Questions and Answers

AMMI Project Medicare 101 Training Series

Q: How does one defer Medicare Part B if a beneficiary plans to continue working past age 65?
A: If a beneficiary and/or spouse plan to continue working past age 65 and the beneficiary and/or spouse's employer has more than 20 employees and they have their employer's health insurance or, are on their spouse's employer health insurance plan they can defer their Medicare Part B until they are ready to retire.

During Part B deferment, beneficiaries will not have to pay their Medicare Part B monthly premium. Intentionally deferring Part B *by notifying SSA and the employer* the beneficiary(s) will not incur late enrollment penalties on their Part B premium. If a beneficiary wants to defer their Medicare Part B as they work past age 65, they will want to begin this conversation with their employer 3 months prior to their 65th Birthday.

NOTE: When a Medicare beneficiary defers their Part B coverage *(eligibility requirement is they work for an employer that has more than 20 employees)* they will be required to provide Social Security Administration (SSA) with proof of "credible coverage" annually. Credible coverage means that their current employer health insurance coverage is as good as or better than Medicare. Proof of credible coverage is required for every year a beneficiary defers their Part B.

**Proof of credible coverage is provided annually by the beneficiary's employer and the beneficiary should always retain a copy of every credible coverage letter they receive from their employer as proof of coverage in case it's ever needed later. Without proof of comparable coverage for every year that Part B is deferred the beneficiary will be subject to a Part B late enrollment penalty. Part B late enrollment penalties are 10% of the Medicare Part B premium for every year they did not enroll in Medicare when first eligible e.g., when they first turned 65. The late enrollment penalty is a lifetime penalty.

Regarding Medicare Part A and working past age 65: If a beneficiary has *"premium free" Part A (Hospital Insurance), they can choose to sign up for Part A when they turn 65 or can do so later *(it is recommended to take your premium free Part A at 65). * Most people have already pre-paid for their Medicare Part A through their work history where they have paid into the federal FICA tax for 10 years; as result, these beneficiaries do not have a Medicare Part A premium when they become Medicare eligible.*
By taking your Medicare Part A when you turn 65 even if working past age 65, Medicare Part A will coordinate benefits with your employer coverage on in-patient covered services; the beneficiaries employer health insurance pays as primary, and Medicare Part A pays as secondary.

****NOTE:** ***A beneficiary working for an employer with less than 20 employees** MUST enroll in Medicare when they are first eligible when turning 65. There is **not an option to defer Part B** when the employer has less than 20 employees. They can continue to work but, Medicare is their only option.*
Please refer to this link for more information on Medicare and working past age 65:
WWW.medicare.gov.gov/basics/get-started-with-medicare/medicare-basics/working-past-65

Q: Are Naturopaths (ND) covered by Medicare?
A: No**.** Medicare does not cover Naturopath's (NDs).

Q: Is the Medicare Advantage (MA)/Part C insurance premium deducted from the beneficiaries monthly Social Security income like the Medicare Part B premium?

A: No. If a beneficiary decides to enroll in a Medicare Advantage plan, the beneficiary will be billed a monthly premium from the MA health plan and, the beneficiary will need to pay the MA health plan directly.
NOTE: *The MA health plan monthly insurance premium is in addition to the Medicare Part B premium that is deducted each month from the beneficiaries Social Security monthly income.*

Q: I'm 65, still working and already in enrolled in Medicare Part B. Since enrolling, I decided I want to defer my Part B until I am ready to retire; can I still defer my Part B? If I can still defer my Part B, will I be subject to pay the current Part B premium that is now due even though I haven't used my Part B benefits?

A: Yes, if you work for an employer who has more than 20 employees, you can defer your Medicare Part B even if you already enrolled. You will need to notify your employer and SSA that you want to defer your Part B until you retire. *You will be responsible for any Part B premiums due prior to deferring your Part B regardless of if you used your Part B benefits or not.* **Please refer to this link for information on Medicare and working past age 65:** WWW.medicare.gov.gov/basics/get-started-with-medicare/medicare-basics/working-past-65.

Q: I heard that once people have signed up for Medicare Advantage, they cannot switch back to Original Medicare. Is that true?

A: No, that is not true. If a beneficiary is currently on a Medicare Advantage (MA) plan and are:

1) Dual eligible beneficiaries can change their Medicare coverage 4 times in a calendar year. This includes dropping their MA plan and going back to Original Medicare and visa-versa.

2) Non-dual eligible beneficiaries can drop their MA plan and change to Original Medicare and visa-versa during the annual Medicare Open Enrollment Period October 15 – December 7.

3) Non-dual beneficiaries can also change from their MA plan to Original Medicare and visa-versa during the annual Medicare Advantage Open Enrollment Period January 1 – March 31.

4) Non-dual beneficiaries have a "12-month Trial Right" period when they are first eligible for Medicare and enroll in an MA Plan, at any time during the first twelve months of having the MA plan, they can switch to Original Medicare.
*** Coverage change goes into effect the first of the following month.
Note: *Non duals switching back to Original Medicare from an MA plan should think about whether they need a Medigap to pick up the 20% that is not covered by Original Medicare. There are only a few very specific times beneficiaries on Original Medicare will be eligible for Medigap supplemental coverage, these plans are sold by private insurance carriers – for more info on Medigaps please contact SHIBA.*
Please refer to this link for additional information on switching plans and/or contact SHIBA 800.562.6900:
https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

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Q: Can dual eligible beneficiaries change their Medicare Advantage (MA)DSNP plan and/or if on Original Medicare change their Part D Prescription Drug Plan during the Dual Eligible Special Enrollment Period?

A: Yes, **dual eligibles** can change their MA plan to a different MA plan or, drop their MA plan and go to Original Medicare and Part D prescription drug plan and visa-versa.

Reminder: The Dual Eligible Special Enrollment Period (SEP) allows dual eligible's to change their Medicare **one time** during the following periods *(allowing them 3 changes between January and September)*:

January 1 – March 31st

April 1 – June 30th

July 1 – September 30th

Dual eligibles can also make a change to their Medicare one time during Medicare's annual Open Enrollment Period October 15th – December 7th *(allowing dual eligibles a total of 4 changes to their Medicare in a calendar year).*

Q: If a beneficiary has a Medicare Savings Program (MSP) *aka S03* **should they be paying more than $10.50 for prescriptions?**

A: All Part D plans have a formulary regardless of the plan type be it a Medicare stand-alone Prescription Drug Plan (MPDP/PDP), a Medicare Advantage Part D plan (MAPD) or, MA DSNP - if the dual eligible beneficiary is paying more than $10.50 for a prescription or the prescription is not covered at all, we know the medication prescribed is **not** on their Part D formulary. The beneficiary should check with their prescribing doctor to see if there are any other options for an equivalent medication that is on their formulary, if not, they can be referred to the "WA State Prescription Drug Program" for assistance paying for their medication – please refer to: https://www.hca.wa.gov/about-hca/programs-and-initiatives/prescription-drug-program.

Q: What is the Part D Deductible?

A: The 2023 Part D deductible is $505. For more information regarding Medicare Part D deductible please contact SHIBA 1.800.562.6900 and/or refer to the Medicare & You handbook (link provided below).

Q: What are some examples of added benefits that a Medicare Advantage plan might offer?

A: It depends on the Medicare Advantage plan/DSNP and is best to check with the MA plan to know for sure what a specific MA plan's added benefits and services are. ***The following are a few examples of added benefits/services MA plans may offer.*** Food allowance, a specific dollar amount to spend on food per month, home delivered meals, meals following IP hospital stay, housing support, gym memberships, hearing, vision, dental, pest control, OTC medications, cell phone, acupuncture, LGBTQAI+ resource assistance, companionship coverage pairs people w/ pals to socialize, play games, watch movies, help with light housework/meal prep. ***This is not an exhaustive list and does not include the specific details of any possible added benefits and services – please contact the MA plans directly for specifics regarding any one plan's added benefits and services.***

Q: What is the difference between the General Enrollment Period (GEP) and Medicare Annual Open Enrollment (AOEP/OEP)?
A: The **G**eneral **E**nrollment **P**eriod (GEP) occurs **annually January 1st – March 31st** and is specifically in place **for** those **individuals who missed their Initial Enrollment Period** (IEP).

The **I**nitial **E**nrollment **P**eriod (IEP) is the **seven-month Medicare enrollment period** for **individuals to enroll in Medicare when they first become eligible for at age 65.** They must enroll in Medicare during their IEP to avoid late enrollment penalties. The IEP begins three months before their *65th birthday,* the month of their 65th birthday and, three months after their 65th birthday *(this time-period makes up the 7- month IEP).*

The Medicare **A**nnual **O**pen **E**nrollment **P**eriod *(may be referred to as: OEP/AEP/AOEP)* occurs **every year October 15th – December 7th**. This is the one time each year individuals **already on Medicare can make changes to their Medicare coverage**; any changes made will take effect January 1st.

Q: What makes a Medicare client dual eligible?
A: A dual eligible client is an individual who is eligible for both Medicare and Medicaid.

Q: Can a DDA client can sign up for MA with dental and vision?
A: Medicare Advantage (MA) Plans aka Part C plans often include supplemental benefits and/or services that are **not** covered by Original Medicare (OM) such as dental, vision and hearing. Depending on the MA plan, ***some*** supplemental dental benefits may be included, however, the beneficiary or Authorized Representative (AR) will need to contact the MA plan directly and specifically ask them what their supplemental dental benefit covers as most likely it will **not** be comprehensive dental coverage. **All Medicare beneficiaries** can elect to purchase a separate individual dental plan from a private insurance carrier to get comprehensive dental coverage. They can opt to purchase from the same insurance company as their MA plan if they sell dental coverage or, they can purchase an individual dental plan from a different insurance company; either way, the beneficiary will be billed a separate monthly premium for their dental plan and will be responsible for any related co-payments, co-insurance, and deductibles.

Q: Who pays the Broker/Agent commission for MA plan enrollment?
A: Independent insurance brokers and agents who contract with insurance companies to sell the insurance company's Medicare Advantage Plan products are paid a commission for each Medicare Advantage plan they enroll a Medicare beneficiary in; the commission rate is a set amount determined annually by CMS.

Q: Late Medicare enrollment penalties: Can they be waived or does Medicaid help cover those? Is the penalty due up front or is it spread out over the monthly premiums?
A: Medicare Part B and D late enrollment penalties are lifetime penalties. Medicare Part B penalty applies for every 12 months an individual goes without enrolling in Medicare Part B from when they were first eligible for Medicare. The part B penalty is 10% of the Part B premium for every year they have gone without Medicare. Medicare Part D late enrollment penalty is 1% for every month an individual has gone without enrolling in Medicare Part D from when they were first eligible upon turning 65. If a beneficiary is subject to a late

enrolment penalty, the penalty amount is added to the monthly Part B and Part D premium respectively. Again, these are lifetime penalties. A beneficiary does have the right to appeal the late enrollment penalty; Please refer to the follow resource regarding additional information and instruction for appealing the Medicare **L**ate **E**nrollment **P**enalty (LEP) https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/premium-appeals/appealing-the-part-b-late-enrollment-penalty.

NOTE: If a beneficiary qualifies for a Medicare Saving Program (MSP) by meeting the limited income and assets requirement, they may be eligible to receive help with their Medicare Part B premium. If eligible for a MSP, they will automatically qualify for the SSA's Extra Help also known as Limited Income Subsidy (LIS) which would then help with costs associated with their Part D coverage. People who qualify for Extra Help under Part D won't be charged a late enrollment penalty when they join a Medicare drug plan. If a person drops their Medicare drug plan and goes 63 days or more in a row without other creditable coverage, Medicare may charge a late enrollment penalty if they join a Medicare plan later and are no longer eligible for Extra Help. However, when Medicare determines the person's late enrollment penalty, Medicare won't count any uncovered months from before the person became eligible for Extra Help. Please refer to: *https://www.cms.gov/outreach-and-education/outreach/partnerships/downloads/11222-p.pdf on Part D & LIS. See the HCA's website for more information on MSPs at https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/medicare-savings-program*

Q: Can you please share the link for the Medicare and Medicaid differences.
A: The following link provides a good explanation of the distinct difference between state Medicaid and federal Medicare https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProgramBasicsText-Only.pdf .

Q: Does the Medicare Part D premium go up in price if the Medicare beneficiary does not enroll in a Part D plan when they are first eligible?
A: Yes. Medicare beneficiaries who do **not** enroll in Medicare Part D coverage when they are first eligible and do not have proof of other creditable prescription drug coverage (ex: employer drug coverage) a late enrollment penalty will be applied to their Part D premium. The Medicare Part D penalty is 1% of the Part D premium for every month the beneficiary goes without Part D coverage. Once applied, the Part D penalty is a lifetime penalty. The following link is a good resource for more information about Medicare Part D prescription drug coverage and ways to avoid late enrollment penalties:
https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d-late-enrollment-penalty https://www.medicare.gov/basics/costs/medicare-costs/avoid-penalties.

Q: What is the benefit of the Medicare Savings Program (MSP) versus Medicare Part C?
A: Medicare Advantage (MA) Plans *(also known as Medicare Part C)* is one way you can elect to get your Medicare health insurance coverage. MA plans are sold by private insurance companies that contract with the

federal government to administer Medicare benefits in this way. A Medicare Advantage plan is the only other option aside from Original Medicare to get one's Medicare benefits.
Medicare advantage plans are required to cover everything that Original Medicare covers, and they may offer extra benefits and/or services that Original Medicare doesn't cover. The Medicare beneficiary must already have Medicare Part and A and Part B to be eligible for a Medicare Advantage plan.
This is a good resource to learn more about Medicare Advantage Plans:
https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf

Whereas**: M**edicare **S**avings **P**rograms (MSPs), also known as "state Medicare Buy-In programs" or the "Medicare Premium Payment Assistance Programs" the MSPs help eligible Medicare beneficiaries pay for costs associated with their Medicare Part B as long as the beneficiary meets the limited income requirements.

There main MSP programs are below, each with different benefits and eligibility requirements:
1. **Qualified Medicare Beneficiary (QMB):** Pays for Medicare Parts A and B premiums. If you have QMB, typically you should not be billed for Medicare-covered services when seeing Medicare providers or providers in your Medicare Advantage Plan's network.
2. **Specified Low-income Medicare Beneficiary (SLMB):** Pays for Medicare Part B premium.
3. **Qualifying Individual (QI) Program**: Pays for Medicare Part B premium.

NOTE: If a beneficiary is enrolled in an MSP, they will **automatically** get **Extra Help.** Extra Help is also known as **L**imited **I**ncome **S**ubsidy **(LIS)**; this is a **federal program through** the **Social Security Administration** (SSA) that helps pay Medicare Part D prescription drug plan costs. The following link is a good resource to learn more about the Medicare Savings Programs: https://www.medicare.gov/medicare-savings-programs .

Q: What is a Medicaid spend-down and how does it relate to Medicare?
A: Spend-down is a way for someone with Medicare to qualify for Medicaid even if the person's income is higher than the state's Medicaid limit. The following is an excellent resource regarding Medicaid spend-down as related to Medicare: https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-and-medicaid/spend-down-program-for-beneficiaries-with-incomes-over-the-medicaid-limit .
Spend-downs specifically with regard to Washington residents who are on Medicare and, do not meet the financial eligibility for Medicaid, there are ways they may be able to qualify:
1) Medically Needy Pathway – Washington's Medically Needy (MN) or Medically Needy Program (MNP) allows seniors who have income over Medicaid's limit to still become income-eligible if they have high medical expenses. Sometimes called a Spenddown program, one's "excess" income is used to cover medical bills. This may include medical transportation, health insurance deductibles, hospital visits, medical supplies, and prescription drugs. The amount one must "spend down" is the difference between one's monthly income and the Medically Needy Income Limit (MNIL). This can be thought of as a deductible. In 2023, the MNIL in WA is $914 / month for a single senior applicant, as well as for a married couple. The spend-down period is either

three or six months, based on the decision of the Medicaid applicant. Once one has their spenddown, they are income-eligible for Medicaid services for the remainder of the period. The Medically Needy Pathway has an asset limit of $2,000 for an individual and $3,000 for a couple.

2) Asset Spend Down – Persons who have assets over Medicaid's asset limit can still qualify for Medicaid by "spending down" extra assets. This can be done spending countable assets on things that are exempt (non-countable). Examples include making home renovations and modifications (wheelchair ramps, chair lifts, new plumbing or heating system), prepaying funeral and burial expenses, and paying off debt. One must be cautious when "spending down" assets to avoid violating Medicaid's Look-Back Rule. It is recommended one keep documentation of how assets were spent as proof this rule was not violated.

3) Medicaid Planning – The majority of persons considering Medicaid are "over-income" and / or "over-asset", but they still cannot afford their cost of care. For these persons, Medicaid planning exists. By working with a Medicaid planning professional, families can employ a variety of strategies to help them become Medicaid eligible and to protect their home from Medicaid's Estate Recovery Program. Connect with a Medicaid Planner. **For more information specific to WA State regarding spend-downs please visit:** https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/medicare-and-spenddown.

Q: How can I change my name/address with Medicare?

A: To change your official address with Medicare, you must contact Social Security, even if you don't get Social Security benefits. There are three ways you can do this:

1) Update your information in your *my* Social Security account using the **My Profile** tab; **this is the fastest way to update your information**.
2) Call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.
3) Visit your local Social Security office. You can get the address and directions to your local SSA office from the Social Security Office Locator.
4) ***Note**: If your name has legally changed, you will need to fill out an Application for a Social Security Card - PDF, which you can return to your local field office or you can complete online. You will need to also provide proof of your identity. If you have questions, contact Social Security.*

Q: You had mentioned a difference related to renal conditions or clients in renal failure/have dialysis needs; can you explain further?

A: This was regarding waiting periods for individuals under the age of 65 who are eligible for Medicare due to disability. These individuals, once they have applied and have been approved for Social Security Disability Benefits (SSDI) they will have a 24-month waiting period before getting Medicare coverage.

*However, the 24-month waiting period **is waived for individuals** with **End Stage Renal Disease (ESRD) or Amyotrophic lateral sclerosis (ALS)** (also known as Lou Gehrig's Disease). As soon as a person with ESRD or ALS applies and is approved for SSDI, their Medicare coverage starts right away, they are not subject to the 24-month waiting period.*

Q: What is the income threshold to qualify for Medicaid?
A: The income limit for SSI/Categorically Needy Medicaid are $914. SSA disregards the first $20 of income so effectively the limit is $934.

Q: United Health Care (UHC) dual complete, are these cross over claims or, does Medicaid need to be billed as secondary?
A: UHC Dual Complete is the brand name for one of United Health Care's (UHC) Dual Special Needs Plans (DSNP). The provider will need to bill Medicaid for any copay, co-insurance, or deductible amounts when their patient is a full dual eligible beneficiary *("dual eligible" means an individual who is eligible for both Medicare & Medicaid).*

Q: What happens a beneficiaries Medicare Part B coverage was stopped due to non-payment of their Part B premium; Can they still apply for the Medicare Savings Program (MSP)? If they can still apply and are deemed eligible for an MSP will their Medicare Part B restart?
A: If determined eligible for a Categorically Needy (CN) program or an MSP, their Medicare Part B will be reinstated effective when WA Medicaid Agency sends the eligibility information and Part B payment (buy-in) – the process takes approximately 90 days.

Q: How or where can people go renew their Medicaid when they are on Medicare?
A: To renew one's Medicaid eligibility, go to: https://www.washingtonconnection.org/home/ additional information can also be found at: Age 65 and older or Medicare eligible | Washington State Health Care Authority

Remember the Medicare and You (M&Y) handbook is an excellent Medicare resource; below is the link to the 2023 M&Y handbook pdf. https://www.medicare.gov/publications/10050-Medicare-and-You.pdf

SHIBA is a great resource for all thing Medicare & Medicare counseling; this is a free un-biased service offered through the WA Office of the Insurance Commissioner 1.800.562.6900 / www.insurance.wa.gov