

National I&R Support Center
Webinar: Medicare Basics
October 30, 2019

Welcome everyone. We can see people are joining at a rapid clip. I will wait another minute or two to formally get started with the webinar.

Good afternoon. I am Damon Terzaghi, a senior director here at Advancing States the organization formerly known as NASUAD. On behalf of Advancing States and the National Information and Referral Support Center, a project of Advancing States, I would like to welcome you to the webinar on Medicare basics. Before we get started, let me cover a few housekeeping items. As we are aware, many of you will be interested in receiving the slides for today's webinar. We want you to know that they will be available as well as an audio recording and transcript on the Advancing States website within the next several days. Please visit the National I&R Support Center project on the Advancing States website and see our web page on the monthly calls. This web link is posted in the chat box which is on the right-hand side of your screen for your reference. During today's call, all of our listeners are on mute to reduce background noise. We welcome your questions and comments and ask that you submit them through the Q&A function available on your screen. Again, this will be on the right-hand side of the webinar box. Please feel free to submit your questions at any time during the presentation and we will address them after the formal remarks during the Q&A session. We also have real-time captioning available for the webinar today. On your screen on the right-hand side you should see a multimedia viewer panel on the bottom. The captioning will appear here. You can minimize this panel or have it open and it will not block the slide portion of the presentation. You may need to enter the event ID number to see the captioning. If the request for the event ID number pops up, please enter 417-1336.

Today's presentation is very timely because the Medicare open enrollment period always brings greater attention to the program that is serving a growing number of older adults as well as people with disabilities. We are glad that you have joined us for the webinar on the basics of Medicare to strengthen or refresh your understanding of key components of the program. Our presenter today is Sherill Mason, Sherill is principal adviser of Mason Advisors, LLC. Sherill specializes in the analysis of regulatory initiatives impacting Medicare, with an emphasis on post-acute services. Prior to founding Mason Advisors, Sherill held a number of leadership roles in health care and policy operations including a Senior Policy Analyst with the Marwood Group, Senior Vice President of Resident Care and Services for Sunrise Senior Living and the Director with the Senior Care Services Advisory Practice of KPMG. Sherill is an expert on Medicare broadly, with specific policy and programmatic knowledge of post-acute services and operations. I will add that given that I have known her for a number of years, I will note she is an all-around good person and a great friend to have. We are very grateful for Sherill to take the time to share her expertise today. Let me turn it over to Sherill to get it started. Thank you again.

How nice of you, Damon. I like the last bit the best. That was kind of you. Hi, everybody, happy Wednesday afternoon or morning depending on where you are in our beautiful country today. We will go through the understanding of the basics of Medicare. I apologize in advance a bit. This is about as dry as toast. There is not a lot I could do to jazz it up or make it funny or use anecdotes to make it interesting. Use heavy doses of caffeine to access that but we will get through it. It is important information and one of the reasons I enjoy doing webinars and educational sessions is I learn along with you as I prepare to do a presentation.

So, moving on, here is the questions that we will answer today. The basics. Who is eligible for Medicare? What are the Medicare coverage options? What do the various options cost? What kind of help is available to Medicare beneficiaries to offset the cost of coverage? when can they enroll, which is a key bit of information, particularly right now. And then certainly where can I find more information?

Let's start with the first one. Who is eligible for Medicare? To qualify for Medicare, a person must be a U.S. citizen or legal resident for five consecutive years and age 65 or older, younger than 65 with qualifying disability, or any age with a diagnosis of ALS or end stage renal disease. Those two diseases enjoy a special status within the Medicare program, for other people with qualifying disabilities there is a two-year waiting period to access Medicare. Coverage begins the first day of the month a person qualifies. Let's say my 65th birthday is July 10th, I would qualify more Medicare beginning July 1st providing I went through the enrollment process in a timely manner.

What are the coverage options? I have been doing this for a long time. The longer I do it, the more complicated it gets. We have alphabet soup here. We have Medicare Part A, B, C and D. I hope we stop at D. Basically Medicare Part A, if you think about Part A is basically being inpatient care with a few exceptions that we will talk about. Part B is mostly outpatient care. Think of that as the physician benefit, covers doctor visits, clinic visits, that sort of thing. Part C is Medicare Advantage which is a managed Medicare option and Part D is easy to remember because D is for drugs. D is coverage for prescription drugs. So, going a little deeper into Medicare Part A, as I said before, it covers inpatient hospital stays and that includes not just acute care hospitals, but inpatient rehab facilities or IRFs, LTACs, long term acute hospitals and mental health hospitals. All of those are covered by Part A. Part A also covers skilled nursing facility stays for certain patients that require a skilled service and had a three-day hospital stay immediately preceding their admission to the nursing home. It also covers skilled home health services. So -- that is for minutes that are home bound and require, again, skilled services. It's provided on -- home health is different than it is under Medicaid because it's provided on a per visit basis rather than in longer blocks of time. Then the other thing that Part A covers is hospice care. As you know, hospice care is primarily provided in people's homes but can be provided in nursing homes or assisted living facilities or inpatient hospice unit. So that is the Part A benefit. Certainly, Part A covers preexisting conditions. There is no waiting period for that.

How much does Part A cost? If you are an old person like me and you have been working for a long time and paying taxes for a long time, most people don't have to pay a Part A premium. They only have to pay a Part A premium if they haven't been employed for long enough to pay enough taxes into the system to qualify. Most people don't pay a Part A premium. There is a late enrollment penalty for people that need to pay a Part A premium if they don't sign up when they are first eligible. That is a tiny subset of people. I will go through each of the settings and potential cost to the beneficiary is. For inpatient hospital care the patient pays over \$1,300 per benefit period. Now, that raises the question, what is a benefit period? Benefit periods, which is interesting, are not tied to the calendar year, but a benefit period starts when a patient is admitted to an inpatient setting either one of those hospitals that I described or a nursing home. The benefit period goes on until after discharge once the patient has been not in an inpatient setting for 60 days, they can get a new benefit period to start if they get readmitted on day 61 and forward. Then it starts the clock again. So, that is a benefit period. For an inpatient hospital stay for the first 60 days, there is no coinsurance and for days 61 to 90, now you know I mean because of what we do for a living, those people would be outliers because the average length of stay in a hospital is nowhere near 60 days. 61 to 90, \$341 coinsurance per day. 91 days and beyond you are getting into lifetime reserve days and a much higher copayment. Again, that only applies in a relatively small subset of people.

So, skilled nursing -- home health services are covered with no coinsurance and there is no limit to the number of episodes a person can get under home health, as long as they meet the guidelines under the supervision of a physician and requiring a skilled service. Hospice covered with no coinsurance but there could be a copayment of no more than \$5 for each prescription drug related to the hospice diagnosis and 5% of the covered amount for in patient respite care. Many hospices do not charge patients for the coinsurance. Mental health inpatient stays, that benefit mirrors the benefit for the acute care hospital stay as I described earlier.

Skilled nursing facility days covered up to 100 days of care. It's important to know that the average length of stay for Medicare beneficiary is about 27 days. So, 100 days would be an unusual long stay. And they only cover -- Medicare only covers nursing home stays if the person requires a skilled service for every single day that they are there. It was never intended to be a long-term care benefit. That is an important distinction from Medicaid. No coinsurance for days 1 through 20 and days 21 through 100, it's \$170 and change coinsurance per day. These are 2019 and numbers that I am giving you.

Moving on to Medicare Part B, hopefully. Medicare Part B covers basically outpatient services. Think physician, office visits, outpatient hospital services, clinics, outpatient physical speech and occupational therapy, outpatient mental health services, durable medical equipment that is provided in patient's homes and certain enteral feeding and certain limited home infusion therapy medications and equipment.

So, beneficiaries pay a monthly premium for Part B coverage based in part on what the income is. The standard premium for Part B in 2019 and is over \$135. But for high income beneficiaries, let's say you are over 65 and still working and making a good salary, the premium can go up to over \$460 a month for people who have an income of over \$500,000. It's graduated obviously up, there are certain tiers up from \$135.50 to \$460. There is a late enrollment penalty. That's really, really important to make sure that the beneficiaries understand that. We will talk about when people can sign up but basically there is a late enrollment penalty up to 10% of the standard premium that applies as long as the person is enrolled in Part B. You want to make sure that people get signed up as soon as they are eligible for it. There is an annual deductible of \$185 a year. Once the deductible is met, then the -- Medicare Part B covers 80% of approved charges. Sorry my screen jumped ahead of me a bit. I'm not as fast as the slides as I could be.

So, moving on to Medicare Part C and Part C as I mentioned earlier is basically Medicare Advantage or managed Medicare. It's an optional program that beneficiaries have to decide it's something that they want to do. And Part C insurance companies that contract with Medicare to provide and manage the Part C benefit, they have to cover all the services that are covered under traditional Medicare parts A and B, but they can do additional things. They can cover hearing aids, vision care, dental care, health club memberships and, recently, CMS has allowed Part C to begin covering personal care services. I hate to use the word nonskilled home health. That is the most frequently used term if you watched a home health aid work you know they have tremendous skills. Forgive me for using that but it's the easiest way to communicate that. That change became effective this past year. Waiting to see -- it hasn't been universally adopted by Medicare Advantage plans to any great extent but the fact that they can do that now gives them more flexibility to try to keep people out of the hospital basically and support them in the least intensive site of care. So, premiums, deductible, copayments, coinsurance all of that varies by plan but insurance companies can, if they want to, combine A, B and D into one plan.

So, to qualify for Part C a person has to be enrolled in A and B, live in a planned service area so the insurance companies basically -- they cover certain counties and, so, you have to live in an area that they service, and you can't have end stage renal disease. Part C covers preexisting conditions and because it's a managed care program, Part C plans usually require members to use in network health care providers are be responsible for payment for certain services. If a beneficiary is making the decision, "do I stick with traditional Medicare? Or do I go with Part C because I need a hearing aid and I want my glasses covered and perhaps some cover dental work? That would be a better deal for me but look out, I got to restrict the providers that I use", just as those that are employed and have managed care insurance through our employers. The other thing about Part C programs, they typically have robust prior approval and prior authorization systems and gatekeepers to prevent the overutilization of services.

Moving on to Medicare Part D, Medicare Part D is the newest aspect of the Medicare benefit. It actually came into being during the second Bush

administration. It covers prescription drugs. Like Part C, private insurance companies contract with Medicare to administer the benefit. The formularies, the list of medications that are covered, vary terrifically among plans. There are certain protected categories that have to be covered, but which actual drugs are covered vary a lot. So, if you are helping somebody decide how to go about picking a Part D plan, understanding what the formulary is a critically important aspect of that decision. Deductible, copayments, coinsurance and premiums vary by plan. There is also on this one a late enrollment penalty that may apply, if for any continuous period of 63 days or more -- how did they come up with 63 days or more? I would love to talk to the person that made that up, after the initial enrollment period, the beneficiary goes without Part D or other creditable prescription drug coverage, then the penalty applies for as long as the beneficiary has a Medicare drug plan. As far as not being able to prove that they had credible coverage, it's important -- I met people -- I talk about what I do for a living with strangers sometimes. People will say why are there all these penalties for late enrollment, like if I want to keep my insurance that I have through work? If you can prove you have credible coverage through your employer the penalties do not apply. They apply to patients or beneficiaries who actually had a lapse in coverage. There is something called IRMA, income related Medicare adjustment something and basically, again, much as we talked about under Part B, under Part D, beneficiaries that earn more than a certain amount of money are charged an additional monthly fee for Part D up to \$77.40 a month based on income. There are four coverage stages under Part D. An initial benefit that covers the cost up to \$3,820, that's the initial coverage stage. Then we are getting into the doughnut hole which is confusing. Between that amount and \$5,100, beneficiaries pay 25% of the cost of brand name drugs and 37% of the cost of generics. That is known as the coverage gap stage or doughnut hole. Then once they get up to \$5,100, beneficiaries are responsible for 5% of the drug costs. That is called the catastrophic coverage stage.

Now I will talk about Medicare supplement insurance plan. This is optional for Medicare beneficiaries. They cover gaps in what traditional Medicare Part A and B cover, copayments and deductibles and things like that. The plans are offered by private insurance companies and vary widely in their cost and coverage. Now we have more alphabet soup and so many I won't read the letters. You can read them on the screen. Then there is a high deductible plan F. If you look at plan C, F, and high deductible F, they offer first dollar coverage meaning that if you become eligible for Medicare before 2020 and you select one of these, you actually don't have to pay a penny when you go to see your doctor. So, as long as you are following all of the rules. In 2020 for newly eligible beneficiaries, that first dollar coverage is getting phased out. The reason is that the government believes that they want to make sure that beneficiaries, I hate this term skin in the game that they were spending actual dollars on health care and not overconsuming. Coverage is guaranteed to continue as long as premiums are paid and the plan goes with the patient anywhere in the United States.

Taking a breath, there are programs available to certain qualified individuals. I will go through them and ask Damon to chime in if you have anything -- if I missed something or you would like to embellish.

Basically, in order to qualify, the Qualified Medicare Beneficiary (QMB) eligibility criteria is that the income is below 100% of the federal poverty level and resources below \$7,400 for an individual or \$11,000 and change for married couples. Those amounts get adjusted every year. What you get if you qualify then is assistance with Part A and B premiums and with deductible, coinsurance, and copayments. So, if you qualify as a QMB plus, if your income is below 100% of the federal poverty level and resource restrictions is previously stated are met and you meet the state Medicaid eligible, all Medicaid-covered services are provided and QMB benefits as well. There is another category for Specified Low Income Medicare beneficiary (SLMB). That is a slightly different range between 100 and 120% of the federal poverty level with the resource restrictions as previously stated. And if you qualify as an SLMB, all the alphabet soups, you get assistance with your Part B premium. If you are a qualified individual, the resource requirement, eligible requirement is different, between 120 and 135% of the federal poverty level. You can get assistance with your Part B premium. If you are a qualified, disabled and working with income below 200% of the federal poverty level, resources below \$4,000 for an individual or \$6,000 for a married person and if you lost eligible for premium-free Part A because you are working, you can get assistance with the Part A premium.

So, the states are allowed a certain degree of flexibility to disregard certain types of income or assets. This is why I have so much respect for all of you that work in Medicaid. As I tell my colleague Damon, I know a little bit about Medicare but to know everything about Medicaid you have to multiply it by better than 50. In this case disregards can be blanket or targeted. We have a link for the Medicare savings programs that you can visit that and gather additional information on the availability of those programs. So, I don't know, Damon, do you have anything you would like to add to that?

I don't, I don't believe so. I would encourage those of you around the country to take a look at what your state-specific policies are because they may have utilized this opportunity to make the Medicare savings programs a little bit more generous and accessible to some individuals.

Excellent. So, individuals that qualify if one of those categories as well as other fully eligible Medicaid beneficiaries are eligible for the Part D low income subsidy. Basically, what this means is the individuals don't have to be actively apply for LIS eligibility and the LIS should begin the month after the termination of eligible for other programs begins. Again, we have a link for additional information on that program as well.

So, some individuals may not qualify for premium-free Part A services due to a lack of work history, as I said earlier. So, in order to be eligible for QMB a person has been to be enrolled in Part A and B and that creates a situation where we are chasing our tail. The person may not qualify for premium free services and can't afford the premium. SSA, in cases like that, can process a conditional application that will enroll the individual in Part A once OMB status determined or discarded if QMB status is denied. That can let the person enroll outside of the standard

initial enrollment period provided they are in a Part A buy-in state and we have a link with additional information.

So, here is a timely topic. When can beneficiaries enroll? So, newly eligible beneficiaries can enroll three months before or three months after the month they turn 65. If I turn 65 in July, I can begin the enrollment process in April, okay. Or I can wait for three months after if I so choose to do that. But I strongly recommend that if we are helping anybody do this, to make sure that they do it at the very earliest point possible. If people are working after the age of 65, we talked about earlier beneficiaries can enroll in parts A and B but I would recommend them to speak to the benefits administrator and make sure that they keep records of their health insurance coverage to avoid late enrollment penalties. Right? We talked about that a little earlier as well. After 65, beneficiaries may be eligible for special enrollment periods for Part A and B up to eight months after employer coverage ends, or Part C and D up to two full months after the month when employer health insurance coverage ends. So, for Medicare Supplemental Plans, eligibility begins the first day of the month when the person is 65 or older and enrolled in Medicare Part B. Open enrollment for parts A, B, goes C and D began October 15th and ends December 7th. That is where we are, in the heart of open enrollment period or in the beginning of it.

So, where can you find more information? I have to say the Medicare website is better than it used to be. If I was giving have talk to you six or seven years ago, I would have not directed you to the Medicare website. It was almost impossible to find anything on it. But today Medicare.gov has good educational tools. The amount of information can be overwhelming. I will share with you that I did recently turned 65. I know of what I speak. I turned 65 in July and I got the "Medicare and You" handbook that is in fine print, if you are old enough to remember telephone books, that kind of tissue-y paper, 200 pages thick. I looked at it and thought really, I'm a policy analyst and I was overwhelmed by that. I think that you are in a good position to help people get through what can be difficult and confusing by using the resources at Medicare.gov. We have the State Health Insurance Assistance Program (SHIP). We have a link so you can find your SHIP center. There is a SHIP locator available. This is a federally funded program. Basically, the only reason it exists is to help educate people and guide them through Medicare enrollment, understanding the benefit, et cetera. So, I really - - they are an excellent resource. I recommend that you reach out to them if you have questions or a beneficiary that you are helping to direct them in that way. Those are the folks who are very, very expert at Medicare. With that I will stop talking and start listening. My contact information is here. If there is anything that I can do to be helpful to you in the future, please let me know. I will turn it over to Damon again.

Great, thank you so much, Sherill for that great and dense information. I have been chugging coffee the whole time and was able to follow along as you recommended. So, for those participants, a couple of quick notes. We are moving into the question and answer period of today's call. We would like to note that this is a general call on Medicare policy. We do ask that you not submit any information that may be specific to an

individual's case or contain personally identifiable information. If there are case specific questions that you have, we encourage you to reach out and utilize resources in your state. If you have any trouble locating those resources, feel free to contact us here at ADVancing States and we can direct you in the right place. We know that one of the most common questions we get is regarding availability of slides. As a reminder, the slides, audio recording and transcript from the webinar will be posted to the ADVancing States website in the next couple of days. There is a link available in the chat box on the right side of your screen. One last note is that you will see three quick questions on your screen about the webinar pop up in a moment. We ask that you take a moment during the Q and A period to respond to these quick questions as it will help us evaluate this webinar as well as plan future events. So, with that, you may submit any questions you have to the Q and A section of the screen on the right-hand side. We will pause now as you submit those questions and when we have some come in, we will go ahead and get started with that.

So, the first question, Sherill, is asking about the A through N Medicare. They are saying, "I'm confused. Can you help me understand?" I believe what they are referring to there is the discussion of the different Medigap options that you talked about earlier. So, maybe we could go back to that slide and you could provide a little more context on those Medigap plans.

Sure. Let me scroll back up here. The thing that is important about Medigap plans -- I'm finally getting there. There we are. Is that they are very different as to what they will cover, what they will cost, what their deductibles are like, how restrictive the network is, right? The less expensive options have the higher deductible, et cetera, et cetera. It is -- there is -- if you go to Medicare.gov and look at the different categories, it will give you a description of what each letter means and what is covered under each one of those letters. I didn't want to go into -- I apologize for not going into great depth on this presentation because it gets complicated. So, that's why I focused more on the C, F and high deductible F and the other issue. The other options, if you think about who offers the programs, AARP is one of the biggest providers of Medigap programs. They contract with UnitedHealthcare to offer their programs. So, I would -- if you are curious, you can go to their website as well and take a look at what their offerings are. Other insurance companies do that directly as well. So, I hope that is helpful. Basically, the purpose is, if you think about it, there is no out-of-pocket limit under traditional Medicare. If you are getting your insurance through the Affordable Care Act, through an exchange your out-of-pocket total -- a maximum ceiling as to how much you can pay. Under Medicare parts A and B there is no ceiling. If you have, let's say you don't have a Medigap policy and you get sick and go to the hospital and in a nursing home for a long time and expensive medications, you know, you might still, despite the fact that we have a wonderful benefit for people over 65, it's still possible for you to have a bankruptcy because of medical costs. That's why, again, in advising people, there is a chart. I'm picturing it in my head. If the person that asked the question would like me to, I can E-mail it to them or get it to you, Damon. It's a chart with the letters and description of how each one of those different

letters works and the differences between them so I can get that -- happy to get that to you after the call.

I think that is helpful. If I were to summarize from someone that doesn't know this as well as you, it might be helpful for those on the call, that there are these core Medicare coverage services that may have a lot of out-of-pocket costs. The ability for you if you choose to purchase private insurance that helps you manage those costs and then there's some standardization of the types of plans that are available out there for that Medigap coverage and they are standardized through this naming convention from A through M. Does that summarize it for someone like me that doesn't know so much?

That is perfect. You made it very, very clear. I would like to give an example, too. I think when you think about -- as well as doing policy work, I'm still a nurse. If you think about a person who has a disease process that causes them to have extremely medication that is reimbursed at a physician's office under Medicare Part B. If it costs \$1,000 a dose and you are responsible for 20% of that, that adds up quickly. That's what these plans, supplemental plans are designed to protect the beneficiaries from being responsible for that cost.

Do we have any other questions?

We are going back to the questions, Sherill. We have one that was related to this. Someone is asking if the Medicare supplement an example of coinsurance?

I wouldn't say that that is the definition, example of coinsurance. It's a supplemental policy. So, there is a little bit of a difference there. I would use the word supplemental policy. That is basically what it does, supplements the basic Medicare benefits.

So, we do have another question which asks how easy is it to switch from year to year between Part C and back A and B?

It is not hard at all. It's not hard at all. You need someone probably many people would need someone to help them through, you know, they are not good with computers, people that are the older elderly, maybe in their 80s or such and not as good on computers or if they don't have access to a representative nearby, they may need help. It's not a hard thing to do. It's a matter of you make the choice and you do it either online or you can do it other ways as well. It's not hard and it doesn't upset your preexisting condition situation or anything like that.

We had another question that asks a little bit about drug costs when you hit the doughnut hole. Maybe it would be useful to go back to that slide as well and do a quick refresh on the different levels of coverage and what individuals are responsible for when they do hit that doughnut hole.

Sure. I will give history on the Part D benefit. This is ,being apolitical, but I remember when I was a home health nurse for a brief period of time and when I was starting up home health agencies, I wanted to know what being in the field was like so I did home visits and I did

one in Florida, before we had Medicare Part D and we were doing a visit outside. It was a beautiful day. Sitting under a palm tree with this gentleman that had congestive heart failure. I said let me see your medicine. I never asked what drugs they were on. I asked to see them. The wife came out with this huge box full of medicine and rolls of medications that were in individual packets and it was medicine bottles and some were empty. I just thought my gosh I cannot imagine how this guy manages all of this and how do they pay for it? I said I notice some of the boxes are empty, are they discontinued? She said sometimes we have to decide whether we pay the mortgage or pay for his medicine and keep him alive. That's how bad it was before we had Part D. Part D is a flawed program, I'm just sharing my opinion. Because of the doughnut hole and because of some of the limitations in coverage and strict formularies it's not perfect but people that opposed it held their nose and voted for it because it was better than nothing, which was what we had before. What happens is in -- most people never make it to the past that first initial coverage stage which is \$3,820. But once you get past that, between there and \$5,100 in costs, the beneficiaries now, they used to be responsible for all of the cost between those two numbers. Now because of other legislation that has been passed including starting with the Affordable Care Act and layering on a couple of bills after that or laws after that, beneficiaries pay 25% of the cost of brand name drugs and 37% of the cost of generics and basically the organizations that cover the rest of the costs are the pharmacy benefit managers and manufacturers. That's the coverage gap stage where you pay 25% or 37% depending on if it's a brand name or generic drug. Once you hit \$5,100, then the beneficiaries are responsible for 5%. That's the catastrophic stage. It's a small portion of beneficiaries, small and very sick, unfortunately or using very expensive medications. Those are the different levels. That gives you a little information about the history of how this came to be so very complicated.

Yes, I can agree. I was with the state government when Part D went live and trying to work with people on the whole doughnut hole issue was extremely challenging when they realized that, yes, they get coverage but, oh, dear, there might be huge gaps that were unexpected and unanticipated. Like you said, it's better than nothing which existed beforehand.

Right, exactly. We have another question. If a person is in skilled nursing home on hospice care does Medicare cover the nursing home daily charge and the hospice care?

I love that question. It's right in my wheelhouse. Basically, what happens, if a person is in a skilled nursing facility under a Part A stay, they can't be on a Part A stay and also access the Medicare hospice benefit at the same time. What would happen is, the people that you typically see in nursing homes accessing hospice are usually under Medicaid stays or private pay stays because Part A would not pay for two things at the same time. Now, if a person who is in a nursing home under a Part A stay decides they want to go on hospice, it doesn't mean they have to leave the nursing home. What it means is that the hospice would have to pay the nursing home. They won't want to do that. Usually what would happen if it was a dually eligible beneficiary, perhaps what they

would do is stay in the nursing home under a Medicaid stay rather than Part A stay. If you look at the purpose of a Part A nursing home stay or Part A period other than hospice, it's to get people better. Never meant to be a long-term care benefit. It was meant that people are going to get better and progress and go home. That is always the hope. If you have someone there under Part A stay and they are getting intensive rehab therapy or whatever else it is that they need then it would be an odd choice to decide that they want to go on hospice at that particular moment in time. It's usually two different patient populations. They would have to make the decision do they want to stay in the nursing home under Part A and continue to receive curative care which is hopefully what nursing homes do under Part A, or do they want to elect hospice and potentially go home with support services or go to an inpatient hospice unit or be in a nursing home under a general inpatient stay that is reimbursed by the hospice to the nursing home. That is about -- I know it's a complicated answer but that is how it would work.

Great.

Our next question is when we talk about beneficiary earnings -- when we talk about earnings and income for some of the income eligibility, you talked about with Part B and D and those sort of things, are we talking about the individual's earnings or the household earnings?

Well there are -- hang on a second and let me scroll back to -- let me see where we are here. Let's go back to Part B. Sorry. This is something affecting me because I still work. I get these separate bills from -- this is -- I'm being clumsy with my scrolling. I apologize. Okay. There are -- it's basically for individuals so if you got \$85,000, there is a separate -- that is an individual number. There is a separate threshold for families. So, being there are two separate thresholds. I put down the individual one here. There is another -- a different threshold, a higher threshold, obviously, for families.

Sherill, I assume that that information would be available on the Medicare.gov website?

Absolutely, yes.

Again, if somebody like me -- I could get that information to you, Damon and shoot it to whoever needs it.

Absolutely.

If someone never signed up for a Medigap or supplemental policy, what are the options under Medicare Advantage? Does Medicare Advantage help cover the additional costs?

If you have a Medicare Advantage program, if you signed up for Medicare Advantage, let me just -- can you restate the question, Damon. I'm sorry.

Basically, it's asking like if an individual doesn't have Medigap coverage and might be subject to out-of-pocket costs, what are the

options under Medicare Advantage, if they go into Part C are there the same out of pocket costs or does the plan help with those?

Right.

It's different plan by plan. If you are advising somebody, you need to understand because these are private contracts between the government and private insurance companies, the copayments, deductibles can be different. So, for example, there is some Medicare Advantage plans that roll up Part C and Part D and there are no premiums for those plans, right? So that might be an attractive option for somebody who has fewer financial resources than traditional Medicare, but they will have a limited network that they can access. So, that is the critical decision point. Under Medicare Part A and B, you have a full choice of any Medicare-approved provider. You can go anywhere and to anyone you want and -- but under Medicare Advantage that is not the case. Like any managed care program. That is the critical decision-making factor. Oftentimes the out of pocket is less for individuals under Medicare Advantage. So, that would be something to take into consideration as you are advising them.

Great, thanks.

Next question is if a person enrolls at age 65 and is still working, does this person still receive Part A and how would they consider declining or accepting Part B? That kind of gets into that, you mentioned, the credible coverage and other sources in relation to the penalty. Maybe kind of refreshing on when the penalty applies, when it doesn't apply, if they be in Part A and what they should think about and take into consideration for accepting or declining Part B if they are still working.

Sure, absolutely. So, the first thing I would do if someone came to me and asked that question, "should I enroll for Part B?", go talk to your benefits manager at work because they will understand the interaction between your particular employer-sponsored plan and Medicare. But if you can prove that you have -- they will understand what constitutes credible coverage, right? And if it's -- employer sponsored health insurance policy that is considered credible. But for Part D there has to be a prescription drug benefit as well. Otherwise, you know, those penalties would apply. But long as you have that coverage it's an individual decision whether or not you want to enroll in Part B. You need to make sure to keep documentation that you have that credible coverage, so you don't get stuck with the penalty. 10% is a lot, right? It's life-long. As long as you got Part B. So, it's important to avoid that and the Part D penalty as well.

So, in our particular state, we have never heard of the term QMB plus. There is a discussion of QMB, SLMB, QI. Do the terms vary by state? I will take this one. Short answer is, yes. Every state might call them something different. I remember our coding screens when I was working for the state government were a little different than this. When you look at it at a national level, they try to standardize the language. When we talk about this, in the aggregate functions, we will refer to how CMS

describes them for ease and these are the terms that they use. I will say I had never heard of the term QMB plus until I came to D.C. as well. We called it something totally different when we were at the state. Though one takeaway I would say is that when we are talking about QMB plus, it's really just talking about individuals who qualify for the QMB Medicare savings programs and the benefits that come with that, the assistance with the premiums and coinsurance and who also are full benefit Medicaid eligibles. Sometimes individuals are viewed as dually eligible for Medicaid and Medicare even if all they receive under Medicaid is that assistance with coinsurance and premiums, and calling them QMB plus is a way to distinguish those who receive the full array of Medicaid benefits as well. Hopefully that is helpful.

So, we had another question that is a little bit nuanced. I have to admit that I don't know the answer to it. Maybe you do and maybe something that we research and follow-up later. The question is how is Medicare enrollment impacted by disabled veterans' benefits?

Honestly, I would -- to give you a good answer on that, I would need to do some research and get back to you. I would be happy to do that.

That is fine. We have the information for the person that submitted that question and we can follow-up after the call.

Sure.

Another question is -- let's generalize it a bit but scenario where maybe a working age adult is taking care of their parent and the question is really related to who is considered a household for the purpose of determining income under these programs? So, the question is basically like if a working-age husband and wife are taking care of one of their older parents, would the work husband and wife's income be counted toward that older parent's family income when determining some of these costs and resources?

No, I don't believe that it would be.

Okay, great.

We had one question about credits and qualifying for Medicare. I don't know, Damon if you can speak to that in terms of generally people are qualifying based on their work earnings and history, Sherill or Damon. Are there any other ways that somebody might qualify based on credits for Medicare?

The specific question asks how does one borrow credits for Medicare qualification?

I'm not aware that that is possible.

Only based on an individual's earning quarter of coverage through their individual employment?

Perhaps if the person who submitted that question wants to follow-up after the call with more details, we can do a little bit of follow-up research and get back to you at a later date.

Okay. Another question if a person enrolls in Part C and relocated to a new geographic area before the next open enrollment period, would they have an opportunity to change their plan or to move into fee-for-service before the next open enrollment?

Yes, there is what is called a special enrollment period. So, if you have a life-changing event like that, if you move out of the service area of your existing Medicare Part C plan, then you are allowed to enroll in a different plan obviously in your new geography or opt out of Part C and transition back to traditional fee for service.

Okay. So, there was a follow-up to the borrow credits and the question says, you know, surviving spouses and children may be able to utilize their family members work credits to qualify for Medicare coverage. That is providing the context to that earlier question.

I see. That is something that I would have to get back to you on.

Okay. Great. So, we will make a note to follow-up with that particular questioner at a later date. Okay. So, the next question asks about clients who have never paid into Medicare maybe through various issues related to employment or those sorts of things, never made Medicare taxes. Are they still able to enroll in Medicare and if so, would they have to pay for Part A or what is the process for those individuals that did not pay the underlying Medicare tax prior to turning 65?

Sure. They can pay into Medicare Part A, the premium is about, I want to say \$450 a month. And then they -- they would be able to access it in that way. Which sounds like a lot of money but when you think about paying for private insurance, that is about what a relatively simple plan costs a working age adult at this point if not more.

Okay. We have reached the end of our webinar. For those of you who may have questions still in queue or who didn't have a chance to ask yours before the webinar ended, please feel free to reach out to us here at ADvancing States via email and we will do our best to coordinate a response to any remaining questions that participants have. With that, we are going to go ahead and close today's webinar. Let me offer my heartfelt thanks to you, Sherill, for taking your time to help everyone in our network learn more about Medicare. I personally found the webinar extremely helpful and learned several things that I didn't know as well. I love it when that happens. So, thank you all for participating, thank you, Sherill for your generosity with your time and wisdom and we will go ahead and close today's webinar. Thank you all again. Good-bye.

Bye. [Event Concluded]