Medicare Overview

This job aid provides information and guidance for Navigators, Certified Application Counselors (CACs), and Enrollment Assistance Personnel (EAPs) (collectively, assisters) on Medicare and related Marketplace considerations.

Table of Contents

Version 3.0. July 2024. This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator assistance personnel in a Federally-facilitated Marketplace. The terms “Federally-facilitated Marketplace” and “FFM,” as used in this document, include FFMs where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

Overview

Approximately 60 million Americans are enrolled in Medicare, a federal health coverage program for people:

- Age 65 or older;
- Under 65 receiving Social Security based on disability; and
- Of any age with end-stage renal disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) or Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease).

Medicare isn't part of the Health Insurance Marketplace®[i], but assisters should have a general idea of how both Medicare and Marketplace coverage work to provide consumers with fair, accurate, and impartial information about their health coverage options. Generally, it's a good idea to refer consumers to their State Health Insurance Assistance Program (SHIP) if they have specific questions about Medicare. More information about SHIP is available at Local Medicare Help. Consumers can find contact information for their local Medicare office at Contact Medicare.

Parts of Medicare

The different parts of Medicare help cover specific services. Exhibit 1 reviews each part and the services covered.

Exhibit 1 – Parts of Medicare

Medicare Parts	Coverage
Medicare Part A (Hospital Insurance)	▪ Covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some home health care. ▪ Most Medicare beneficiaries have Medicare Part A without a premium, but others may have to pay a premium for Part A.

Medicare Parts	Coverage
Medicare Part B (Medical Insurance)	▪ Covers certain doctors' services, outpatient care, home health care, durable medical equipment and supplies, preventive services, and other services. ▪ There's generally a premium for Part B. Recent policy updates: ▪ Due to a provision in the Consolidated Appropriations Act, 2021[ii], there is a new benefit, Medicare Part B Immunosuppressive Drug (Part B- ID). Patients who meet certain criteria will be able to qualify for continuous Medicare-covered immunosuppressive drugs. ▪ Effective July 2023, the Inflation Reduction Act of 2022 waived the deductible and limits coinsurance for insulin furnished through covered durable medical equipment pumps.[iii] ▪ Starting January 1, 2024, Medicare Part B (Medical Insurance) covers intensive outpatient program services at a hospital, community mental health center, Federally Qualified Heath Center, Rural Health Clinic., or opioid treatment program (for treating opioid use disorder).[iv]

Medicare Parts	Coverage
Medicare Part C (Medicare Advantage Plans)	▪ Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health and drug coverage. To be eligible for a Medicare Part C (Medicare Advantage) plan: You must be enrolled in Original Medicare (Parts A and B). These plans include Part A, Part B, and usually Part D. ▪ Plans generally must cover all of the medically necessary services that Original Medicare covers. Most plans offer some extra benefits that Original Medicare doesn't cover—like some routine exams and vision, hearing, and dental services. ▪ Medicare drug coverage (Part D) is included in most plans. In most types of Medicare Advantage plans, enrollees can't join a separate Medicare drug plan. ▪ In many cases, Medicare Advantage enrollees may only use doctors and other providers who are in the plan's network (for non-emergency care). Some plans offer non-emergency coverage out of network, typically at a higher cost. ▪ Medicare Advantage enrollees may need to get a referral to visit a specialist. ▪ In some cases, Medicare Advantage enrollees have to get a service or supply approved ahead of time for the plan to cover it. ▪ Medicare Advantage enrollees pay the monthly Part B premium and may also have to pay the plan's premium. Plans may have a $0 premium and may help pay all or part of the enrollee's Part B premium. ▪ Out-of-pocket costs vary—plans may have different out-of-pocket costs for certain services. ▪ Plans have a yearly limit on what consumers pay out of pocket for services Medicare Part A and Part B cover. Once the enrollee reaches the plan's limit, they pay nothing for services Part A and Part B cover for the rest of the year. ▪ Medicare Advantage enrollees can't buy and don't need Medigap. ▪ Plans generally don't cover care outside the U.S. Some plans may offer a supplemental benefit that covers emergency and urgently needed services when traveling outside the U.S.
Medicare Part D (Prescription Drug Coverage)	▪ Covers prescription drugs. ▪ Health insurance companies approved by Medicare offer Part D coverage. ▪ Medicare Advantage plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug plans. ▪ There's generally a premium for Part D. The Inflation Reduction Act of 2022 provided Part D Improvements: ▪ Access to recommended adult vaccines without cost-sharing ▪ Insulin available at $35/month per covered prescription ▪ A yearly cap ($2,000 in 2025) on out-of-pocket prescription costs in Medicare ▪ Expansion of the low-income subsidy program (LIS or "Extra Help") under Medicare Part D to 150 percent of the federal poverty level

Consumers who have Medicare Part A or Part C have qualifying health coverage, called minimum essential coverage (MEC), that meets the Affordable Care Act requirement for coverage. Part B and Part D do not count as MEC if enrolled in either or both of these programs alone.

Eligibility and Costs

Medicare Part A

Most people get Part A for free, but some have to pay a premium for this coverage.

Eligibility for premium-free Medicare is different for consumers age 65 and older and for consumers younger than 65. Exhibit 2 describes eligibility for each group.

Exhibit 2 - Premium-free Medicare Part A Eligibility

Consumers can get premium-free Medicare Part A at age 65 or older if:	Consumers can get premium-free Medicare Part A before age 65 if:
▪ They or their spouse worked for the equivalent of 10 years, either consecutively or non-consecutively, in Medicare-covered employment (this is what is called the "40 quarters of work" requirement). ▪ They are already receiving (or are eligible to receive) retirement benefits from Social Security or the Railroad Retirement Board (RRB). ▪ They or their spouse had Medicare-covered government employment.	▪ They have received Social Security or RRB disability benefits for 24 months. ▪ They have amyotrophic lateral sclerosis (ALS) and are receiving Social Security or RRB disability benefits. ▪ They have ESRD and meet other specific requirements.

If a consumer doesn't qualify for premium-free Part A, they can buy Part A if they meet eligibility requirements. If they choose NOT to buy Part A, they can still buy Part B.

In most cases, if a consumer chooses to buy Part A, they must also:

- Have Medicare Part B.
- Pay monthly premiums for both Part A and Part B.

Medicare Part B

Individuals who are eligible for premium-free Part A are also eligible to enroll in Part B once they are entitled to Part A. Individuals who must pay a premium for Part A can enroll in Part B if they are:

- Age 65 or older;
- A U.S. resident; or

- Either a U.S. citizen or have been lawfully admitted for permanent residence and have been residing in the U.S. for five continuous years prior to the month of filing an application for Medicare.

Part B is a voluntary program which requires the payment of a monthly premium for all months of coverage. People who are automatically enrolled have the choice whether they want to keep or refuse Part B coverage.

Most consumers will pay only the standard monthly premium amount for Part B. However, if a consumer's modified adjusted gross income (MAGI) as reported on their IRS tax return from two years ago is above a certain amount, they may pay an Income-related Monthly Adjustment Amount (IRMAA) in addition to the standard monthly premium amount for Part B. They may also pay an IRMAA in addition to the monthly premium if they enroll in a Part D plan.

Medicare Part C

To join a Medicare Advantage plan, individuals must:

- Have Part A and Part B.
- Live in the plan's service area.
- Be a U.S. citizen or lawfully present in the U.S.

Medicare Advantage enrollees' out-of-pocket costs in a Medicare Advantage plan depend on:

- Whether the plan charges a monthly premium. Many Medicare Advantage plans have a $0 premium. If an individual enrolls in a plan that does charge a premium, they pay this in addition to the Part B premium (and the Part A premium if they don't have premium-free Part A).
- Whether the plan pays any of the enrollee's monthly Part B premiums. Some Medicare Advantage plans will help pay all or part of the Part B premium. This is sometimes called a "Medicare Part B premium reduction".
- Whether the plan has a yearly deductible or any additional deductibles for certain services.
- How much the enrollee pays for each visit or service (copayments or coinsurance). Medicare Advantage plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
- The type of health care services the enrollee needs and how often they get them.
- Whether the enrollee gets services from a network provider or a provider that doesn't contract with the plan. If the enrollee goes to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network for non-emergency or non-urgent

care services, the plan may not cover their services, or their costs could be higher. In most cases, this applies to Medicare Advantage plans, Health Maintenance Organizations (HMOs), and Preferred Provider Organizations (PPOs). It also applies to private Fee-for-Service (FFS) plans that have a contracted network of providers.

- Whether the enrollee goes to a doctor or supplier who accepts assignment (if they're in a PPO or private FFS plan, or Medical Savings Account plan and they go out of network).
- Whether the plan offers extra benefits (in addition to Original Medicare benefits) and if the enrollee needs to pay extra to get them.
- The plan's yearly limit on enrollees' out-of-pocket costs for all Part A and Part B medical services. Once an enrollee reaches this limit, they'll pay nothing for Part A and Part B covered services.
- Whether the enrollee has Medicaid or gets help from their state through a Medicare Savings Program (MSP).

Enrollment

Types of Enrollment

Some people get Medicare Part A and Medicare Part B automatically, and other people have to sign up for it. Exhibit 3 describes eligibility for these enrollment types.

Exhibit 3 - Parts A and B Enrollment Types

Automatic Enrollment	Active (Manual) Enrollment
For consumers who: ▪ Turn 65 and have already been receiving Social Security benefits (SSB) or RRB benefits at least four months prior to their 65th birthday. ▪ Are under age 65 and have been receiving Social Security disability benefits or RRB disability benefits for 24 months. ▪ Have ALS and have been receiving Social Security or RRB disability benefits.	For consumers who: ▪ Are not receiving SSB or RRB benefits at least four months prior to their 65th birthday. ▪ Have ESRD and receive a regular course of dialysis or a kidney transplant*. ▪ Must pay a premium for Medicare Part A (i.e., those not eligible for premium-fee Medicare Part A). ▪ Live in Puerto Rico. They are signed up for Part A automatically if they receive SSB or RRB benefits, but they must sign up for Part B manually.

*Note: Eligibility for Medicare coverage based on ESRD works differently than other types of Medicare eligibility. If a consumer is eligible for Medicare based on ESRD and doesn't sign up right away, their coverage could start up to 12 months before the month they apply. More information can be found at Medicare.gov: End-Stage Renal Disease (ESRD).

If automatically enrolled, the consumer will receive a Medicare card in the mail three months before their 65th birthday.

When a consumer must actively enroll in Medicare, they can sign up with the Social Security Administration (SSA) by:

- Visiting SSA.gov.
- Calling the SSA at 1-800-772-1213 (TTY: 1-800-325-0778).
- Visiting a local Social Security office.

If a consumer has retired from the railroad, they can enroll with the RRB by calling their local RRB office or 1-877-772-5772 (TTY: 312-751-4701).

Enrollment Periods

Initial Enrollment Period

The Initial Enrollment Period (IEP) to sign up for Medicare Part A and for Medicare Part B, if not automatically enrolled, is seven months long. Consumers who must actively sign up for Medicare are encouraged to sign up during their IEP. The IEP begins three months before the consumer's 65th birthday, includes the birth month, and ends three months after their 65th birthday. If the consumer's birthday falls on the first of the month, their IEP starts four months prior to the consumer's 65th birthday. If consumers are about to become eligible for Medicare, their best option is usually to enroll in Medicare immediately or as soon as their IEP begins. They may experience increased costs, late enrollment fees, and gaps in coverage if they don't sign up for Medicare when they first become eligible.

If an individual is enrolled in a Medicare Advantage plan during their IEP, they can change to another Medicare Advantage plan (with or without drug coverage) or go back to Original Medicare (with or without a separate Medicare drug plan) within the first three months they have Medicare.

If they do not enroll during their IEP, most consumers may have to:

- Wait until Medicare's General Enrollment Period (GEP) or
- Qualify for a Medicare Special Enrollment Period (SEP).

General Enrollment Period

The GEP is a 3-month period that takes place from January 1 through March 31 of each year. Part B and premium Part A coverage will begin the month after a person enrolls during the GEP.

If an individual has Part A coverage and they get Part B for the first time during the GEP, they can also join a Medicare Advantage plan. They must have Part A and Part B to join a Medicare Advantage plan.

Special Enrollment Period

Terminating Marketplace coverage does not result in an SEP to enroll in Medicare. Assisters should remind consumers that SEPs for Medicare are not the same as SEPs for the Marketplace. Rules about when a consumer can make changes and the types of changes they can make are different for each SEP.

For example, consumers may enroll in Medicare during an SEP if they do not enroll in Part B or premium Part A when they were first eligible because they were covered under a group health plan based on their own or a spouse's current employment (or the current employment of a family member, if disabled). Consumers may also be eligible for an SEP if they miss an enrollment period because of certain exceptional circumstances, like being impacted by a natural disaster or an emergency, incarceration, employer or health plan error, or losing Medicaid coverage.[v] For more information on Medicare SEPs, visit Medicare.gov: Special Enrollment Periods.

Open Enrollment Period

Individuals can join, switch, or drop a Part D or Medicare Advantage plan during the Open Enrollment Period (OEP) each year, which begins October 15 and ends December 7. Their coverage will begin on January 1 (as long as the plan gets the request by December 7). If they join a Medicare Advantage plan during this period but change their mind, they can switch back to Original Medicare or change to a different Medicare Advantage plan (depending on which coverage works better for them) during the Medicare Advantage OEP (January 1 – March 31).

Medicare Advantage Open Enrollment Period

If an individual is enrolled in a Medicare Advantage plan (with or without drug coverage), during this period, they **can:**

- Switch to another Medicare Advantage plan (with or without drug coverage).
- Drop their Medicare Advantage plan and return to Original Medicare. They'll also be able to join a separate Medicare drug plan.

During this period, they **can't:**

- Switch from Original Medicare to a Medicare Advantage plan.
- Join a separate Medicare drug plan if they're in Original Medicare.
- Switch from one Medicare drug plan to another if they're in Original Medicare.

An individual can only make one change during this period, and any changes they make will be effective the first of the month after the plan gets their request. If they're returning to Original Medicare and joining a separate Medicare drug plan, they don't need to contact their Medicare Advantage plan to disenroll. The disenrollment will happen automatically when they join the drug plan.

Medicare Advantage Special Enrollment Periods

In most cases, if an individual is enrolled in a Medicare Advantage plan, they must stay enrolled for the calendar year starting the date their coverage begins. However, in certain situations, like if they move or lose other insurance coverage, they may be able to join, switch, or drop a Medicare Advantage plan during an SEP.

If a Medicare Advantage plan, Medicare drug plan, or Medicare Cost plan with a five-star rating is available in an enrollee's area, they can use the five-star SEP to switch from their current Medicare plan to a Medicare plan with a "five-star" quality rating. The five-star SEP begins December 8 and ends November 30 and can be used only once during this period.

Effective Dates

Coverage is effective for those automatically enrolled into Medicare on the first of the month they turn 65.

Consumers who are turning 65 and must actively sign up for their premium-free Part A can sign up any time after their IEP begins. The date a consumer's coverage starts depends on which month they sign up during their IEP. Coverage always starts on the first of the month:

- If they sign up for premium-free Part A and/or Part B during the first three months of their IEP, their coverage starts the first day of the month they turn 65. If their birthday is on the first day of the month, their coverage starts the first day of the prior month.
- They can sign up for premium-free Part A any time during or after their IEP starts. If they sign up within six months of their 65th birthday, coverage will start at one of these times:
    - The first day of the month they turn 65; or
    - The month before they turn 65 (if their birthday is the first of the month).
- If they sign up later than six months after their 65th birthday, the premium-free Part A coverage start date will go back (retroactively) six months from when they sign up. Coverage can't start earlier than the month they turn 65.
- Refer to Exhibit 4 for Part B effective dates.

Consumers who are eligible for Premium Part A must decide if they want to enroll and pay premiums for Part A. If they decide to do so, they must also elect to buy Part B. They must sign up during their IEP, or they may have to wait until the Medicare GEP or qualify for an SEP to sign up. If consumers have to buy Part A and they don't buy it when they're first eligible for Medicare, their monthly premium may go up 10 percent. They'll have to pay the higher premium for twice the number of years they didn't sign up.

Exhibit 4 illustrates the coverage effective dates for Premium Part A and Part B Medicare.

Exhibit 4 - Part B and Premium Part A Coverage Start Dates

Enrollment Date	Coverage Start Date
Before the month a consumer turns 65	The month a consumer turns 65
The month a consumer turns 65 or during the three months after	The next month

Medicare and Marketplace Coverage

Eligibility for Marketplace Coverage

If a consumer is enrolled in a Marketplace plan first and then becomes eligible for or enrolled in Medicare, they can choose to remain enrolled in their Marketplace plan at least through the end of the plan year, but they will have to pay full cost for their Marketplace plan. Even if consumers have Marketplace coverage, they should generally enroll in Medicare when they are first eligible to avoid the risk of a delay in Medicare coverage and the possibility of a Medicare late enrollment penalty. Here are some important points to consider if they have Marketplace coverage:

- Consumers need to terminate (end) their Marketplace coverage in a timely manner to avoid an overlap in coverage.
- Once a consumer is considered eligible for or enrolled in Part A or Part C, they won't qualify for help from the Marketplace to pay their Marketplace plan premiums or other medical costs. If they continue to get help paying for their Marketplace plan premiums after they have Medicare, they may have to pay back some or all of the help they got when they file their federal income taxes.

Eligibility for Financial Assistance

Some consumers are eligible for programs to lower their qualified health plan (QHP) costs through a Marketplace plan [i.e., advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs)]. However, consumers will lose eligibility for APTC and CSRs through a Marketplace plan when they become eligible for Medicare Part A or Part C based on their age or when they are considered eligible for their Medicare Part A coverage to start, regardless of the basis for their eligibility for Medicare.

Consumers who are enrolled in a Marketplace plan first and then become eligible for Medicare can stay enrolled in the Marketplace plan but will no longer qualify for APTC or CSRs once they are considered eligible for Medicare. However, consumers with premium-free Part A Medicare typically pay less for health coverage than they would for Marketplace coverage.

Terminating Marketplace Coverage

When consumers with Marketplace coverage are enrolled in Medicare, they should terminate their Marketplace coverage in a way that avoids both gaps in coverage and dual coverage.

Marketplace coverage generally doesn't automatically end when a consumer is enrolled in Medicare.

Termination of Marketplace coverage can take effect as soon as the day the consumer requests termination of coverage. To avoid a gap in coverage, consumers should not terminate their Marketplace plan before their Medicare coverage begins.

In some cases, consumers will need to end their Marketplace coverage by calling the Marketplace Call Center. In other cases, consumers can end their coverage online using HealthCare.gov. This depends on:

- If everyone on the application is ending their coverage; or
- If just some people on the application are ending their coverage.

A consumer should call the Marketplace Call Center to:

- End Marketplace coverage for only some people (e.g., end Marketplace coverage for themselves but keep it for a spouse).
    - The person who is ending coverage will need to change their status to a non-applicant (i.e., a household member who does not need coverage).
- Ensure that those remaining on their Marketplace plan don't lose their coverage.

Note: The best way to ensure consumers receive their desired coverage end date is by contacting the Marketplace Call Center to request the change. Instructions on ending Marketplace coverage are available at Healthcare.gov: When your income or household changes.

Periodic Data Matching

The Marketplace sends Medicare periodic data matching (PDM) notices to consumers who may be dually enrolled in Medicare that is MEC (i.e., Medicare Part A and Medicare Part C) and Marketplace coverage with APTC and CSRs. Notices are uploaded to the consumer's HealthCare.gov account or mailed via the U.S. Postal Service, depending on the consumer's stated preference. Medicare PDM notices will include:

- Name(s) of consumer(s) found to be dually enrolled.
- A recommendation that individuals found to be enrolled in MEC Medicare and a Marketplace plan should end their Marketplace coverage.
- Instructions on how to end Marketplace coverage or Marketplace financial assistance.
- Where to find contact information to confirm if they are enrolled or if they have any questions about Medicare.

Applicants have the option to provide written consent for the Exchange to end their Marketplace coverage if they are later found to be enrolled in Medicare through the Medicare PDM process by using an attestation to the Marketplace application.

If a consumer has both Medicare and a Marketplace plan with APTC and CSRs, they will have 30 days from receipt of the notice to return to the Marketplace to either:

- End APTC and CSRs; or
- End their Marketplace plan.

Based on a consumer's Medicare enrollment status, they will also have the option to:

- Disagree with the results of the Medicare PDM notice if they think they aren't enrolled in Medicare; or
- Change their attestation response from "agree" to "disagree" if they no longer want the Marketplace to end their coverage.

If the consumer doesn't take any action after the 30-day period ends, the Marketplace will either:

- End APTC and CSRs[vi]; or
- End Marketplace coverage (if the consumer provided written consent to the Marketplace to act on their behalf and end Marketplace coverage if found to be enrolled in both Medicare and the Marketplace at a later date)[vii].

Consumers Dually Eligible for Medicare and Medicaid

"Dually eligible beneficiaries" generally describes beneficiaries enrolled in Medicare and Medicaid. The term includes beneficiaries enrolled in Medicare Part A and/or Part B and getting full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through the Medicare Savings Program (MSP).

Medicare pays covered dually eligible beneficiaries' medical services first, then Medicaid pays the difference between the provider's allowable charge and Medicare's payment, up to the state's payment limit. Medicaid may cover medical costs Medicare may not cover or partially covers (such as nursing home care, personal care, and home and community-based services). For more information on services Medicaid covers when an individual becomes eligible for Medicare, consumers may contact their local SHIP office at Contact Medicare.

Medicare Cost Savings

Consumers with Medicare might be eligible for help paying Medicare costs.

- Medicare Savings Programs (MSPs), run by state Medicaid programs, help with Medicare Part A and Part B costs. These programs include:

- Qualified Medicare Beneficiary (QMB) helps cover Part A and/or Part B premiums and cost-sharing, deductibles, coinsurance, and copayments (for services and items that Medicare covers).
- Specified Low-income Medicare Beneficiary (SLMB) covers the Part B premiums.
- Qualifying Individual (QI) covers the Part B premiums.
- Qualified Disabled and Working Individuals (QDWI) helps pay the Part A premium.

- Enrollment in the MSPs automatically confers enrollment into the Medicare Part D Low-Income Subsidy program (Extra Help). The Extra Help Program helps eligible consumers pay for Medicare Part D drug coverage such as plan premiums, deductibles, and costs when consumers fill their prescriptions (i.e., copayments or coinsurance).

Every state Medicaid program must provide MSP assistance. For more information, consumers may visit Medicare Savings Programs or Extra Help.

Medigap Plans

Medigap is Medicare Supplemental Insurance that helps fill "gaps" in Original Medicare (Part A and Part B) and is sold by private companies. Original Medicare pays for much, but not all, of the costs for covered health care services and supplies. A Medigap policy can help pay some of the remaining health care costs, like copayments, coinsurance, and deductibles. To find Medigap plans available in a specific state, consumers should contact their state's Department of Insurance.

Some Medigap policies also cover services that Original Medicare doesn't cover, like medical care when consumers travel outside the U.S. If consumers have Original Medicare and they buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then, the Medigap policy pays its share.

For more information on Medigap policies, visit Medigap. Consumers can find information on Medigap policies available in their area at Find a Medigap Policy.

Medicare Eligibility and Immigration Status

Generally, to purchase Medicare premium Part A, consumers must live in the U.S. and be U.S. citizens or lawful permanent residents of the U.S. for at least five consecutive years. To purchase Medicare Part B, consumers must be U.S. citizens or lawful permanent residents and live in the U.S. continuously for the past five years preceding the month in which they submit an application for Medicare Part B. Medicare claims under Part A and Part B will not be paid for consumers who are not lawfully present in the U.S., even if they earned enough quarters of coverage to qualify. To join a Medicare Advantage plan (Part C), the individual must be a U.S. citizen or lawfully present in the U.S.

Consumers who are not U.S. citizens can contact the SSA for more information about Medicare eligibility requirements.

Scenarios

Exhibit 5 highlights common situations assisters may encounter when helping consumers with questions on Marketplace and Medicare eligibility.

Exhibit 5 - Common Marketplace and Medicare Consumer Situations

If consumers…	Then Consumers…	And…
Are receiving Social Security retirement or Social Security disability benefits	Will get information about Medicare a few months before they're automatically enrolled in Medicare Part A and Part B.	They should consider signing up for Medicare Part D at the beginning of their IEP so they will have prescription drug coverage on their first day of eligibility unless they have other creditable prescription drug coverage.
Are newly eligible for Medicare and don't get Social Security benefits yet	Will have an IEP to sign up for Medicare Part A and Part B and should consider signing up for Part D at that time if they want prescription drug coverage and do not have creditable prescription drug coverage.	▪ For someone turning 65 years old, the IEP includes the three months before, the month of, and the three months after a consumer turns 65. ▪ If consumers don't sign up for Medicare during their IEP and don't have employer-sponsored coverage (ESC) (including coverage through a Small Business Health Options Program (SHOP) Marketplace), they may have a gap in coverage.
Have ESC based on current employment, including coverage through a SHOP Marketplace	Should sign up for premium-free Medicare Part A (if eligible) when their IEP begins and consider delaying enrollment in Part B until the ESC or the current employment ends, whichever occurs first.	If they sign up for premium-free Medicare Part A at this time, they should also consider signing up for Part D unless they have other creditable prescription drug coverage.

If consumers…	Then Consumers…	And…
Are eligible for programs to lower their QHP costs through a Marketplace (i.e., APTC and CSRs)	▪ Will lose eligibility for APTC and CSRs through a Marketplace when they become eligible for Medicare coverage. ▪ Note: Consumers who are enrolled in a Marketplace plan first and then become eligible for Medicare can stay enrolled in the Marketplace plan but will no longer qualify for APTC or CSRs once Medicare begins.	
Want help to pay for some of their health care costs that their original Medicare plan doesn't cover	Should consider purchasing a Medicare Supplemental Insurance (Medigap) policy or enrolling in a Medicare Advantage plan.	▪ For consumers enrolled in original Medicare (Part A and Part B) and a Medigap policy, Medicare and Medigap will each pay its share of covered health care costs. ▪ Generally, when a consumer buys a Medigap policy, they must have Medicare Part A and Part B. ▪ Consumers cannot enroll in a Medigap policy if they have Medicare Advantage because Medigap only helps consumers with costs that Original Medicare doesn't cover. ▪ Most Medicare Advantage plans offer coverage for things Original Medicare doesn't cover, like fitness programs and some vision, hearing, and dental services. Plans can also choose to cover even more benefits. For example, some plans may offer coverage for services like transportation to doctor visits, over-the-counter drugs, and services that promote health and wellness. Consumers should check with the plan before enrolling to identify what benefits it offers, if they might qualify, and if there are any limitations.

Additional Resources

CMS.gov:

- Assisting Clients with Transitions from Marketplace to Medicare Coverage
- From Marketplace to Medicare: Transitioning from Marketplace to Medicare Coverage
- Medicare and the Marketplace
- Medicare Periodic Data Matching (PDM) – External Frequently Asked Questions (FAQ)

HealthCare.gov:

- When your income or household changes

Medicare.gov:

- Contact Medicare
- End-Stage Renal Disease (ESRD)
- Extra Help
- Find a Medigap Policy
- Medicare Savings Program
- Medicare & You Handbook
- Medigap

SHIPhelp.org: Local Medicare Help

SSA.gov

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[i] Health Insurance Marketplace® is a registered service mark of the Department of Health & Human Services.
[ii] PUBLIC LAW 116–260
[iii] H.R. 5376 Inflation Reduction Act of 2022
[iv] 42 CFR 410.111
[v] Federalregister.gov/documents/2022/11/03/2022-23407/medicare-program-implementing-certain-provisions-of-
[vi] 45 CFR 155.330(e)
[vii] 45 CFR 155.430(b)(1)(ii)