

Marketplace Insurance to Medicare Transitions — Frequently Asked Questions

1. What are Health Insurance Marketplaces?

The Marketplaces (also known as Exchanges) are shopping forums created by the Affordable Care Act where individuals and small business owners can compare and purchase health insurance plans. U.S. citizens and lawfully present residents will be able to purchase health insurance plans through the Marketplace online or over the phone. People who have Medicare will not be able to get Medicare coverage in the Marketplace.

Each state has its own Marketplace and can choose how to operate it. A state's Marketplace may be known as something other than a Marketplace or Exchange. Additionally, a state may want individuals to contact a different organization first before calling the state Marketplace so they can be screened for other types of insurance first before enrolling into a Marketplace plan. For more information on a state's Marketplace, individuals can contact that state's State Health Insurance Assistance Program (SHIP) or State's Department of Insurance. To find a SHIP, call 877-839-2675 or visit www.shiphelp.org.

2. Who is eligible to participate in the marketplace?

In order to participate in the Marketplace, an individual must:

- Live in the Marketplace service area,
- Be a U.S. citizen or national or be a lawfully present non-citizen;
- And, not be incarcerated.

Also note that it is illegal for a Health Insurance Marketplace representative to sell to a person with any part of a Medicare plan.

3. What is a Qualified Health Plan?

Qualified Health Plans (QHPs) are health insurance policies that meet protections and requirements set by the Affordable Care Act. QHPs are sold in federal- or state-run forums (referred to as Marketplaces or Exchanges; see question 1) where individuals can shop for coverage online or over the phone. QHPs must follow federally established cost-sharing limits and provide essential health benefits. At the very least, essential health benefits include ambulatory patient services, prescription drugs, emergency services, rehabilitative services/devices, hospitalization, laboratory services, maternity and newborn care, preventive and wellness services, chronic disease management, mental health and substance abuse services, and pediatric services. QHPs are offered at the *Bronze*, *Silver*, *Gold*, and *Platinum* level of cost-sharing, in which the beneficiary, on average, pays 40%, 30%, 20%, and 10% of the cost of health care services, respectively.

Note: People shopping for insurance may also come across short-term limited duration (STLD) plans and association health plans (AHPs) as other coverage options. These plans are not required to meet the same standards as QHPs, meaning they may not provide comprehensive coverage or may

exclude certain services. Additionally, STLD plans are generally unavailable for people with pre-existing conditions.

4. Who is eligible for Medicare?

People 65 and older are eligible for Medicare if they receive or qualify for Social Security retirement cash benefits. Someone 65 and older can also be eligible if they currently reside in the United States and are **either** a U.S. citizen or are a permanent U.S. resident who has lived in the U.S. continuously for five years prior to applying. Those under the age of 65 can also be eligible for Medicare if they have received Social Security Disability Insurance (SSDI) checks for at least 24 months or if they have been diagnosed with End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

5. Can someone with Medicare have a QHP?

QHPs are typically not for people with Medicare. If an individual currently has a QHP and is becoming eligible for Medicare, in most cases they should disenroll from their QHP and enroll in Medicare. However, there are a few circumstances in which someone might choose to delay Medicare enrollment to stay in a QHP (see questions 9 and 10).

For individuals who have a QHP and are becoming Medicare-eligible, there are a few important things to know. First, no type of Medicare coverage is sold through the Marketplaces, and it is illegal for someone to sell a QHP to an individual that they know has Medicare. In most cases, an individual with Medicare is ineligible for cost assistance (see question 6) to help pay for QHP premiums. There is additionally no guarantee that a QHP will pay for an individual's care if they have or are eligible for other insurance—meaning an individual may have little or no coverage. In many cases, when someone is eligible for Medicare but does not have it, the insurance they do have can refuse to cover most if not all of their health care costs. Finally, an individual will likely experience gaps in coverage and have to pay premium penalties if they delay enrolling in Medicare or disenroll and instead choose a QHP.

6. Who is eligible for tax subsidies to offset the cost of Marketplace plans?

People with incomes below 400% of the FPL can receive Advanced Premium Tax Credits (APTC) to help offset the cost of Marketplace plans, but not if they are eligible for government-sponsored minimum essential coverage (MEC). This means that:

- An individual is ineligible for APTCs if they qualify for premium-free Part A due to age or disability (see question 7).
- An individual can be eligible for APTCs if they are eligible for ESRD Medicare but have not enrolled (since Social Security hasn't yet found them to be eligible for Medicare; see question 10).
- An individual can be eligible for APTCs if they don't qualify for premium-free Part A and they don't enroll in premium Part A.
- If an individual receives APTCs when they aren't eligible for them, they may need to pay them back.

Note that Medicare Part B does not count as a MEC but that a person who is eligible for premium-free Part A cannot enroll in Part B only.

7. Who is eligible for premium-free Medicare Part A?

If an individual is eligible for Medicare due to age, Medicare Part A is free if they have at least 40 calendar quarters of work in any job where they paid Social Security taxes in the U.S., are eligible for Railroad Retirement benefits, or have a spouse that qualifies for premium-free Part A. An individual may also be eligible for premium-free Part A if they were a federal employee any time after December 31, 1982, or a state or local employee any time after March 31, 1986. Additionally, if an individual is eligible for Medicare due to a disability, End-Stage Renal Disease (ESRD), or Amyotrophic Lateral Sclerosis (ALS), they are eligible for premium-free Part A.

If an individual does not meet the criteria above, they will likely pay a monthly premium for Part A. The monthly Part A premium will depend on how many years an individual or their spouse worked in any job at which they paid Social Security taxes in the U.S. In 2021, the Part A monthly premium will be \$240 if an individual or their spouse worked between 30 and 39 quarters (7.5 and 10 years), or \$437 if they or their spouse worked fewer than 30 quarters (7.5 years). If an individual's income is low, they may be eligible for the Qualified Medicare Beneficiary (QMB) program, which pays for their Medicare Part A and B premiums and other Medicare costs. People can contact their SHIP to learn about QMB eligibility in their state. To find a SHIP, call 877-839-2675 or visit www.shiphelp.org.

8. Should an individual enroll in Medicare if they have a QHP from the Marketplace?

If an individual qualifies for premium-free Part A, they should not continue using the Marketplace to get health and drug coverage. They should enroll in Medicare when they are first eligible and disenroll from their QHP in a timely manner to avoid paying extra premiums.

9. What do people need to know about QHP enrollment and Medicare if they do not qualify for premium-free Part A?

If an individual is eligible for Medicare but would have to pay a premium for Part A, they can keep their QHP and still qualify for APTCs (see question 6) as long as they do not enroll in any part of Medicare. Individuals should consider all consequences carefully before deciding to keep a QHP instead of Medicare. If someone ever decides to enroll in Medicare, they may have to wait for the General Enrollment Period (GEP) to sign up. Using the GEP to enroll means an individual may experience gaps in coverage and incur a late enrollment penalty (LEP). If they qualify for premium-free Part A, an individual should not continue using the Marketplace to get health and drug coverage. They should enroll in Medicare when they are first eligible (see question 15) and disenroll from their QHP in a timely manner to avoid paying extra premiums (see question 14).

10. What do people with ESRD need to know about QHP enrollment?

If an individual has kidney disease that requires dialysis or transplant and is eligible for Medicare, they have the choice to enroll in or stay enrolled in a QHP with APTCs. These individuals should be

sure to consider how the QHP's coverage and costs compare to Medicare before deciding to delay Medicare enrollment.

One important coverage consideration is the coverage of immunosuppressant drugs. After a kidney transplant, an individual will need to take immunosuppressant drugs for the rest of their life to prevent their body from rejecting the donor organ. Medicare covers these drugs differently depending on the circumstances:

Time-limited Part B coverage: If the kidney transplant is in a Medicare-approved facility, Medicare Part B will cover an individual's immunosuppressant drugs for 36 months after their hospital departure if the individual:

- Had Part A at the time of the transplant
- Has Part B when getting their prescription filled
- And, is only eligible for ESRD Medicare
 - If the kidney transplant was successful, Medicare coverage will end 36 months after the month of the transplant.

Note: If the individual did not have Medicare when they had the transplant, they can enroll retroactively in Part A within a year of the transplant.

Part B coverage for life: If the kidney transplant is in a Medicare-approved facility, Medicare Part B will cover the individual's immunosuppressants for the rest of their life if the individual:

- Had Part A at the time of the transplant
- Has Part B when getting their prescription filled
- And, qualifies for Medicare based on age or disability

Part D coverage: If the individual did not have Part A when they received the transplant, their immunosuppressants will be covered by Part D after the transplant. Part D coverage for this type of drug typically means higher costs and additional restrictions, such as having to go to specific in-network pharmacies for drugs.

This all means that if an individual with ESRD chooses to not enroll in Medicare within a year of their transplant (allowing them to have Part A at the time of the transplant if they enroll retroactively), and to instead enroll in or stay in a QHP from the Marketplace, it could affect their immunosuppressant costs and coverage for life. For more counseling regarding these options, contact the State Health Insurance Assistance Program (SHIP). To find a beneficiary's SHIP, call 877-839-2675 or visit www.shiphelp.org.

11. What is the Small Business Health Options Program?

Insurance plans offered through the Small Business Health Options Program (SHOP) are job-based insurance plans purchased through the Marketplace. SHOP allows businesses with fewer than 50 employees and their employees to search for and buy health coverage. SHOP plans follow the same rules as other insurance based on current work. An individual's plan is primary or secondary

depending on the size of their employer and whether their Medicare eligibility is based on age, disability, or End-Stage Renal Disease (ESRD). Some people with a SHOP plan may have the option to delay Medicare enrollment (see question 12).

12. Should an individual enroll in Medicare if they have a SHOP from the Marketplace?

If an individual likes their SHOP plan and it is primary, they can choose to delay Medicare enrollment.

- If an individual is eligible for Medicare due to age and their employer has:
 - 20 or more employees, their SHOP plan pays **primary**.
 - Fewer than 20 employees, their SHOP plan pays **secondary**.
- If an individual is eligible for Medicare due to disability, their SHOP plan will always pay **secondary**.

Individuals should be sure to compare their plan's costs and coverage to Medicare's and make the decision that is best for them. If an individual's SHOP plan is secondary, they may want to enroll in Medicare because their SHOP plan may pay little to nothing for their care. In either case, an individual has a Special Enrollment Period (SEP) to enroll in Part B.

SHOP plans may also offer creditable drug coverage. If an individual's SHOP plan drug coverage is creditable, they can choose to delay Part D enrollment without penalty. If they decide to delay taking Part D, they should keep a record of their insurance until they enroll in Medicare. Individuals may need this documentation in order to sign up for Part D later.

Individuals with a SHOP plan should talk to their employer to see whether they need Medicare in addition to their SHOP coverage. After speaking to an employer, they should confirm what they have learned with the Social Security Administration (800-772-1213) and get all answers in writing.

Note: There are different rules for individuals who are Medicare-eligible due to End-Stage Renal Disease (see question 10).

13. Will Marketplace plans notify beneficiaries that they should transition to Medicare when they become eligible?

A Marketplace plan may not let beneficiaries know when they become eligible for Medicare. Individuals should know to enroll in Medicare during their Initial Enrollment Period (IEP). See question 15.

14. How can an individual disenroll from their Marketplace QHP?

An individual should notify a state or federal Marketplace representative of their intent to disenroll from their QHP at least 14 days before their Medicare coverage begins. It will be helpful to know the start date of their Medicare coverage and to request that the end date of their Marketplace coverage be the day their Medicare coverage begins. This will help an individual avoid gaps in coverage or paying double premiums for overlapping coverage.

- If an individual is enrolled in a QHP through the federal Marketplace, they should contact the Marketplace Call Center at 800-318-2596 or visit www.healthcare.gov.
- If an individual is enrolled in a QHP through their state's Marketplace, they should contact the state marketplace to learn how and when to disenroll from their plan.
- Individuals should ask for disenrollment steps from a Marketplace representative if they are enrolled in a family plan, to ensure they do not unintentionally end coverage for other members on the Marketplace plan.

15. How does one enroll in Medicare?

Once becoming eligible for Medicare, some people are automatically enrolled in Medicare. If they are receiving Social Security retirement benefits or Railroad Retirement benefits, they will be automatically enrolled in both Medicare Part A and Part B. If an individual becomes eligible for Medicare because of a disability and has been receiving SSDI or railroad disability annuity checks for 24 months, they should automatically be enrolled in both Medicare Parts A and B at the start of their 25th month. Those with ALS should be automatically enrolled in Medicare the first month they receive SSDI. If an individual is automatically enrolled in Medicare, they should not have to contact anyone. They should receive a package in the mail three months before their coverage starts with their new Medicare card. There will also be a letter explaining how Medicare works and informing an individual that they were automatically enrolled in Parts A and B.

If an individual is eligible for Medicare but not currently receiving Social Security retirement benefits or Railroad Retirement benefits, they can use their Initial Enrollment Period (IEP) to actively enroll. The IEP is a seven-month period, which includes the three months before, the month of, and the three months following their 65th birthday. The date when an individual's Medicare coverage begins depends on when in their IEP they sign up.

If an individual missed their IEP and needs to enroll in Medicare, they likely will have to enroll during either a Special Enrollment Period (SEP) or the General Enrollment Period (GEP). If they are eligible for the Part B SEP, they can enroll in Medicare without penalty at any time while they have job-based insurance and for eight months after losing their job-based insurance or they (or their spouse) stops working, whichever comes first. Enrolling during the GEP, which takes place January 1 through March 31 of each year, means an individual's coverage will start on July 1. Until that time they will not be covered by Medicare. Enrolling during the GEP also means an individual may have to pay a Part B premium penalty.

To actively enroll in Medicare, an individual can call Social Security at 800-772-1213, apply online at www.ssa.gov, visit their local Social Security office, or mail a signed and dated letter to Social Security that includes the individual's name, Social Security number, and the date they would like to be enrolled in Medicare.