About This Workbook

This workbook provides scenarios on advanced topics related to the Medicare Program. It’s a companion to the 2019 *Understanding Medicare Workbook*, which provides an overview of the basics of the Medicare Program and supplements the *Understanding Medicare* training module developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. The information in that module was correct as of June 2019. To check for an updated version, visit CMSnationaltrainingprogram.cms.gov.

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How to Use This Workbook

The *Scenario-Based Learning Workbook* complements the *Understanding Medicare Workbook* and training module. Each of the 8 scenarios in this workbook includes questions and answers about the scenario, as well as key messages and resources. These scenarios are representative and may not be comprehensive. Appendix A presents the scenarios in a “worksheet” format that includes the questions but not the answers. Appendix B provides information on training resources from the CMS NTP. Here are some ways to use this workbook:

**Ideas for Participants**

- Take notes in the workbook during the training event.
- Retain the workbook as a quick reference tool.
- Use the worksheets as a self-assessment to check your understanding of advanced Medicare topics. The resources listed can be used to research the answers.
- Use the worksheets as training tools to conduct scenario-based learning for others in your organization.
Scenario 1

**Medicare prescription drug coverage for transplant (immunosuppressive) drugs**

Mrs. Williams’ profile

- Has had Medicare Part A and Part B based on End-Stage Renal Disease (ESRD) for 5 years
- Chose not to get Medicare Part D when she enrolled in Medicare
- Had a Medicare-covered kidney transplant at a Medicare-approved facility 8 months ago
- Is about to turn 65

Scenario

Mrs. Williams is at the pharmacy refilling her immunosuppressive drug prescription, which Medicare covers. She has two new expensive prescriptions that aren’t related to ESRD. The pharmacist asks her if she has any other drug coverage. She says, “I only have Medicare. I was told that if I wanted Medicare prescription drug coverage, I’d have to pay a penalty because I didn’t get it when I first got Medicare.”

Let’s answer some important questions about Medicare coverage for immunosuppressive drugs and other prescription drugs.
Q&A

1. Does Medicare cover transplant (immunosuppressive) drugs under Part A or Part B? Explain your answer.

   **It depends.** Both Part A and Part B (if you have them) can cover transplant (immunosuppressive) drugs, depending on the setting. Medicare Part A covers transplant (immunosuppressive) drugs and other medically necessary drugs during an inpatient hospital stay. Part B covers self-administered outpatient immunosuppressive drugs. In both instances, you must be enrolled in Part A at the time of the transplant, and the transplant surgery must have taken place in a Medicare-approved facility.

2. Does Medicare Part D ever cover transplant (immunosuppressive) drugs? Explain your answer.

   **Yes.** Part D may cover transplant (immunosuppressive) drugs if you don’t meet the requirements for Part B coverage—that is, if you weren’t enrolled in Part A at the time of transplant, and the transplant didn’t take place in a Medicare-approved facility. You must have Part A and/or Part B to enroll in a Part D plan. If your transplant (immunosuppressive) drugs are covered by Part B, but you chose not to enroll in Part B, Part D won’t cover your transplant (immunosuppressive) drugs.

3. Which part of Medicare will pay for transplant (immunosuppressive) drugs when a person under 65 with Medicare based on ESRD turns 65? Explain your answer.

   **It depends.** Medicare Part B continues to pay for immunosuppressive drugs with no time limit if you were enrolled in Part A at the time of the transplant, the transplant took place in a Medicare-approved facility, and you’re still enrolled in Part B at the time the drugs are purchased. As long as you’re enrolled in Part B, you continue to have coverage for immunosuppressive transplant drugs under Part B. Medicare Part D (if you have it) covers these drugs if you don’t meet the requirements for Part B coverage.

4. How long does Medicare pay for Part B-covered transplant (immunosuppressive) drugs? Please explain.

   **It depends.** If you’re entitled to Medicare only because of ESRD, your Medicare coverage will end 36 months after the month of a successful transplant. Medicare won’t pay for any services or items, including immunosuppressive drugs, for patients who aren’t entitled to Medicare. However, Medicare will cover these drugs as long as you’re enrolled in Part B. So, if your Medicare coverage ended after the 36 months of successful transplant, and you turn 65 and reenroll in Medicare based on age, your Medicare Part B coverage of transplant (immunosuppressive) drugs
will resume. If you turn 65 before you reach the 36-month limit, you’ll continue to have coverage of transplant (immunosuppressive) drugs through Part B without interruption.

5. **In this scenario, if Mrs. Williams enrolls in Part D during her Initial Enrollment Period, or IEP (the 7-month period that starts 3 months before, and ends 3 months after the month of her 65th birthday), would she have to pay a late enrollment penalty (LEP)? Why or why not?**

**No.** If Mrs. Williams enrolls during her IEP, she won’t have an LEP. However, if Mrs. Williams delays enrolling in Part D until her IEP ends, she’ll have to wait until the next Open Enrollment Period (October 15–December 7 each year) or a Special Enrollment Period (if she qualified for one) to enroll. Her LEP would be 1% of the base beneficiary premium ($33.19 in 2019) times the number of months she could’ve had Part D but didn’t. She would have to pay this LEP for as long as she has Part D unless she qualifies for Extra Help (the low-income subsidy).

**Note:** If you have Part D with an LEP before you turn 65 because of a disability or ESRD, the LEP is removed at 65.

6. **Besides the penalty mentioned in the scenario, why might Mrs. Williams want to consider enrolling in Part D during her IEP?**

**There are two main reasons.** Part D covers other prescription drugs Mrs. Williams may need now, or in the future. Also, enrolling during her IEP can help her avoid an LEP.

7. **Can Mrs. Williams enroll in a Medicare Advantage (MA) Plan during her IEP if she wants to? Why or why not?**

**Yes.** She can choose to enroll in an MA Plan because she had a successful transplant and she has both Part A and Part B. Most MA Plans include Part D coverage.
Key messages

- You can get Medicare at any age if you’re diagnosed with End-Stage Renal Disease (ESRD) and have the required number of work credits yourself, as a dependent spouse, or as a dependent child.

- If you have Medicare due to ESRD, you’ll have a new Initial Enrollment Period at 65.

- There’s no Special Enrollment Period for Part B if you’re eligible for Medicare because of ESRD.

- If you don’t get Part D when you’re first eligible, you may have to pay a late enrollment penalty if you enroll later.

- Transplant (immunosuppressive) drugs can be costly. If you’re worried about paying for them after your Medicare coverage ends, talk to your doctor, nurse, pharmacist, or social worker. There may be other ways to help pay for these drugs.

Resources

Drug Plan Coverage Rules (web page)

I Have End-Stage Renal Disease (ESRD) (web page)

Medicare & You: End Stage Renal Disease/Kidney Transplant Eligibility & Enrollment (video)

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (CMS Product No. 10128) (PDF)

Medicare for People with ESRD (National Training Program Module 6)
Scenario 2

Income Related Monthly Adjustment Amount (IRMAA)

Ms. Garcia’s profile

- Recently turned 65
- Divorced in 2018
- Enrolled in Original Medicare (Part A and Part B) and a Medicare Prescription Drug Plan (Part D)
- Still working and decided to delay getting Social Security retirement benefits

Scenario

Ms. Garcia was 64 last year when she divorced. She changed from filing a joint federal tax return to filing as an individual for 2018. Her modified adjusted gross income (MAGI) was $75,000. In 2017, while she was still married, the MAGI listed on her joint federal tax return was $250,000. She expects her income to remain at about $75,000 per year for the next few years.

She recently got an “Initial IRMAA Determination Notice” for 2019 from Social Security. The letter states that her Part B monthly premium is $270.90, and she has to pay an additional $31.90 for her Part D monthly premium based on her 2017 income.
Q&A

1. Based on the scenario, what would you tell Ms. Garcia about the IRMAA information in her “Initial IRMAA Determination Notice”?

The 2019 IRMAA amounts for Part B and Part D are based on her 2017 federal tax return. Social Security uses MAGI from income reported to the Internal Revenue Service from 2 years prior. Her income has changed since 2017 to a level that caused a significant reduction in her MAGI, which may decrease or eliminate IRMAA.

- The “Initial IRMAA Determination Notice” includes information about her appeal rights.
- The charts below summarize how Social Security determines the IRMAA amount.

Part B premium in 2019 based on 2017 tax return:

<table>
<thead>
<tr>
<th>File Individual Tax Return</th>
<th>File Joint Tax Return</th>
<th>File Married &amp; Separate Tax Return</th>
<th>You pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
<td>$85,000 or less</td>
<td>$135.50</td>
</tr>
<tr>
<td>Above $85,000 up to $107,000</td>
<td>Above $170,000 up to $214,000</td>
<td>Not applicable</td>
<td>$189.60</td>
</tr>
<tr>
<td>Above $107,000 up to $133,500</td>
<td>Above $214,000 up to $267,000</td>
<td>Not applicable</td>
<td>$270.90</td>
</tr>
<tr>
<td>Above $133,500 up to $160,000</td>
<td>Above $267,000 up to $320,000</td>
<td>Not applicable</td>
<td>$352.20</td>
</tr>
<tr>
<td>Above $160,000 and less than $500,000</td>
<td>Above $320,000 and less than $750,000</td>
<td>Above $85,000 and less than $415,000</td>
<td>$433.40</td>
</tr>
<tr>
<td>$500,000 or above</td>
<td>$750,000 and above</td>
<td>$415,000 and above</td>
<td>$460.50</td>
</tr>
</tbody>
</table>
Part D premium in 2019 based on 2017 tax return:

<table>
<thead>
<tr>
<th>File Individual Tax Return</th>
<th>File Joint Tax Return</th>
<th>File Married &amp; Separate Tax Return</th>
<th>You pay Income-related monthly adjustment amount + your plan premium (YPP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
<td>$85,000 or less</td>
<td>YPP</td>
</tr>
<tr>
<td>Above $85,000 up to $107,000</td>
<td>Above $170,000 up to $214,000</td>
<td>Not applicable</td>
<td>$12.40* + YPP</td>
</tr>
<tr>
<td>Above $107,000 up to $133,500</td>
<td>Above $214,000 up to $267,000</td>
<td>Not applicable</td>
<td>$31.90* + YPP</td>
</tr>
<tr>
<td>Above $133,500 up to $160,000</td>
<td>Above $267,000 up to $320,000</td>
<td>Not applicable</td>
<td>$51.40* + YPP</td>
</tr>
<tr>
<td>Above $160,000 and less than $500,000</td>
<td>Above $320,000 and less than $750,000</td>
<td>Above $85,000 and less than $415,000</td>
<td>$70.90* + YPP</td>
</tr>
<tr>
<td>$500,000 or above</td>
<td>$750,000 and above</td>
<td>$415,000 and above</td>
<td>$77.40* + YPP</td>
</tr>
</tbody>
</table>

*IRMAA is adjusted each year, as it’s calculated from the annual beneficiary base premium

2. Can Ms. Garcia request a new initial determination? If so, how would she do it?

Yes. Ms. Garcia can file a request for a new initial determination (someone already enrolled but whose income changes can file a request for a redetermination). In this scenario, because her income has changed since she filed her joint 2017 federal tax return to a level that caused a significant reduction to her MAGI, she can file a request for a new initial determination. She can also file a new initial determination because she got divorced, which is a life-changing event (LCE). Other examples of LCEs include death of a spouse, marriage, and work reduction. She needs to fill out Form SSA-44. Ms. Garcia can mail the completed form to Social Security, or schedule an interview with her local Social Security office by calling 1-800-772-1213. TTY users can call 1-800-325-0778. Form SSA-44 provides detailed instructions about what’s needed to accurately file the request.

The type of information Ms. Garcia needs to provide to Social Security includes the date and type of LCE, with documentation, and documentation of her MAGI.

- She needs a signed copy of her filed federal tax return or a signed copy of an amended federal income tax return. She can provide an estimate of her MAGI. However, Social Security will ask her to provide a signed copy of her federal tax return when she files her taxes.
Scenario 2

- Since Ms. Garcia is now divorced, she'll need a certified copy of the divorce decree. In some cases, Social Security may be able to accept another type of evidence if she doesn’t have the certified copy of the divorce decree. She should ask a Social Security representative what documents are acceptable.


Part B and Part D IRMAA are separate amounts, but have similar payment options:

- **Direct Bill:** If you don’t get a monthly Social Security or Railroad Retirement Board (RRB) payment (like Ms. Garcia), you’ll get a “Medicare Premium Bill” (CMS-500) from the Centers for Medicare & Medicaid Services (CMS). If you only have Part B, your premiums (including Part B IRMAA) are billed quarterly. If you’re billed for Part A and/or Part D IRMAA, you’ll be billed monthly for all premiums. Since Ms. Garcia is billed directly and also has to pay Part D IRMAA, she’ll be billed monthly for her Part B and Part D IRMAA on the same “Medicare Premium Bill.”
  - If her bank offers an online bill payment service, she can use it to pay her Medicare premiums electronically.
  - She can also pay by check, money order, or credit card.

- **Medicare Easy Pay (MEP):** Ms. Garcia can sign up for MEP. MEP is a free electronic payment option that allows her to have her Medicare premium payments automatically deducted from a savings or checking account each month.

- **Social Security or RRB Benefit Payments—Automatic Deduction:** Currently, Ms. Garcia doesn’t get benefit payments. When she starts getting her benefit payments, the Part B and Part D premiums and any IRMAA amounts (and late enrollment penalties, if applicable) must be automatically deducted from her monthly payment, as long as it covers the payment amounts.

  If her Social Security benefit doesn’t cover her full Medicare premiums, Social Security will bill her for the difference on her Part B one time a year. She’ll have to pay her Part D plan monthly premium and Part D IRMAA separately. CMS will send regular bills for the Part D IRMAA. She’ll be required to pay any Part D plan premium to the plan and the Part D IRMAA in a timely manner to stay enrolled.

Information about these payment options can be found on the “Medicare Premium Bill” or Medicare.gov. It’s important to suggest setting up automatic payments like Medicare Easy Pay when working with someone who’s direct billed. That way, if the person is unable to review bills, such as when traveling, he or she won’t be disenrolled for failure to pay Part B and/or Part D IRMAA in a timely manner.
4. **Should Ms. Garcia pay her IRMAA while her request for a new initial determination is processed? What would happen if she doesn’t pay the IRMAA?**

**Yes.** Ms. Garcia should continue to pay the amount calculated in the “Initial IRMAA Determination Notice,” even though she disagrees with the amount. Ms. Garcia is required by law to pay any IRMAA amount(s) to keep her Medicare Part B and/or Part D coverage. **If she fails to pay any applicable Medicare IRMAA, she may be disenrolled from Medicare Part B and/or Part D.** She’d have to wait until her next available enrollment period to reenroll in Part B and/or Part D, and she may be subject to a monthly late enrollment penalty.

If Social Security determines that Ms. Garcia’s IRMAA should be reduced or eliminated, any IRMAA she pays while waiting for her new initial determination won’t be reimbursed directly to her. The overpayments of IRMAA will be applied to her future bills—first to Part B, then to any applicable Part A premium, and finally to Part D IRMAA.

**Key messages**

- Social Security uses modified adjusted gross income from income reported to the Internal Revenue Service from 2 years prior to determine Income Related Monthly Adjustment Amount (IRMAA).
- Certain life-changing events can qualify you for a new initial determination.
- Requests for new initial determinations and redeterminations are reviewed and approved by Social Security, not Medicare.
- Part B and Part D IRMAA are separate amounts, but have similar payment options; Automatic Deduction from Benefit Payments, Direct Bill, or Medicare Easy Pay.
- If you don’t continue to pay the premium and the IRMAA while waiting for Social Security to issue a new initial determination, you could lose your Medicare coverage. Any IRMAA overpayment is applied toward future Medicare Part A premium payments.

**Resources**

- [Initial IRMAA Determination Notices (HI 01101.035)](web page) (web page)
- [Medicare Premium Bill (CMS-500)](web page)
- [The Reconsideration Process for the Income-Related Monthly Adjustment Amount (HI 01140.005)](web page) (web page)
Scenario 3

Health Savings Accounts (HSAs) and Medicare considerations

Mr. Kingly’s profile

- Is 65
- Has had Medicare for 4 months
- Has been getting Social Security retirement benefits for 9 months
- Was automatically enrolled in Medicare
- Has an HSA with a family high-deductible health insurance plan through his former employer
- Currently contributes to his HSA through an automatic deposit each month

Scenario

Mr. Kingly went to get his federal taxes done in January. His accountant told him he was no longer eligible to contribute to his HSA because he has Medicare. Also, he could be assessed a 6% penalty for excess contributions to his HSA.
Q&A

1. Is Mr. Kingly’s accountant correct? Why or why not?

   Yes, his accountant is correct. Mr. Kingly was no longer eligible to contribute to his HSA once his Medicare became effective. Under Internal Revenue Service (IRS) rules, Mr. Kingly can’t contribute to an HSA once he has Medicare (Part A and/or Part B). The IRS can charge a 6% tax penalty on any funds contributed to his HSA, and any earnings from those funds, for every month he had Medicare.

2. What can Mr. Kingly do now to prevent the penalty?

   Mr. Kingly generally may withdraw excess contribution amounts and report it as income to avoid paying the penalty. Those funds must be withdrawn before the due date for the current year’s federal tax return (with extensions).

3. What could Mr. Kingly have done earlier to prevent the penalty?

   He should’ve made arrangements to stop his HSA contributions beginning with the first month he was enrolled in Medicare.

4. Before Mr. Kingly enrolled in Medicare, he had a $3,000 balance in his HSA. Can he use the funds now? If so, on what expenses can he use them?

   Yes. He may still use the account funds for qualified medical expenses incurred by himself, his spouse, and his dependents who could’ve been claimed on his tax returns. Account funds may also be used to pay for Medicare premiums, deductibles, coinsurance, and copayments. HSA funds may not be used to pay for Medicare Supplement Insurance (Medigap) policy premiums.

5. If Mr. Kingly’s spouse owned the HSA with a high-deductible health plan with family coverage, and she wasn’t enrolling in Medicare, would there be an IRS penalty for her after Mr. Kingly enrolls in Medicare?

   No. If an HSA owner’s spouse enrolls in Medicare, no IRS penalty will be incurred.

6. What could you do if you want to continue contributing to your HSA, and you weren’t automatically enrolled in Medicare at 65?

   If you want to continue contributing to your HSA under these conditions, you could delay enrolling in Medicare (Part A and Part B). You should talk to your benefits administrator before you turn 65 to learn more about your options. The effective date of your Medicare Part A could be retroactive back 6 months, but no earlier than the month of your initial eligibility.

   In this situation, it’s important that you plan to stop contributions to your HSA up to 6 months before you enroll in Medicare or apply for Social Security retirement benefits.
Key messages

- If you get Social Security retirement benefits, you’re automatically enrolled in Medicare when you turn 65.

- You may be able to delay Medicare enrollment if you want to continue Health Savings Account (HSA) contributions beyond 65. Talk to your benefits administrator and tax professional.

- You should stop contributing to the HSA beginning with the month you’re enrolled in Medicare to avoid any Internal Revenue Service (IRS) penalties.

- A 6% IRS tax penalty on any contributions and interest (while enrolled in Medicare at the same time) could be incurred unless the amount is withdrawn from your HSA before the due date for the current year’s federal tax return (with extensions).

- If you have Medicare, you can use funds left in your HSA to pay qualified medical expenses including Medicare premiums (if the account owner is 65), deductibles, coinsurance, and copayments. Funds can’t be used for Medicare Supplement Insurance (Medigap) policy premiums.

- If you own an HSA with family coverage, your spouse’s eligibility for enrollment in Medicare won’t impact your ability to contribute to your HSA, or cause you to incur IRS penalties, as long as you aren’t enrolled in Medicare.

Resources

Benefits Planner: Retirement (web page)

Coordination of Benefits: Getting Started (CMS Product No. 11546) (PDF)

Enrolling in Medicare Part A & Part B (CMS Product No. 11036) (PDF)

Health Savings Accounts and Other Tax-Favored Health Plans (IRS Publication No. 969) (PDF)

Medical and Dental Expenses (Including the Health Coverage Tax Credit) (IRS Publication No. 502) (PDF)

Original Medicare (Part A and B) Eligibility and Enrollment (web page)
Scenario 4
Marketplace and Medicare enrollment options

Ms. Stone’s profile

- Has a Marketplace plan and likes it
- Qualifies for a premium tax credit and cost-sharing reductions with her Marketplace plan
- Turns 65 next month
- Is a U.S. citizen
- Doesn’t have a work history

Scenario

Ms. Stone was married for 15 years and is now divorced (for 12 years). Her former spouse is 63, worked for over 40 years, and paid Federal Insurance Contributions Act (FICA) taxes. She isn’t getting Social Security benefits, and neither is her former spouse. She wants to know if she can keep her Marketplace plan or if she should enroll in Medicare.
Q&A

1. Does Ms. Stone qualify for Medicare?
   Yes. She’s a U.S. citizen and is turning 65.
   Since she was married to a Medicare-qualifying spouse for 10 years or more, and the spouse is over 62, she qualifies for premium-free Medicare Part A (Hospital Insurance). She doesn’t qualify on her own work history since she didn’t pay FICA taxes, according to Social Security laws.

2. What should Ms. Stone consider when she turns 65?
   - Ms. Stone should consider enrolling in Medicare Part A and Part B (Medical Insurance). Medicare Part A is minimum essential coverage, so she doesn’t need a Marketplace plan. If she decides to enroll in Medicare, she should enroll during her Initial Enrollment Period (IEP).
   - Once she’s considered eligible for premium-free Part A, she won’t qualify for a premium tax credit or cost-sharing reductions. If she continues to get help paying the Marketplace plan premiums after she has Medicare, she may have to pay back the help she got when she files her taxes.
   - To make sure her Marketplace coverage ends in a timely manner and there’s no gap or overlap in coverage, she should call the Marketplace Call Center at 1-800-318-2596; TTY: 1-855-889-4325, or visit HealthCare.gov to connect to the Marketplace in her state.

3. Do Marketplace plans and Medicare coordinate benefits?
   No. The Marketplace and Medicare don’t coordinate benefits.

4. What should Ms. Stone consider when deciding about her Medicare coverage?
   a. When should she enroll?
      In most cases, it’s to her advantage to sign up for Medicare Part A and Part B when she’s first eligible (IEP) to avoid any delay in coverage and late enrollment penalty.
   b. What happens if she enrolls in Medicare Part B after her IEP ends?
      She may have to pay a late enrollment penalty for as long as she has Medicare. She may also have to wait to enroll in Medicare Part B during the Medicare General Enrollment Period (GEP), which is January 1–March 31 each year. Her coverage would start on July 1 of that year.
c. If she chooses Original Medicare, what are the other considerations?

- She may consider buying a Medigap policy, but she must have Medicare Part A and Part B. The best time to buy a Medigap policy is during her Medigap Open Enrollment Period. This period lasts for 6 months. It begins on the first day of the month in which she’s both 65 or older and enrolled in Medicare Part B.

- She may also consider joining a Medicare Prescription Drug Plan (Part D). Not all Marketplace plans offer creditable prescription drug coverage (meaning at least as good as Medicare prescription drug coverage), so a Part D late enrollment penalty may also be applied if she enrolls in Part D after her IEP ends.

d. Can she choose to join a Medicare Advantage (MA) Plan?

- Yes, if she has both Medicare Part A and Part B, she can choose to enroll in an MA Plan in her area. It would likely include prescription drug coverage (Part D). Medigap policies don’t work with MA Plans.

- Many Marketplace issuers also offer MA Plans, so she could contact her insurance company to see if they offer MA Plans in her area.

e. Would she be eligible for help with her Medicare costs?

- Since Ms. Stone qualified for a premium tax credit and cost-sharing reductions in her Marketplace plan, she should consider applying for a Medicare Savings Program to help with her Medicare out-of-pocket expenses.

- Also, she should apply for Extra Help to help cover the cost of Medicare prescription drug coverage if she enrolls in a Part D plan.

5. How would you advise Ms. Stone if she didn’t qualify for premium-free Medicare Part A?

If Ms. Stone had to pay for Part A, she should compare her Medicare benefits and premiums with her Marketplace plan to see which one best meets her needs and budget.

She can keep the Marketplace plan and qualify for premium tax credits and cost-sharing reductions.

If she doesn’t enroll in Medicare during her IEP, she’ll have to wait for the GEP and may have to pay a late enrollment penalty for Part A, Part B, and Part D.
Key messages

- Medicare isn’t part of the Marketplace and doesn’t coordinate benefits with the Marketplace.

- It’s against the law for someone who knows that you have Medicare to sell you a Marketplace plan. This is true even if you have only Part A or Part B.

- If you have coverage through an individual Marketplace plan (not through an employer), you may want to end your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty.

- It’s important to terminate your Marketplace coverage prior to the effective date of Medicare eligibility to avoid a gap or overlap in coverage. Once you’re considered eligible for premium-free Part A, you won’t qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you may have to pay back the help you got when you file your taxes.

- Call the Marketplace Call Center at 1-800-318-2596 to find out how to terminate your Marketplace plan or Marketplace financial help when your Medicare enrollment begins. TTY users can call 1-855-889-4325.

Resources

- Checklist for Online Medicare, Retirement, & Spouse’s Application (PDF)
- Coordination of Benefits (web page)
- Frequently Asked Questions Regarding the Relationship Between Medicare & the Health Insurance Marketplace (web page & downloadable PDF)
- If You Have Medicare (web page)
- Medicare & the Health Insurance Marketplace (CMS Product No. 11694) (PDF)
- Medicare and the Marketplace (web page)
- Medicare Financial Management Manual (CMS Publication No. 100-06) (web page)
- Medicare Secondary Payer Manual (CMS Publication No. 100-05) (web page)
- Should I Get Parts A & B? (includes “I have Marketplace or Other Private Insurance”) (web page)
Mr. Roberts' profile

- Got Part A at 65
- Has had Medicare Part A for 2 years
- Has a group health plan (GHP) (from an employer) through his wife
- His wife retired 10 months ago

Scenario

Mr. Roberts has Medicare Part A, but he delayed enrolling in Part B because he was covered by his wife’s GHP. His doctor bills were getting paid by the GHP, even after she retired. Recently, he got a bill for his last doctor’s visit. He called the doctor’s billing office to ask why. The billing representative told Mr. Roberts that his GHP denied the payment, and said they also recalled 2 more claims for other visits dating back to the first month after his wife retired. They said it’s because Medicare is his primary insurance. The billing office plans to refile all 3 as Medicare claims. Mr. Roberts said he’s not enrolled in Medicare Part B, which pays for outpatient claims.

He then called Social Security and tried to enroll in Part B so the bills would be covered by Medicare. Social Security told him he can’t enroll in Part B retroactively. Since he didn’t enroll in Part B during his Initial Enrollment Period (IEP), and he didn’t enroll after his wife retired, he has to wait until the Medicare General Enrollment Period (GEP), which is from January 1–March 31 each year. His coverage won’t start until July, and he may have to pay a late enrollment penalty.
Q&A

1. Would Mr. Roberts’ retiree GHP through his wife be able to recall all of the claims wrongly paid as primary? Why or why not?

Yes. The plan could recall the claims wrongly paid as primary since his wife retired. That’s because the Medicare secondary payer provision doesn’t apply to retired beneficiaries who are covered by GHPs as a result of past employment (retiree coverage) and don’t have GHP coverage from their own or a spouse’s current employment status.

Employers with more than 20 employees are required to offer their employees who are 65 or over, and dependents, the same coverage they offer to employees and employees’ spouses under 65—that is, coverage that’s primary to Medicare. However, the requirement doesn’t apply to beneficiaries who don’t have GHP coverage as the result of their own or a spouse’s current employment status.

This means the plan can require you to enroll in Medicare or else pay as if Medicare was primary. The plan should have advised Mr. Roberts to enroll in Medicare Part B when his wife’s employment ended to make sure that Medicare would pay primary and the plan secondary. However, the responsibility to enroll in Medicare rests with Mr. Roberts.

2. What will happen to Mr. Roberts’ outpatient medical claims from the month after his wife retired until his Medicare Part B becomes effective?

- The plan may recall all 3 medical claims wrongly paid as primary from the first month after his wife retired. The provider would have to submit the recalled claims to Medicare first, and to the plan after Medicare processes the claims. However, Mr. Roberts would have to be enrolled in Medicare Part B, and the Medicare claims would have to have been filed within the allowable time limits (generally 1 year from the date of services), for them to be covered.

- If he enrolls in Part B during the GEP, his Medicare coverage is effective July 1 of that year.

- Since Mr. Roberts was enrolled in Medicare Part A, any inpatient hospital claims incurred since his wife retired could be filed with Medicare for primary payment. For outpatient medical claims, such as the 3 claims Mr. Roberts incurred after his wife retired, the GHP may process those claims as if he was enrolled in Medicare Part B and pay for the Part B deductible and coinsurance only. Since he wasn’t enrolled in Part B, he may have to pay the Medicare share of the cost. Mr. Roberts needs to consult with his benefits administrator to evaluate his options.
### Scenario 5

<table>
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<th>Primary payer</th>
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<tr>
<td>Covered by Medicare Part A and spouse’s retiree GHP</td>
<td>Medicare Part A for Part A-covered services&lt;br&gt;Mr. Roberts must pay primary for Part B services since he’s not enrolled in Medicare Part B</td>
<td>Retiree GHP for Part A and Part B-covered services</td>
<td>For doctor’s office visits during this time frame&lt;br&gt; Retiree GHP only pays for co-insurance and deductibles&lt;br&gt; Wrongly paid claims can be recalled</td>
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<tr>
<td>Covered by Medicare Part A and Part B and spouse’s retiree GHP</td>
<td>Medicare Part A and Part B</td>
<td>Retiree GHP</td>
<td></td>
</tr>
</tbody>
</table>

3. **Would Mr. Roberts have to pay a Part B late enrollment penalty?**

**Most likely.** We don’t have the exact dates, so we can’t calculate the exact penalty. However, his monthly premium for Part B may go up 10% of the standard premium for each full 12-month period that he could’ve had Part B, but didn’t sign up for it. He’ll have to wait until the GEP (January 1–March 31) to enroll in Part B. Coverage will start July 1 of that year.

The premium penalty is determined by counting the number of months when he could’ve been (but wasn’t) enrolled in Part B after the end of his IEP, through the end of the enrollment period in which enrollment occurs, and subtracting the months that he was covered under the GHP based on current employment.
Key messages

- Medicare pays first (primary) and group health plans (GHPs) pay second if you're 65 or over and don't have GHP coverage as the result of your own or your spouse's current employment status.

Employers with more than 20 employees are required to offer to their employees 65 or over and dependents the same coverage they offer to actively working employees and employees' spouses under age 65, i.e., coverage that’s primary to Medicare. However, the requirement doesn’t apply to beneficiaries who don’t have GHP coverage as the result of their own or a spouse’s current employment status.

- The Initial Enrollment Period (IEP) is when you can first enroll in Medicare. It lasts 7 months. It starts 3 months before your 65th birthday, includes your birthday month, and ends 3 month after your birthday month.

- If you have GHP coverage based on current employment, you may qualify to enroll in Medicare Part B (and Part A if you have to pay for it) without a late enrollment penalty during any month in which you're enrolled in a GHP based on current employment status, or in any of the 8 consecutive months following the last month you were enrolled in the GHP based on current employment status.

- If you don’t enroll in Medicare Part B (or Part A if you have to pay for it) during your IEP, and you don’t qualify for another opportunity to enroll based on certain events in your life, you may have to pay a late enrollment penalty.

Note: The same requirements apply to individuals under 65 entitled to Medicare on the basis of disability who are covered under a large group health plan as a result of the individual’s or family member’s current employment status with an employer that has 100 employees or more. However, this requirement doesn’t apply to retiree health coverage.

Resources

- [Claims & Appeals](#) (web page)
- [Coordination of Benefits](#) (web page)
- [Medicare and Other Health Benefits: Your Guide to Who Pays First (CMS Publication No. 02179)](#) (PDF)
- [Medicare Secondary Payer Manual](#) (web page with downloadable PDF)
- [Part A & Part B Sign Up Periods](#) (web page)
- [Part B Late Enrollment Penalty](#) (web page)
- [Retiree Insurance](#) (web page)
Scenario 6
Medigap changes for 2020

Mr. and Mrs. Perry’s profile

- Both are covered by Mr. Perry’s group health plan (GHP) based on his current employment. His company has 5,000 employees.
- Mrs. Perry turned 65 on May 14, 2019. She has Medicare Part A.
- Mr. Perry turns 65 on July 20, 2020.
- Both plan to enroll in Medicare Part B when Mr. Perry retires in December 2020.
- Both are interested in enrolling in Medigap Plan F, which has the most benefits, including Part B deductible coverage.

Scenario

Mrs. Perry got a Medigap advertisement in the mail. She thinks a Medigap policy could provide good coverage, along with Medicare, when Mr. Perry retires and their GHP coverage ends. She calls the number on the advertisement and talks with the Medigap company’s representative. She says she’s interested in Plan F, which has the most benefits and covers the Part B deductible. She mentions that she wants to be enrolled in the same Medigap plan as her husband when he retires. The representative says Mrs. Perry and her husband must each buy his or her own policy. Also, the representative says to get a Medigap policy, they must be enrolled in Medicare Part A and Part B first, and that Plan F will no longer be available in 2020 for newly eligible Medicare beneficiaries. Let’s answer some questions about Medigap choices and plan changes for 2020.
Q&A

1. Does Mrs. Perry have to enroll in Medicare Part B now? Why or why not?

   **No.** Mrs. Perry doesn't have to enroll in Medicare Part B while she’s covered by her husband’s GHP based on current employment.

   She’s eligible to enroll in Medicare Part B at any time while she’s covered under the GHP based on his current employment, or during the 8 months after the month her husband retires or the GHP terminates, whichever happens first.

   The best time to buy a Medigap policy is during the Medigap Open Enrollment Period. This period lasts for 6 months. It begins on the first day of the month in which you're 65 or older and are enrolled in Medicare Part B.

   You should always compare the Medigap policies sold in your area. Although each Medigap plan with the same letter has to offer the same coverage, different companies may have lower costs.

2. What are the specific changes to Medigap policies for 2020 that would affect Mr. and Mrs. Perry’s choices?

   - The Medicare Access and CHIP Reauthorization Act of 2015 prohibits the sale of Medigap policies that provide **coverage of the Part B deductible for you if you’re newly eligible for Medicare** as of January 1, 2020.

   - Companies that sell Medigap policies can’t sell **Plans C or F** to you if you turn 65 on or after January 1, 2020, or if you get premium-free Part A (due to a disability or End-Stage Renal Disease) as of January 1, 2020, or later.

3. Can Mrs. Perry wait until next year to enroll in Medicare Part A and Part B, and be able to then enroll in Medigap Plan F?

   **Yes.** Since Mrs. Perry became eligible for Medicare before January 1, 2020, she isn’t affected by this change.

   **She’ll have all of the Medigap options available to her,** including Plans C and F, as well as Plans D and G, including high-deductible Plan G.

4. What options are available to Mr. Perry?

   - Since Mr. Perry becomes eligible for Medicare after January 1, 2020, **he won’t be able to enroll in a Medigap plan that covers the Medicare Part B deductible.**
He’ll be able to choose among 9 different plan options, including Plan G, which is almost identical to Plan F, except for the Medicare Part B deductible coverage. Plan G also has a high-deductible option.

Key messages

- The Medicare Access and CHIP Reauthorization Act of 2015 changed who can purchase a Medigap policy that provides coverage of the Part B deductible (specifically, Plans C and F).

- Companies that sell Medigap policies can’t sell you Plans C or F if you turn 65 on or after January 1, 2020, or if you get premium-free Part A (due to a disability or End-Stage Renal Disease) as of January 1, 2020, or later. If you aren’t a “newly eligible Medicare beneficiary” on January 1, 2020, or later, you can buy Plan C or Plan F.

- Medigap companies can sell Plan C or Plan F to you if your Medicare premium-free Part A is retroactive before January 1, 2020.

- The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This 6-month period begins on the first day of the month in which you’re 65 or older and enrolled in Medicare Part B. After this enrollment period, you may not be able to buy a Medigap policy. If you’re able to buy one, it may cost more.

- If spouses both want a Medigap policy, each has to buy his or her own policy.

- Although benefits are the same in each Medigap plan with the same letter, costs can vary by company.

Resources

Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (CMS Product No. 02110) (PDF)

Medicare Supplement Insurance: Getting Started (CMS Product No. 11575) (PDF)
Mr. Greene’s profile

- Is 80
- Is enrolled in Medicare Part A and Part B
- Lives with his daughter Lisa, who has power of attorney to act on his behalf

Scenario

Lisa’s on the phone with her local State Health Insurance Assistance Program (SHIP). She tells the representative that her father just got a bill from an ambulance provider for $31,000. The ambulance provider said Medicare didn’t pay because the trip by air ambulance wasn’t medically necessary. Lisa tells the representative she called an ambulance when she noticed that her father wasn’t able to feed himself during dinner and couldn’t move his right arm. Mr. Greene was transported to the emergency room (ER) at a local hospital, where they did a CT scan. He was diagnosed with acute cerebrovascular accident (CVA), which is the medical term for a stroke. The treating doctor asked for a transfer to a facility with a higher level of care (neurological specialty) for neurointerventional radiology, which was not available at the first hospital, and arranged the transfer by air ambulance because Mr. Greene’s condition was too critical for ground transportation.

Lisa’s very concerned and wants to know about their options.
Q&A

1. Does Medicare pay for air ambulance transportation from one hospital to another?

Yes, air ambulance transportation is covered if you transfer from one hospital to another, if the medical appropriateness criteria are met. That means that transportation by ground ambulance would endanger your health, and the transferring hospital doesn’t have adequate facilities to provide the medical services you need.

Examples of specialized medical services that are generally not available at all types of facilities may include, but aren’t limited to, burn care, cardiac care, trauma care, and critical care.

Transportation from one hospital to another hospital is covered only if the hospital to which you’re transferred is the nearest one with appropriate facilities. Transport isn’t covered if the hospital is capable of treating you or because you or your family prefer a specific hospital or doctor.

2. Does Mr. Greene’s condition fit the coverage requirement?

Yes, it seems so. According to Mr. Greene’s treating doctor, his condition was critical, and transporting him by ground ambulance would have endangered his life. Also, the hospital wasn’t an adequate facility and didn’t have the necessary specialty to treat his condition. Mr. Greene was having a stroke and needed urgent neurointerventional radiology, which was not available in the first hospital.

3. Is the ambulance provider able to bill Mr. Greene if he didn’t request the air ambulance?

Maybe. Here are some things to consider:

- After determining that a service won’t be covered, Medicare must determine who’s financially liable for the denied service. When a service is denied as not reasonable or necessary, Medicare must determine if you and the provider either knew or could reasonably be expected to know that the item or service wouldn’t be covered. This is known as the limitation of liability provision.

- If you were informed by your provider or supplier in writing in advance of getting the service that Medicare may not make payment (through an Advanced Beneficiary Notice (ABN)), you may be responsible for the cost of the denied item or service. If the provider or supplier knew or could reasonably be expected to know the item or service wouldn’t be covered, but you didn’t know, then the provider or supplier may be responsible for the cost of the denied item or service.
Based on the information from Mr. Greene’s daughter, there’s no evidence to show that the provider notified Mr. Greene or his daughter in advance that the service wouldn’t be covered by Medicare. Therefore, Mr. Greene didn’t know, and couldn’t reasonably have been expected to know, that the item or service wouldn’t be covered. In that case, the provider is responsible for the cost of the denied service.

In general, a provider/supplier may not issue an ABN to a person who has a medical emergency or is under similar duress. Since Mr. Greene was having a medical emergency, forcing delivery of an ABN may be considered coercive. ABN usage in the ER may be appropriate in some cases, where the person is medically stable with no emergent health issues.

Issuance of the ABN is mandatory for ambulance transport services only in limited circumstances—for example, if the service is covered by Medicare, and the provider believes that it would be denied because the person doesn’t meet the medical condition, and the ambulance transportation is provided in a non-emergency situation. For example, a beneficiary might require non-emergency ground transportation from a local hospital to the nearest hospital properly equipped to treat his or her condition, but his family requests transportation by air ambulance. The ambulance service is a covered benefit, but the level of care (air transport) is not reasonable and necessary for this patient’s condition. Therefore, an ABN must be issued prior to providing the service in order for the provider to shift liability to the beneficiary.

4. Is a letter or statement from the doctor enough to establish medical necessity?

No. Here are some things to consider:

- It’s only medically appropriate for an air ambulance to transport you when the time needed to transport you by land, or if transporting by land, poses a threat to your survival or seriously endangers your health. Having or not having a signed doctor’s order for an ambulance transport doesn’t prove or disprove that the transport is medically necessary. In all cases, the correct documentation must be kept on file and, upon request, presented to the Medicare Part A and/or Part B Medicare Administrative Contractor (MAC).

- The ambulance service must meet all program coverage criteria in order for payment to be made.

- To determine the medical appropriateness of air ambulance services, the Medicare Part A and/or Part B MAC may request that you provide documentation that shows the air ambulance services were reasonable and necessary to treat your life-threatening condition.
Documentation (like an ambulance run sheet) should be on file with the ambulance service to support the service billed. Information should include the type of vehicle used, your condition upon arrival, origin and destination, and any specialized care provided during transport. In this scenario, the ambulance run sheet should include the following:

- The patient noted right arm numbness and weakness on the date of service.
- That evening, the patient’s daughter reported that he was unable to feed himself normally and was taken to the ER, where a CT scan was performed. He was diagnosed with symptoms of acute CVA, having a stroke.
- The doctor identified the need for a higher level of care (neurological specialty) for urgent neurointerventional radiology and arranged an emergency transport to the closest facility that could provide the necessary care.

Since the original claim was denied, the next step is for Mr. Greene’s daughter to request that the ambulance provider file a reconsideration with the MAC. As long as medical necessity for the air transport is validated (if the above information is presented with the reconsideration request), payment would be allowed for the services in the Medicare-approved amount.
Key messages

- The ambulance benefit is defined as an ambulance service where the use of other methods of transportation is warned against, based on your condition.
- You must be transported in an appropriate vehicle, and the origin and destination of the transport must be locations that are covered by Medicare.
- If any other means of transportation other than ambulance could’ve been used without endangering your health, payment cannot be allowed for the transport. This rule applies whether or not other means of transportation are available.
- Transportation is allowed to the nearest facility equipped to treat your condition.
- Having or not having a signed doctor’s order for an ambulance transport doesn’t prove or disprove that the transport is medically necessary. Documentation like an ambulance run sheet should be on file to support the service billed, and information documenting the type of vehicle, your condition upon arrival, origin and destination, and any specialized care provided during transport should be noted.

Resources


Medicare Coverage of Ambulance Services (CMS Product No. 11021) (PDF)

Medicare Ambulance Transports (Medicare Learning Network booklet)

Program Integrity Manual: Chapter 3—Verifying Potential Errors and Taking Corrective Action, Section 33.2.1.1 B (CMS Publication 100-08) (Internet-Only Manual)

Title 42 of the Code of Federal Regulations (CFR), Section 410.40-41 (web page)

Who Are the MACs (web page for locating local Medicare Administrative Contractors)
Appendix A
Scenario Worksheets
Scenario 1

Medicare prescription drug coverage for transplant (immunosuppressive) drugs

Mrs. Williams’ profile

- Has had Medicare Part A and Part B based on End-Stage Renal Disease (ESRD) for 5 years
- Chose not to get Medicare Part D when she enrolled in Medicare
- Had a Medicare-covered kidney transplant at a Medicare-approved facility 8 months ago
- Is about to turn 65

Scenario

Mrs. Williams is at the pharmacy refilling her immunosuppressive drug prescription, which Medicare covers. She has two new expensive prescriptions that aren’t related to ESRD. The pharmacist asks her if she has any other drug coverage. She says, “I only have Medicare. I was told that if I wanted Medicare prescription drug coverage, I’d have to pay a penalty because I didn’t get it when I first got Medicare.”

Let's answer some important questions about Medicare coverage for immunosuppressive drugs and other prescription drugs.
Questions

1. Does Medicare cover transplant (immunosuppressive) drugs under Part A or Part B? Explain your answer.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. Does Medicare Part D ever cover transplant (immunosuppressive) drugs? Explain your answer.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3. Which part of Medicare will pay for transplant (immunosuppressive) drugs when a person under 65 with Medicare based on ESRD turns 65? Explain your answer.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

4. How long does Medicare pay for Part B-covered transplant (immunosuppressive) drugs? Please explain.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

5. In this scenario, if Mrs. Williams enrolls in Part D during her Initial Enrollment Period, or IEP (the 7-month period that starts 3 months before, and ends 3 months after the month of her 65th birthday), would she have to pay a late enrollment penalty (LEP)? Why or why not?

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Scenario 1

6. Besides the penalty mentioned in the scenario, why might Mrs. Williams want to consider enrolling in Part D during her IEP?

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______________________________________________________________
______________________________________________________________
______________________________________________________________

7. Can Mrs. Williams enroll in a Medicare Advantage (MA) Plan during her IEP if she wants to? Why or why not?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Resources

Drug Plan Coverage Rules (web page)

I Have End-Stage Renal Disease (ESRD) (web page)

Medicare & You: End Stage Renal Disease/Kidney Transplant Eligibility & Enrollment (video)

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (CMS Product No. 10128) (PDF)

Medicare for People with ESRD (National Training Program Module 6)
Scenario 2

Income Related Monthly Adjustment Amount (IRMAA)

Ms. Garcia’s profile

- Recently turned 65
- Divorced in 2018
- Enrolled in Original Medicare (Part A and Part B) and a Medicare Prescription Drug Plan (Part D)
- Still working and decided to delay getting Social Security retirement benefits

Scenario

Ms. Garcia was 64 last year when she divorced. She changed from filing a joint federal tax return to filing as an individual for 2018. Her modified adjusted gross income (MAGI) was $75,000. In 2017, while she was still married, the MAGI listed on her joint federal tax return was $250,000. She expects her income to remain at about $75,000 per year for the next few years.

She recently got an “Initial IRMAA Determination Notice” for 2019 from Social Security. The letter states that her Part B monthly premium is $270.90, and she has to pay an additional $31.90 for her Part D monthly premium based on her 2017 income.
Questions

1. Based on the scenario, what would you tell Ms. Garcia about the IRMAA information in her “Initial IRMAA Determination Notice”?

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_____________________________________________________________________________________________
_____________________________________________________________________________________________

2. Can Ms. Garcia request a new initial determination? If so, how would she do it?

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_____________________________________________________________________________________________
_____________________________________________________________________________________________


_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

4. Should Ms. Garcia pay her IRMAA while her request for a new initial determination is processed? What would happen if she doesn’t pay the IRMAA?

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Resources

Initial IRMAA Determination Notices (HI 01101.035) (web page)

Medicare Premium Bill (CMS-500) (web page)

The Reconsideration Process for the Income-Related Monthly Adjustment Amount (HI 01140.005) (web page)
### Part B premium in 2019 based on 2017 tax return:

| File Individual Tax Return | File Joint Tax Return | File Married & Separate Tax Return | You pay  
|---------------------------|-----------------------|-----------------------------------|--------|
| $85,000 or less           | $170,000 or less       | $85,000 or less                    | $135.50  
| Above $85,000 up to $107,000 | Above $170,000 up to $214,000 | Not applicable                     | $189.60  
| Above $107,000 up to $133,500 | Above $214,000 up to $267,000 | Not applicable                     | $270.90  
| Above $133,500 up to $160,000 | Above $267,000 up to $320,000 | Not applicable                     | $352.20  
| Above $160,000 and less than $500,000 | Above $320,000 and less than $750,000 | Above $85,000 and less than $415,000 | $433.40  
| $500,000 or above         | $750,000 and above     | $415,000 and above                 | $460.50  

### Part D premium in 2019 based on 2017 tax return:

| File Individual Tax Return | File Joint Tax Return | File Married & Separate Tax Return | You pay income-related monthly adjustment amount + your plan premium (YPP)  
|---------------------------|-----------------------|-----------------------------------|---------------------------------|
| $85,000 or less           | $170,000 or less       | $85,000 or less                    | YPP                             
| Above $85,000 up to $107,000 | Above $170,000 up to $214,000 | Not applicable                     | $12.40* + YPP                   
| Above $107,000 up to $133,500 | Above $214,000 up to $267,000 | Not applicable                     | $31.90* + YPP                   
| Above $133,500 up to $160,000 | Above $267,000 up to $320,000 | Not applicable                     | $51.40* + YPP                   
| Above $160,000 and less than $500,000 | Above $320,000 and less than $750,000 | Above $85,000 and less than $415,000 | $70.90* + YPP                   
| $500,000 or above         | $750,000 and above     | $415,000 and above                 | $77.40* + YPP                   

*IRMAA is adjusted each year, as it’s calculated from the annual beneficiary base premium*
Scenario 3
Health Savings Accounts (HSAs) and Medicare considerations

Mr. Kingly’s profile

- Is 65
- Has had Medicare for 4 months
- Has been getting Social Security retirement benefits for 9 months
- Was automatically enrolled in Medicare
- Has an HSA with a family high-deductible health insurance plan through his former employer
- Currently contributes to his HSA through an automatic deposit each month

Scenario

Mr. Kingly went to get his federal taxes done in January. His accountant told him he was no longer eligible to contribute to his HSA because he has Medicare. Also, he could be assessed a 6% penalty for excess contributions to his HSA.
Questions

1. Is Mr. Kingly’s accountant correct? Why or why not?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2. What can Mr. Kingly do now to prevent the penalty?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

3. What could Mr. Kingly have done earlier to prevent the penalty?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

4. Before Mr. Kingly enrolled in Medicare, he had a $3,000 balance in his HSA. Can he use the funds now? If so, on what expenses can he use them?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

5. If Mr. Kingly’s spouse owned the HSA with a high-deductible health plan with family coverage, and she wasn’t enrolling in Medicare, would there be an IRS penalty for her after Mr. Kingly enrolls in Medicare?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

6. What could you do if you want to continue contributing to your HSA, and you weren’t automatically enrolled in Medicare at 65?
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________

Scenario 3

A–8
Scenario 3

Resources

Benefits Planner: Retirement (web page)

Coordination of Benefits: Getting Started (CMS Product No. 11546) (PDF)

Enrolling in Medicare Part A & Part B (CMS Product No. 11036) (PDF)

Health Savings Accounts and Other Tax-Favored Health Plans (IRS Publication No. 969) (PDF)

Medical and Dental Expenses (Including the Health Coverage Tax Credit) (IRS Publication No. 502) (PDF)

Original Medicare (Part A and B) Eligibility and Enrollment (web page)
Scenario 4
Marketplace and Medicare enrollment options

Ms. Stone’s profile

- Has a Marketplace plan and likes it
- Qualifies for a premium tax credit and cost-sharing reductions with her Marketplace plan
- Turns 65 next month
- Is a U.S. citizen
- Doesn’t have a work history

Scenario

Ms. Stone was married for 15 years and is now divorced (for 12 years). Her former spouse is 63, worked for over 40 years, and paid Federal Insurance Contributions Act (FICA) taxes. She isn’t getting Social Security benefits, and neither is her former spouse. She wants to know if she can keep her Marketplace plan or if she should enroll in Medicare.
Questions

1. Does Ms. Stone qualify for Medicare?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2. What should Ms. Stone consider when she turns 65?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

3. Do Marketplace plans and Medicare coordinate benefits?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

4. What should Ms. Stone consider when deciding about her Medicare coverage?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

5. How would you advise Ms. Stone if she didn’t qualify for premium-free Medicare Part A?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
Scenario 4

Resources

Checklist for Online Medicare, Retirement, & Spouse’s Application (PDF)

Coordination of Benefits (web page)

Frequently Asked Questions Regarding the Relationship Between Medicare & the Health Insurance Marketplace (web page & downloadable PDF)

If You Have Medicare (web page)

Medicare & the Health Insurance Marketplace (CMS Product No. 11694) (PDF)

Medicare and the Marketplace (web page)

Medicare Financial Management Manual (CMS Publication No. 100-06) (web page)

Medicare Secondary Payer Manual (CMS Publication No. 100-05) (web page)

Should I Get Parts A & B? (includes “I have Marketplace or Other Private Insurance”) (web page)
Scenario 5
Medicare secondary payer and late enrollment penalties

Mr. Roberts’ profile

- Got Part A at 65
- Has had Medicare Part A for 2 years
- Has a group health plan (GHP) (from an employer) through his wife
- His wife retired 10 months ago

Scenario

Mr. Roberts has Medicare Part A, but he delayed enrolling in Part B because he was covered by his wife’s GHP. His doctor bills were getting paid by the GHP, even after she retired. Recently, he got a bill for his last doctor’s visit. He called the doctor’s billing office to ask why. The billing representative told Mr. Roberts that his GHP denied the payment, and said they also recalled 2 more claims for other visits dating back to the first month after his wife retired. They said it’s because Medicare is his primary insurance. The billing office plans to refile all 3 as Medicare claims. Mr. Roberts said he’s not enrolled in Medicare Part B, which pays for outpatient claims.

He then called Social Security and tried to enroll in Part B so the bills would be covered by Medicare. Social Security told him he can’t enroll in Part B retroactively. Since he didn’t enroll in Part B during his Initial Enrollment Period (IEP), and he didn’t enroll after his wife retired, he has to wait until the Medicare General Enrollment Period (GEP), which is from January 1–March 31 each year. His coverage won’t start until July, and he may have to pay a late enrollment penalty.
Scenarios 5

Questions

1. Would Mr. Roberts’ retiree GHP through his wife be able to recall all of the claims wrongly paid as primary? Why or why not?

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2. What will happen to Mr. Roberts’ outpatient medical claims from the month after his wife retired until his Medicare Part B becomes effective?

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3. Would Mr. Roberts have to pay a Part B late enrollment penalty?

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Resources

Claims & Appeals (web page)
Coordination of Benefits (web page)
Medicare and Other Health Benefits: Your Guide to Who Pays First (CMS Publication No. 02179) (PDF)
Medicare Secondary Payer Manual (web page with downloadable PDF)
Part A & Part B Sign Up Periods (web page)
Part B Late Enrollment Penalty (web page)
Retiree Insurance (web page)
Mr. and Mrs. Perry’s profile

- Both are covered by Mr. Perry’s group health plan (GHP) based on his current employment. His company has 5,000 employees.
- Mrs. Perry turned 65 on May 14, 2019. She has Medicare Part A.
- Mr. Perry turns 65 on July 20, 2020.
- Both plan to enroll in Medicare Part B when Mr. Perry retires in December 2020.
- Both are interested in enrolling in Medigap Plan F, which has the most benefits, including Part B deductible coverage.

Scenario

Mrs. Perry got a Medigap advertisement in the mail. She thinks a Medigap policy could provide good coverage, along with Medicare, when Mr. Perry retires and their GHP coverage ends. She calls the number on the advertisement and talks with the Medigap company’s representative. She says she’s interested in Plan F, which has the most benefits and covers the Part B deductible. She mentions that she wants to be enrolled in the same Medigap plan as her husband when he retires. The representative says Mrs. Perry and her husband must each buy his or her own policy. Also, the representative says to get a Medigap policy, they must be enrolled in Medicare Part A and Part B first, and that Plan F will no longer be available in 2020 for newly eligible Medicare beneficiaries. Let’s answer some questions about Medigap choices and plan changes for 2020.
Questions

1. Does Mrs. Perry have to enroll in Medicare Part B now? Why or why not?
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   ______________________________________________________________________________________________
   ______________________________________________________________________________________________

2. What are the specific changes to Medigap policies for 2020 that would affect Mr. and Mrs. Perry’s choices?
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   ______________________________________________________________________________________________
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   ______________________________________________________________________________________________

3. Can Mrs. Perry wait until next year to enroll in Medicare Part A and Part B, and be able to then enroll in Medigap Plan F?
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   ______________________________________________________________________________________________
   ______________________________________________________________________________________________

4. What options are available to Mr. Perry?
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   ______________________________________________________________________________________________
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Resources

Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (CMS Product No. 02110) (PDF)

Medicare Supplement Insurance: Getting Started (CMS Product No. 11575) (PDF)
Scenario

Mr. Greene’s profile

- Is 80
- Is enrolled in Medicare Part A and Part B
- Lives with his daughter Lisa, who has power of attorney to act on his behalf

Scenario

Lisa’s on the phone with her local State Health Insurance Assistance Program (SHIP). She tells the representative that her father just got a bill from an ambulance provider for $31,000. The ambulance provider said Medicare didn’t pay because the trip by air ambulance wasn’t medically necessary. Lisa tells the representative she called an ambulance when she noticed that her father wasn’t able to feed himself during dinner and couldn’t move his right arm. Mr. Greene was transported to the emergency room (ER) at a local hospital, where they did a CT scan. He was diagnosed with acute cerebrovascular accident (CVA), which is the medical term for a stroke. The treating doctor asked for a transfer to a facility with a higher level of care (neurological specialty) for neurointerventional radiology, which was not available at the first hospital, and arranged the transfer by air ambulance because Mr. Greene’s condition was too critical for ground transportation.

Lisa’s very concerned and wants to know about their options.
Questions

1. Does Medicare pay for air ambulance transportation from one hospital to another?

2. Does Mr. Greene’s condition fit the coverage requirement?

3. Is the ambulance provider able to bill Mr. Greene if he didn’t request the air ambulance?

4. Is a letter or statement from the doctor enough to establish medical necessity?
Scenario 7

Resources


Medicare Coverage of Ambulance Services (CMS Product No. 11021) (PDF)

Medicare Ambulance Transports (Medicare Learning Network booklet)

Program Integrity Manual: Chapter 3—Verifying Potential Errors and Taking Corrective Action, Section 33.2.1.1 B (CMS Publication 100-08) (Internet-Only Manual)

Title 42 of the Code of Federal Regulations (CFR), Section 410.40-41 (web page)

Who Are the MACs (web page for locating local Medicare Administrative Contractors)
Appendix B

CMS National Training Program Resources
CMS National Training Program Resources

The Centers for Medicare & Medicaid Services (CMS) National Training Program (NTP) develops materials and leads training opportunities to help people make informed health care decisions. We also provide resources, PowerPoints, and job aids that can be used to educate others.

See the CMS NTP website to access all of our materials and educational opportunities that will help you better understand and educate others about Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Health Insurance Marketplace.