Introduction

Whether you're new to Medicare or experienced with Medicare market offerings, this job aid includes critical information about key concepts and recent changes in the Medicare landscape.

What Is Medicare?

Medicare is a federal program that provides health care coverage to people who are age 65 and older or have certain disabilities. Medicare and Medicaid were enacted in 1965 as part of the Social Security Act to provide health insurance for the aged and to complement Social Security Title II benefits. The program is administered by the Centers for Medicare & Medicaid Services (CMS), a division of the Department of Health and Human Services.

In 1972, Medicare eligibility was expanded to include individuals under age 65 with certain long-term disabilities and to individuals with end-stage renal disease (ESRD). Over the years additional changes were legislated to payment schedules for providers and beneficiaries. The most recent and significant changes were the result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) which improved access to care for Medicare beneficiaries. The MMA added prescription drug benefits, new Medicare supplement choices, new Medicare Advantage choices, and income indexing that ties the premium cost to the beneficiary's income for Part B benefits.

Medicare Today

The Medicare market is a growing and changing part of the American health care system. The number of Medicare-eligible individuals is expected to grow to 62 million by 2020 as baby boomers begin to reach age 65. This is a significant increase from 1965 when only about half of seniors had insurance coverage. When Medicare was implemented in 1966 more than 19 million individuals enrolled on July 1.

Looking toward the future, baby boomers will have a significant impact on the Medicare program. There are an estimated 78.2 million baby boomers born between the years of 1946 and 1964. The first baby boomers turned 65 in 2011 and are now eligible for Medicare. By 2030, an estimated 57.8 million baby boomers will be between the ages of 66 and 84. We can expect additional changes to Medicare as this generation reaches retirement age.

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)

The MMA introduced prescription drug benefits by first creating a prescription drug discount card effective until 2006 at which time the new voluntary Part D outpatient prescription drug benefit became available. It also introduced new Medicare supplement choices (plans K and L), benefits, and delivery options for Medicare beneficiaries. The MMA created price indexing related to the premium charge for Original Medicare Part B benefits beginning in 2007. This act also allowed Medicare to consider beneficiary income for the first time and made prescription drug subsidies available to beneficiaries with incomes of less than 150% of the federal poverty limit. The MMA also allowed for competition among health plans to foster innovation and flexibility in coverage, authorized coverage for new preventive benefits, and made numerous other changes.

The MMA was designed to improve access to care for people with Medicare and to respond to changes in the nation's economy and health care delivery system. Though the Medicare program has been modified many times since its inception, the MMA represents the most significant reform to the Medicare Program since 1965.

The key reforms introduced by the MMA were scheduled to roll out over three years:

2004	2005	2006
▪ Drug Discount Card ▪ Changes to Medicare Advantage (Part C): ○ Private-fee-for-service plans offered ○ Local PPO and HMO plans offered ▪ Moratorium on therapy caps until January 1, 2006	▪ Drug Discount Card ▪ New preventive services ▪ Part B deductible increases ▪ First Annual Enrollment Period	▪ Medicare Prescription Drug (Part D) plans effective (end of Drug Discount Card program) ▪ Medicare Advantage Regional PPOs offered ▪ Medigap: new plans K & L added

To learn more about Medicare or the MMA, visit www.medicare.gov.

Medicare Coverage

Medicare is separated into four parts:

- Part A, Hospital Insurance (Original Medicare)
- Part B, Medical Insurance (Original Medicare)
- Part C, Medicare Advantage Program (established in the 1997 Balanced Budget Act as Medicare + Choice and reformed under the Medicare Modernization Act (MMA) in 2003)
- Part D, Prescription Drug Program (part of the 2003 MMA reforms and effective January 1, 2006)

Original Medicare

Medicare pays for about half of all beneficiary health care spending, and was never intended to cover all health care costs. It consists of two parts – Part A which helps cover inpatient care in hospitals and skilled nursing facilities and Part B which helps cover medical services like doctors' visits, outpatient care and other medical services not covered by Part A. The two parts together are referred to as Original Medicare.

Original Medicare generally requires cost sharing in the form of deductibles, copays and coinsurance for most services. Some medical expenses are not covered at all by Parts A or B.

Medicare Part A – Hospital Insurance

Part A is part of the Original Medicare program introduced in 1965. Often referred to as Hospital Insurance, it covers medically necessary:

- Inpatient hospital stays, including inpatient mental health care
- Skilled nursing facility care
- Hospice care
- Home health services
- Blood at a hospital or skilled nursing facility during a covered stay

Medicare-approved inpatient hospital care is covered based on a "benefit period." A benefit period begins the day a beneficiary goes into a hospital or skilled nursing facility. The benefit period ends when the beneficiary hasn't received any inpatient hospital care (or care in a skilled nursing facility) for 60 days in a row. If a beneficiary is discharged and readmitted to a hospital or skilled nursing facility within 60 days, the previous benefit period continues. If a beneficiary goes into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins.

Beneficiaries are responsible for deductibles and coinsurance related to their Medicare Part A benefits.

Lifetime reserve days are 60 extra days of Part A coverage members can use in their lifetime. They are not renewable.

Skilled nursing facility care is covered following a three-day inpatient hospital stay for a related illness or injury. Care is covered for up to 100 days in a benefit period. This type of care cannot be long-term care, such as becoming a resident of a nursing home.

Medicare also covers home health and hospice care. Home health care is limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services, including therapy, social services and medical equipment and supplies. Medicare covers 100% of the cost of medically necessary home health care services except for 20% coinsurance that beneficiaries pay for medical equipment.

Hospice care is for people with a terminal illness who have a life expectancy of six months or less, and includes coverage for drugs for pain relief, medical and support services, and other services such as grief counseling. Medicare covers 100% of the cost for most hospice care.

Medicare Part B – Medical Insurance

Medicare Part B is the second part of Original Medicare. Although Part B coverage is discussed at the time the beneficiary enrolls in Part A, there is more flexibility for enrollment in Part B coverage. Part B helps cover medically necessary **outpatient** care including:

- Doctor visits
- X-rays and laboratory services
- Ambulance services
- Emergency or urgent care
- Therapy and rehabilitative care
- Chiropractic services
- Outpatient mental health care
- Outpatient surgery and other procedures
- Certain preventive screenings and tests, such as colorectal screenings, bone mass measurements, cancer screenings, cardiovascular screenings, diabetes screenings, glaucoma tests, mammograms, pap test and pelvic exam, and prostate cancer screenings
- Yearly "Wellness" visit in addition to the "Welcome to Medicare" exam
- Diabetic self-management training and diabetic testing supplies
- Durable medical equipment and prosthetic/orthotic items
- Flu, Hepatitis B and pneumococcal shots
- Kidney dialysis services and supplies
- Home health services not covered by Part A
- Other medical services that Part A doesn't cover

Most Medicare Part B services are subject to an annual calendar-year deductible.

What's Not Covered by Original Medicare

This list represents some of the services not covered by Medicare Part A and/or Part B:

- Acupuncture
- Cosmetic surgery
- Custodial care at home or in a nursing home
- Deductibles, coinsurance and copays
- Dental care and dentures (with only a few exceptions)
- Some diabetic supplies (others may be covered by Part D)
- Routine vision care and most eyeglasses
- Routine foot care
- Hearing aids and hearing exams
- Most prescription drugs (may be covered by Part D)
- Services received outside the United States (with limited exceptions)

Medicare Part C – Medicare Advantage

Originally called Medicare + Choice, Medicare Advantage plans are designed to offer more health care coverage choices and better health care benefits for beneficiaries. Medicare Advantage (MA) plans are health plan options that are approved by Medicare and administered by private companies. They are part of the Medicare program and sometimes called Part C.

MA plans replace Original Medicare benefits and are an alternative to Original Medicare plus Medigap or Medicare Cost plans. MA plans are offered by private health plans based on an annual contract with CMS. Medicare pays a capitated rate to the private health plan to administer Original Medicare benefits for its members. The MA plan may also charge an additional premium to offer a higher level of benefits than Original Medicare and/or incorporate Part D prescription benefits into the MA plan creating a Medicare Advantage-Prescription Drug (MA-PD) plan.

Benefits and premiums may change on an annual basis and members who join an MA plan use the health care card provided by the plan. Members are replacing the benefit structure of their Original Medicare benefits with the benefits offered by the MA plan in which they've enrolled. MA plan members do not have access to Original Medicare benefits but are still enrolled in the Medicare program and have all the rights and protections of Original Medicare.

Types of Medicare Advantage Plans

Medicare Advantage plans are available with and without Medicare Part D prescription drug coverage. If they cover drugs, the plans are referred to as MA-PD plans. There are three main types of Medicare Advantage plans:

- Medicare Advantage Coordinated Care Plans, including:
  - Health Maintenance Organizations (HMO)
  - Local or Regional Preferred Provider Organization Plans (PPO)
  - Medicare Advantage Special Needs Plans (SNP)
- Medicare Advantage Private Fee-for-Service Plans (PFFS)
- Medicare Medical Savings Account Plans (MSA)

SNP and MSA plans have very unique benefit structures. The other three types of plans have somewhat similar benefit structures with defined copay and/or coinsurance benefits. Where HMO, PFFS and PPO plans differ most significantly is in their provider contracting structures.

Medicare Advantage Coordinated Care Plans

Coordinated Care Plans use contracted networks of doctors, hospitals, and other health care providers. A Coordinated Care Plan can reduce out-of-pocket expenses for deductibles and co-payments. It may also offer unlimited coverage of some benefits that have limits under Original Medicare. Benefits vary from plan to plan.

Health Maintenance Organizations (HMO)

Usually, members of these plans must select a **primary care physician** to coordinate all of their health care needs and **obtain referrals** for services outside their primary care clinic. Members do not typically have out-of-network benefits except for:

- Medical emergencies
- Urgently needed care outside of the plan's service area
- Out-of-area renal dialysis

HMOs typically do not pay for non-referred care.

Preferred Provider Organizations (PPO)

PPO plans have **contracted provider networks**. Members may use any in-network provider to receive in-network benefits. Members do not have to choose a primary care physician or clinic and never need referrals.

PPO plans also offer **defined out-of-network benefits** that cover eligible services at a reduced benefit level leaving the member with a higher out-of-pocket cost.

Special Needs Plans (SNP)

SNPs are designed to meet the needs of people with unique chronic health conditions and/or financial situations. They help manage and coordinate the multiple services and providers that these members need. Typically SNPs are available to people who:

- Live in institutions such as nursing homes,
- Are eligible for both Medicare and Medicaid or,
- Have one or more specific chronic or disabling conditions.

SNPs may design their plan to cover people in just one of these groups, but may also offer the plan to others.

Medicare Advantage Private Fee-For-Service (PFFS) Plans

A PFFS plan can reduce out-of-pocket expenses for deductibles and copays. The PFFS plan, not Medicare, decides how much the plan pays and how much the member pays for medical services. The PFFS plan must pay providers at a rate that does not put the provider at financial risk.

PFFS plans may or may not have direct contracts with providers. If they choose NOT to have signed contracts with providers, they must pay providers rates that are equal to or greater than Original Medicare payments.

In general, PFFS plan members may go to any provider that is:

- Eligible to be paid by Medicare **AND**
- Willing to accept the payment terms of the plan.

Services provided to a PFFS member by a provider will classify that provider into one of three provider types:

- **Direct-contracting** providers have a signed contract with the MA organization;
- **Deemed-contracting** providers:
  - Are aware in advance that the person receiving services is a PFFS member;
  - Have reasonable access to the terms and conditions of plan payment; and
  - Are providing services covered by the plan
- **Non-contracting** providers do not have a direct contract and are not deemed.

Medicare Medical Savings Account (MSA) Plans

MSA plans combine a high deductible Medicare Advantage (MA) Plan with a Medical Savings Account. MSA plans are not available in all areas.

Medicare Advantage Plan Overview

HMO plans generally:

- Require members to choose a primary physician or clinic
- Require members to obtain referrals for services outside their primary clinic
- Do not offer out-of-network benefits except for emergency or urgent care

PPO plans:

- Have contracted provider networks
- Offer specific out-of-network benefits
- Do not require members to choose primary care providers
- Do not require members to request referrals

PFFS plans:

- May or may not have contracted providers
- Allow plan members to go to any provider that is eligible to be paid by Medicare AND is willing to accept the terms of the plan's payment.

Contact your local plan for additional details on Medicare Advantage plans that may be available in your state.

Medicare Part D – Prescription Drug Coverage

Established as part of the MMA, Part D became effective January 1, 2006. This program offers prescription drug benefits and catastrophic prescription drug protection to all eligible Medicare beneficiaries.

Part D coverage is provided by private health insurance companies and organizations through annual contracts with CMS. Members may purchase Part D coverage in one of two ways:

- As a stand-alone Prescription Drug Plan (PDP) in addition to Original Medicare and certain other Medicare plans, or

- As prescription drug coverage included as part of a Medicare Advantage plan (MA-PD), such as an HMO or PPO

Medicare Part D may be purchased to complement PFFS, Medigap or Medicare Cost plans even if they are from other carriers. Medicare Part D may also be purchased by beneficiaries who are enrolled in Original Medicare only.

The MMA established a standard Medicare Part D plan design illustrated next. Some PDPs and MA-PDs offer coverage or options greater than the standard benefit for an additional premium.

Network Pharmacies

The health plan contracts with the pharmacies to provide Part D benefits to members. CMS requires that members purchase their prescriptions from network pharmacies, except when circumstances prevent them from reasonably using a network pharmacy.

Using network pharmacies reduces members' costs since members can purchase drugs at a pre-negotiated discounted price. Network pharmacies must also collect any member copay/ coinsurance amounts and file claims electronically for members. **Medications purchased outside the U.S. are not covered by Part D plans.**

Formulary

A formulary is the list of drugs the plan will cover. Medicare requires each plan to cover a minimum of two prescription drugs within each therapeutic classification. Formularies may also be divided into "tiers" and benefits may vary based on which tier a particular drug is on. Drugs not listed on the formulary are not covered, unless an exception request filed by the member and his/her physician is approved by the plan. The exception process is described in the plan's formulary list.

Formularies are subject to change during the year as new drugs are approved by the FDA, as generic forms of brand-name drugs become available, or if a drug is recalled by the FDA.

Excluded Drugs

CMS has determined that there are a number of drugs that will NOT be covered by any Medicare Part D plan, including but not limited to:

- Barbiturates (those not used for the treatment of epilepsy, cancer or a chronic mental disorder)
- Benzodiazepines (those not used for the treatment of epilepsy, cancer or a chronic mental disorder)
- Over-the-counter (OTC) medications
- Compound drugs
- Non-FDA approved medications
- Drugs used to promote fertility
- Drugs used for cosmetic purposes
- Drugs used to treat erectile dysfunction

Excluded drugs are NOT eligible for exception requests. ***Excluded drugs are also subject to change during the year.*** Some Part D plans may include these drugs on their formulary but they are not eligible for Part D coverage and purchases will NOT be applied to the total prescription drug costs or the member's TrOOP calculation.

Other Programs and Supplements

To help beneficiaries manage the out-of-pocket health care costs that Original Medicare leaves behind, and provide more choices and benefits, additional programs and supplements are available:

- Medigap plans, such as Medicare Supplement or Select plans
- Medicare Cost plans

Medigap Plans

Individuals with Original Medicare (both Parts A and B) may purchase a Medigap policy – also known as Medicare supplement insurance – from private insurance companies or organizations. Medigap insurance pays Medicare's deductibles and/or coinsurance/copays and may also offer coverage for services not covered by Original Medicare. Medigap plans coordinate with Original Medicare as secondary insurance coverage.

Medigap policies are regulated by state insurance authorities within guidelines set by the federal government. Prior to the MMA in 2003, there were 10 standardized plans (A-J) available in most states.

Two new standard Medigap plans became available in 2006 (K and L), although companies may not be actively marketing or selling those plans. Plans K and L offer a higher member cost-sharing amount but often have less expensive premiums than the other standard plans.

There were changes to the standard Medigap plans for coverage purchased on June 1, 2010, or later. Following are some highlights of the changes.

- Medigap plans E, H, I and J are no longer available for new sales. Members already enrolled in those plans can continue their current coverage.

- Two additional lower cost options – plans M and N were introduced.

- Preventive care and at home recovery benefits were dropped from all plans. This was done because Medicare covers these services at 100% in most cases.

- New hospice benefits were added to all plans.

Additional information about the new plans is available from carriers that offer the new plans.

Three states – Massachusetts, Minnesota and Wisconsin – do not offer the original 10 standardized plans, although Plans K, L, M and N may be available. Carriers in these states offer plans with somewhat different benefit packages. Among these is an option called Medicare Select, a preferred provider Medigap plan.

Medicare Cost Plans

Medicare Cost plans are similar to Medicare Advantage plans but there are differences. Similar to Medicare Advantage (Part C) plans, Medicare Cost plans are offered by private insurance companies or organizations that have an annual contract with the federal government. These plans are the first generation of plans to involve administration of Medicare benefits by private companies. In some ways, Cost plans are the forerunners of Medicare Advantage.

Cost plan sponsors are reimbursed for actual claims costs plus administrative fees. Cost plans coordinate with Original Medicare for Part A services, but function as the single, primary payer for most Part B services. They are often referred to as a "hybrid" between Medigap and Medicare Advantage plans.

Summary

- Medicare is a federal program, administered by CMS, that provides health care coverage to people who are age 65 and older or who have certain disabilities or end-stage renal disease (ESRD).

- The Medicare Modernization Act of 2003 introduced a prescription drug benefit as well as new health plan choices, benefits and delivery options for Medicare beneficiaries.

- Medicare consists of four parts:
  - Part A: Hospital insurance (Original Medicare)
  - Part B: Medical insurance (Original Medicare)
  - Part C: Medicare Advantage plans
  - Part D: Prescription drug coverage

- Parts A and B are considered Original Medicare.

- Parts C and D were added through subsequent acts of Congress.

- With a Medicare Advantage (MA) plan, Medicare pays a monthly amount to a private company to administer Original Medicare coverage for its members.

- MA plans replace Original Medicare, and some MA plans require payment of monthly premiums for extra benefits and options.

- MA plans include HMOs, PPOs, SNPs and PFFS.

- Medicare Part D, the first comprehensive prescription drug benefit, was made available beginning January 1, 2006.

- Beneficiaries may elect Part D coverage as a stand-alone prescription drug plan (PDP) or as part of a Medicare Advantage plan that includes prescription drug coverage (MA-PD).

- The Part D Standard Plan Design is the building block of all Part D plans and includes an annual deductible, specified cost-sharing, out-of-pocket maximums and catastrophic coverage.

- Medigap and Medicare Cost plans may be purchased to supplement Original Medicare benefits.

- These plans are designed to reduce or eliminate Medicare's deductibles, copays and/or coinsurance, offering beneficiaries more comprehensive medical coverage.

Introduction

This section provides information about beneficiary eligibility and CMS-designated enrollment periods for Original Medicare, Medicare Advantage and Medicare Prescription Drug (Part D) plans. Some enrollment periods are the same for both Medicare Advantage and Prescription Drug Plans, while others apply to only one product, but may affect the other. Basic eligibility and enrollment information is also described for Medigap and Medicare Cost plans.

Generally, once beneficiaries elect a Medicare Part D or Medicare Advantage plan, they are "locked in" to that coverage for the remainder of the plan year. (A plan year is usually a calendar year.) This "lock-in" also creates circumstances in which beneficiaries may be "locked out" of other plans until the next valid enrollment period.

The Medicare Advantage Disenrollment Period allows beneficiaries to disenroll from a Medicare Advantage plan between January 1 and February 14 each year.

Medicare Coverage

Medicare is separated into four parts:

- Part A, Hospital Insurance (Original Medicare)
- Part B, Medical Insurance (Original Medicare)
- Part C, Medicare Advantage Program (established in the 1997 Balanced Budget Act as Medicare + Choice and reformed under the Medicare Modernization Act (MMA) in 2003)
- Part D, Prescription Drug Program (part of the 2003 MMA reforms and effective January 1, 2006)

Original Medicare Eligibility

To receive Medicare benefits, an individual must:

- Be a U.S. citizen,

or

- Have a resident visa and have lived in the U.S. for five consecutive years,

and

- Meet the age or disability qualifications and requirements outlined for eligibility for Medicare programs.

Who's Eligible for Part A?

Age 65 remains the starting date for Medicare eligibility, although the retirement age for full Social Security benefits is increasing. An individual can get Medicare Part A at age 65 without paying a premium if:

- The individual or spouse has had Medicare taxes deducted from salaries or wages for at least 40 quarters (10 years), or
- The individual is already receiving retirement benefits from Social Security or the Railroad Retirement Board, or
- The individual is eligible to receive Social Security or Railroad benefits but has not yet filed for them, or
- The individual or spouse had Medicare-covered government employment

An individual under age 65 can get Part A without paying a premium if:

- The individual has received Social Security Disability Insurance (SSDI) or Railroad Retirement Board disability benefits for 24 months, or
- The individual has end-stage renal disease (ESRD) and is a kidney dialysis or kidney transplant patient, regardless of age

Individuals who have not paid into Medicare for the required 40 quarters may purchase Part A by paying a monthly premium. The amount of the premium depends on the number of quarters that Medicare taxes were paid. People with limited income or resources may be eligible for Part A premium payment help from their state.

When to Enroll in Part A

Enrollment in Part A is designed to be automatic for individuals who have applied for Social Security benefits, and coverage begins the first day of the month in which the individual turns age 65. Eligible individuals with a birthday that falls on the first of the month will be enrolled in Part A on the first of the month prior to their 65th birthday month. A Medicare card should arrive two to three months prior to that date. If the beneficiary does not receive a card, he or she must contact Social Security to enroll in Medicare Part A and, if desired, Part B.

People born between 1943 (age 65 in 2008) and 1954 are not eligible to collect their full Social Security benefit until they turn 66 although Medicare benefits are available to eligible beneficiaries at age 65 regardless of whether they begin collecting Social Security benefits. Enrollment will not be automatic if the individual is not collecting Social Security benefits at age 65. In this instance, the individual must call his or her local Social Security office to obtain Medicare enrollment materials.

Who's Eligible for Part B?

Individuals are eligible for Part B coverage if they:

- Are age 65 or older and entitled to Part A
- Are disabled and have received 24 months of Social Security Disability Insurance (SSDI)
- Have end-stage renal disease (ESRD), regardless of age

- Part A and Part B premium costs are subject to change each year
- Call 1-800-MEDICARE or visit www.medicare.gov for updated information

When to Enroll in Part B

Enrollment in Part B is voluntary and requires paying a monthly premium. Anyone who is entitled to Part A is also eligible for Part B, and Part B is often discussed at the time the beneficiary enrolls in Part A.

Beginning in 2007, Part B premiums began to be indexed based on income so that people with higher incomes pay higher premiums.

Medicare Part B has three enrollment periods during which eligible individuals may choose to enroll:

- **Initial Enrollment Period** (IEP): For most individuals this is the seven-month period that begins three months before the month in which the person turns age 65, includes the month he or she turns age 65, and continues for three months after turning age 65. If the beneficiary elected Social Security benefits in the month(s) preceding their IEP, he or she will automatically be enrolled in Part A and Part B (and will have the opportunity to decline Part B). Those who have **not** elected Social Security benefits will need to apply with the Social Security Administration during their IEP.

- **Special Enrollment Period** (SEP): If an individual does not enroll in Part B when first eligible because of having group health coverage from his or her employer or a spouse's employer (based on full-time active employment), then the individual may enroll at one of these times, whichever is first:
    - Anytime they are still covered by group health coverage available through current employment
    - Eight months following the month the group health coverage ends
    - When the employment ends

  Individuals who enroll in Part B during this SEP do not pay a penalty for the Part B premium. If an individual continues group health coverage through COBRA after employment ends, their Part B SEP begins when employment ends, not when COBRA ends. If the individual enrolls when COBRA ends, a penalty may apply.

- **General Enrollment Period**: The General Enrollment Period runs from January 1 through March 31 each year, with coverage taking effect the following July 1. Individuals who did not enroll in Medicare Part B during their IEP or SEP, or dropped Part B (for reasons other than full-time employment providing group benefits) and want to re-enroll, can sign up during this time. Individuals signing up during the General Enrollment Period will be subject to a penalty charge. Typically, the cost of the Medicare Part B premium will go up 10% for each full 12-month period that the individual was eligible but did not enroll. This penalty is assessed by the Social Security Administration.

Since Part B coverage is voluntary, newly-eligible individuals need to evaluate their options. Eligible individuals who are enrolling in Part A typically enroll in Part B at the same time. Individuals eligible for employer or union group health benefits through full-time employment or as a dependent of a spouse who is working full time may prefer to delay enrollment. Part B coverage is not retroactive – it begins based on the enrollment period during which the individual enrolls. Even though there is a premium for Part B coverage, individuals not enrolled in employer/union group benefits should be encouraged to join during their IEP because:

- Out-of-pocket costs for medical care are lower with Part B than without
- Individuals must have Part B in order to enroll in a Medicare Advantage plan (Part C) or purchase a Medigap product (also known as Medicare Supplement) or Medicare Cost product
- They can only enroll during a general open enrollment period after their IEP, and may pay a penalty for late enrollment in the form of higher monthly premiums for the rest of their life
- Both Parts A and B are required for Medicare to cover certain dialysis treatment and kidney transplant services

CMS Enrollment and Disenrollment Guidance for Medicare Advantage and Part D

CMS provides Plan Sponsors guidance for eligibility and enrollment into or disenrollment from Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD) Plans and Medicare Part D in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual.

Basic Eligibility Guidelines for Medicare Advantage and Part D

All Medicare beneficiaries are eligible to apply for a Medicare PDP, MA or MA-PD plan. Each type of plan has specific eligibility requirements a Medicare beneficiary must meet in order to enroll.

MA/MA-PD Eligibility

Medicare beneficiaries can apply for an MA or MA-PD if they:

- **Have both Medicare Part A and Part B.** Most beneficiaries do not pay premiums for Part A. However individuals who did not work enough quarters to qualify for Part A with no premium may enroll in and pay premiums for Part A benefits. Beneficiaries also pay premiums for Part B. To enroll in an MA or MA-PD plan, beneficiaries must continue to pay their Part B premium (and Part A if applicable) if not otherwise paid for by Medicare or another third party.
- Reside in the plan's service area.
- Do not have end-stage renal disease (ESRD), unless they are currently a member of other coverage offered by the plan when they apply and the disease is being covered by their current plan OR they have had a successful kidney transplant and/or no longer need dialysis.
- Enroll during a valid enrollment period.

PDP Eligibility

Medicare beneficiaries can apply for a PDP if they:

- Have Medicare Part A **and/or** Part B. Beneficiaries not enrolling in Part B for any reason should still consider enrolling in a PDP when they are first eligible to avoid late enrollment penalties.
- Reside in the plan's service area.
- Enroll during a valid enrollment period.

In 2011, Medicare Part D enrollees began paying income-related premium adjustment amounts to Medicare, called the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA). Social Security determines which beneficiaries have to pay the higher amounts and notifies affected members. The income-related amounts Part D members will pay are in the chart on the next page. This amount is in addition to any late enrollment penalty that may apply.

Enrollment Periods

In order for a Plan Sponsor to accept a request for enrollment or disenrollment, it must be made during a valid enrollment period. CMS identifies several enrollment periods that are described below. It is up to the Plan Sponsor to verify that requests for enrollment or disenrollment are valid based on the enrollment period.

Annual Enrollment Period (AEP)

The AEP occurs from October 15 through December 7 each year. During this time, all Medicare-eligible beneficiaries can enroll in, disenroll from or change MA, MA-PD or PDP plans.

Coverage changes made during the AEP are effective January 1 of the following year. If Medicare-eligible beneficiaries do not make a change, their current coverage continues into the next year with any applicable premium or benefit design adjustments.

Beneficiaries can make multiple enrollment elections during this period. However, the last enrollment or disenrollment choice made during this enrollment period, as determined by the application date, will be the choice that becomes effective January 1. The application date is the date the enrollment request is received by the plan. **Remember that receipt by a sales person is considered receipt by the plan.**

Medicare Advantage Disenrollment Period (MADP)

The Medicare Advantage Disenrollment Period (MADP) occurs every year from January 1 through February 14. During this time, all Medicare-eligible beneficiaries can disenroll from an MA or MA-PD plan and return to Original Medicare. They can also enroll in a stand-alone prescription drug plan at that time, regardless of whether the plan from which they are disenrolling includes drug coverage.

The effective date of the new coverage will be the first of the month following the application date.

The **application date** is the date the enrollment request is received by the plan. This includes the date it is received by a sales person.

Initial Enrollment Period (IEP) & Initial Coverage Election Period (ICEP)

Newly-eligible beneficiaries have two enrollment periods that often coincide: the Initial Enrollment Period (IEP) and the Initial Coverage Election Period (ICEP). The difference is that the IEP is the individual's initial eligibility for Part D while the ICEP is an individual's initial eligibility for MA plans. Both enrollment periods generally last seven months – beginning three months before the individual's 65th birthday month, including the birthday month, and ending three months after the birthday month.

Remember that the initial enrollment period for Original Medicare occurs for most people at age 65. It may be later if the person continues to work beyond age 65 or earlier if the person is disabled or diagnosed with ESRD. Enrollment is usually automatic if the individual has already applied for or is receiving Social Security benefits. However, those born between 1943 and 1954 are not eligible to collect their full Social Security benefit until age 66 and will need to apply for Medicare if they do not choose to start receiving Social Security payments by age 65.

The IEP for Part D is triggered by the beneficiary's entitlement to Part A benefits, regardless of whether the beneficiary enrolls in Part B at the same time. The beneficiary does not need to elect both Part A and Part B to be eligible for Part D benefits. However, delaying enrollment in Part B does impact the ICEP by reducing the enrollment period timeframe.

The enrollment periods for prescription drug and MA plans often happen simultaneously. For beneficiaries, this means that during their IEP they may make one Part D election, including enrollment into an MA-PD plan if they enroll in both Part A and Part B. During their ICEP, beneficiaries may also make one MA election, including enrollment into an MA-PD plan. If the beneficiary elects an MA-PD plan, they have used both their IEP for prescription drug coverage and their ICEP for MA plan coverage.

If enrollment into Part B is postponed, beneficiaries should still consider enrolling in Part D, particularly if they do not have creditable prescription drug coverage. If beneficiaries do not enroll for Part D when first eligible and they do not have creditable prescription drug coverage, they face paying a late enrollment penalty (LEP) when they enroll at a later date. Information about creditable prescription drug coverage and the late enrollment penalty can be found in *Section 5*.

Example 1: IEP for Part D surrounding 65th birthday:

Mrs. Smith's 65th birthday is on April 20, 2010. She is eligible for Medicare Part A and her Part B initial enrollment period begins on January 1, 2010. Therefore, her IEP for Part D begins on January 1, 2010, and ends on July 31, 2010.

Example 2: IEP for working individual:

Mr. Hackerman's 65th birthday is March 23, 2010. He is currently working, and while he signed up for his Medicare Part A benefits, effective March 1, 2010, he declined his enrollment in Part B, given his working status. He is eligible for Part D since he has Part A and lives in the service area. Even though he did not enroll in Part B, his Part B IEP is still the 3 months before, the month of, and the 3 months following his 65th birthday – that is, December 2009 – June 2010. Hence, his IEP for Part D is also December 2009 – June 2010.

Note: Not all employers require age 65 or older employees to enroll in Medicare. Individuals who continue working past age 65 should check with their employer to see what is required.

Beneficiaries under age 65 who qualify for Original Medicare are also eligible to enroll in Part D or MA plans, although the timeframes for enrolling may differ based on their individual circumstances. Sales persons and/or beneficiaries should contact Medicare for additional information in these situations.

Beneficiaries entitled to Original Medicare before age 65 receive a second IEP for Part D when they reach age 65.

> The **application date** is the date the enrollment request is received by the plan. This includes the date it is received by a sales person.

IEP/ICEP Effective Dates

The effective date of coverage for IEP/ICEP enrollments is based on the application date, and whether it is before or after the month a beneficiary becomes entitled to Medicare:

- Beneficiaries who submit applications during the three months ***before*** they are entitled to Medicare have an effective date of coverage of the first day of the month in which they are entitled to Original Medicare. Using the example of Julia who turns 65 in June, if her application date is March 15, her effective date of coverage is June 1, the first day of the month in which she is entitled to Medicare.
- Beneficiaries with an application date ***during*** the month of entitlement, or in the three months ***following*** the month of entitlement to Medicare, will have an effective date of coverage of the first of the month following the month of the application date. If Julia's application date is July 15, her effective date of coverage is August 1.

Special Enrollment Periods (SEPs)

Special enrollment periods occur for a limited amount of time and are offered due to unique circumstances defined by CMS. SEPs may apply to either or both Part D and MA enrollments and disenrollments. However, the reason for the SEP determines the particular election option(s) available to the individual.

The SEP ends once an election is made, or when the time frame for that SEP expires, whichever occurs first. The effective date of coverage depends on the individual SEP and the circumstances that caused the SEP. Some of the most common reasons for a SEP include:

- Permanent change in residence (move) into or out of a service area
- Enrolling in or leaving employer/union group health coverage (unless the loss of coverage was due to non-payment of premiums)
- Qualifying or no longer qualifying for low income subsidy (LIS)
- Qualifying as "dual-eligible" (eligible for both Medicare and Medicaid)
- Moving into or out of a long-term care facility, such as a nursing home
- A Plan Sponsor decides not to renew a contract or a Plan Sponsor's contract is terminated by CMS
- Involuntarily losing creditable prescription drug coverage
- Leaving a PACE program

- Belonging to a state pharmacy assistance program (SPAP)
- Moving back to the U.S. after permanently living outside the U.S.
- Wanting to enroll in a plan with a 5-Star Rating

Since 2012, there has been a SEP that will allow individuals to enroll in a 5-Star Medicare Advantage or Part D plan anytime during the year (except for a one-week period of time from December 1 through December 7). The change will be effective the first of the following month.

Individuals may also qualify for a SEP due to product misrepresentation by a sales person or plan/Part D sponsor. This type of SEP can only be granted by CMS when the beneficiary contacts CMS with this concern.

In addition to more information on situations qualifying for SEPs, CMS also identifies numerous SEPs that qualify for "Exceptional Conditions" as described in Chapter 2 of the Medicare Managed Care Manual and the PDP Guidance. Some common SEPs for Exceptional Conditions include:

- The **SEP Employer Group Health Plans (EGHP)** which allows enrollment into or disenrollment from MA and/or PDP plans when the beneficiary has an opportunity to enroll in or disenroll from an employer/union group health plan.

- The **SEP for Individuals who Dropped a Medigap Policy When They Enrolled for the First Time in an MA Plan and Who Are Still in a "Trial Period"** allows Medigap members who leave their Medigap plan to try an MA plan for the first time to disenroll from the MA plan and return to their Medigap plan within the first 12 months they are a member of the MA plan. The MA disenrollment allows the member a guaranteed issue opportunity to return to a Medigap policy without medical underwriting. Individual state laws determine what Medigap policies are available.

- **Part D Coordinating SEPs** apply in situations when enrollment into or disenrollment from an MA or PDP plan creates a SEP for the other type of plan.

- **SEP for Beneficiaries Age 65 (SEP65)** allows a newly eligible beneficiary who enrolls in Part A and Part B and elects a Medicare Advantage plan at age 65 the opportunity to disenroll from the MA plan within a 12-month period, and be guaranteed the right to purchase a Medigap policy without medical underwriting.

For additional information on SEPs:

- Review the Medicare Managed Care Manual, Chapter 2 – Enrollment and Disenrollment
- Review the Medicare Prescription Drug Benefit Manual, Chapter 3 – Eligibility, Enrollment and Disenrollment
- Contact the Broker Help Desk
- Contact the Plan Sponsor

Because it's possible that more than one enrollment period may apply when a beneficiary is enrolling, the following questions may help sales persons determine the valid enrollment period and possible effective date:

1. Is the beneficiary newly eligible for Medicare?
2. What are the beneficiary's Part A and Part B effective dates?
3. Does the beneficiary have a situation that may allow for a Special Enrollment Period (SEP)?
4. Is the beneficiary applying during the Annual Enrollment Period (AEP)?

Beneficiaries are eligible for Part D coverage if they are entitled to Part A and/or enrolled in Part B of Original Medicare, so you must also consider which product they wish to enroll in. CMS enrollment guidance includes a hierarchy that is used to determine the effective date of coverage when a beneficiary is eligible for more than one enrollment period.

Other Programs and Supplements

To help beneficiaries manage the out-of-pocket health care costs that Original Medicare leaves behind, and provide more choices and benefits, additional programs and supplements are available:

- Medigap plans, such as Medicare Supplements or Select plans
- Medicare Cost Plans

Medigap Plans

Individuals with Original Medicare (both Parts A and B) may purchase a Medigap policy – also known as Medicare supplement insurance – from private insurance companies or organizations. Medigap insurance pays Medicare's deductibles and/or coinsurance/copays and may also offer coverage for services not covered by Original Medicare. Medigap plans coordinate with Original Medicare as secondary insurance coverage.

Who's Eligible for a Medigap Plan?

Individuals are eligible for a Medigap plan if they:

- Are a permanent resident of the state in which the plan is offered
- Are enrolled in Medicare Part A and Medicare Part B
- Continue to pay the Part B premium

When to Enroll in a Medigap Plan

Medigap plans are typically open for enrollment year-round. Medigap plans may require enrollees to complete a health history application and may deny coverage due to current or past health conditions (medical underwriting) unless the enrollee is eligible for "guaranteed issue" rights including:

- Enrollment during the 6-month federal open enrollment window that begins with the effective date of Part B coverage

- 12-month trial periods for Medicare Advantage plans
- Enrollment during a Special Open Enrollment Period offered by the plan
- Enrollment related to loss of other coverage due to a "qualifying event"

Contact your local carrier for additional details about Medigap eligibility and enrollment.

Medicare Cost Plans

Similar to Medicare Advantage (Part C) plans, Medicare Cost plans are offered by private insurance companies or organizations that hold an annual contract with the federal government. These plans are the first generation of plans to involve administration of Medicare benefits by private companies. In some ways, Cost plans are the forerunners of Medicare Advantage.

Who's Eligible for a Medicare Cost Plan?

Individuals are eligible for a Medicare Cost plan if they:

- Are a permanent resident of the service area in which the plan is offered
- Are enrolled in Medicare Part A and Medicare Part B **or** Medicare Part B only
- Continue to pay the Part B premium

Beneficiaries with end-stage renal disease (ESRD) may not be eligible to enroll. Exceptions to the ESRD limitation include:

- An ESRD patient who has had a successful kidney transplant
- An ESRD patient who was previously covered on a group plan offered by the carrier with coverage for the ESRD diagnosis or another MA plan offered by the same carrier

When to Enroll in a Medicare Cost Plan

Medicare Cost plans are typically open for enrollment year-round and never require medical underwriting. Contact your local carrier for additional details about Medicare Cost plan eligibility and enrollment.

Summary

- Enrollment in Medicare Part A is designed to be automatic for qualified individuals at age 65. Eligible beneficiaries not yet collecting Social Security benefits must actively enroll by contacting the Social Security Administration.

- Enrollment in Medicare Part B is voluntary during specified enrollment periods and requires payment of a monthly premium.

- During the Annual Enrollment Period (AEP), from October 15 through December 7 each year, all eligible beneficiaries may enroll in, disenroll from or make a change to their PDP, MA or MA-PD plan.

- During the Medicare Advantage Disenrollment Period (MADP), from January 1 through February 14 each year, beneficiaries may disenroll from the MA or MA-PD plan they are enrolled in. Beneficiaries who disenroll will return to Original Medicare and may enroll in a stand-alone prescription drug plan.

- The Initial Enrollment Period (IEP) is when a newly eligible person may apply for Medicare Part D coverage.

- The Initial Coverage Election Period (ICEP) is the period in which a newly eligible person may enroll in an MA or MA-PD plan.

- A newly eligible beneficiary electing an MA-PD plan uses both the ICEP and IEP simultaneously.

- There are numerous situations that may result in a beneficiary having a Special Enrollment Period (SEP) including but not limited to:
    - Change in permanent residence
    - New or continued eligibility for Low Income Subsidy (LIS) or Medicaid benefits
    - Termination of Plan Sponsor's contract with CMS
    - Changes in employer/union group health benefits
    - Trial periods (typically 12 months) related to Medicare Advantage enrollment
    - Opportunity to enroll in a plan with a 5-Star Rating from Medicare