The Women's Bar Association of the State of New York

presents

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Continuing Legal Education Series

Understanding Medicare

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Table of Contents

- I. Enactment/Legislative History
- II. Medicare Eligibility and Coverage,
  - A. Medicare Part A
    - 1) Coverage
    - 2) Premiums, Deductibles & Co-Pays
    - 3) Skilled Nursing Care
    - 4) Benefit Periods
  - B. Medicare Part B
    - 1) Premiums/IRMAA
    - 2) Deductibles
    - 3) Coverage, Coinsurance
    - 4) Medigap Policies
  - C. Medicare Part C
    - 1) Coverage
    - 2) Costs and Considerations
    - 3) Premiums, Deductibles
  - D. Medicare Part D
    - 1) Coverage/Formularies
    - 2) Tiers
    - 3) Restrictions
    - 4) Costs, Coverage Periods
- III. Enrollment Periods/Late Enrollment Penalties
- IV. Assistance Programs
  - A. Extra Help
  - B. Medicare Savings Program
  - C. EPIC
- V. Coordination of Benefits
- VI. ObamaCare

Legislative History

Medicare Part A & B
Medicaid

Individuals over 65 years of age discovered it was virtually impossible to get private health insurance coverage. As such, Medicare was created to provide individuals healthcare once they reached the age of 65. This has helped improve the health and longevity of older Americans.

The Social Security Amendments of 1965, Pub.L.89-97, 79 Stat. 286, was enacted on July 30, 1965. Signed into law by President Lyndon Johnson, this legislation contained provisions which resulted in the creation of two programs: Medicare and Medicaid.

This legislation added two amendments to the Social Security Act of 1935.

Title XVIII, which became known as Medicare, includes Part A, which provides hospital insurance for those 65 years of age and older, and Part B, which provides supplementary medical insurance. Finally, health insurance was provided to people 65 years of age and older without regard to their income or medical history.

Title XIX, which became known as Medicaid, provides federal matching funds to states that finance healthcare for individuals who were at or close to the public assistance level.

Medicare Part C and Medicare Part D

Originally as part of the Balanced Budget Act of 1997, Medicare beneficiaries could use private insurers to receive their Medicare benefits. These plans were called "Part C" or "Medicare+Choice" plans. The Medicare Prescription Drug, Improvement and Modernization Act (MMA) changed "Medicare+Choice" plans to "Medicare Advantage Plans" and set parameters for coverage and enrollment.

The Medicare Prescription Drug, Improvement and Modernization Act also known as MMA (Pub. L 108-173, 117 STAT. 2066) was signed into law by President George W. Bush. This law was an amendment to Title XVII of the Social Security Act. It represented a major overhaul of the Medicare program adding new entitlements to the program pertaining to Medicare Advantage Plans (Part C) and prescription coverage (Part D).

With the increasing costs of prescription drugs seniors were making the difficult choice of either eating or buying prescriptions. Many seniors turned to Canada to purchase medications while others got into the habit of splitting pills so their prescriptions would last longer and cost less. Medicare Part D sought to address this problem.

Who is eligible for Medicare?

Individuals 65 years or older (seniors),

Individuals with end-Stage Renal Disease
(permanent kidney failure treated with dialysis or a transplant),

Some disabled individuals (after a 24 month qualifying period).

What does Medicare cover?

In general, Original Medicare covers 80% of the Medicare approved amount of a medical service or product. This leaves an individual responsible for a co-insurance of 20% of the Medicare approved amount.

Co-insurance is a percentage of the bill the patient is required to pay.

Co-payment (co-pay) is a set amount to be paid by the patient.

Coverage under Medicare Part C (Medicare Advantage Plans) can differ from plan to plan and from Original Medicare in regard to co-pays and co-insurance. Individual plan coverage is outlined in their Evidence of Coverage.

Medicare Part D covers prescription drugs based on a drug formulary. Restrictions, deductibles, co-pays, co-insurance may apply.

Medicare Part by Part
Coverage

Medicare has four parts:

Medicare Part A also known as Hospital insurance covers Medicare inpatient care including care received while in a hospital, skilled nursing facility, and in limited circumstances at home. Part A also covers prescription medications administered in a hospital

Medicare Part B covers services and supplies that are medically necessary to treat an individual's health condition. This includes most doctor services (including most doctor service while a hospital patient), outpatient therapy, durable medical equipment, preventative care, ambulance services and certain medications administered by a doctor (i.e. infusion therapy).

Medicare Part C covers hospitals, doctors, labs, durable medical equipment, skilled nursing facilities and most times prescription medications. May also cover extras such as hearing aids, dental examinations, and health club memberships.

Medicare Part D covers prescription medications.

Original Medicare consists of Medicare Part A & Part B.

Medicare Advantage Plans fall under Medicare Part C and provides for Medicare Part A, Part B and in most cases, Part D coverage. Theses plans are sold privately by insurance companies that contract with Medicare as an alternative to Original Medicare. These plans can be found online through Medicare' website.

Medicare Part D can be purchased separately or is included in Part C Medicare Advantage Plans,

Medicare Supplemental Plans also known as Medigap Policies covers the gaps in Original Medicare such as the 20% co-insurance on Medicare covered services and deductibles. Medigap Policies are not part of Medicare. They are sold privately by insurance companies to supplement Original Medicare.

Medicare
A la carte or price fixed

An individual can choose their Medicare coverage in two ways:

Original Medicare is the a la carte option. It provides more freedom in choosing doctors and hospitals, but, that freedom comes at a higher price. It is a more expensive option since this option requires the purchase of a Medicare Supplemental Plan (Medigap) and a separate Medicare Prescription Drug Plan (Part D) each with additional monthly premiums, deductibles and co-pays.

Medicare Advantage is the price fixed option. In general, these plans restrict an individual's choice of doctors and hospitals to a network of providers, however, drug coverage is generally included in these plans and a supplemental plan is not required with these plans.

Medicare Part A
Premiums

Most people do not pay a monthly premium for Part A (sometimes called "premium-free Part A").

An individual of 65 years or an individual who is eligible to receive Social Security benefits or Railroad Retirement Board benefits and has paid Medicare taxes for 40 quarters (10 years) qualifies for $0.00 monthly premium for Part A.

An individual, who paid Medicare taxes for 30-39 quarters, pays the standard Part A monthly premium of $240.00

An individual, who paid Medicare taxes for less than 30 quarters, pays the standard Part A monthly premium of $437.00

Medicare Part A
Hospital Inpatient Deductibles and Copays

In 2019: A patient pays—

- $1,364.00 deductible for each benefit period*
- Days 1-60: $0.00 copay for each benefit period
- Days 61-90: $341.00 copay per day of each benefit period
- Days 91-150: $682.00 copay 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

Medicare Part A
Skilled Nursing Facility Coinsurance

First 20 days of inpatient care each benefit period*:	$ 0.00
For days 21-100 each benefit period:	$170.50/day

* Medicare Part A Benefit Period

In Medicare Part A, a benefit period begins the day an individual is admitted to a hospital or skilled nursing facility and ends when they have been out for sixty (60) days in a row. The individual can re-enter the hospital within the same sixty (60) days without paying a new Part A deductible (same benefit period).

However, if the individual goes back to the hospital after sixty (60) days then a new benefit period starts and the deductible is applicable again. The individual will be responsible to pay two deductibles in this case-one for each benefit period even if they are admitted to the hospital both times for the same health problem. The amount of the co-pays required will also be affected by a new benefit period

Medicare Part B Premiums

The standard Part B premium amount in 2019 is $135.50

An individual pays the standard premium amount under the following circumstances:

1. They enroll in Part B for the first time in 2019;
2. They do not get Social Security benefits;
3. They are directly billed for their Part B premiums (meaning that the premiums are not deducted from their Social Security benefits);
4. They have Medicare and Medicaid and Medicaid pays their Part B premium. (Their state will pay the standard premium amount of $135.50)

If an individual pays their Part B premium through their monthly Social Security benefits, their premium may be lower than the standard premium since their Social Security benefits did not increase enough to cover the increase in the Part B premium from 2018 to 2019.

When an individual enrolls in Medicare Part B, they are informed by the Social Security Administration of the amount of their premium.

Medicare Part B and Income Related Monthly Adjustment Amount (IRMAA)

If an individual's modified adjusted gross income (total adjusted gross income and tax-exempt interest income {MAGI}) is above a certain amount, they may pay an Income Related Monthly Adjustment Amount (IRMAA). The IRMAA will increase an individual's Part B and Part D premiums by a set amount depending on their income level.

Medicare uses the modified adjusted gross income reported on an individual's most recent tax return provided to the Social Security Administration by the Internal Revenue Service. The chart below indicates the amount of premium an individual will pay depending on their MAGI in 2017 (on 2018 tax return).

File individual tax return	File Joint tax return	File married or separate	Add to B	Part B Premium	Add to Part D prem.
$85,000 or less	$170,000 or less	$85,000 or less	(+$0.00)	$135.50	(+$ 0.00)
Above $85,000 up to $107,000	Above $170,000 up to $214,000	See below	(+$54.10)	$189.60	(+$12.40)
Above $107,000 up to $133,500	Above $214,000 up to $267,000	See below	(+$135.40)	$270.90	(+$31.90)
Above $133,500 Up to $160,000	Above $267,000 up to $320,000	See below	(+$216.70)	$352.20	(+51.40)
Above $160,000 up to $499,000	Above $320,000 up to $750,000	Above $85,000	(+297.90)	$433.40	see below*
Equal or above $500,000	Equal or above $750,000	Equal or above $415,000	(+$325.00)	$460.50	see below*

*Add to Part D premium

Above $160,000 Up to $214,000	Above $320,000 up to $428,000	Above $415,000 (+$77.90)	(+70.90)
Above $214,000 Up to $500,000	Above $428,000 up to $750,000	(+$77.90)	(+70.90)
Above $500,000	Above $750,000	See above	(+77.40)

The Social Security Administration will notify an individual/couple if they qualify for IRMAA, the amount and of their right to appeal the determination.

Medicare Part B Deductibles

The Part B deductible in 2019 is $185 per year.

After the deductible is met, an individual typically pays twenty (20%) percent of the Medicare approved amount for

1. Most doctor services (Doctor must accept Medicare. Most accept Medicare but not all do),
2. Outpatient therapy,
3. Durable medical equipment,
4. Preventive services,
5. Ambulance services.

Some Medigap policies cover the Medicare Part B deductibles and the remaining twenty (20%) percent coinsurance.

Medicare Supplemental Insurance
Medigap Policies

A Medicare Supplemental Insurance (Medigap) policy, sold by private companies, can help pay some of the health care costs that Original Medicare does not cover, like copayments, coinsurance, and deductibles.

Some Medigap policies also offer coverage for services that Original Medicare does not cover, like medical care when an individual travels outside the United States. If an individual has Original Medicare and they buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered healthcare costs. Then the Medigap policy pays its share.

Medigap policies are alphabetical, A, B, C, D, F, G, K, L, M, N (except in Massachusetts, Minnesota, Wisconsin) and each have a set number of services they cover. Different companies sell Medigap plans at difference prices, but, the coverage is the same. So if AARP sells a Medigap Plan A and United Healthcare sells a Medigap Plan A each plan covers the same services, but, they can charge different premiums. So it is important to not only review what type of coverage is needed (A, B, C, D, F, G, K, L, M, N), but, also to shop around for the best price for that particular plan.

Retiree health insurance provided by unions or from government entities sometimes can act as Medigap Plans thereby negating the need for extra insurance. In fact an individual who has such coverage needs to be careful. If they enroll in a Medicare Advantage Plan or a Medicare Part D plan, they can risk losing retiree coverage from a union or government entity.

Medicare Part C
Costs and Considerations

There are four types of Medicare Advantage Plans:

Health Maintenance Organization (HMO) Plans
Preferred Provider Organization (PPO) Plans
Private Fee-for-Service (PFFS) Plans
Special Needs Plans (SNPs)

Always read the plan's Evidence of Coverage (EOC) since costs vary from plan to plan. Medicare Advantage Plans (MA) are the privatization of Medicare. Individuals enter into contracts with private companies for medical coverage.

Each company establishes plans with its own premiums, deductibles, copays, coinsurance, out of pocket costs, and formularies.

Premiums: Many Medicare Advantage plans take an individual's Part B premium as payment leaving enrollees with a $0 premium. However, plans can charge extra premiums in addition to the Part B premium depending on the plan. The average (extra) monthly premium charged by Medicare Advantage plans is $28 in 2019.

Deductibles: Most MA plans follow the yearly Part B deductible; however, some have additional deductibles (check individual plan's Evidence of Coverage).

The rules change every year so it is important to check for changes before continuing in a MA plan for the next year.

Medicare Part D
Medicare Prescription Drug Plan

There are two types of Part D plans;

1. Stand alone plans
2. Coverage included in Medicare Advantage Plans.

Part D covers only prescription medications. It does not cover over the counter medications. Prescription medications are covered pursuant to a formulary of drugs which establishes what drugs are and are not covered by a particular plan. It also shows the restrictions placed on the dispensing of a particular drug and the tier in which the drug is placed. Each Part D plan also has a network of pharmacies and mail order companies.

Medicare Part D and Tiers

The cost of a prescription drug is set by the tier in which a plan places it.

Tier 1: Most Generic prescription drugs

Tier 2: Preferred Brand Name prescription drugs

Tier 3: Non-Preferred Brand Name prescription drugs

Tier 4: Specialty Prescription Drugs (i.e. cancer medications)

Some plans have additional tiers for preferred and non-preferred generic prescription drugs resulting in plans with 6 Tiers of drug pricing.

The lower the tier the less expensive the drug is going to cost. The higher the tier the more expensive the drug is going to cost.

Medicare Part D and Restrictions

Even if a prescription drug is included in a Part D plan's formulary, it may be subject to restrictions,

PA: Prior Authorization-the patient needs to get the doctor to show the Part D plan that there is a medically necessary reason why the patient must use that particular drug.

QL: Quantities Limited-the patient can only get a certain/set amount of the medication as authorized by the plan. If the patient needs a larger amount of the drug, they or their doctor needs to request it from the plan (formulary change).

ST: Step Therapy-the plan can require the patient to use a less expensive drug or drugs other than the one prescribed to them before the plan will cover the one prescribed by their doctor.

Medicare Part D
Costs

Premiums: Monthly premiums vary by plan and may be subject to IRMAA. The national average premium for a Part D plan in 2019 is $33.19 per month.

Deductible: Deductibles varies by plan, however, Medicare prescription plans cannot have an annual deductible that exceed $415.00 in 2019. Many plans do not charge a deductible; however, such plans tend to have a higher monthly premium. In many cases, coverage for a Medicare Part D plan does not start until the deductible has been met. However, many plans cover low cost generic prescription drugs during the deductible period. Therefore, for individuals with no or few or all generic prescriptions, it is best to take a plan with a higher deductible, but, a lower premium. Such an individual will never meet the deductible, but, they will save money every month with lower premiums.

Copays and Coinsurances: The cost the patient pays for the prescription medication varies by plan.

Coverage Period: After an individual meets their deductible (if they have one) prescription medications are covered (with or without a co-pay or co-insurance payment) until they reach the plan's initial coverage of $3,820.00 in 2019.

Once an individual reaches that level, they fall into the Donut Hole.

Donut Hole/Coverage Gap* starts at $3,820.00 and lasts until an individual spends a total of $5,100.00 (out of pocket threshold-TrOOP) in 2019.

Catastrophic Coverage: Once an individual reaches $5,100.00 out of pocket, they exit the Donut Hole and are covered under catastrophic coverage. During this period an individual pays a small co-pay or coinsurance for their prescription drugs.

2019 Donut Hole Discounts*

For brand name drugs purchased while in the Donut Hole, Part D enrollees receive a 75% Donut Hole discount on the total cost of those drugs. The discount includes a 70% discount paid by the brand name drug manufacturer and a 5% discount paid by the enrollee's Medicare Part D plan. The 70% paid by the drug manufacturer combined with the 25% paid by the enrollee counts toward the enrollee's true out of pocket costs (TrOOP) or Donut Hole exit point.

For example: If an individual reaches the Donut Hole and purchases a brand name medication with a retail cost of $100, they will pay $25 for the medication, and receive a $95 credit toward meeting their 2019 total out of pocket spending limit.

Medicare Part D beneficiaries who reach the Donut Hole will also pay a maximum of 37% copay on generic drugs purchased while in the Coverage Gap (receiving a 63% discount).

For example: If an individual reaches the 2019 Donut Hole and their generic medication has a retail cost of $100, they will pay $37.00. The $37.00 will count towards their TrOOP or Donut Hole exit point.

*source QIMedicare.com

Understanding Medicare Part D
Helpful Hints

The least expensive plan might not be the best plan. Paying for an inexpensive plan that does not cover the individual's prescription medications is useless.

Premiums, deductibles, and drug formularies can change. An individual must check the plan's drug formulary every year and read notifications regarding formularies during the year to ensure that prescription medications are still covered without a cost increase or added restrictions.

If an individual is a snowbird, they need to enroll in a National Part D plan to insure they will have coverage in whatever state they are living.

Enrollees in Part D plans should know if the pharmacy they like to use is within their Part D plan's network. They should also know which pharmacies in their plans are considered preferred pharmacies since preferred pharmacies offer lower co-pays and coinsurance payments. Also, enrollees should consider using mail order for their prescriptions; however, prices for such services should be check against preferred pharmacy prices to insure they are getting the best price for their medications.

Getting Assistance

There are many programs on a federal and state level that are available that can assist individuals and married couple help defray the high costs of Medicare.

Extra Help

Extra help is a federal program that provides financial assistance to low income individuals in regard to the Medicare Part D program. If enrolled in an Extra Help Part D plan an individual can qualify for $0 premium if fully eligible.

To qualify individuals must have an income below $18,735.00 per year for single individuals and $25,365 for a married couple living together. Living with dependent children or grandchildren can raise the allowable income level for an individual. Housing assistance, food stamps, scholarships, education grants, assistance from others to pay for household expenses are excluded as income for Extra Help purposes. Check with SSA for additional income exclusions.

To qualify individuals in 2019 must have resources below $12,890* or $25,720.00* if married and living together. Resources for Extra Help purposes include bank accounts, stocks and bonds and real estate (not primary residence). *An additional $1,500.00 for individuals and $3,000.00 for couples maybe excluded from resources as a burial exclusion thereby increasing the resource limit. An individual's primary residence, car, personal possessions, life insurance policies are also excluded from the resource level for Extra Help purposes. Check with SSA for additional resource exclusions.

Medicare Savings Programs

The Medicare Savings Program is funded by the federal government but administered by individual states.

There are four Medicare Savings Programs (MSP) in New York State which are administered by Medicaid

1. Qualified Medicare Beneficiary (QMB) Program
2. Specified Low-Income Medicare Beneficiary (SLMB) Program
3. Qualifying Individual (QI) Program
4. Qualified Disabled Working Individual (QDWI) Program

If eligible, individuals in these programs can obtain financial assistance toward paying their Medicare Part A premium, Medicare Part B premium, co-pays, co-insurance and/or deductibles.

Different states have different names and income/resource requirements for the Medicare Savings Program. For example, North Carolina has the Comprehensive Medicare Savings

Program (MQB-Q), Limited Medicare Savings Program (MQB-B) and Limited Medicare Savings Program (MBQ-E).

For more information on Medicare Savings Programs in New York State check online at https://www.health.ny.gov/health_care/medicaid/program/update/savingsprogram/.

Elderly Pharmaceutical Insurance Coverage Program (EPIC)

EPIC is a New York State Program

There are two plans under this program: the Fee Plan and the Deductible Plan.

The Fee Plan requires EPIC members to pay a set fee based on their income to the EPIC program. The fee set by a schedule on a sliding scale based on an individual's or married couples' income from the prior year. Once the member meets their Part D deductible, EPIC will help lower their Part D copayments on their prescription drugs. EPIC copays range from $3.00 to $20.00. Under the Fee Plan, EPIC will also cover premium expenses up to $39.00 per month. Therefore, if an individual or married couple enrolls in a benchmark Part D plan (listed plans that have a $39.00 or less monthly premium); they will have a $0.00 premium.

The Deductible Plan requires an individual or married couples meet a deductible before EPIC will assist in paying for their Part D prescription drugs. Deductibles are set by a schedule on a sliding scale based on an individual's or married couples' income from the prior year. To provide Part D premium assistance, the EPIC deductible shown on the Deductible Plan Schedule is further reduced by $468.00 per year, the annual cost of basic benchmark Part D drug plan.

For more information on eligibility, income requirements, fee and deductible schedules and benefits see https://www.health.ny.gov/health_care/epic/.

Enrolling in Medicare

Initial Enrollment Period (IEP)

When an individual is first eligible for Medicare, they have a seven (7) month Initial Enrollment Period (IEP) to sign up for Part A and/or Part B/and Part D or a Medicare Advantage Plan.

The Initial Enrollment Period begins:

- three (3) months before the month an individual turns 65 years of age,
- includes the month the individual turns 65 years of age and
- ends three (3) months after the month an individual turns 65 years of age.

In order for Medicare coverage to begin at 65 years of age, it is recommended that an individual enrolls three (3) months before their 65th birthday.

General Enrollment Period (GEP)

If an individual misses their Initial Enrollment they can enroll in Part A and/or Part B, during the General Enrollment Period which runs from January 1st-March 31st each year if each of the conditions listed below apply:

- The individual did not sign up when they were first eligible;
- The individual is not eligible for a Special Enrollment Period;
- The individual must pay premiums for Part A and/or Part B.

If enrolled during General Enrollment Period, coverage will not start until July 1st. The individual may have to pay a higher premium for late enrollment in Part A and/or a higher premium for late enrollment in Part B (see late enrollment penalty).

Annual Enrollment Period (AEP) a/k/a Fall Open Enrollment Period

The AEP runs from October 15th-December 7th every year.

This is the time for Medicare beneficiaries to review their coverage and decide what kind of coverage they desire for the following year. Do they want to stay with Original Medicare or switch to a Medicare Advantage Plan? Do they want to enroll in or change a Medicare Prescription Plan? Those enrolled in Medicare Advantage Plans and Medicare Prescription Drug Plans must particularly review their plans for any upcoming changes in coverage for the new year that may affect their future coverage. Individuals may wish to change or disenroll in plans due to an increase in premiums and costs of medications, additional restrictions, less coverage of prescription medications, alterations in networks/formularies/providers/pharmacies.

Medicare Open Enrollment Period (MA OEP) for Medicare Advantage Plans

Individuals enrolled in Medicare Advantage get a one time chance to change their plans outside of their Initial Enrollment Period and the Annual Enrollment Period from January 1st to March 31st of each year.

During this time period, and individual can either change from one Medicare Advantage Plan to another Medicare Advantage Plan or an individual can disenroll from a Medicare Advantage Plan and enroll in Original Medicare.

Special Enrollment Periods (SEPs)

Special enrollment periods provide an individual with a special 8 month period outside the IEP or AEP to enroll in Medicare Part B, a Medicare Advantage Plan or a Medicare Part D plan without incurring a late enrollment penalty.

To qualify for a Special Enrollment Period, an individual must:

- be eligible for Medicare;
- either enrolled in Medicare Part B or had coverage from a current employer or from their spouse's current employer when first eligible for Medicare and;
- from the time of first eligibility did not incur a lapse in coverage of more than eights consecutive months.
- with Medicare Part D must have had creditable coverage from another source.

Special Enrollment Periods allow an individual to enroll in Medicare Part B or Medicare Part D outside of the IEP or AEP under special circumstances:

- An individual loses their current coverage;
- An individual has a chance to get other coverage;
- An individual's plan changes its contract with Medicare;
- An individual moves out of the plan's coverage area;
- Other special situations (check with Medicare)
  i.e. An individual is eligible for both Medicare and Medicaid

Check www.medicare.gov for further qualifying events for a SEP.

Benefits of Special Enrollment Period

If an individual misses their Initial Enrollment Period, they will be forced to wait for the General Enrollment Period. This can result in an individual being without healthcare coverage for an extended period of time due to a delay in enrollment. The individual may also face a late enrollment penalty for the period of time they are not enrolled.

A Special Enrollment Period allows an individual to enroll sooner and obtain coverage quicker and with a smaller penalty if any.

Medicare and Late Enrollment Penalty
Part B and Part A

In most cases, if an individual does not sign up for Part B when first eligible (IEP), they will have to pay a late enrollment penalty.

This penalty lasts for as long as the individual has Part A/or Part B. Their monthly premium for Part B can go up 10% for each full 12-month period that they could have had Part B but did not sign up for it.

In addition, they may have to wait until the General Enrollment Period to enroll in Part B.

Part A has a similar late enrollment penalty that can apply as well if an individual pays a Part A premium.

Part D

Creditable Coverage is coverage that is considered as good as, if not better than coverage provided by Part D. Those who have creditable coverage from their employers do not have to enroll in Medicare Part D when first eligible. Their employer will provide them with a notice of creditable coverage every year which must be retained as proof to avoid a possible Part D late enrollment penalty. There are other forms of creditable coverage such as Veteran's Benefits.

If an individual goes without Part D coverage or creditable drug coverage for a continuous period of sixty-three (63) days or more after their Initial Enrollment Period (IEP) ends they can be subject to a late enrollment penalty.

Medicare calculates the penalty by multiplying 1% of the "national base beneficiary premium" ($33.19 in 2019) times the number of full uncovered months that an individual did not have Part D coverage or creditable coverage. The monthly premium is rounded to the nearest $.10 and added to the individual's monthly Part D premium. The penalty is permanent and lasts as long as person has Part D coverage.

The national base beneficiary premium increases each year, so the penalty amount may also increase each year.

Coordination of Benefits

Many times an individual may have multiple sources of insurance coverage.

They may have insurance that is considered the primary payer (the insurance that pays first) and insurance that is considered the secondary payer (the insurance that pays second).

The primary payer pays up to the limits of its coverage. Examples of primary payers include depending on the circumstances: Medicare, Worker's Compensation, Black Lung benefits, No-Fault Insurance (including auto insurance), Liability (self insurance plans and auto insurance)

The secondary payer only pays if there is a primary payer and there are costs the first payer did not cover. Therefore, if there is no primary insurance in place, a secondary payer will not pay. Also, the secondary payer may not pay all of the uncovered costs. It depends on its policy.

If Medicare is the primary payer and an individual's employer is the secondary payer, the individual needs Medicare Part B before their employer's insurance will pay.

If an individual has retiree insurance from a former employer—**Medicare pays first.**

If an individual is 65 years or older has group health insurance from their or their spouse's current employer who has 20 + employees-**Group health insurance pays first.**

If an individual is under 65 years of age and is disabled and has group health insurance from their or a family member's current employer and the employer has 100+ employees-**Group health insurance pays first.**

If an individual has Medicare due to End-Stage Renal Disease (permanent kidney failure) requiring dialysis or a kidney transplant-**Group health insurance pays first for the first 30 months after they become eligible for Medicare, then Medicare pays first after this 30 month period ends.**

If an individual has Marketplace coverage and then ages into Medicare (retaining their Marketplace plan)—**Medicare pays first.**

Medicaid will never pay first for services that Medicare covers. It will only pay after Medicare, employer health plans, and or Medicare Supplemental Insurance (Medigap) has paid.

To B or Not to B

Many people working and covered by large group health plans (more than 20 employees) turn down Medicare Part B because they are adequately covered under their employer's insurance. In such a case the employer's plan is primary and Medicare is secondary.

If an individual's employer has less than 20 employees, their insurance is considered a small group health plan and Medicare pays first and the employee's plan pays second. In such a case the individual needs Medicare Part B. Without it their employer's plan will not cover them since it is secondary coverage and without Part B the individual will not have primary coverage.

Retiree coverage is considered secondary coverage and an individual will need to enroll in Medicare Part B for primary coverage.

Before deciding if they need to enroll in Part B or not, individuals should check with their HRA manager for more information as to what type of coverage they have with their employer –primary or secondary.

Even if an individual has primary coverage through their employer, they should consider if it is adequate coverage for their needs (policy limits). The cost of Medicare Part B might help supplement their coverage.

Coordination of Benefits and Part C

Be careful, if an individual has a retirement health coverage plan (i.e. teachers) they can lose it if they enroll in a Medicare Advantage plan. Most retirement health coverage act as a supplement to Original Medicare and if they do not have Original Medicare, then the retirement coverage will have nothing to supplement and will terminate. The individual may not be able to retrieve it later.

An individual who has a retirement health coverage plan also cannot have a Medigap plan or a Medicare Advantage plan (unless it is part of the retirement plan) for the same reason.

The Patient Protections and Affordable Care Act (PPACA)
a/k/a Affordable Care Act (ACA)
a/k/a Obamacare

The ACA was enacted into law as an amendment to the Public Health Service Act (Pub. L 111-148,124 STAT. 119-1024).

It was signed into law by President Barack Obama on March 23, 2010.

The ACA requires that every individual who meets residency requirements have "minimum essential coverage'. Unless qualified for an exemption, an individual without such coverage faces a federal penalty. To provide individuals and businesses with coverage, Health Insurance Exchanges (Marketplaces) were established for them to purchase health insurance plans. While having health insurance is mandatory, using the Health Insurance Exchanges is not. However, there is an incentive to purchasing plans within the Exchanges. Incentives include advance payment of tax credits and cost sharing subsidies to help offset the cost of plans sold in the exchange. Plans are ranked by color: Platinum, Gold, Silver and Bronze. Different plans provide different services at varying costs, but all are required to provide essential services.

Obamacare and Medicare
Coordination of Benefits

In regard to Medicare, the major concern with ACA is the coordination of benefits.

Individuals enroll in marketplace plans to obtain required "minimum essential coverage", however, Medicare is considered "minimum essential coverage" so an individual who is eligible for Medicare does not need a marketplace plan.

Subsidies on premiums for plans in the individual market exchange (exchange plan) end when an individual becomes eligible for premium free Medicare Part A. As such there is no benefit to keeping the exchange plan since it becomes very expensive to keep and since it does not coordinate with Medicare.

Since 2014, beneficiaries of exchange plans must actively cancel their coverage when eligible for premium free Medicare Part A or risk paying full premiums for coverage in exchange for no benefit.

Do not delay enrolling in Medicare thinking an exchange plan provides coverage. This can result in late enrollment and penalties.

Those who do not qualify for premium free Medicare Part A, can buy a plan in the exchange in lieu of Medicare, however, if they change their mind later, it can result in an late enrollment penalty. For more information see Analysis of the Coordination of Benefits Between Medicare and Qualified Health Plans Purchased Through American Health Benefit Exchanges and the Small Business Health Options Program NYSBA Health Law Journal Fall 2013/Vol. 18/ No. 3.