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 takes effect at the beginning of the 25th month after you began receiving Social Security disability benefits. The 24 months do not need to 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 are 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 younger than age 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 included in the plan. 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. Whether you're talking about Original Medicare (Part A and Part B), or private insurance options provided through Part C (Medicare Advantage) or Part D (drug coverage), it is important to understand the costs that you are responsible for covering as a beneficiary. 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.

2019 COSTS AT A GLANCE	
Part A premium	Most people don't pay a monthly premium for Part A if they've paid Medicare taxes for 40 or more quarters. If you paid Medicare taxes for 30-39 quarters, the standard Part A monthly premium is $240. If you paid Medicare taxes for less than 30 quarters, the standard Part A monthly premium is $437. If you don't qualify for premium-free Part A, but your spouse does, you may be able to get Part A without a premium, based on your spouse's employment history.
Part A hospital inpatient deductible and coinsurance	You Pay: • $1,364 deductible for each benefit period • 1-60 days in hospital: $0 coinsurance for each benefit period • 61-90 days in hospital: $341 coinsurance per day of each benefit period • More than 90 days in hospital: $682 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 $135.50 (or higher depending on your income).
Part B deductible and coinsurance	$185 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 (dme)
Part C premium	The Part C monthly premium varies by plan.
Part D premium	The Part D monthly premium varies by plan (higher-income consumers may pay more).

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. Below is a list of trusted resources available to beneficiaries to help work through it all.

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 or doctors you may see. This tool will help you sort through the various plans to ensure your selections best meet your needs. There are also private enrollment tools available to help you navigate plan options. There are also private enrollment tools available to help you navigate plan options, which include eHealthMedicare.com, Medicare.com, Healthcare.com, and HealthSherpa.com.

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. For more information visit www.shiptacenter.org.

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, 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. To find help in your area visit https://eldercare.acl.gov/Public/Index.aspx

Financial Assistance for Medicare

Sometimes Medicare beneficiaries need cost assistance 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.

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 Program)
- Get Supplemental Security Income (SSI) benefits

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.

Additional programs available to qualifying individuals include the following:

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.

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 other services 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

To find a PACE plan in your area visit https://www.medicare.gov/find-a-plan/questions/pace-home.aspx.

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; 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.