



What Tax Practitioners Need To Know About Medicare

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Introduction to Medicare Parts A and B

- Established in 1965, Medicare is a federal health insurance program that originally covered individuals 65 years of age and older
- It is now also offered to younger people under 65 who have been receiving Social Security Disability Insurance (SSDI) benefits for two years, those with end-stage renal disease, or those with amyotrophic lateral sclerosis (ALS)
- Medicare is divided into several parts:
 - Part A (hospital insurance)
 - Part B (medical insurance)
 - Part C (Medicare Advantage)
 - Part D (prescription drug coverage)



Introduction to Medicare Parts A and B

- Parts A and B of Medicare are called Original Medicare or traditional Medicare
 - Administered federally by the Centers for Medicare & Medicaid Services (CMS)
 - Part A covers inpatient care at hospitals, skilled nursing facilities, and other facilities
 - Part B covers outpatient care, such as trips to a doctor's office and medical devices such as walkers and wheelchairs
- Most Americans qualify for Medicare when they turn 65
- Individuals younger than age 65 may be eligible for Medicare if they have a qualifying disability or condition such as end-stage renal disease or amyotrophic lateral sclerosis, also known as Lou Gehrig's Disease



Medicare at a Glance

Total enrollment	69.7 million
Average enrollment rate	About 100,000 new beneficiaries per month
Percentage of beneficiaries who qualify by age	89.9%
Percentage of beneficiaries who qualify by disability	9.1%
Medicare Advantage enrollment	About 5 out of 10 Medicare beneficiaries
Part D enrollment	56.4 million



Medicare at a Glance

Dual Medicare and Medicaid enrollment rate	19%
Total projected Medicare spending	\$1.2 trillion
Most commonly covered Part D medication	Atorvastatin calcium (generic Lipitor)
Medication that costs Medicare the most in total spending	Eliquis (\$18.2 billion)
Most common health condition	High blood pressure



When Eligibility for Medicare Coverage Starts

- Age 65 or under 65 and qualify because of a disability or another special situation, and
- U.S. citizen or legal resident who has lived in the U.S. for at least 5 consecutive years
- Call 800-633-4227 when it is time to enroll in Medicare
- Help from Medicare is available 24 hours a day, 7 days a week, except some federal holidays



When Medicare Coverage Starts

- An individual applying for Medicare coverage must be age 65
- Even if an individual begins receiving Social Security at an age younger than age 65, the individual must wait to enroll in Medicare until he or she is age 65
- The age of the individual's spouse is irrelevant
- Even if an individual is not yet collecting Social Security, an individual is eligible for Medicare if he or she has attained age 65
- Two ways to get Medicare:
 - Medicare Parts A and B; or
 - Medicare Advantage – Part C



Parts C and D of Medicare

- Part C or Medicare Advantage plans are offered by private companies approved by Medicare
- Part C plans provide all of Part A and Part B coverage and may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs
- Most Part C plans include Medicare prescription drug coverage
- Part D plan covers the cost of outpatient prescription drugs
- An individual can acquire Part D coverage through a standalone prescription drug plan that he or she can use alongside Original Medicare, or the individual can join a Medicare Advantage plan that includes Part D drug coverage
- The plans have a formulary or list of covered drugs that may change year-to-year



Advantages and Disadvantages of Medicare Part A (Hospital Coverage)

Advantages

- Most participants do not pay a monthly premium
- Covered individual only pays deductible — first \$1,736 in 2026 for a hospital stay of less than 60 days
- Covered individual can go to any qualified hospital in the US that accepts new Medicare patients
- Enrollment is easy
- The applicant cannot be turned down because of medical history or pre-existing illness

Disadvantages

- Long hospitalizations can be expensive — stays greater than 60 days require a daily copayment
- Multiple hospital stays may mean the individual must pay a deductible amount multiple times
- Medicare normally does not cover hospital care outside the United States



Advantages and Disadvantages of Medicare Part B (Doctor Visits)

Advantages

- Part B works the same way throughout the United States
- Insured can get medical care wherever he or she is in the United States
- Insured can receive care from any participating physician that accepts new Medicare patients
- Enrollment is easy—medical history or pre-existing illness does not prevent enrollment

Disadvantages

- If wait to apply, may have to pay a higher premium and wait for future effective date
- Preventive health care is limited
- The covered individual must generally pay 20% of the Medicare approved cost with no ceiling on expense incurred
- Generally, health care coverage outside the United States is not covered



Costs That Part A and Part B Do Not Cover

- Long-term care
- Most dental care
- Eye exams related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Routine foot care



Long-term Care

- Long-term care is a range of services and support for personal care needs
- Most long-term care is not medical care but constitutes help with activities of daily living life like bathing, dressing, and using the bathroom
- Medicare will help pay for a short stay in a skilled nursing facility if the individual meets all of the following conditions:
 - Individual had a hospital admission with an inpatient stay of at least 3 days
 - Individual is admitted to a Medicare-certified nursing facility within 30 days of that inpatient hospital stay
 - Individual needs skilled care, such as skilled nursing services, physical therapy, or other types of therapy



What Skilled Nursing Facility Care Medicare Will Pay For

- Original Medicare will pay a portion of the costs for up to 100 days for each benefit period as follows:
 - For the first 20 days, individual pays \$0 after paying the \$1,736 amount in 2026
 - For days 21 through 100, the individual pays a daily copayment of \$217 each day in 2026 and Medicare pays any balance
 - After day 100, the individual pays all long-term costs
- Medicare does not pay costs for days incurred in a skilled nursing facility after day 100
- Medicare Advantage plans must cover the same long-term care services, but the cost sharing formula may vary



Income-related Monthly Adjustment Amount (IRMAA)

- If MAGI as reported on a tax return from two years ago exceeds certain thresholds, taxpayer may pay a higher Part B and Part D premium known as the income-related monthly adjustment amount (IRMAA)
- For 2026, individuals with a 2024 MAGI over \$109,000 or married couples over \$218,000 will pay increased premiums
- See: <https://www.medicare.gov/Pubs/pdf/11579-Medicare-Costs.pdf>



Medicare Premiums Paid by Social Security

- Individuals receiving monthly benefit payments from Social Security, Railroad Retirement or a federal annuity from the Office of Personnel Management will have their Medicare premiums taken out of these payments
- Those not receiving benefit payments from Social Security will be directly billed and must send their payments to the Medicare Premium Collection Center
- If Medicare bills a patient directly, the covered individual will be billed quarterly, but the individual can ask to be billed monthly
- A covered individual can pay by check, money order, or with a credit card
- It is possible to arrange with the Social Security Administration to have someone other than the beneficiary make Medicare premium payments (e.g., a union or a child of a disabled parent) primarily through the "Representative Payee Program"
- If a beneficiary cannot manage their finances due to age or impairment, the SSA appoints a representative payee to receive payments and pay bills, including Medicare premiums
- Beneficiaries can tell a Social Security representative if they have a specific person they would like to have as their payee



Income-Related Monthly Adjustment Amount (IRMAA)

- All Medicare beneficiaries who enroll in Part B of Medicare must pay a premium — see <https://www.medicare.gov/Pubs/pdf/11579-Medicare-Costs.pdf>
- The Standard Part B premium is \$202.90 per month for 2026
- The IRMAA is an extra fee that is added to the individual's monthly Medicare premium
 - If income on individual's federal tax return for 2024 exceeded \$109,000 as an individual or \$218,000 as a couple filing jointly, the monthly premium will be higher than \$202.90
- Those with higher incomes can pay up to \$689.90 per month for 2026
- A similar calculation applies to high-income beneficiaries enrolled in Part D — see <https://www.medicare.gov/Pubs/pdf/11579-Medicare-Costs.pdf>



Appealing Part B and Part D Medicare Premiums

- Taxpayers may file an appeal with Medicare on Form SSA-44 for the purpose of lowering their Medicare Part B and Part D premiums
- The individual may prevail by arguing that a particular event was a qualifying life-changing event that would justify a reconsideration of the Part B and Part D premiums
- The individuals must provide their past AGI and what they expect their new, lower AGI to be
- Proof of a life-changing event causing a significant reduction in modified adjusted gross income (MAGI)
- A “significant” reduction in MAGI is a reduction that decreases or eliminates the income-related monthly adjustment amount (IRMAA) for a specific tax year



A Life-changing Event (LCE) Can Be One or More of the Following Events:

- Death of spouse
- Marriage
- Divorce or annulment
- Work reduction
- Work stoppage
- Loss of income-producing property (beyond the beneficiary’s control)
- Loss of employer pension (plan failure or termination, or scheduled cessation)
- Employer settlement payment (as a result of an employer or former employer’s closure, bankruptcy, or reorganization)
- Loss of dividend income due to criminal theft could qualify as an LCE



Transactions Not Treated As Life-changing for IRMAA Purposes

- Ordinary loss of dividend income;
- Higher medical expenses;
- Higher living expenses;
- Loss of child support;
- Loss of alimony; or
- Voluntary sale of income-producing property



Requesting Use of More Recent Tax Year

- There are situations where a beneficiary may request the use of a more recent tax year for a new initial determination because a one-time event caused an increase in their income for the tax year used to impose IRMAA
- Consider this type of event as a non-qualifying event
- Some examples of one-time income that cause an increase and are non-qualifying events (NQE) include:
 - Capital gains from the sale of property;
 - Lottery winnings;
 - Casino winnings;
 - Conversion of an IRA; or
 - Cashing bonds



Part B Premium Amounts

- An individual who fails to pay his or her Part B premiums will eventually be disenrolled from all parts of Medicare
- Medicare will send a delinquent individual a premium due notice and a delinquency notice
- The delinquent individual will be given a grace period within which he or she must make payment of the delinquent premiums
- If no payment is made, Medicare will then send the individual a final notice of delinquency and eventually disenroll the individual from Medicare
- If an individual is disenrolled from Part B and the individual is in a Medicare Advantage Plan (Part C), he or she will also be disenrolled from Part C
- Trying to be re-enrolled in Medicare part B once coverage has been terminated is an experience to avoid!



Part B Savings Clause

- A savings clause prevents beneficiaries of Social Security or Railroad Retirement from being impacted by an increase in their Part B premium greater than the yearly cost-of-living increase in their Social Security or Railroad Retirement benefit
- The savings clause caps the premium increase so it does not exceed a beneficiary's cost of living adjustment (COLA)



Part B Savings Clause

- The savings clause applies only to those who have their Part B premium taken out of their Social Security or Railroad Retirement monthly payment
- The savings clause does not apply in the following circumstances:
 - If an individual is paying his or her premium directly to Medicare because he or she has elected not to draw on his or her Social Security yet;
 - Someone else is paying the individual's Medicare premium; or
 - If the individual is receiving a federal pension instead of Social Security



Loss of Part D Coverage

- A delinquent individual with Part D prescription drug coverage will not lose their Part D prescription drug coverage because the individual must be enrolled in either Part A or Part B to get Part D coverage
- If a delinquent individual has only Part A coverage and has a stand-alone prescription drug plan, the individual will not be disenrolled from it



Individuals Turning Age 65 Who Continue To Work

- Medicare requires enrollees to sign up during a limited window before and after their 65th birthday
- Failure to enroll in a timely manner leads to potentially expensive, long waits for coverage to begin and late-enrollment penalties that continue for the life of the insured
- The one major exception is that those who are still employed and on a group plan for a firm with 20+ employees when they turn 65 can stay with their employer-provided group coverage
- As long as an individual has group health insurance from an employer with 20 or more employees for which the individual or his or her spouse actively works after he or she turns 65, the individual can delay enrolling in Medicare until the employment ends or the coverage stops, whichever happens first, without incurring any late penalties if the individual enrolls in Medicare later



Individuals Turning Age 65 Who Continue To Work

- Some commentators advise individuals to sign up for Medicare's Part A hospital coverage even if they are covered under an employer's health insurance
- Part A will not incur a late penalty if an individual has paid their Medicare taxes for 10 years while working, because, in that case, Medicare does not charge a monthly premium
- Part A is added financial protection
- Medicare may not cover benefits that commercial insurance does not cover



Individuals Turning Age 65 Who Continue To Work

- Part A is free and if the individual goes to the hospital, Medicare may help cover the gaps that the individual's work insurance does not
- Eligibility for Part A begins three months before an individual's 65th birthday
- People who did not put in 10 years of work will pay a premium for Part A coverage
- Planning note: Those who sign up for any part of Medicare are not allowed to contribute to a health savings account



Individuals Turning Age 65 Who Work for a Large Employer

- An employer with 20 or more employees is considered a "large employer" under Medicare Secondary Payer (MSP) rules
- This means their group health plan is the primary payer for employees aged 65 or older
- The threshold requires 20 or more full-time or part-time employees for at least 20 weeks in the current or preceding year
- Workers age 65 or older who have health insurance from a large employer – 20 or more employees – do not have to sign up for Part A or Part B until they retire and give up their employer's coverage
- A worker should confirm with the employer's benefits office that the coverage does, in fact, meet Medicare's requirement that the employer has at least 20 workers because employers with fewer than 20 employees are subject to different rules
- It is not always clear whether the 20-worker threshold has been met if the company uses contractors or part-time employees
- When an individual eventually does sign up for Part B, he or she will need the employer to provide documentation to prove to Medicare that the individual was eligible to defer enrolling in Part B without penalties
- A 65-year-old worker may also be able to delay signing up for Part B if he or she is covered by his or her spouse's employer-provided health insurance



Individuals Turning Age 65 Who Work for a Large Employer

- An employer is large if it had 20 or more employees on each working day in at least 20 calendar weeks in the current year or the prior year
- The weeks do not need to be consecutive
- Part-time employees count toward the 20, so long as they are on the employer's payroll each working day of the counted week
- Once the threshold is met, the employer is treated as "large" for the rest of that year and all of the following year, even if headcount later dips
- An individual should ask his or her spouse's insurance plan administrator if the plan requires the individual to obtain Medicare coverage in order to have full coverage as an eligible dependent
- To avoid a Part B penalty after retiring, an individual should sign up within 8 months of losing employer health insurance coverage
- It may make more sense to align the individual's Part B coverage start date with the end of their employer coverage so there are no gaps in health insurance coverage



Medicare and COBRA

- COBRA coverage does not qualify as employer coverage under Medicare
- Under COBRA, workers who are laid off or quit after the age of 65 can continue their employer coverage for 18 months
- But to avoid a late enrollment penalty, Part B's 8-month enrollment period applies
- The commercial insurance carrier providing the COBRA benefits is not obligated to pay for charges that Medicare parts A & B would otherwise cover
- Thus, an individual on COBRA at age 65 needs to enroll in Medicare



Medicare Initial Enrollment Period for Small Company Plans

- Small company plans do not have the same requirements to provide a minimum, standard level of coverage to workers over 65 as do large employers
- If an employer has fewer than 20 workers, Medicare becomes the primary health insurer for 65-year-old workers and the employer's health insurance policy is the insured's secondary coverage
- To avoid the Part B penalty, an individual should sign up within a 7-month period that begins 3 months before the individual's 65th birthday, includes the individual's birthday month, and continues for 3 months after that
- This is known as the initial enrollment period
- If the individual wants the insurance to start at 65, he or she must sign up during the 3 months before his or her 65th birthday



Part B Late Enrollment Penalties

- When the employer's health insurance coverage ends, the individual is entitled to a special enrollment period of up to 8 months to sign up for Medicare
- Active employment is required in order for the late enrollment penalty not to apply
- But an individual cannot delay enrolling in Medicare without incurring a penalty if his or her employer-sponsored coverage comes from retiree benefits or COBRA because these do not count as active employment



Part B Late Enrollment Penalties

- If an individual works for a company with 20 or fewer employees, Medicare is the primary payer — employees of such companies should sign up for Medicare at age 65
- If the insurance carrier requires the employee to enroll in Medicare, then Medicare automatically becomes the primary insurer, and the employer plan provides secondary coverage
- Thus, Medicare settles the insured's medical bills first and the employer's group plan only pays for services that it covers but Medicare does not cover
- In such a case, if an individual fails to sign up for Medicare when required, he or she will essentially be left with a gap in health insurance coverage
- An individual who received health insurance from an exchange under the ACA may need to switch to Medicare at age 65. Subsidies are not available to those 65 or older.
- Some plans may allow individuals over age 65 to continue individual coverage but beware missing the open enrollment window for enrolling in Medicare



Part B Late Enrollment Penalties

- If an individual did not enroll in Part B in a timely manner, he or she will be penalized
- Cost for Part B will increase 10% for each 12-month period that he or she could have had but did not have Part B
- The 12 months are total, not necessarily consecutive
- Example:
 - Mike reached age 65 in October of 2024 but did not enroll in and begin Part B until July of 2026. He must pay a 10% penalty for life.
 - Part B's effective date will only be February 1, March 1, or April 1 of the following year for late enrollees



Health Savings Accounts (HSAs) and Medicare

- Many employers offer high-deductible health insurance plans that are often paired with health savings accounts (HSAs)
- Only insureds with high-deductible health plans can make contributions to an HSA
- Medicare is not a high-deductible plan, so contributions to an HSA must stop when the individual enrolls in Medicare



Medicare Advantage Plans

- Medicare Advantage Plans (Part C) are private insurance alternatives to Original Medicare, offering varied structures like HMOs, PPOs, PFFS, SNPs, and MSAs
- Medicare Advantage Plans bundle Part A (hospital) and Part B (medical), often with Part D (drugs), and extra benefits like dental or vision, with options for network restrictions and referral requirements



Advantages and Disadvantages of Medicare Advantage Plans (Part C)

Advantages

- Convenience of a single plan
- Many may include prescription drug coverage for no additional premium
- Many may offer additional benefits not covered by Medicare such as dental care, vision coverage and hearing, and preventive care
- Eligibility for enrollment is not affected by health or financial status
- Special rules for end-stage renal disease

Disadvantages

- In many plans, individual receives coverage only in a specific service area — except for an emergency
- Access to specific doctors and hospitals may be restricted
- Plan premiums and terms can change from year to year



Types of Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Special Needs Plans (SNP)
- Private Fee-for-service (PFFS)
- Medical Savings Account (MSA) Plans



Health Maintenance Organization (HMO) Plans

- Many HMOs charge a premium in addition to the monthly Part B premium
- Often need a referral from insured's doctor to use a specialist
- If you want drug coverage, you have to join an HMO that offers it. You can't get a separate Medicare drug plan.
- Usually, must choose a primary care doctor
- Must get care and services from providers and facilities in the plan's network (except emergency or urgent care or out-of-area dialysis)
- In an HMO Point-of-Service (HMOPOS) plan you may be able to get some services out of network, but you usually pay more



Preferred Provider Organization (PPO)

- Many PPOs charge a premium in addition to the monthly Part B premium
- If you want drug coverage, you have to join a PPO that offers it
- You cannot get a separate Medicare drug plan
- Do not need to choose a primary care doctor
- Each plan has a network of doctors, hospitals, and other providers that you may go to
- You may also go out of the plan's provider network, but you may pay more
- Do not need a referral from my doctor to use a specialist



Private Fee-for-service (PFFS) Plan

- Offered by private insurance companies
- Many charge a premium in addition to the monthly Part B premium
- No need to choose primary care doctor
- No need to obtain a referral to use a specialist
- Many plans may offer prescription drug coverage
- Many such plans offer additional benefits beyond Original Medicare Parts A and B
- No restrictions on which doctors or hospitals an insured can use
- Private fee-for-service doctors and hospitals must accept the pay terms and conditions of the private insurance company
 - Payment comes from the private fee-for-service plan, not Medicare
 - Important to make sure doctor or hospital will accept payment from a specific plan each time before receiving services



Special Needs Plans

- Special needs plans are designed for people with special and often complex health care needs, such as:
 - Residents of nursing homes
 - People eligible for both Medicare and Medicaid
 - People with certain chronic diseases such as diabetes or heart disease
- Coordinated care plans focus on helping members receive well-coordinated care:
 - Holistic, proactive approach
 - Specialized care team
 - Enhanced education and communication
 - Many charge a premium in addition to the monthly Part B premium



Special Needs Plans

- All SNPs must offer Medicare drug coverage (Part D)
- Some SNPs require the insured to choose a primary care doctor and others do not
- If the SNP is an HMO, the insured must get care and services from doctors or hospitals in the SNP's network (except for emergency, urgent care, or out-of-area dialysis)
- However, if the SNP is a PPO, the insured can get Medicare-covered services out of network
- If the SNP is an HMO, the insured needs a referral, but if the SNP is a PPO, no referral is required



Medical Savings Account (MSA)

- No separate monthly premium, but you must continue to pay your monthly Part B premium
- If you join an MSA Plan and want Medicare drug coverage, you'll have to join a separate Medicare drug plan
- No need to choose a primary care doctor
- MSA plans generally do not have network providers. You can go to any Medicare-approved provider or facility that agrees to treat you and hasn't opted out of Medicare for services that Original Medicare covers.
- Do not need a referral from doctor to use a specialist



Medicare Drug Coverage for 2026

- For 2026, Medicare drug coverage (Part D) features a \$2,100 annual out-of-pocket maximum for prescription drugs
- The total, combined amount the insured pays for deductibles, copays, and coinsurance is capped at \$2,100 in 2026
- Once the insured pays \$2,100 in 2026, he or she pays nothing for the rest of the year
- Because costs change annually, beneficiaries should review their plan year 2026 documents, which are usually provided during the annual enrollment period (Oct 15 – Dec 7)



Medicare Drug Coverage for 2026

- No Medicare drug plan may have a deductible higher than \$615 in 2026
- An insured may pay his or her \$2,100 cap amount in monthly installments rather than all at once at the pharmacy
- While out-of-pocket costs for drugs are capped, premiums for Part D plans may fluctuate
- Out-of-pocket costs for insulin remain capped at \$35 for a 30-day supply



Medicare Drug Coverage Stages

- Generally, Medicare drug plans and Medicare Advantage Plans with drug coverage have 3 stages:
 - Deductible stage: If your Medicare plan has a deductible, you pay all out-of-pocket costs until you reach the full deductible. No Medicare drug plan may have a deductible of more than \$615 in 2026. Some Medicare drug plans don't have a deductible.
 - Initial coverage stage: After you reach your full deductible (if your plan has a deductible), you'll pay 25% of the cost as coinsurance for your generic and brand-name drugs until your out-of-pocket spending on covered Part D drugs reaches \$2,100 in 2026



Medicare Drug Coverage Stages

- Catastrophic coverage stage
 - You will not have to pay out-of-pocket for covered Part D drugs for the rest of the calendar year
 - When you have Medicare drug coverage, you will get an explanation of benefits (EOB) the month after the pharmacy bills your plan
 - Your EOB shows the prescriptions you filled, what your plan paid, what you and others have paid, your coverage stage, and what counts toward your out-of-pocket costs and your total drug costs



How To Pay the Plan Premium

- An insured can choose to pay a premium by:
 - Having the plan deduct it from his or her checking or savings account
 - Charging it to a credit or debit card (fees may apply)
 - Having the plan send the insured a bill each month
 - Most plans bill in advance for next month's coverage
 - Send the payment to the plan — not to Medicare
- Have the premium withheld from the insured's Social Security payment
- Contact the plan — not Social Security — to ask for this payment option
- It may take up to 3 months to start
- In cases where premiums were not withheld from your Social Security payment until 1 or 2 months after you joined a Medicare drug plan, you will get a bill for the months your drug plan's premiums were not withheld
- The insured must pay the drug plan's monthly premium directly to the insured's plan for those months



Part D Premiums

- An individual can either get his or her monthly Part D premium deducted from his or her Social Security or Railroad Retirement check or make arrangements to pay the premiums directly
- Most plans accept checks, credit cards, automatic withdrawals, etc.
- If an insured's income is above a certain limit, he or she will pay an income-related monthly adjustment amount in addition to his or her plan premium that can be found here:
<https://www.medicare.gov/Pubs/pdf/11579-Medicare-Costs.pdf>
- As with Part B, an individual is penalized with a higher premium if the individual did not join Part D when he or she was first able to join
- The cost of the late enrollment penalty depends on how long an individual went without prescription drug coverage



Late Enrollment Penalties for Medicare Part D

- The 2026 Medicare Part D late enrollment penalty is a permanent monthly surcharge added to premiums if you go 63+ consecutive days without creditable drug coverage
- Calculated as 1% of the \$38.99 2026 national base premium per uncovered month, this penalty is added to monthly payments for as long as you have Part D
- The penalty is added to the insured's monthly plan premium, usually paid directly to the insured's private Medicare plan provider, not Medicare itself



Income Surtaxes for Part D

- Beneficiaries who have higher incomes are subject to paying surtaxes on their Part D premiums, just as with Part B premiums
- The rules on who is subject to these penalties, what income counts, what tax years are used etc., are identical to Part B; though the amounts are different



Income Surtaxes for Part D

- If an individual fails to pay his or her Part D premium, the plan has the option to disenroll the individual
- The plan must give notice and at least a one-month grace period before it disenrolls the individual
- There are special protections for the insured if there is a mistake such as having the individual billed by another plan or the individual having Social Security withhold the individual's premium, etc.
- If an individual is disenrolled, he or she will be able to enroll again in a Part D plan during the next Annual Election Period (October 15 to December 7 of each year), with an effective date of January 1



Medicare Supplement Insurance (Medigap)

- Medigap or Medicare Supplement Insurance that helps fill gaps in Original Medicare coverage and is sold by private companies
- Original Medicare pays for much, but not all, of the cost for covered health care services and supplies
- A Medigap policy can help pay some of the remaining health care costs, such as:
 - Copayments
 - Coinsurance
 - Deductibles



Requirements for Medicare Supplement Insurance (Medigap)

- Insured must have Medicare Parts A and B
- A Medigap policy is different from a Medicare Advantage Plan
- Those plans are ways to get Medicare benefits, while a Medigap policy only supplements the insured's Original Medicare benefits
- The insured pays the private insurance company a monthly premium for his or her Medigap policy in addition to the monthly Part B premium that the insured pays to Medicare
- A Medigap policy only covers one person, so if both insured and spouse want Medigap coverage, each must buy separate policies
- An insured can buy a Medigap policy from any insurance company that is licensed in his or her state to sell one



Requirements for Medicare Supplement Insurance (Medigap)

- Any standardized Medigap policy is guaranteed renewable even if the insured has health problems
- This means the insurance company cannot cancel an insured's Medigap policy as long as the insured pays the premium
- Some Medigap policies sold in the past cover prescription drugs but currently this is not allowed
- Enrollment in a Medicare supplement plan is possible without medical underwriting and/or pre-existing conditions as long as the effective date is within the 6 months immediately after initial enrollment in Medicare part B



Requirements for Medicare Supplement Insurance (Medigap)

- If the insured wants prescription drug coverage, he or she can join a Medicare Part D plan
- If an insured wants to buy a Medigap policy and a Medicare drug plan from the same company, the insured may need to make two separate premium payments
- It is illegal for anyone to sell a person a Medigap policy if that person has a Medicare Advantage Plan, unless the individual is switching back to Original Medicare
- Medigap policies generally do not cover long-term care, vision or dental care, hearing aids, eyeglasses, or private duty nursing



Advantages and Disadvantages of Medicare Supplement Insurance Plans (Medigap Plans)

Advantages

- Depending on the plan, some or all out-of-pocket costs for care under Medicare Parts A and B are covered
- Individual has a guaranteed right to buy a Medigap plan during his or her open enrollment period
- Helpful for budgeting because individual has a predictable monthly premium — cost sharing hard to anticipate

Disadvantages

- Prices for the same coverage can vary sharply
- In some plans, premiums rise as the insured ages
- In some states, an individual can be denied coverage based on health if individual applies for coverage after his or her open enrollment period



Enrollment Windows for Medicare Part A

When to First Enroll in Medicare Part A

- Any time after individual is 64 years and 9 months old or otherwise becomes eligible for Medicare
- Enrollment will be automatic if individual is already receiving Social Security benefits
- Otherwise, the individual must enroll at his or her local Social Security office or online at www.Medicare.gov

Individual Enrolled Late in Medicare Part A

- Generally, there are no penalties for signing up late
- May pay a penalty on premium for signing up late if individual pays a monthly premium for Part A because neither individual nor spouse contributed enough to Social Security



Enrollment Windows for Medicare Part B

When to First Enroll in Part B

- 7-month window
- Generally, can first enroll 3 months before 65th birthday month, during birth month, and up to 3 months after birth month

Individual Enrolled Late in Part B

- If individual enrolls after the Initial Enrollment Period, premiums will be higher unless he or she qualifies for an exception. There will also be a postponement of the effective date to February 1, March 1, or April 1 of the following year.



Enrollment Windows for Medicare Part C

When to First Enroll in Part C

- 7-month window
- Most individuals can first enroll 3 months before their 65th birthday month, during their birth month, and up to 3 months after their birth month

Individual Enrolled Late in Part C

- If the individual misses his or her enrollment window, he or she must wait to enroll between October 15 and December 7, unless he or she qualifies for an exception



Enrollment Windows for Medicare Part D

When to First Enroll in Part D

- 7-month window
- Generally, most individuals can first enroll 3 months before 65th birthday month, during their birth month, and up to three months after their birth month

Individual Enrolled Late in Part D

- If the individual misses his or her enrollment window, he or she must wait to enroll between October 15 and December 7, unless he or she qualifies for an exception



Medicare Choices

- The average Medicare beneficiary has 42 Medicare Advantage plan options, according to KFF, a nonprofit health policy research, polling, and news organization
- To help you find the best Medicare Advantage plan, we reviewed Medicare Advantage health insurance companies based on factors such as plan ratings from the Centers for Medicare and Medicare Services, types of plans, financial ratings, customer service ratings, and where plans are available
- *<https://www.forbes.com/health/medicare/best-medicare-advantage-providers/>



Medicare Choices

- Each year, people with Medicare can review their coverage options and change plans during the annual open enrollment period (October 15 to December 7)
- Nearly 7 in 10 (69%) Medicare beneficiaries did not compare their coverage options during the 2021 open enrollment period, according to a KFF analysis*
- A significant majority of Medicare Advantage prescription drug plan enrollees (82%) and stand-alone prescription drug plan (PDP) members (69%) failed to compare their coverage options
- Each September, Medicare sends an Annual Notice of Change document via mail or email, listing the changes in the person's current coverage for the year ahead, including premiums and co-pays
- Medicare also mails "Medicare & You," which contains detailed information about plan options
- Insurance companies bombard the airwaves and mailboxes with information about policy choices
- *<https://www.kff.org/medicare/nearly-7-in-10-medicare-beneficiaries-did-not-compare-plans-during-medicare-open-enrollment-period/>



Medicare Choices

- Some commentators believe if an individual is enrolled only in Original Medicare with a Medigap supplemental plan and does not use a drug plan, there is no need to re-evaluate plan options, though the presenter believes that Part D and Advantage plan options should be reviewed annually
- List of covered drugs changes annually and access to drugs, including new quantity limits, might apply
- Apparently, insurers believe that consumers are more likely to compare premiums than other plan features, so they offer lower premiums but increase the enrollees' deductibles
- Medicare reports that 30% of enrollees found the Medicare program was “somewhat difficult” or “very difficult” to understand



State Health Insurance Assistance Programs

- Federally funded counseling services that provide free one-on-one assistance in every state
- Medicare Rights Center offers a free consumer help line: 800-333-4114
- See Welcome to Medicare: <https://www.medicare.gov/>

Thank you!
