To be eligible for Medicare, you must be either a U.S. citizen or a legal permanent resident for at least five continuous years. Medicare is available for people age 65 or older, younger people with disabilities and people with end-stage renal disease (permanent kidney failure requiring dialysis or transplant) or ALS (Lou Gehrig's disease).

Qualifying Based on Age

If you are qualifying based on your age, you must be at least 65 years old and:

- a U.S. citizen, or
- a permanent legal resident who has lived in the U.S. for a minimum of five years before applying, or
- a green card holder who has been married to a fully insured U.S. citizen or green card holder for at least one year.

Qualifying Based on a Disability

Medicare coverage begins at the beginning of the 25th month after you began receiving Social Security disability benefits. The 24 months do not need be consecutive. For example, if you received benefits for a few months, then lost eligibility but qualified again at some later date (even years later), all the months in which you received benefits would count toward the 24-month waiting period.

The 24-month waiting period may be waived in two circumstances:

- If you have permanent kidney failure — known as end-stage renal disease (ESRD) and defined as needing regular dialysis or a kidney transplant — you may qualify for Medicare within one to three months. The start of Medicare coverage depends on what kind of care you need (dialysis or a kidney transplant) and whether you have coverage under an employer plan.
- If you have amyotrophic lateral sclerosis — known as ALS or Lou Gehrig's disease — you must apply for Social Security disability. Your Medicare coverage begins at the same time as you start receiving disability benefits (usually five months after your disability application has been approved).

Regarding additional disabilities, a person who is entitled to monthly Social Security or Railroad Retirement Board benefits is automatically entitled to Medicare Part A after receiving disability benefits for 24 months. Additionally, disabled federal, state and local government employees who are not eligible for monthly Social Security or Railroad Retirement Board benefits may get disability benefits and automatically entitled to Part A after being disabled for 29 months.

THE ENROLLMENT PROCESSES

Enrollment in Medicare can happen in a few different ways.

Automatic Enrollment

Generally, if you're receiving Social Security or Railroad Retirement Board benefits, you will be automatically enrolled in Medicare when you turn 65. If you're under 65 and have been receiving disability benefits from Social Security or the Railroad Retirement Board for two years, or if you have ALS or ESRD, you also qualify for automatic enrollment.

Initial Enrollment Period

If you do not qualify for automatic enrollment in Medicare, you need to apply when you become eligible during

the Initial Enrollment Period. This is a seven-month period that starts three months before the month of your 65th birthday, includes the month you turn 65 and ends three months after your birthday month. This period applies to benefits of original Medicare (Part A and Part B) or selection of a private plan to deliver Medicare benefits, called Medicare Advantage.

General Enrollment Period

If you did not qualify for automatic enrollment and you missed the Initial Enrollment Period, you can still enroll in Part A and Part B during the General Enrollment Period which runs from January 1 to March 31 each year. If you enroll in Medicare during the General Enrollment Period, your coverage begins in July of that same year.

Open Enrollment Period

Additions to existing plans or changes to coverage, including Part C (Medicare Advantage plans) and Part D (prescription drug coverage) can be made during the Open Enrollment Period. Medicare beneficiaries will start to receive information in October each year about changes the plans have made. These may include details such as cost, coverage and what providers and pharmacies are in their networks. Beneficiaries should carefully read this information so they can make the best decisions regarding whether or not it is in their best interest to maintain their current plan or move to a different provider to ensure their specific needs are best met.

PREMIUMS & CO-PAYMENTS

While the Medicare program provides healthcare coverage, there are some out-of-pocket costs to consider and there are instances where you are responsible for paying for a share of your health coverage. Whether you're talking about Original Medicare (Part A and Part B), or private insurance options provided through Part C (Medicare Advantage) Part D (drug coverage), it is important to understand the costs that you are responsible for covering as a beneficiary.

2017 COST AT A GLANCE	
Part A premium	Most people don't pay a monthly premium for Part A (sometimes called "premium-free Part A"). If you paid Medicare taxes for less than 30 quarters, the standard Part A premium is $413. if you paid Medicare taxes for 30-39 quarters, the standard Part A premium is $227.
Part A hospital inpatient deductible and coinsurance	You Pay: • $1,316 deductible for each benefit period • Days 1-60: $0 coinsurance for each benefit period • Days 60-90: $329 coinsurance per day for each benefit period • Daya 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: all costs
Part B premium	The standard Part B premium amount is $134 (or higher depending on your income). However, most people who get Social Security benefits will pay less than this amount ($109 on average)
Part B deductible and coinsurance	$183 per year. After your deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment.
Part C premium	Part C monthly premium varies by plan
Part D premium	The Part D monthly premium varies by plan (higher-income consumers my pay more).

There are also additional costs to consider that a beneficiary is responsible for covering. These include the following:

- Deductible – the amount you must pay for healthcare or prescriptions before Medicare begins to pay its share
- Co-Insurance – the amount you may be required to pay for services after you pay any deductibles, as a percentage of the cost of the service or item.
- Co-Payment – the fixed dollar amount you pay for each medical service, such as a doctor's visit, or prescription

INFORMATION AND ASSISTANCE NAVIGATING THE MEDICARE PROCESS

The Medicare eligibility and enrollment processes can sometimes be difficult to navigate due to the amount of information and options to consider. To help beneficiaries work through it all, there are trusted resources available to assist in providing the help many individuals need in ensuring they have a full understanding of what is available to them.

State Health Insurance Assistance Programs (SHIPs)

The State Health Insurance Assistance Programs (SHIPs) provide free, in depth, one-on-one insurance counseling and assistance to Medicare beneficiaries, their families, friends, and caregivers. SHIPs operate in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.

SHIPs answer questions about Medicare and assist people in obtaining coverage through options that include the Original Medicare program (Part A and Part B), Medicare Advantage (Part C) Plans, Medicare Prescription Drug (Part D) Plans, and programs designed to help people with limited incomes pay for their healthcare, such as Medicaid, the Medicare Savings Program, and the Low Income Subsidy. SHIPs also help people compare Medicare Supplemental insurance policies (Medigap) and explain how they work with Medicare. In addition, SHIPs provide information on long-term care insurance and, when needed, refer beneficiaries to agencies such as the Social Security Administration and local Medicaid offices for additional assistance.

Area Agencies on Aging (AAA)

Area Agencies on Aging (AAAs) were established to help Americans 60 and over in communities across the country. By providing seniors with a range of community-based services options and services that suit them best, AAAs make it possible for older adults to "age in place" in their homes and communities. They also work in helping older adults with Medicare enrollment through one-on-one counseling, assistance in selecting a Medicare Part D prescription drug plan, and outreach to low-income beneficiaries not yet enrolled in money-saving programs.

Medicare Plan Finder

To help you navigate your plan options, Medicare.gov offers a Plan Finder that allows you to search based on region and your specific coverage needs, including the specific prescription medications you take. This useful tool will help you sort through the various plans to ensure your selections best meet your needs.

Financial Assistance for Medicare

Sometimes Medicare beneficiaries need assistance in paying costs associated with their coverage and overall healthcare needs. There are programs available to help individuals who meet the qualifications.

If a beneficiary meets certain income and resource limits, they may qualify for a Medicare program available to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance. Other people pay only a portion of their Medicare drug plan premiums and deductibles based on their income level.

Even if someone doesn't qualify for Extra Help, their state may have programs that can help pay their prescription drug costs. They should contact their state's Medicaid office or their State Health Insurance Assistance Program (SHIP) for more information. Extra help can be applied for at any time if income or resources change.

Some people automatically qualify for Extra Help if they have Medicare and meet any of the following conditions:

- Have full Medicaid coverage
- Get help from their state Medicaid program paying Part B premiums (in a Medicare Savings Programs)
- Get Supplemental Security Income (SSI) benefits

Additional programs available to qualifying individuals include the following:

Programs of All-Inclusive Care for the Elderly (PACE)

Programs of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their healthcare needs in the community instead of going to a nursing home or other care facility. PACE organizations have contracts with specialists and providers in the community to provide care and services to those who need them. Depending on whether an individual has Medicaid or Medicare, beneficiaries may have to pay a premium for some services.

PACE provides all the care and services covered by Medicare and Medicaid if authorized by the beneficiary's healthcare team, and may cover others deemed necessary that fall outside the scope of both programs.

Services covered by PACE include:

- Adult day primary care
- Dentistry
- Emergency services
- Home care
- Hospital care
- Laboratory/x-ray services
- Meals
- Medical specialty services
- Nursing home care
- Nutritional counseling
- Occupational therapy
- Physical therapy
- Prescription drugs

Medicare Savings Programs

There are assistance programs that can help you pay for your Medicare premiums. These programs, each with their own eligibility requirements and income limits, can help with costs associated with Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) deductibles, coinsurance, and copayments.

- The Qualified Medicare Beneficiary (QMB) Program helps pay for the following:
  - Part A premiums
  - Part B premiums
  - Deductibles, coinsurance, and copayments
- Specified Low-Income Medicare Beneficiary (SLMB) Program helps pay for the following:
  - Part B premiums only

- Qualifying Individual (QI) Program helps pay for the following:
  - Part B premiums only
- Qualified Disabled and Working Individuals (QDWI) Program helps pay for the following:
  - Part A premiums only

To see if you qualify for any of the Medicare Savings Programs listed above, contact your state's Medicaid Program Office or consult with experts at SHIP who can aid in navigating the application process.

Medicaid

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services. It is possible to be eligible for both Medicare and Medicaid and the two programs can work hand in hand. There may also be ways to qualify for Medicaid even if an individual's income exceeds their state's income levels by being deemed "medically needy".

Each state has different eligibility requirements so it is best to connect with your state's Medicaid Program Office to determine if you qualify for this assistance.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a cash benefit paid by Social Security to people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits are intended to help people meet basic needs for food, clothing, and shelter, and are not the same as Social Security benefits.

To see if you qualify for SSI assistance, visit benefits.gov/ssa, and use the "Benefit Eligibility Screening Tool". You may also call Social Security at 1-800-772-1213 or contact your local Social Security office for more information.

TYPES OF MEDICARE COVERAGE

Part A and Part B (Original Medicare)

Original Medicare, divided into Part A (hospital benefits) and Part B (medical insurance), is administered by the federal government and is available to American citizens and permanent residents 65 years of age or older. Others may qualify before this age due to end-stage renal disease (ESRD), amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease), or of they've received certain disability benefits for two years or more from the Social Security Administration or the Railroad Retirement Board.

Beneficiaries choosing to access their Medicare services through Original Medicare can go to any doctor, other healthcare provider, hospital, or other facility that's enrolled in Medicare and is accepting new Medicare patients.

- Part A
  - Medicare Part A helps pay for the costs of inpatient care in the hospital and short-term skilled nursing facilities. It also pays for some home health services and hospice care, if the conditions for coverage are met.
- Part B
  - Medicare Part B covers doctor appointments, outpatient care and medications that are administered by a physician. These medications, many of which are administered via injection or an IV infusion, are typically used to treat complex and serious conditions like cancer, arthritis or immune disorders.

Part C (Medicare Advantage)

Medicare Advantage plans are administered by private insurance companies that contract with Medicare and include services of Part A and Part B. These plans may also cover outpatient prescription drugs (Part D).

You can sign up for a Medicare Advantage plan when you're first eligible for Medicare or during the annual Open Enrollment Period (Oct. 15 – Dec. 7). Beneficiaries enrolled in a Medicare Advantage plan pay a monthly premium for their coverage and out of pocket copayments, coinsurances, and deductibles continue to apply as well.

Beneficiaries choosing to access their Medicare services through a Medicare Advantage plan need to use doctors, hospitals, and other providers considered in-network to their specific plan or they pay more or all the costs.

Part D (Prescription Drug Coverage)

Medicare Part D, which began in 2006, added outpatient prescription drug coverage to the Medicare program. Unlike Medicare Parts A and B which are directly administered by the federal government to beneficiaries, Part D coverage is provided by private insurance companies, though the government has oversight over the program. Medicare beneficiaries must opt in for Part D coverage and can choose or change plans each year during the Open Enrollment Period (Oct. 15 – Dec 7). During this time, beneficiaries compare the plans available in their state and choose the coverage that best fits their specific health and financial needs. This open marketplace creates competition between plans and incentives for insurers to keep coverage broad and prices low. These savings can be passed to beneficiaries in the form of lower copays, deductibles or premiums in their Part D plans. CMS reviews and approves these plans and generates a national average bid amount. Individual plan premiums are determined by comparing each plan's bid to the national average bid.

Medigap

Medigap is Medicare supplemental insurance. Sold by private insurance companies, they can help pay some of the healthcare costs ("gaps") Original Medicare doesn't cover, such as Medicare deductibles, coinsurance and some extra benefits such as care when you travel outside the U.S.

To buy a Medigap policy you must access Medicare benefits through Original Medicare, not Medicare Advantage. It is also important to know that a Medigap policy only covers the individual (not a spouse), so if both want this supplemental coverage, separate policies must be purchased.