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Module 4 – Healthcare Planning and Counseling

Introduction

Transitioning from dependence on public benefits to greater financial independence through paid employment involves more than just monthly income. Many Social Security beneficiaries also rely heavily on publicly supported health insurance such as Medicaid or Medicare to pay for essential healthcare services and products. CWICs must be able to offer competent counseling in the area of healthcare planning to ensure that they explore all available options to meet the healthcare needs of beneficiaries over time.

Content in this module will focus on:

- Medicaid;
- Medicaid waiver programs;
- Medicare (Medicare Parts A, B, and D);
- Medicare Savings Programs;
- Medicare Part D Low Income Subsidy Programs;
- Healthcare options for veterans;
- Private health insurance coverage options (employer-sponsored health plans and health plans on the Marketplace); and
- Interaction of Medicaid, Medicare, and other health insurance options

CWIC Core Competencies

- Demonstrates knowledge of the availability and eligibility for all state Medicaid programs including categorically eligible Medicaid

group, optional Medicaid groups, Medicaid buy-in programs, Medicaid waiver programs, and SCHIP, as well as Health Insurance Premium Payment programs that Medicaid funds.

- Demonstrates an understanding of eligibility for and the operations of the federal Medicare program including Medicare Parts A (Hospital) and B (Medical), Medigap insurance plans, the Medicare Prescription Drug Program (Part D), as well as the interaction of Medicare with other public and private health insurance.
- Demonstrates knowledge of the key components of the Affordable Care Act (ACA) applicable to Social Security disability beneficiaries and their families and the relationship of ACA provisions to multiple public health insurance programs for individuals with disabilities.
- Demonstrates an understanding of eligibility for and key provisions of TRICARE and the VA healthcare programs for veterans and how these programs interact with Medicare and Medicaid.
- Demonstrates knowledge of regulations protecting the healthcare rights of persons with disabilities starting new jobs or changing jobs.
- Demonstrates an understanding of the complex interactions between private healthcare coverage and public healthcare programs as well as key considerations in counseling beneficiaries as they make choices regarding health coverage options and opportunities resulting from employment.
- Demonstrates the ability to provide effective counseling to support beneficiaries in understanding available healthcare options and making informed healthcare coverage choices throughout the employment process.

Competency Unit 1 – Understanding Medicaid

Introduction

Medicaid is a critical health insurance program for many people with disabilities. Supplemental Security Income (SSI) or Title II disability beneficiaries frequently cite the fear of losing healthcare coverage as a major barrier to successful employment. Medicaid is typically the most important of all the healthcare programs because it provides coverage for basic healthcare needs as well as long-term care services, which aren't covered by other health insurance programs. Because of this, CWICs need a general understanding of what Medicaid has to offer and the various methods of establishing or retaining eligibility.

Medicaid Basics

Medicaid, also known as Medical Assistance, is a cooperative federal-state program authorized by Title 19 of the Social Security Act. It was created in 1965 as an optional program for states to provide healthcare coverage to certain categories of people with low income. Since the early 1980s, all states have chosen to have a Medicaid program.

To understand how Medicaid works, it's essential to recognize it's a jointly funded federal and state program. At the federal level, the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (DHHS) administer Medicaid. CMS provides regulations and guidance about how states must operate their program. For a state to receive the federal funding, it must abide by the federal regulations. The purpose of these federal guidelines is to ensure each Medicaid program provides a basic level of coverage to certain groups of people.

Examples of federal guidelines include:

- Covered services must be available statewide;
- Service providers must be reasonably prompt;

- Beneficiaries have free choice of providers;
- Services must be available in a manner similar to the general population;
- Amount, duration, and scope of services must be sufficient to reasonably achieve the services' purpose;
- Service providers mustn't reduce or deny the amount, duration, and scope of services for an individual based upon his or her diagnosis, disability, or condition.

States may request a waiver from one or more of these regulations. But to get a waiver, CMS must approve it, and the deviations must improve the quality or efficiency of the Medicaid program. It's also important to recognize that federal regulations provide states with considerable flexibility in designing their Medicaid program. As a result, Medicaid programs vary significantly from state to state in terms of who receives covered services, what services the program pays for, and when recipients receive the services. No two states are exactly the same when it comes to the design of their Medicaid program. Within broad federal guidelines and state options available from the federal government, states use a great deal of discretion in establishing the eligibility standards for their Medicaid program, determining the types, amounts, and duration of services available to Medicaid recipients, and in setting the rates of payments for services. In designing their Medicaid program, some states have even given their Medicaid program a unique name, such as California's Medi-Cal program or Tennessee's TennCare program.

At the state level, overall responsibility for Medicaid must rest with one state agency. That agency is responsible for developing the Medicaid State Plan, which is the written contract between CMS and the state outlining the details of the Medicaid program. The State Plan provides details for how the state will meet the federal requirements and defines the way that the state will implement specific options where states have flexibility. While the state agency is also responsible for administering Medicaid, it often delegates program operations to any number of other entities, including one or more other state agencies, county-run agencies, or health maintenance organizations (if the state uses a managed care model for any part of its Medicaid delivery system).

Because Medicaid differs substantially from one state to another, this unit won't provide the details of each individual state's Medicaid program. Instead, this unit will provide details about the federal regulations and some common state variations. CWICs need to learn the state-specific nuances of their state's Medicaid program, in particular:

- The specific name of the state Medicaid program;
- The name of the state agency responsible for administering Medicaid;
- How to access the state Medicaid agency's policy manual (online or paper version);
- The services Medicaid covers;
- The Medicaid eligibility groups (in particular for people with disabilities);
- The long-term service waivers currently approved by CMS in the state;
- The process to apply for Medicaid;
- The process to appeal an adverse Medicaid decision.

In gathering this information, CWICs should reach out to other CWICs who have been doing this work for several years, as they are likely familiar with these details. Additionally, CWICs should build relationships at the local Medicaid office and at the state Medicaid policy unit.

Services Medicaid Covers

In creating the State Plan, the state must outline the medical services and items that will be covered by the Medicaid program. CMS requires states to provide certain medical items or services to individuals who are eligible for Medicaid under mandatory eligibility groups. Mandatory eligibility groups are specific groups of people with low income that the federal government requires state Medicaid programs to cover, and it usually includes SSI recipients. In many states, most if not all Medicaid eligibility groups (optional as well as the mandatory) have access to the same set of services listed in the State Plan. States do have some leeway

to change the services provided under section 1115 of the Medicaid law that will be explained further on in this unit.

NOTE: The service entitlements below don't apply to the Children's Health Insurance Program (CHIP) which is covered at the end of this unit.

The mandatory services states must, at least, include in the State Plan for those eligible under a mandatory eligibility group include:

- Inpatient hospital (excluding inpatient services in institutions for mental disease);
- Outpatient hospital including Federally Qualified Health Centers (FQHCs) and, if permitted under state law, rural health clinic and other ambulatory services provided by a rural health clinic that are otherwise included under states' plans;
- Other laboratory and x-ray;
- Certified pediatric and family nurse practitioners (when licensed to practice under state law);
- Nursing facility services for beneficiaries age 21 and older;
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21;
- Family planning services and supplies;
- Physicians' services;
- Medical and surgical services of a dentist;
- Home health services for beneficiaries entitled to nursing facility services under the state's Medicaid plan;
- Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when there is no home health agency in the area;
- Home health aides;

- Medical supplies and appliances for use in the home;
- Nurse midwife services;
- Pregnancy-related services and service for other conditions that might complicate pregnancy; and
- 60 days postpartum pregnancy-related services.

States may also include optional services in their Medicaid State Plan, including:

- Podiatrist services;
- Optometrist services and eyeglasses;
- Chiropractor services;
- Private duty nursing;
- Clinic services;
- Dental services;
- Physical therapy;
- Occupational therapy;
- Speech, hearing, and language therapy;
- Prescribed drugs (some exceptions);
- Dentures;
- Prosthetic devices;
- Diagnostic services;
- Screening services;
- Preventive services;
- Rehabilitative services;
- Transportation services;

- Services for persons age 65 or older in mental institutions;
- Intermediate care facility services;
- Intermediate care facility services for persons with mental retardation or developmental disabilities and related conditions;
- Inpatient psychiatric services for persons under age 22;
- Services furnished in a religious nonmedical health care institution;
- Nursing facility services for persons under age 21;
- Emergency hospital services;
- Personal care services;
- Personal assistance services (non-medical);
- Hospice care;
- Case management services;
- Respiratory care services; and
- Home and community-based services for individuals with disabilities and chronic medical conditions.

Other factors to consider with Medicaid and other health coverage options include how much of a particular service a person can receive and for how long he or she can receive that service. Individual states define both the amount and duration of services offered under their Medicaid programs within broad federal guidelines. For instance, states may limit the number of days of hospital care, the number of physician visits, or the number of hours per week of personal assistance services. However, in setting these parameters, states must meet several requirements. First of all, they have to ensure that the level of services they are providing is sufficient to reasonably achieve the purpose of the service. Secondly, states mustn't discriminate amongst beneficiaries based on medical diagnosis or condition in setting these limits. Generally, states must meet a comparability standard, meaning that the services they provide to all groups must be equal or comparable in terms of scope, intensity, and duration.

There are important exceptions to this requirement. First, included in the list of mandatory Medicaid services is the Early Prevention Screening Diagnosis Treatment (EPSDT) Program. The EPSDT program applies to children with disabilities under the age of 21. Under the EPSDT program, states must provide all medically necessary services to children enrolled in Medicaid. This includes a requirement to provide “optional” services, even if the state elects not to cover these services for adults. A second exception to the comparable services standard is under the Medicaid waiver provisions, which will be explained later in this unit.

As a CWIC, your job doesn’t include being an expert on Medicaid covered services. However, to be able to help beneficiaries make decisions about whether to obtain, maintain, or stop Medicaid when working, CWICs must have a basic understanding of the covered services. As a result, CWICs should, at the very least, locate a list of the Medicaid-covered services in their state and identify the appropriate place to refer beneficiaries to get more details on coverage, if needed.

Eligibility for Medicaid: In General

In order to provide effective work incentives counseling, CWICs must become experts in Medicaid eligibility for people with disabilities. To be eligible for Medicaid, someone must first be a member of a category. There are six categories:

1. People with disabilities,
2. People age 65 or older,
3. Children,
4. Pregnant women,
5. Parents or caretaker relatives, and
6. Adults.

Within each category are Medicaid eligibility groups. Each Medicaid eligibility group has specific eligibility criteria, including income, and, in many cases, resource limits. To be eligible for Medicaid, a person must first fit into a category and then meet the requirements of a specific Medicaid eligibility group within that category.

There are more than 60 different Medicaid eligibility groups. Some are mandatory, which means states must provide Medicaid to those who meet the eligibility criteria. Other groups are optional, which means the state can choose to include them in the State Plan. If a person meets the eligibility criteria of a mandatory and an optional eligibility group, his or her eligibility should default to the mandatory group. The details of every Medicaid eligibility group won't be covered in this unit. Instead, this unit will provide the details for the mandatory eligibility groups for people with disabilities plus some general information about the more common optional eligibility groups for people with disabilities.

Mandatory Medicaid Eligibility Groups

There are a number of mandatory eligibility groups for individuals who are blind or disabled. This unit will focus on the eligibility groups that people with disabilities living in the community (not in an institution, such as a nursing facility) can use. The most commonly used mandatory eligibility groups are directly tied to receipt of SSI benefits: SSI eligible and 1619(b). The other mandatory eligibility groups that will be covered are for people who had SSI at one time but lost it due to very specific reasons. Those groups include Pickle Amendment individuals, Medicaid Protected Childhood Disability Beneficiaries, and Disabled Widow(er)s. These groups are referred to collectively as "special Medicaid beneficiaries." In total, five mandatory Medicaid eligibility groups will be covered in this unit.

IMPORTANT Clarification of Terms:

- The terms "SSI program" and "SSI benefits" are used throughout this manual. By that, we mean the individual may either be receiving cash benefits under Title XVI (SSI) or be a 1619(b) participant who is receiving Medicaid benefits but not SSI cash payments.
- By State Supplementary Payment (SSP), we mean individuals who receive a cash benefit in addition to a federal SSI benefit, which the state or the federal government may administer.
- In some cases, individuals may receive only the State Supplementary Payments (SSP) with no federal SSI cash

payments. In both cases, these individuals are eligible for the special Medicaid continuation groups described here, and the state should have eligibility processes in place to assess whether these individuals would be eligible for one of these special groups.

Mandatory Group #1: SSI Eligible

In most states, Medicaid eligibility is automatic once Social Security establishes SSI eligibility. When Congress created SSI in 1972 it wanted states to give Medicaid to those who were SSI eligible. Some states supported this idea; other states didn't. As a result, Congress decided to give states three options:

- **1634 States:** A state would use Social Security's approval of SSI as an automatic approval of Medicaid. In other words, if Social Security finds a person entitled to SSI, he or she automatically receives Medicaid. Thirty-four states and the District of Columbia use this option and are called "1634 states." This title refers to the part of the Social Security Act that authorizes the states to enter into agreements with Social Security to make Medicaid eligibility decisions.
- **SSI Criteria or SSI Eligibility States:** A state would use the same income and resource rules as SSI to determine Medicaid eligibility, but a beneficiary must file an application specifically for Medicaid with the state Medicaid agency (or its designee). Eight states (Alaska, Idaho, Kansas, Nebraska, Nevada, Oklahoma, Oregon, and Utah) and the Northern Mariana Islands use this option and are called "SSI Criteria States" or "SSI Eligibility States." In these states, Social Security doesn't make any Medicaid decisions; instead, the state makes all Medicaid eligibility decisions.
- **209(b) States:** A state would use most, but not all, of the SSI income and resource rules to determine Medicaid eligibility. These states use at least one more restrictive eligibility criterion than the SSI program. The beneficiary must apply for Medicaid at the state Medicaid agency (or its designee). The Medicaid eligibility employed by 209(b) states vary greatly from state to state. These requirements may be more restrictive or more liberal than SSI's criteria for different parts of the decision.

Eight states have chosen this option: Connecticut, Illinois, Minnesota, New Hampshire, Virginia, Hawaii, Missouri, and North Dakota. Every 209(b) state is different in terms of how it defines Medicaid eligibility. CWICs residing in 209(b) states need to contact the state Medicaid agency to access the income and resource rules specific to that state. In these states Social Security doesn't make any Medicaid decisions; instead, the state makes all Medicaid eligibility decisions.

Mandatory Group #2: 1619(b) Eligible

Since 1987, Section 1619(b) of the Social Security Act has provided one of the most powerful work incentives currently available for SSI recipients. Section 1619(b) provides continued Medicaid eligibility for SSI recipients whose earned income is too high to qualify for SSI cash payments, but not high enough to offset the loss of Medicaid. Individuals who are eligible for Section 1619(b) don't receive SSI payments because their countable income is over the break-even point (BEP) after Social Security has applied all income exclusions and deductions. There's no time limit regarding 1619(b); a person can continue to use it as long as he or she continues to meet the eligibility criteria.

To benefit from the 1619(b) provisions, an individual must meet all five of the eligibility criteria described below. If at any point a beneficiary fails to meet one or more of these criteria, the individual won't be eligible for Medicaid coverage under the 1619(b) provision.

- 1. Eligible individuals must continue to meet the Social Security disability requirement.** Individuals in 1619(b) status continue to be subject to medical continuing disability reviews and must pass those reviews (not be found medically improved) to remain eligible. Because those in 1619(b) status aren't receiving an SSI payment, beneficiaries may assume that medical CDRs won't occur anymore. It's important to remind beneficiaries that they are still subject to those reviews and must respond to related paperwork in a timely manner. If a person turns 65 and elects to have his or her SSI based on age, rather than being based on disability or blindness, he or she won't be able to use 1619(b).

- 2. Individuals must have been eligible for a regular SSI cash payment based on disability for a previous month within the current period of eligibility.** This “prerequisite month” requirement simply means that 1619(b) isn’t available to someone who wasn’t previously eligible for SSI due to disability. Additionally, for those in 209(b) states, the SSI beneficiary must have been eligible for Medicaid in the month immediately prior to becoming 1619(b) eligible.
- 3. Eligible individuals must continue to meet all other non-disability SSI requirements:** Countable resources must remain under the allowable limits of \$2,000 for an individual and \$3,000 for an eligible couple. In addition, countable unearned income must remain under the current Federal Benefit Rate (FBR). Finally, individuals must also meet all SSI citizenship and living arrangement requirements. All of these non-disability SSI requirements apply when Social Security initially establishes 1619(b) eligibility and remain in effect forever onward.
- 4. Eligible individuals must need Medicaid benefits in order to continue working.** Social Security determines this “need” by applying something called the “Medicaid Use Test.” This “test” has three parts; a person only needs to meet one of the parts to pass. An individual depends on Medicaid coverage if he or she:
 - Used Medicaid coverage within the past 12 months; or
 - Expects to use Medicaid coverage in the next 12 months; or
 - Would be unable to pay unexpected medical bills in the next 12 months without Medicaid coverage.

To make this determination a Social Security employee must call or meet with the recipient to ask questions related to the three parts listed above. A “yes” answer to any of the questions indicates that the person does need Medicaid in order to continue working. A “no” response indicates there are sufficient alternate sources available to the individual to pay for his or her medical care (e.g., comprehensive medical coverage through health insurance or membership in a health plan, access to other health programs). The Social Security employee makes initial Medicaid use

determination at the time the individual reports earnings that will cause ineligibility for an SSI cash payment. Social Security personnel make subsequent Medicaid use determinations at each scheduled 1619(b) re-determination.

For more information about the Medicaid use test, refer to POMS SI 02302.040 The Medicaid Use Test for Section 1619(b) Eligibility <https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302040>

5. Eligible individuals can't have earnings sufficient to replace SSI cash benefits, Medicaid benefits, and publicly funded personal or attendant care that they would lose due to their earnings. Social Security uses the "threshold" concept to measure whether an individual has sufficient earnings to replace these benefits. Social Security only looks at gross earnings in making this threshold determination; it doesn't consider unearned income. Social Security makes the initial threshold determination at the time the individual reports earnings that would cause ineligibility for SSI cash payments (i.e., the break-even point). The agency makes threshold determinations for the 12-month period beginning with the month 1619(b) status begins and conducts them annually during the 1619(b) re-determination. In addition to the annual re-determination Social Security requires for 1619(b) cases, Social Security must verify earned income and exclusions from earned income at least quarterly. Local Social Security offices may choose to do this more frequently.

For more information about the threshold test, refer to POMS SI 02302.045 The Threshold Test for Section 1619(b) Eligibility: <https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302045>

1619(b) Threshold Amounts and How Social Security Determines Them

Social Security uses a threshold amount to measure whether an individual's earnings are high enough to replace his or her SSI and Medicaid benefits. This threshold is based on the amount of earnings that would cause SSI payments to stop in a person's home state and average Medicaid expenses in that state. Each state calculates its threshold in this manner:

1. Multiply the annual state supplementation rate (if any) by 2
2. Add to this the current annual SSI break- even point ($FBR \times 2 + \$85 \times 12$)
3. Add the average per capita Medicaid expenses by state
4. The total amount equals the state threshold amount

The current threshold amounts for each state are shown in the POMS at: <https://secure.ssa.gov/poms.nsf/lnx/0502302200>

Social Security revises these charted threshold amounts on an annual basis. If Social Security determines the individual's countable earned income for the 12-month period is equal to or less than the threshold amount shown on the chart, he or she meets this threshold requirement.

1619(b) Individualized Threshold Amounts

If an individual has gross earnings above the charted threshold amount for the state, Social Security can look to see if the agency should calculate a higher individualized threshold. A person may get a higher individualized threshold amount if he or she has above-average Medicaid costs. The objective of the individualized threshold calculation is to determine if the individual has earnings sufficient to replace all the benefits that he or she would actually receive in the absence of those earnings. Obviously, for individuals with unusually high Medicaid costs, they would need a higher amount of earned income to replace the Medicaid coverage.

In addition, when Social Security is evaluating income for threshold determinations, it's required to consider any Impairment Related Work Expenses (IRWE) or Blind Work Expenses (BWE) the person has, as well as income excluded under an approved PASS. In some instances, applying these income exclusions may lower countable income below the standard threshold amount, thus allowing an individual to retain Medicaid eligibility under 1619(b) even though gross earnings exceed the state's charted threshold amount.

Finally, Social Security considers the value of publicly funded (other than Medicaid) personal or attendant care the individual receives when making a threshold determination. Social Security recognizes that some SSI recipients may require attendant care services to assist with essential work-related or personal care functions. For purposes of determining Section 1619(b) eligibility, attendant care (including personal care and other domestic assistance and supportive services) means assistance with:

- Work-related functions; and
- Personal needs such as bathing, communicating, cooking, dressing, homemaking, eating, and transportation, regardless of whether such needs are work-related.

Social Security considers the cost to the governmental entity for providing such services when performing the individualized threshold calculation if:

- A person paid under a publicly funded program other than Medicaid provides or provided assistance; and
- The SSI individual would no longer qualify for attendant care service due to earnings of an amount that causes ineligibility for SSI benefits.

Social Security assesses Medicaid expenses and attendant care or personal care costs used in making individualized threshold determinations for the 12-month period preceding the determination.

For more information about individualized threshold determinations, refer to POMS SI 02302.050 Individualized Threshold Calculation:

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302050>

You will find an individualized threshold calculation worksheet Social Security personnel use to make these determinations at POMS SI 02302.300 Individualized Threshold Calculation Worksheet – Exhibit:

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302300>

How Social Security Counts Earnings during 1619(b) Threshold Determinations

Social Security makes threshold determinations prospectively for the month period beginning the month 1619(b) status begins — meaning when the person first hits the break-even point and SSI cash payments cease. Social Security personnel estimate future earnings using the standard procedures described in POMS SI 00820.150 - Estimating Future Wages. If the beneficiary has estimated annual earnings under the current threshold amount and meets all other eligibility requirements, Social Security will find the person eligible for 1619(b). If estimated earnings are over the standard state threshold amount, the Social Security employee checks to see if he or she can establish an individualized threshold amount. When estimating future earnings, Social Security generally uses the amounts the beneficiary earned in the past few months, which are often the best guide. However, Social Security may consider any indication given by the recipient that he or she anticipates a change in earnings.

Social Security reviews earnings annually during the 1619(b) re-determination, as it does all other forms of unearned income, resources and other relevant eligibility information. In addition to the annual re-determination required for Section 1619(b) cases, Social Security must verify earned income and exclusions from earned income at least quarterly, although local Social Security offices may choose to do this more frequently. It's important to reassure recipients that Social Security doesn't re-determine 1619(b) eligibility under the threshold test each quarter; the agency merely verifies earnings against the original estimate. However, if during these quarterly evaluations the annual estimate for the upcoming 12-month period exceeds the current threshold amount, and if there is no indication that an individualized threshold is in order, eligibility for 1619(b) may stop. If Social Security finds an individual ineligible for 1619(b) because of excess income (earned or unearned) or resources, Social Security doesn't terminate the individual, but the individual goes into a 12-month suspension period. If the individual can re-establish eligibility again within this 12-consecutive-month period, Social Security may reinstate benefits again without the individual filing a new application.

Other Benefits of 1619(b)

As a work incentive, Section 1619(b) preserves Medicaid coverage for SSI recipients whose earnings cause total countable income to go over the break-even point. This is an exceptional benefit, but 1619(b) offers more than this.

For example, 1619(b):

- Allows eligible recipients to receive an SSI cash payment in any month in which countable income falls below the break-even point;
- Enables people who are ineligible for 1619(b) because earnings exceed the 1619(b) earning threshold to get SSI cash payments again if earnings fall below the break-even point within 12 months;
- Allows people who are ineligible for 1619(b) because earnings exceed the 1619(b) threshold amount to regain Medicaid eligibility if earnings drop below the threshold amount within 12 months; and
- Enables people whose eligibility (including 1619(b) eligibility) Social Security suspends for less than 12 months to be reinstated to cash benefits or 1619(b) status without a new application or new disability determination.

1619(b) in 209(b) States

As mentioned before, certain states (referred to as 209(b) states) have their own eligibility criteria for Medicaid. Many 209(b) states have a more restrictive definition of disability than that of the SSI program. Individuals who are eligible under 1619(a) or 1619(b) status and reside in a 209(b) state can retain their Medicaid eligibility (as long as they meet all 1619 requirements) provided they were eligible for Medicaid in the month prior to becoming eligible for 1619 provisions. The state must continue Medicaid coverage so long as the individual continues to be eligible under section 1619(a) or (b).

1619(b) for Eligible Couples

There are some important details about 1619(b) and married couples that CWICs should be aware of. For the purposes of SSI, an eligible couple exists when two SSI recipients are married to each other or are holding themselves out as married to the local community. For more information about how Social Security determines when an eligible couple exists, refer to Unit 5 of Module 3.

If both members of the eligible couple are working, both can get 1619(b) protection. For 1619(b) to apply to both members of the couple, it doesn't matter how much either person is earning. One person may even be earning less than the \$65 earned income exclusion. If both members have earned income at some level, both may be eligible for 1619(b). In addition, the threshold amount applies to each member of the couple individually. In other words, each member can earn up to the state chartered or individualized threshold amount and remain in 1619(b) status. Unfortunately, if only one member has earned income, 1619(b) can only apply to that one person, not the unemployed spouse. Because 1619(b) is a work incentive, it's only available to persons who are working. This means that the working spouse will receive 1619(b), so Social Security will terminate the non-working spouse from the SSI-related Medicaid eligibility group (unless Social Security finds him or her eligible under a different Medicaid eligibility group).

Keep in mind that an SSI recipient who marries an ineligible spouse will be subject to all applicable income and resource deeming rules. If the ineligible spouse's income cause's the eligible spouse's SSI to drop to \$0, 1619(b) won't be an option for that SSI eligible spouse. The SSI eligible spouse must be ineligible for SSI solely due to his or her own earned income.

1619(b) Eligibility and Redeterminations

Social Security is responsible for determining whether a person meets the 1619(b) eligibility criteria. The process can and should occur when the beneficiary starts reporting earned income to Social Security. Once the Social Security employee makes a determination, he or she must enter a special code on the SSI record to note the beginning of 1619(b). The

steps that follow vary depending on whether the person is in a 1634 state, a SSI Criteria and Eligibility state, or a 209(b) state.

- **1634 State:** Because Social Security's SSI eligibility determination serves as the Medicaid eligibility determination, Medicaid simply continues when Social Security finds the person eligible for 1619(b). If the agency finds the person ineligible for 1619(b), it will send a letter with appeal rights.
- **SSI Criteria Eligibility and 209(b) States:** Because the state Medicaid agency or its designee determines Medicaid eligibility for SSI recipients in these states, the process differs from that of 1634 states. The state Medicaid agency and Social Security share data through a shared data system known as the State Data Exchange (SDX). When the Social Security enters the special code on the beneficiary's record noting 1619(b) status, the Medicaid eligibility worker will be able to see that code. When the beneficiary reports his or her earnings to the Medicaid agency, the Medicaid eligibility worker will need to look in the data system to see that Social Security has made a 1619(b) determination for that person. With that coding in place, the Medicaid eligibility worker can continue the person's eligibility. If there is no coding indicating that Social Security made a 1619(b) determination, or if the worker isn't familiar with the code, the Medicaid worker will generally issue a Medicaid termination notice, which will come with appeal rights.

Once Social Security determines a person is eligible for 1619(b), the agency will conduct annual re-determinations. Social Security conducts these re-determinations to ensure that individual continues to meet the 1619(b) eligibility criteria.

Mandatory Group #3: Pickle Amendment

Effective July 1, 1977, under section 503 of Public Law 94-566, the "Pickle Amendment," Title II beneficiaries who would continue to receive SSI or State Supplement Payments (SSP) (or would continue to be eligible for benefits under section 1619(b) but for their Title II COLAs, the state continues to consider SSI recipients for Medicaid purposes. If an individual's other income wouldn't have precluded continuing SSI payments (or deemed payments under 1619(b) without the Title II

COLAs, the state must continue to consider the individual to be Medicaid eligible.

NOTE: As used in this provision, the term “Pickle” refers to the surname of the Congressman who introduced the legislation. This legislation is also referred to as Section 503, referring to the section of P.L. 94-566 that requires states to continue Medicaid in these circumstances.

Beneficiaries must meet three eligibility requirements for states to find them eligible for continued Medicaid coverage under the Pickle Amendment. States provide Medicaid only to an individual who:

1. Is receiving Title II benefits;
2. Lost SSI/SSP but would still be eligible for SSI/SSP benefits if all the Title II cost-of-living increases he or she received since losing SSI and SSP benefits were deducted from his or her income; and
3. Was eligible for and receiving SSI or a state supplement concurrently with Title II benefits for at least one month after April 1, 1977.

Social Security doesn't make Pickle eligibility decisions; the state Medicaid agencies are responsible for these determinations. When a state Medicaid agency computes Pickle eligibility, it subtracts all the COLAs from the Title II benefit since the SSI and SSP stopped. It combines the reduced Title II amount with any other unearned income, then applies a \$20 General Income Exclusion. The agency then calculates countable earned income using the SSI income deductions. Finally, the agency then compares total countable income to the current Federal Benefit Rate (FBR). If the countable income, using the reduced Title II amount, is less than the current year's FBR, then the person could get Medicaid through the Pickle Amendment. The person must continue to meet all other SSI eligibility requirements (e.g., resources below the limit, etc.).

There are two common misperceptions about who is eligible to receive continued Medicaid under the Pickle Amendment. First, many people mistakenly think that individuals must have been receiving both SSI and Title II cash payments simultaneously before the loss of the SSI payment (or deemed payment under section 1619(b)). This is generally referred

to as being a “concurrent beneficiary.” In actuality, the individual simply needs to have been “entitled” by Social Security to both Title II and SSI for the same month. There is a one-month lag in Title II payments because Social Security doesn’t disburse them until the month after entitlement. In comparison, Social Security makes SSI payments in the month of entitlement.

Examples of this one-month overlap of entitlement:

- a. A person receives SSI while awaiting receipt of Title II payments.** Once the monthly Title II begins, if it exceeds the current FBR, the beneficiary will no longer receive the SSI payment, just the Title II. Even though the person never actually received simultaneous payments from both programs in a single month, he or she would still meet the first Pickle requirement because entitlement for the two programs overlapped.

- b. Social Security finds an SSI recipient entitled to retroactive Title II payments that exceed the SSI/SSP limit for unearned income.** Under the “windfall offset” provisions, Social Security deducts SSI benefits paid up to this point from the retroactive Title II award, and the individual ceases to be eligible for SSI. For the purposes of Pickle Amendment, Social Security actually considers these individuals to have been eligible for and receiving both Title II and SSI benefits concurrently during this retroactive period.

Secondly, there is a common belief that the annual Title II program COLAs must have caused the loss of SSI (or 1619(b)) in order to qualify for the Pickle provision. This isn’t the case. The critical issue for Pickle eligibility is whether the person would otherwise be eligible for SSI and SSP if Social Security deducted the Title II COLA(s), not what actually caused the loss of the SSI.

On several occasions, judicial decisions have clarified this misinterpretation of the Pickle Amendment. Due to these important court cases, it’s no longer necessary for an individual to show that a Title II COLA was the original cause of the loss of SSI and SSP in order to establish eligibility for continued Medicaid under the Pickle provisions. This clarification of the Pickle Amendment has actually made Pickle eligibility determinations much simpler for state Medicaid agencies.

Because causation is no longer relevant, there is no need to research why the individual actually lost eligibility for SSI/ SSP and a person's past Title II disability payment status no longer matters. Under the judicial interpretation, it's only necessary to apply a simple mathematical formula to "back out" any COLAs that Social Security added to the Title II payment since the last month in which the individual was eligible for both Title II and SSI/SSP.

Example of how the Pickle Amendment applies:

Casey was receiving \$529 of SSI in January 2005, which was the Federal Benefit Rate that year. He had no other income. In June 2005 Social Security found that he had reached insured status on his own work record and awarded him a \$700 SSDI benefit, with an entitlement date of June 1, 2005. Following the normal SSDI payment process, he received his June 2005 SSDI payment on July 3rd. As a result, in June he was still due \$579 of SSI. That means in June 2005 he was entitled to both SSI and SSDI.

Now, in July 2005, when his SSI and Medicaid stop, Casey only meets the first and third Pickle criteria; he's receiving a Title II benefit and was eligible for both SSI and Title II in at least one month. He doesn't yet meet the final criteria; he wouldn't be eligible for SSI after deducting for the COLAs, because COLAs haven't occurred yet.

Once Casey reaches a future year where the SSI FBR is more than \$680 (his SSDI without any COLAs, less the \$20 General Income Exclusion), he could potentially get Pickle eligibility. In January 2012 the FBR increased to \$698. At that point it may be possible for Casey to get Medicaid eligibility through the Pickle Amendment.

Social Security informs all states annually about potential members of this group at COLA time. Each state receives two separate files to help it locate potential eligible beneficiaries. SSI recipients who go into payment status E01 because of Title II COLAs are also potential members of this group. 209(b) states have the option to disregard part, all, or none of the Title II benefit or increases. CWICs in 209(b) states will need to research their state specific rules.

WARNING! Pickle People are a growing class. If the SSI FBR keeps going up as it has, the FBR can eventually overtake an individual's frozen Title II plus other countable income. In practice this means that over time, there are more and more people who could establish eligibility for Medicaid under the Pickle provisions. CWICs must be aware that some Title II beneficiaries who were once entitled to SSI may become "Pickle-eligible" some years after they initially lost SSI eligibility. You can use a Pickle eligibility screening tool available at the VCU NTDC website at any time to determine whether an individual currently meets the criterion to establish eligibility for Medicaid under the Pickle provisions. States may establish Pickle eligibility at any point in time. There is no "sunset" date or statute of limitation.

The screening tool is available at the VCU NTDC website at:
<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=138>

Mandatory Group #4: Medicaid Protected Childhood Disability Beneficiaries

The Social Security Act requires states to consider certain Title II Childhood Disability Beneficiaries (CDBs) who lose SSI/1619(b) eligibility as if they were still SSI recipients for Medicaid purposes. For this provision to apply, the individual must continue to be otherwise eligible for SSI or 1619(b), but for their entitlement to (or increases in) CDB benefits on or after July 1, 1987. Social Security affords this protection only to individuals who lost SSI or 1619(b) eligibility because of becoming eligible for or getting an increase in the CDB payment. After excluding the CDB (or increase in CDB), the person's countable income must be below the current FBR, or he or she must meet the 1619(b) criteria. 209(b) states have the option to disregard part, all, or none of the CDB benefit or increases. CWICs in 209(b) states will need to research their state-specific rules.

Example when Social Security may exclude the entire CDB payment:

Cindy is 20 and receives SSI. Her mother retired and applied for Social Security Retirement Insurance Benefits. Her mother had high earnings. As a result, Cindy's CDB payment will be \$800 per

month. Cindy is required to apply for this Title II benefit because SSI is payer of last resort. Because \$800 is more than the current FBR plus the \$20 GIE, it's too much unearned income to allow SSI payments. However, because Cindy had no CDB before her mother retired, the state must exclude all of Cindy's CDB benefits when determining her eligibility for Medicaid. If Cindy has other income, it might affect her entitlement to Medicaid.

Example when Social Security may exclude only a CDB payment increase:

Lucy was receiving CDB based on the work record of her stepmother. While the stepmother was alive, Lucy received \$600 per month in CDB payments and a small SSI check. The stepmother died recently, however, and Social Security raised Lucy's CDB benefit to the survivor's benefit level of \$900 per month. Regardless of whether or not Lucy is working, it's excess unearned income that has now made her ineligible for SSI payments. In Lucy's situation, the state Medicaid agency must exclude the \$300 difference between what Lucy was receiving in CDB cash payments before her stepmother's death, and what she currently receives. If Lucy has no other income, she would still be eligible for Medicaid. If she has other income, she may or may not be eligible for Medicaid, depending on the type and amount of the income.

IMPORTANT NOTE: In some states, the Medicaid agency disregards the entire CDB payment when determining eligibility for special Medicaid even in cases when it was an increase in the CDB payment that caused ineligibility for SSI. This is clearly advantageous to beneficiaries. CWICs must conduct research in their home states to determine whether or not their state applies this more generous deduction.

When Social Security sends former SSI recipients their notice indicating that the agency has ceased their SSI benefits due to establishing their eligibility for or receiving an increase in CDB payments, the agency includes special language in the letter indicating that it may be possible to retain Medicaid.

This language reads as follows:

“(You) may be receiving Medicaid from (your state). If (you are), (you) may be able to keep (your) Medicaid coverage under special rules even though (your) SSI payments are stopping. (You) may receive Medicaid under these special rules if all of the following are true:

- (You) are disabled or blind and age 18 or older;
- (You) became disabled or blind before age 22;
- (You no longer receive) SSI because (your) Social Security payments started or increased; AND
- (You meet) the other state rules for Medicaid coverage.

Even if these statements aren’t true about you, you may still be able to receive Medicaid under other state rules.”

In all states it’s the Medicaid agency, not Social Security, who is responsible for making Medicaid Protected CDB determinations. Beneficiaries need to take the notice from Social Security to the local agency that makes Medicaid eligibility determinations and apply for this eligibility group.

There is no time limit for establishing eligibility for special Medicaid coverage as a former SSI recipient who lost SSI due to CDB payments or increases in CDB benefits. If beneficiaries don’t retain this coverage when Social Security first stops the SSI benefits, they can apply for it at a later date, and Social Security can find them eligible. However, special Medicaid coverage isn’t retroactive prior to the date of initial application.

There are certain points in time when CWICs need to be aware that an SSI recipient may establish entitlement for CDB, or when existing CDB payments may increase. These three critical transition points will require specialized counseling on the CWIC’s part to ensure that beneficiaries don’t lose Medicaid coverage needlessly and that their Medicaid continues under this provision in a seamless manner.

- 1.** Social Security may establish CDB eligibility when a parent dies, retires, and starts to collect Social Security benefits, or becomes disabled and collects Social Security benefits. Any time one of

these events occurs, there is potential for change in Medicaid status. In some cases, one of the parents is estranged from the beneficiary and the beneficiary won't anticipate CDB entitlement.

2. When an individual begins receiving CDB off of one parent, and subsequently the other parent dies, retires, and collects Social Security benefits, or becomes disabled and collects Social Security benefits, there is potential for an increase in CDB payments. If two parental work records are available to the beneficiary, Social Security is required to pay the highest benefit available. It's possible that the beneficiary will be transitioned to a higher benefit amount when the second parental work record becomes available.
3. Social Security affords higher CDB payments to beneficiaries when the parent dies than the agency provides when the parent is merely disabled or retired. The death of a parent is always a potential critical transition point with respect to CDB.

Mandatory Group #5: Disabled Widow(er) Beneficiaries

Effective January 1, 1991, Congress amended the Social Security Act to provide Medicaid to any former SSI eligible widow(er) who:

- Would continue to be eligible for SSI benefits or SSP but for his or her Title II benefits;
- Received an SSI/SSP benefit the month before his or her Title II payments began; and
- Isn't entitled to Medicare Part A.

The state will consider a beneficiary to be an SSI/SSP recipient for Medicaid purposes until he or she becomes entitled to Medicare Part A. As with the other special Medicaid beneficiaries, the state Medicaid agency determines eligibility and will apply the SSI deductions to determine countable income. If the countable income, less the DWB, is below the FBR, then the beneficiary could keep his or her Medicaid. The special rule for this group is that the entire or increased DWB isn't listed as unearned income. The 209(b) states have the option to disregard part, all, or none of the DWB benefit or increases. CWICs in 209(b) states will need to research their state specific rules.

NOTE: When Social Security finds a former SSI recipient entitled to DWB benefits, it credits all months on the SSI rolls at any time against the five-month disability waiting period and the 24-month Medicare Qualifying Period (MQP). The SSI months counted from the first month of any (including prorated) payment to the month of DWB entitlement. All months count, including months of nonpayment, suspension, and termination for any reason. Because the Disability Determination Services (DDS) adopts the SSI medical decision for these cases, a DWB who received as little as one payment from SSI more than two years ago and meets the non-disability entitlement factors can become entitled to Title II and Medicare Part A with no waiting period.

Example of how Disabled Widow's Benefit Applies:

Katherine is 53 years old and has never worked. She was receiving an SSI payment in the amount of \$750 (the full FBR for 2018) when her ex-husband, Hal, died in 2018. Katherine applied for benefits on Hal's record as a Disabled Widow, and Social Security awarded them. Katherine's benefit was \$959 per month, and she was no longer eligible for SSI because her countable unearned income was over the 2018 FBR (\$750). The state Medicaid agency must exclude all of Katherine's Disabled Widow's benefit when making a determination about Katherine's eligibility for benefits.

NOTE: The Disabled Widow's Medicaid eligibility group differs from the Pickle and CDB Medicaid eligibility groups in that the Disabled Widow's Medicaid eligibility ends once entitlement to Medicare begins. It's also important to note that this provision doesn't "sunset;" it's permanent. Social Security notifies members of this group as they become ineligible for federally administered payments due to excess income and notifies the 1634 states as these cases occur through the State Data Exchange (SDX).

What Happens to Special Medicaid Beneficiaries When Other Income is Involved?

Both 1634 and SSI eligibility states treat income for Special Medicaid Beneficiaries the same way that the SSI program treats income. States apply the \$20 General Income Exclusion to unearned income; if not used

there, states apply it to earned income. The regular SSI earned income exclusions also apply: SEIE, EIE, IRWE, divide by 2, BWE, and PASS. Only what is left after these deductions counts in determining eligibility for Special Medicaid.

Medicaid agencies in 209(b) states must provide Special Medicaid using the same eligibility criteria basis as Medicaid is provided to individuals who receive SSI benefits. These states have the option of disregarding part, all, or none of the title II benefit or increases in that benefit that make the individual ineligible provided that the same amount is disregarded for all members of the group. For CWICs in 209(b) states, it is critical that they locate and study the income and resource rules that apply to the various State Medicaid programs.

Example of How Earned Income Affects Special Medicaid Eligibility in 1634 States that Follow the SSI Rules:

Medicaid Protected CDB and Earned Income: Let's go back to the example of Cindy who lost SSI eligibility when her mother retired and Cindy became eligible for \$800 per month in CDB. Because Cindy had no CDB before her mother retired, the state excluded all of Cindy's CDB benefits when determining her eligibility for Special Medicaid. After establishing eligibility for Special Medicaid Cindy got a job earning \$1,000 per month. How would this affect her Special Medicaid?

The state Medicaid agency would apply the SSI income disregards to determine countable income for the purposes of Special Medicaid eligibility. Remember that Cindy has NO unearned income to count since the entire CDB check is disregarded. The Medicaid worker would take the gross earned income of \$1,000 and subtract both the \$20 GIE, the \$65 EID, and any approved IRWEs or BWEs. The Medicaid worker would divide the remaining amount of income in half ($\$1,000 - \$85 = \$915$) due to the one-for-two offset. Since the remaining \$457 is less than the FBR, Cindy would continue to be eligible for Medicaid as a Special Medicaid Beneficiary.

Special Medicaid Eligibility when Earned Income Exceeds the FBR

State Medicaid agencies are required to disregard certain Title II disability payments (or portions of payments) when determining eligibility for

Medicaid under the Special Medicaid rules. This exclusion occurs strictly for the purpose of establishing eligibility for this category of Medicaid and applies only if the individual is “otherwise eligible” for SSI. “Otherwise eligible” means that after the Medicaid agency subtracted the excludable part of the Title II benefit, the remaining countable income and resources would meet SSI eligibility criteria.

CWICs must keep in mind that the term otherwise “SSI eligible” refers not just to “otherwise eligible to receive SSI/SSP cash benefits, but also “otherwise eligible” for 1619(b). When a person meets the requirements for 1619(b) Medicaid While Working, he or she is considered to be an SSI eligible individual, simply not in cash payment status. A person in 1619(b) status is neither suspended nor terminated from the SSI program. Continued Medicaid under 1619(b) represents a very unique form of SSI eligibility that simply doesn’t come with a cash payment. The individual remains in Social Security’s computer system and is listed as SSI eligible, but in payment status N01 (non-payment).

So, what does this mean as it relates to Special Medicaid eligibility? Technically, this interpretation of being “otherwise eligible for SSI” means that State Medicaid agencies should allow Special Medicaid eligibility to continue as long as earned income remains below the state’s charted threshold amount and all other SSI eligibility requirements are met. To read a CMS technical assistance document clarifying the definition of “otherwise SSI/SSP eligible” refer to the resource entitled “Groups Deemed to be Receiving SSI for Medicaid Purposes” posted on the VCU NTDC website here:

<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=137>

Unfortunately, state agencies that make Medicaid eligibility determinations often deny benefits to individuals whose total countable income is over the FBR due to earnings. When Medicaid workers are determining eligibility for Special Medicaid, they often assess eligibility based on whether or not the person would otherwise be eligible for a cash SSI payment (countable income under the FBR). Many State Medicaid agencies are unaware that CMS has interpreted “otherwise eligible for SSI” in the past as including meeting the eligibility requirements for 1619(b). The critical difference is the limit on earned income. Under the 1619(b) provisions, the countable earned income limit is NOT the FBR; but rather the state threshold amount (or individual threshold amount, if applicable). For examples of how this policy should be applied when making Special Medicaid eligibility determinations, refer to the resource

document entitled "Special Medicaid Beneficiaries," located on the VCU NTDC web site here:

<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=136>

The Challenge for CWICs when Counseling Special Medicaid Beneficiaries

At the present time, the majority of State Medicaid Agencies are not recognizing the charted threshold amount as the earned income limit for Special Medicaid eligibility. Most states terminate Special Medicaid when beneficiaries' countable income exceeds the FBR. This presents a significant challenge for CWICs. How should CWICs counsel beneficiaries when the policy we believe is correct is not applied in practice? The best course of action is to explain the issue as clearly as possible and suggest that beneficiaries appeal adverse eligibility determinations. Check with your state PABSS program or other advocacy groups to see if they will represent beneficiaries in these cases. Reach out to your VCU TA Liaison for further guidance.

Identifying Potential Special Medicaid Beneficiaries

It's very likely that you will encounter individuals who may be eligible for continued Medicaid, but never were informed by the Medicaid agency or Social Security of this option when they lost the SSI or 1619(b). CWICs are in a prime position to help identify beneficiaries who may fall into one of these groups because of the detailed benefit history that they gather in the normal course of service delivery.

When CWICs identify a potential Special Medicaid Beneficiary, they should encourage these individuals to go to the Medicaid agency, or its designee, and ask for an eligibility determination. The beneficiary may need assistance with this process or may even need a referral to the Protection and Advocacy program if the state wrongfully denies his or her Medicaid eligibility. The CWIC may need to assist the beneficiary with proving that he or she is a member of one of these special protected classes of former SSI recipients — a task that isn't always easy!

First, the beneficiary will need to gather documentation from Social Security indicating when the person's SSI stopped and when his or her SSDI, CDB, or DWB started or was increased. Most beneficiaries won't

have kept the original letters Social Security sent them indicating these facts. In most cases, the CWIC will need to help the beneficiary with this task. Second, the individual will need to prove that he or she meets all other SSI eligibility criteria (earned income, unearned income, and resource limits) after the allowable amount of the Title II payment is exempted. Finally, the worker at the state agency that conducts Medicaid eligibility determinations may be unfamiliar with the special Medicaid provisions or how to apply them, which may cause an improper denial of coverage. In these cases, the beneficiary may have to appeal an initial adverse determination. In these cases, assistance from the state Protection and Advocacy program or other advocacy groups may be necessary. CWICs are advised to have copies of the state Medicaid regulations covering special Medicaid beneficiaries available to show the Medicaid eligibility worker if there seems to be confusion about how to apply these provisions.

An Important Reminder: Because states base these special Medicaid groups on deemed SSI entitlement, the individual must still meet all of the non-income rules for SSI or 1619(b). For example, the individual's countable resources must be at or below the SSI resource limit and the person must continue to have a disability or be 65 or older.

Another important point to remember is that the special Medicaid protections continue to apply to eligible individuals with no "sunset" date. This means that individuals who meet the basic eligibility criteria for one of these groups may establish entitlement for Medicaid at any point in time. It's NOT the case that these protections only apply at the initial point when beneficiaries lose SSI/SSP eligibility due to establishing eligibility for or receiving an increase in a Title II disability benefit. In fact, certain SSDI beneficiaries may not initially be eligible for continued Medicaid under the Pickle provisions, but may become eligible later as the SSI FBR increases.

Special Medicaid provisions serve as a valuable resource when conducting counseling on health care issues. It's imperative that CWICs be knowledgeable about how these provisions apply and who is potentially eligible for them.

Optional Medicaid Eligibility Groups

Over the years Congress has created a number of optional Medicaid eligibility groups that states can choose to cover. When state budgets are strong, states may add new optional groups. Conversely, when state budgets are tight, states may cut one or more of these groups. Because the availability of these groups varies substantially from one state to another, only the most commonly used groups are described in this unit. It's also important to note that many of the optional eligibility groups come with some flexibility, allowing states to set some of the eligibility criteria, such as income and resource limits. As a result, the explanation of each optional Medicaid eligibility group will be generic in nature. Additionally, with most optional eligibility groups, each state has created a unique name; for example, the Medicaid Buy-In Program is called Apple Health for Workers with Disabilities (HWD) in Washington, while in Minnesota it's called Medical Assistance for Employed Persons with Disabilities (MA-EPD). CWICs must conduct research in their state to clarify which optional Medicaid eligibility groups are available, the state specific name used for each group, and the details on the eligibility criteria.

Optional Group #1: Medicaid Buy-In (MBI)

This optional Medicaid eligibility group, the Medicaid Buy-In (MBI), Congress specifically created to provide Medicaid eligibility for workers with a disability. The Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) authorized the MBI. MBI can provide health coverage to working people with disabilities who, because of increased earnings, resources, or both, can't qualify for Medicaid under another category. When using MBI, people with disabilities who are working pay affordable monthly premiums for their Medicaid coverage.

IMPORTANT: CMS gives states a wide berth to set their own rules for the MBI in their state. Some states have no cap on the amount of earned income or resources someone can have in an MBI. Other states, by comparison, are very restrictive as to who gets in but have more liberal rules on earnings and resources after they find the person eligible for and have enrolled him or her in the MBI.

Each state's MBI is unique in its mix of features within the federal rules with which it must operate.

A number of beneficiaries may find the MBI a helpful work incentive. In some states, MBIs may be an affordable way for Title II beneficiaries who return to work to access Medicaid in their state. For people who stopped receiving SSI due to earnings, but can't meet the 1619(b) eligibility criteria, MBI may be a way to maintain Medicaid. Additionally, in some states people with disabilities who have never received SSI or Title II disability because of excess income or resources may be able to apply for the Medicaid Buy-In once they begin working. States generally require the person to meet Social Security's definition of disability, but some states exclude SGA or allow an increased SGA amount when conducting step one of the five-step sequential evaluation process. The state will perform a determination at the time of application for the MBI.

As noted, a state can structure the buy-in in many different ways based on the authorizing federal law the state chose to work with, either the BBA of 1997 or the Ticket Act of 1999.

The original 1997 buy-in included these key eligibility components:

- Most states don't require individuals to have been on SSI or SSDI or any Title II, Title XVI, or Title XIX (Medicaid) benefit for the state to find them eligible for the state's MBI.
- Individuals must have earned income to qualify for this Medicaid option in almost all states.
- States set allowable MBI earned income limits the net countable income of less than 250 percent of the current Federal Poverty Level (FPL), with all SSI income exclusions allowable, for example Impairment Related Work Expenses (IRWEs).
- States may also establish additional disregards that are more generous than SSI exclusions and effectively increase the income limit.
- Except for their earned income, the person with a disability would be otherwise eligible for SSI at time of award of benefits. While this means that SSI resource limits are in effect at the time of application to an MBI, in some states resource rules can change and radically improve after states find the applicant eligible and he or she enrolls in an MBI.

- Substantial gainful activity isn't an eligibility consideration. A person could be eligible at time of application for the buy-in despite earnings in excess of the substantial gainful activity amount. Most states require proof of earned income.
- States could effectively increase the Medicaid resource limits by disregarding resources above the \$2,000 SSI resource standard both at time of application as well as post-enrollment.
- States could charge premiums or other cost-sharing charges with no federal limit on the amount they charge.
- There is no age limit per se (e.g., the person must be under age 65) with a BBA-authorized MBI.

Section 201 of the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) created a second MBI program with several key provisions to make the buy-in program more attractive:

- It allows states to offer a buy-in to individuals at any income or resource level the state elects to establish.
- Individuals must have earned income to qualify for this Medicaid option in all states.
- CMS now allows states to require cost sharing and affordable premiums, based on income on a sliding scale. A state could require some individuals to pay the full premium as long as the premiums don't exceed 7.5 percent of the individual's total monthly income.
- The state must require payment of 100 percent of the premium for individuals with incomes over approximately 450 percent of the FPL.
- MBI enrollees authorized by the Ticket Act must be at least 18 but below 65 years of age.

CMS provides an overview of the Medicaid Buy-In option at the following website at:

<https://www.medicaid.gov/medicaid/ltss/employment/index.html>

Optional Group #2: Medically Needy

The Medically Needy eligibility group (also known as spend-down) is an optional category of Medicaid coverage in 1634 and SSI criteria states. These states have the option of expanding Medicaid eligibility to blind or disabled persons who have high medical costs and too much income to qualify for Medicaid under any other group. Because 209(b) states have at least one more restrictive criterion than the SSI rules, they must offer a spend-down to meet eligibility standards.

With Medicaid Medically Needy, each state sets its medically needy income limit based on family size. Resource limits are typically the same as those in the SSI program. States must also establish income and resource rules for determining eligibility for the Medically Needy eligibility group. The federal government requires that the state's methodology employed in determining income and resource eligibility "shall be no more restrictive than the methodology which would be employed under the [SSI] program in the case of ... blind, or disabled individuals." (NOTE: This requirement doesn't apply to 209(b) states.) States may develop income and resource methodologies that are less restrictive (or more generous) than the SSI program rules by applying Section 1902(r)(2) of the Social Security Act. States may also set their own budget periods, and these may vary based upon an individual's living arrangement. Finally, states may offer a more restrictive package of medical services for this group than applies to the mandatory eligibility groups. It's important to note that states' rules governing what income or resources count in determining eligibility for the spend-down program vary widely. CWICs must access a copy of their state's Medicaid policy manual to find out exactly how their state determines countable income and resources and what medical services are available for this group.

Individuals above the Medically Needy income limit must meet the spend-down before they can get Medicaid coverage. The spend-down is the amount of income that exceeds the Medically Needy income limit, after subtracting all allowable income deductions. The spend-down acts like a deductible that the beneficiary must pay or incur before coverage begins. Most medical expenses that beneficiaries pay or incur can meet a spend-down requirement, even if it's for goods or services the Medicaid state plan doesn't cover. The following is a list of typical out-of-pocket costs or

expenses that the beneficiary can use to meet the spend-down requirement:

- Health insurance premiums and co-payments;
- Doctor bills;
- Mental health treatment bills (including a psychiatrist's services and mental health counseling services);
- Dental bills;
- Home health care;
- Prescriptions drugs;
- Eyeglasses and optometry bills; and
- Over-the-counter drugs or purchases related to health care.

Example of the Medically Needy eligibility group:

Shauna receives \$1,075 per month of SSDI. She has Medicare, but she still spends about \$500 per month on co-insurance and uncovered services. The Medically Needy income limit in her state, given her household size, is \$750 per month. In her state, all her unearned income counts (no unearned income deductions). As a result, Shauna's spend-down will be \$340 per month ($\$1,075 - \$750 = \325). Once Shauna meets her spend-down (\$325 per month), Medicaid will begin providing coverage.

Remember, the rules for calculating a spend-down and the budget period vary substantially from state to state; CWICs must research these details in their state.

When a person using Medically Needy Medicaid begins working, it generally means he or she will have an increase in the amount of his or her spend-down. It's important for CWICs to understand the income and resource limits associated with this eligibility group, as well as the basics for how to calculate the spend-down.

Example of what happens to Shauna when she begins working: Shauna got a job making \$800 per month. She will continue receiving her SSDI of \$1,075 per month since this level of earnings would not be SGA. The state allows the following earned income deductions: SEIE, \$65 earned income exclusion, IRWE, BWE, one-half disregard, and PASS. Shauna will have \$367.50 of countable earned income, given her situation ($\$800 - \$65 \div 2 = \$367.50$). Plus Shauna has \$1,075 of SSDI, which makes her total countable income \$1,442.50 per month. As a result, Shauna's spend-down will increase to \$692.50 per month ($\$1,442.50 - \$750 = \692.50). Shauna will no longer be able to get Medicaid through the Medically Needy eligibility group because she doesn't have enough out-of-pocket medical expenses to meet the spend-down.

CWICs must be prepared to identify and communicate with beneficiaries when their spend-down will increase due to working. They must also be able to identify alternatives, such as the Medicaid Buy-In.

Optional Group #3: State Supplemental Payment (SSP) Eligible

Some states provide a cash payment called a State Supplement Payment (SSP) to supplement the federal SSI benefit and low Title II disability benefit amounts. The maximum SSP amount varies by state as well as by factors such as marital status, living situation, and blind status. Income and resource limits also vary by state. Social Security administers the SSPs for some states, a list of which can be found at: <https://www.ssa.gov/ssi/text-benefits-ussi.htm>

If a person is eligible for a SSP, he or she may also be able to get Medicaid through this related Medicaid eligibility group. If this optional group is available, a CWIC must confirm the SSP income limits, the resource limit, the methodology the state uses to calculate countable income, and the methodology the state uses to determine countable resources.

Example of the SSP eligibility group:

Phillip receives \$820 of SSDI. His state offers up to \$150 per month of a SSP. The income limit for the SSP is \$900 per month, and the state allows all the SSI income deductions when determining eligibility. Phillip's countable income is \$800 ($\$820 - \$20 \text{ GIE} = \800). As a result, he is eligible for \$100 per month of SSP. Because he is eligible for a SSP, he is also Medicaid eligible through the SSP Medicaid eligibility group.

When a person eligible for Medicaid through this group begins working, it's likely his or her earned income could push him or her over the income limit.

Example of what happens to Phillip when he begins working:

Phillip gets a job making \$500 per month, plus he will continue to receive \$820 of SSDI. Using the SSI income deductions, Phillip's countable unearned income is \$800 ($\$820 - \$20 = \800) and his countable earned income is \$217.50 ($\$500 - \$65 \div 2 = \217.50). That means his total countable income is \$1,017.50. The income limit for the SSP is only \$900 per month, which means Phillip is now over income. His SSP cash payment will stop, and he won't be eligible for Medicaid under this eligibility group.

When Social Security administers the SSP, it's treated as if it were an SSI benefit. As a result, a person who loses a Social Security administered SSP can use 1619(b) to maintain Medicaid. With state administered SSPs, CWICs must research the state's Medicaid policy manual to clarify whether loss of SSP due to income will result in loss of the related Medicaid. If that could occur, CWICs must be prepared to identify alternatives, such as the Medicaid Buy-In.

Optional Group #4: Low Income Eligibility

Another optional Medicaid eligibility group that some states use provides Medicaid for people with disabilities with income up to 100 percent of the Federal Poverty Level (FPL). The state can choose the specific income limit, but it can't exceed 100 percent of the FPL. The state must also establish a resource limit. If this optional group is available, CWICs must confirm the income limit, the resource limit, the methodology used to

calculate countable income, and the methodology the state uses to determine countable resources.

A Word about Federal Poverty Levels (FPLs)

The U.S. Department for Health and Human Services (DHHS) establishes annual poverty guidelines that are widely used as a poverty measure for administrative purposes — for instance, when determining financial eligibility for certain federal or state programs. The poverty guidelines are often loosely referred to as the “federal poverty level” (FPL).

DHHS bases the FPL amounts on family size. For example, in 2017 the FPL for a family size of one was \$12,060 (\$1,005 per month) and for a family size of two it was \$16,240 (\$1,353 per month). Each year, there is one set of FPL figures for the 48 contiguous states and another set with higher figures for Alaska and Hawaii. The PFLs (or percentages of them) are used frequently as a standard for income eligibility for various Medicaid programs. The examples in this module use the 2017 FPLs. This is because DHHS publishes updated FPLs January or February of each year, after we publish the updated manual. CWICs will need to research the 2018 FPLs when they become available. More information about the FPLs is available at the DHHS web site here:

<https://aspe.hhs.gov/poverty-guidelines>

Example of the Low Income eligibility group:

Kallie receives \$990 of SSDI. The income limit in her state for this eligibility group is \$1,005, given her household size, and the state allows all the SSI income deductions when determining eligibility. Kallie’s countable income is \$970 ($\$990 - \$20 \text{ GIE} = \970). Because her countable income is below the state’s income limit for this Medicaid eligibility group, she can access Medicaid this way.

When a person eligible for Medicaid through this group begins working, it’s likely his or her earned income could push him or her over the income limit.

Example of what happens to Kallie when she begins working:

Kallie gets a job making \$700 per month, plus she will continue to receive \$990 of SSDI. Using the SSI income deductions, Kallie's countable unearned income is \$970 ($\$990 - \$20 = \970) and her countable earned income is \$317.50 ($\$700 - \$65 \div 2 = \317.50). That means her total countable income is \$1,287.50. The income limit for the Low Income eligibility group is only \$1,005 per month, which means she is now over income limit and won't be eligible for Medicaid under this eligibility group.

CWICs must be prepared to identify and communicate with beneficiaries when their income will exceed the Low Income eligibility group's limit due to working. They must also be able to identify alternatives, such as the Medicaid Buy-In.

Optional Group #5: Home and Community Based Services (HCBS) Waiver Eligible

This next optional eligibility group is available to people who are eligible for a Medicaid Home and Community Based Services (HCBS) waiver. HCBS waivers are a set of special Medicaid services provided to targeted populations, thereby making it possible for the individuals to live with maximum independence in the community rather than live in an institution (e.g., nursing facility).

To use this group, a person must have income below a standard set by the state (not to exceed 300 percent of the SSI FBR, have resources below \$2,000 (\$3,000 for a couple), and be eligible for a HCBS waiver. If a state chooses to use this optional Medicaid eligibility group, they may require "post eligibility treatment of income," which is often called a cost share, patient liability, offset, or cost of care. This cost share is a specific amount of the beneficiary's monthly income that he or she must pay to help cover some of the HCBS waiver services.

It's important to note that a beneficiary doesn't need to use this Medicaid eligibility group to be eligible for a HCBS waiver. On the HCBS waiver application, which the state creates and CMS must approve, there will be a list of Medicaid eligibility groups that can use the waiver (e.g., SSI

eligible, Medicaid Buy-In, Low Income Eligible), one of which could be this optional eligibility group. If a beneficiary is eligible for Medicaid through his or her SSI eligibility and that group is listed on the HCBS waiver application, then the beneficiary wouldn't need to use this optional Medicaid eligibility group. But, if the beneficiary was over income the income limits for SSI, then this could be a way for the person to become eligible for Medicaid and access the HCBS waiver.

Example of the Home and Community Based Services waiver eligibility group:

Denbe receives \$1,500 of SSDI. The income limit in his state for this eligibility group is \$2,250 (300% of the SSI FBR for 2018). All of his income counts when the state determines if he is above or below this limit. Because \$1,500 is below the current income limit, he can access Medicaid this way. When a person is eligible for Medicaid through the HCBS waiver group, his or her total income could exceed the income limit when working.

Example of what happens to Denbe when he begins working:

Denbe gets a job making \$850 per month, plus he will continue to receive \$1,500 of SSDI. Because the state counts all income when determining if a person is above or below this income limit, his total income is \$2,350. He is now over the income limit and will no longer be eligible for Medicaid under this eligibility group.

Some states allow individuals to put excess income into a Miller's Trust, thereby allowing them to meet the income limit for this eligibility group. The availability of Miller's Trusts varies from state to state, so CWICs will need to conduct state-specific research. It's also important to note that if a person has a cost share, the amount he or she pays may also increase when he or she begins working.

It's critical that CWICs understand the income and resource limits associated with this eligibility group, whether Miller's Trusts are an option, and the basics for how the cost share is calculated. CWICs must be prepared to let beneficiaries know if their cost share will increase due to working or if they will likely exceed the income limit. If either of those results is expected, CWICs must help identify alternatives, such as the Medicaid Buy-In, for maintaining Medicaid and waiver services.

Optional Group #6: Affordable Care Act Medicaid Expansion – Adults Group

This final eligibility group isn't specifically for people with disabilities, but it could be useful for Title II disability beneficiaries in the Medicare 24-month qualifying period. This Medicaid eligibility group is referred to as the "adult group," the "133 percent group," or the "VIII group."

Individual states may establish a different name if they adopt this eligibility group. When Congress passed the Affordable Care Act (ACA), it designed the adult group to be a mandatory Medicaid eligibility group. To continue receiving federal funds for the Medicaid program, states would be required to provide Medicaid to everyone who met the eligibility criteria. However, in 2012 the Supreme Court ruled that the mandatory expansion was unfairly coercive on states and determined that a state could refuse to adopt the expansion. As a result, this eligibility group isn't available in all states.

For states that add the adult group to their Medicaid State Plan, there are five specific federal rules that dictate the eligibility criteria. To be eligible, a person must:

1. Have income at or below 133 percent of the Federal Poverty Level;
2. Be between 19 and 64 years of age;
3. Not be pregnant;
4. Not be eligible for Medicare; and
5. Not be eligible for Medicaid under a mandatory eligibility group.

The state won't cover a parent or other caretaker relative who is living with a dependent child under the adult group unless the child is enrolled in Medicaid, the Children's Health Insurance Program (CHIP), or another health care plan with at least minimal essential coverage. The state uses Modified Adjusted Gross Income Based (MAGI-based) methodology to determine whether a person meets the income limit for this group. It finds this by taking the tax-filing group's adjusted gross income (an IRS concept) and adding in all Social Security income. Then it makes a few

additional adjustments for things such as lump sum payments, education scholarships, awards, or grants, and American Indian or Alaskan Native income.

Once the state determines MAGI-based income, it applies a 5 percent Federal Poverty Level (FPL) disregard. As a result, the effective eligibility limit for this group is 138 percent of FPL. The state bases the household size on the tax household size, which generally means married adults and children living together; however, there are some instances where IRS and Medicaid household rules may differ. There is no resource limit for the adult group.

CMS doesn't require states to provide the full scope of Medicaid State Plan services to those in the adult group. They must instead provide "essential health benefits." Those benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorders, prescription drugs, rehabilitation and habilitation services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services. States have the option to propose alternate benefits packages for the adult group, which could include Medicaid State Plan benefits.

Example of the Adult eligibility group:

Luther receives \$1,270 of SSDI. He doesn't have Medicare yet. Given his household size, the income limit for this Medicaid eligibility group is \$1,387 per month (138% of 2017 FPL). His MAGI-based income is below that limit and, as a result, he can access Medicaid this way.

When counseling beneficiaries who use this group, it's important to recognize returning to work could make them ineligible.

Example of what happens to Luther when he begins working:

Luther gets a job making \$500 per month, plus he will continue to receive \$1,270 of SSDI. His MAGI-based income is \$1,770 per month, which is over the income limit for this group. As a result, the state would need to find Luther eligible under a different Medicaid eligibility group in order for him to maintain Medicaid.

CWICs shouldn't only identify those who could be eligible for this group, but should also be familiar with other Medicaid eligibility groups in their state that could benefit workers with disabilities, such as the Medicaid Buy-in group (if available).

Home and Community-Based Services (HCBS) Waivers

Historically, Medicaid only funded long-term care services in an institutional setting. Long-term care (LTC) services include support with activities of daily living (ADLs), such as bathing, dressing, and eating. LTC services have also included support with instrumental activities of daily living (IADLs), such as taking medications as prescribed, managing money, shopping for groceries, and transportation within the community. If an individual needed this type of support, in the past Medicaid would only provide those services in nursing facilities, intermediate care facilities (ICF), intermediate care facilities for those with intellectual disabilities (formerly called ICF or MR), or hospitals.

Example of LTC services:

Denise was in a car accident that caused total paralysis below her waist. She was in the hospital for several weeks, which her parents' insurance covered. Afterwards, she entered a nursing facility, where she had access to nursing care, physical therapy, and occupational therapy. Her parents' insurance had covered much of her care, but there were limitations on the amount of rehabilitation care. She signed up for Medicaid, which covered the services her parents' insurance didn't cover. After three months of services in the nursing facility, Denise began asking when she could move back to her apartment. She met with the facility's social worker, and they created a plan. Denise applied for a program through the state Medicaid agency that provided LTC services to people in their own homes (they also provided support to people in foster homes and group homes, but she wasn't interested in that). A caseworker from the state Medicaid agency came to the nursing facility and conducted an assessment of her LTC support needs. The caseworker let Denise know there were a special set of services to assist people with LTC needs to live in the community, called Home and Community Based Services. She explained that, based on the

assessment results, Denise could have a certain number of hours per day of personal care attendant services and nursing services to support her in living in her own apartment. Denise talked this option over with her parents and the social worker at the nursing facility. Together, with the Medicaid caseworker, they came up with a plan for Denise to move back into the community, using the Home and Community Based Services to support her in living in her apartment.

Over the years Congress has created several options for states to provide LTC services to support people in living in the community, rather than in a Medicaid funded institution. This concept took off in the 1980's when Congress enacted section 1915(c) of the Social Security Act. That has been the main authority states have used to provide home and community- based services over the years. More recently, under the Deficit Reduction Act of 2005, Congress created another option, 1915(i), and then, through the Affordable Care Act of 2010, created the 1915(k) option. The fourth authority that states could use to provide LTC services in the community is through an 1115 demonstration waiver. That authority is broader in context as it allows states to operate their Medicaid program in a unique way so that it can provide better quality services more efficiently.

Beneficiaries who receive these services are often concerned about how working may affect their eligibility. These services provide critical support, without which the individual would most likely need to live in an institution. Given the importance of these services, it's essential that CWICs understand these special Medicaid programs and are clear about how earnings will or won't affect eligibility.

1915 (c) Home and Community Based Services (HCBS) Waivers

This provision allows states, with approval from CMS, to "waive" (or not follow) certain federal Medicaid requirements. These are often referred to as "section 1915(c) waivers." Currently, 47 states participate in these optional waivers to varying degrees, and some states operate several 1915(c) waivers simultaneously. Arizona, Rhode Island, and Vermont use the 1115 demonstration waiver authority to provide home and community-based services, rather than the 1915(c) authority. HCBS

waivers are important for persons with disabilities because they provide a means for receiving critical services that make it possible to live in the community rather than in an institution.

To qualify for HCBS waiver services, applicants must meet the following criteria:

1. Require an institutional-level care (nursing facility, hospital, intermediate care facility, or intermediate care facility for intellectual disabilities);
2. Meet the definition of the target group being served by the waiver (e.g., physical disability, developmental or intellectual disability, traumatic brain injury); and
3. Qualify for Medicaid under one of the Medicaid eligibility groups listed on the specific waiver the person is using.

Under the HCBS waiver authority a state may provide a wider range of long-term care services than is generally allowed under a state's Medicaid program, including non-medical services such as minor home modifications like ramps or special safety devices. Some states have several different HCBS waivers targeted to different populations. States can use the HCBS waiver to waive three key federal Medicaid requirements:

1. Waiver of statewidedness: Ordinarily, the state's Medicaid plan must offer comparable coverage in all regions of a state. The state could establish a waiver that allows them to offer a level of Medicaid coverage in one or more sections of the state that isn't available to recipients statewide.
2. Waiver of comparability: Ordinarily, the state's Medicaid plan must treat all similarly situated recipients equally. A waiver can select a targeted group of Medicaid recipients (such as persons with traumatic brain injury) and offer them a set of services not available to persons who have different disabilities but similar needs.
3. Waiver of certain income and resource rules: The state can implement a waiver that exempts certain populations from the

general income and resource requirements. For example, many states operate waiver programs that insure children with very severe disabilities are eligible for Medicaid without regard to parental income and resources.

The expanded scope of services potentially available through an HCBS waiver can be very important to individuals with disabilities who are pursuing employment. Under federal HCBS waiver regulations, the state can provide a very wide range of services, including:

- Case management
- Homemaker services
- Home health aide services
- Personal care services
- Adult day health
- Habilitation, including Supported Employment services
- Respite
- Partial hospitalization and psychosocial rehabilitation for persons with psychiatric diagnoses
- Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization

States have used the “other services” category to approve things such as home modifications and even modifications to vehicles.

HCBS waivers also differ from standard Medicaid in that they allow states to limit enrollment and to establish waiting lists for services. Under standard Medicaid policies, states must provide services to all eligible individuals with reasonable promptness. However, the states may place on a waiting list any individuals they determine eligible for HCBS waivers and not provide them services until a slot in the waiver becomes available.

In 1997, CMS amended the HCBS regulations to allow for “expanded habilitation services,” which include “prevocational services” and

“educational services.” Under the prevocational and educational services categories, CMS will allow an approved waiver to provide a wide range of services that would prepare an individual with a severe disability to eventually move to either competitive employment, long-term supported employment, or a more traditional vocational rehabilitation program. As a result, CWICs may work with beneficiaries who are receiving crucial employment services that are funded by a HCBS waiver.

A beneficiary may have concerns about how work will affect his or her eligibility for the HCBS waiver he or she is using. To maintain the HCBS waiver services, the beneficiary must continue to meet the three eligibility criteria. The first two are generally not affected when a person begins working; generally, the person continues to have an institutional-level of care need and he or she continues to meet the criteria for the target group. The third criterion is the waiver’s financial criteria; the person must continue to be eligible for one of the Medicaid eligibility groups listed on the waiver. If the state projects the individual will stay in the same Medicaid eligibility group when he or she begins working, then he or she could maintain eligibility for the waiver. If the state projects that the individual will lose eligibility for his or her current Medicaid eligibility group given his or her earning goal, the CWIC should support the beneficiary in identifying other Medicaid eligibility groups listed on the waiver he or she could use.

To provide that support, CWICs must identify which HCBS waivers are available in their state, locate the HCBS waiver application (the approved agreement between CMS and the state) for the waiver the beneficiary is using, and locate Appendix B-4 on that waiver. Appendix B-4 provides a list of the Medicaid eligibility groups that the beneficiary can use to access that specific waiver.

CMS has a website that provides a list of all the approved 1915(c) waivers in each state at: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>

Most states have uploaded the approved HCBS waiver application to each waiver description on this site or onto the state’s Medicaid website. If the state hasn’t uploaded the waiver application, CWICs will need to do some networking to locate a copy.

1915(i) State Plan HCBS Benefit

Through the 1915(i) option, states can include a variety of Home and Community Based services under the Medicaid State Plan. In comparison, under the 1915(c) option the state doesn't consider the services part of the State Plan. Instead, 1915(c) waiver services are special Medicaid programs separate from the State Plan that can only be accessed by those who meet the eligibility criteria. CMS doesn't allow states to limit enrollment for 1915(i) benefits or to establish waiting lists for services under this option.

Additionally, with the 1915(i) option, states can provide the services to a broader group of people than the 1915(c) waivers can serve. The clinical eligibility standards under the 1915(i) must be less stringent than the institutional level of care that is required under 1915(c). What that means is that states can use the 1915(i) option to provide home and community-based services to people with less significant disabilities than those the state serves under the 1915(c) waivers.

Example of 1915(i) option:

Iowa was one of the first states to use the 1915(i) option. The Iowa Department of Human Services worked with CMS to design a program to meet the service needs of Iowans with the functional limitations typically associated with chronic mental illness. This is an example of a population of people who generally don't meet the 1915(c) institutional-level of care eligibility criteria. The services included in this option assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based setting. Services available through this State Plan option include case management, home-based habilitation, day habilitation, prevocational services, and supported employment.

To qualify for 1915(i) specific services, an individual must:

- 1.** Meet the clinical eligibility criteria for 1915(i) services set by the state; and
- 2.** Be eligible for Medicaid; and

3. Have income below 150 percent of the FPL (states may choose to increase the income limit to 300 percent of the SSI rate for individuals who meet institutional-level of care criteria).

The last two criteria are of particular importance for CWICs, because earned income can affect whether a person continues to meet those eligibility standards. In regard to the second criteria, the earlier sections in this unit explain how earnings affect various Medicaid eligibility groups. CWICs must be prepared to help beneficiaries explore other Medicaid eligibility groups that they could use, if needed. The third criterion is actually a new concept in the world of Medicaid. Up to this point, a specific set of services hasn't had an income limit tied to it. But, for a beneficiary to become eligible for and maintain 1915(i) services, his or her income must be below the limit noted in criteria three above, regardless of the income limit for the individual's Medicaid eligibility group. When determining if a person's income is above or below that limit, the state will use the income deductions allowed under the Medicaid eligibility group the person is using.

1915 (k) Community First Choice

Most states currently provide a limited amount of personal care services through the Medicaid State Plan benefit. The Affordable Care Act established Community First Choice (CFC) under 1915(k) of the Social Security Act as a new Medicaid State Plan option that allows states to provide statewide home and community-based attendant services and supports to individuals who would otherwise require an institutional level of care. States taking up the option will receive a 6 percent increase in their federal medical assistance percentage (FMAP) for CFC services. There is no time limit or expiration on the enhanced FMAP and CMS has indicated that the enhanced FMAP also will be available for required CFC activities such as assessments and person-centered planning.

States must provide CFC services statewide with no enrollment caps. States can provide services under an agency-provider model (within which individuals must maintain the ability to have a significant role in the selection and dismissal of providers of their choice), a self-directed model, or other models approved by CMS. States determine specific services following a face-to-face assessment of an individual's needs and a person-centered planning process directed by the individual to the

maximum extent possible. Required CFC services include: services that assist beneficiaries with activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing; services for the acquisition, maintenance, and enhancement of skills necessary for individuals to accomplish activities of daily living, instrumental activities of daily living, and health-related tasks; "self-direction" opportunities including voluntary training on how to select, manage, and dismiss direct care workers; and backup systems (such as beepers or other electronic devices) to ensure continuity of services and supports.

To be eligible for CFC services, beneficiaries must:

- Otherwise require an institutional-level of care;
- Be eligible for Medicaid; and
- If using a Medicaid eligibility group that doesn't offer nursing facility services, the beneficiary must have income below 150 percent of the FPL. **NOTE:** There is no secondary income limit for 1915(k) coverage if an individual is enrolled in a Medicaid category in which coverage for nursing facility services is part of the benefit package.

The last two criteria are of particular importance for CWICs, because earned income can affect whether a person continues to meet the criteria. In regard to the second criteria, the earlier sections in this unit explain how earnings affect various Medicaid eligibility groups. CWICs must be prepared to help beneficiaries explore other Medicaid eligibility groups that they could use, if needed. As noted under the 1915(i) explanation, the third criterion is a new concept in the world of Medicaid. Up to this point, a specific set of services hasn't had an income limit tied to it. But, for a beneficiary to become eligible for and maintain 1915(k) services, he or she must also meet the third criteria. When determining if a person's income is above or below that limit, the state will use the income deductions allowed under the Medicaid eligibility group they are using.

Medicaid and Other Health Insurance

Many beneficiaries have concerns that when they become eligible for Medicare or an employer-sponsored health insurance plan, they will lose eligibility for Medicaid; however, there are many options for individuals to maintain Medicaid and other insurance. Since it is a financial needs-based program, Medicaid is a payer of last resort. As a result, it encourages beneficiaries to pursue other health insurance options. By accessing other health insurance, Medicaid can save money, because the other insurance becomes the primary payer. Some states will require a Medicaid beneficiary to take Medicare if he or she is eligible. If his or her employer or a family member's employer offers the beneficiary "cost-effective" employer-sponsored health insurance, the state may require the beneficiary to take the coverage, and in return, the state will pay the premium. When a beneficiary becomes eligible for new health care coverage, it's important to remind the beneficiary to report this option to his or her Medicaid eligibility worker to clarify his or her options and responsibilities.

Medicaid and Medicare

A number of the beneficiaries a CWIC works with will be concurrent beneficiaries who receive both SSI and Title II disability benefits. In most states, these beneficiaries will eventually be eligible for both Medicare and Medicaid. When a person is eligible for both Medicare and Medicaid, he or she is "dually eligible" in regard to their health insurance. It's also possible that a Title II disability beneficiary can have too much income for SSI but could be eligible for Medicaid through a Medicaid eligibility group that has a higher unearned income limit (e.g., Medicaid Buy-In, HCBS waiver, Medically Needy). When this happens, the person will be eligible for both Medicare and Medicaid. When a Medicaid beneficiary has or can get Medicare, most state Medicaid agencies will require the beneficiary to enroll in the Medicare program. CWICs should research details about this requirement in their state's Medicaid policy manual. When a beneficiary has both Medicare and Medicaid coverage, Medicare always pays first, and Medicaid pays second. Dually eligible individuals often receive assistance with Medicare expenses including premiums, cost sharing, and deductibles.

Medicaid and Employer-Sponsored Health Insurance

In some states, if a beneficiary can get health insurance through his or her own employer, his or her spouse's employer, or his or her parents' employer, the state requires the beneficiary to take it. When a Medicaid beneficiary becomes eligible to apply for another form of health insurance, the state Medicaid agency usually will require that the beneficiary report this new option to the Medicaid eligibility worker. The Medicaid staff will ask the beneficiaries for details about the health insurance policy (e.g., monthly premium amount, deductible, coverage amount, services covered, etc.). With that information the Medicaid staff will determine if the plan is "cost effective." If it's cost effective, in order to maintain Medicaid, the state may require the beneficiary to take the new health insurance option. Generally, if state Medicaid rules require beneficiaries to take the new option, the state will pay the monthly premium. This is called a Health Insurance Payment (HIP). In many cases, Medicaid will also pay for cost sharing associated with the health insurance, including co-payments and deductibles. If Medicaid doesn't consider the plan cost effective, generally the state won't require the beneficiary to take the new health insurance option. The beneficiary could still choose to take it if he or she wants, but the state generally won't pay the premium.

Introduction to Children's Health Insurance Program (CHIP)

While Social Security beneficiaries returning to work are generally able to continue receiving Medicaid coverage for themselves in most states, what about their children? What if they find a job that pays too much for their children to continue on Medicaid, but the employer doesn't provide health insurance? For these individuals, the Children's Health Insurance Program (CHIP) may provide health care coverage. CHIP provides coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. States and the federal government jointly fund the program.

The Children's Health Insurance Program (CHIP) serves uninsured children up to age 19 in families with incomes too high to qualify them for

Medicaid. States have broad discretion in setting their income eligibility standards, and eligibility varies across states. Forty-nine states and the District of Columbia cover children up to or above 200 percent of the FPL, and 19 of these states offer coverage to children in families with income at 300 percent of the FPL or higher. States have the option to provide continuous eligibility to children who remain eligible for CHIP.

It's important that CWICs understand CHIP, its eligibility criteria, and the covered services so that they can offer accurate information to beneficiaries who may have children using this health insurance coverage. For more information on CHIP, visit:
<https://www.medicaid.gov/CHIP/index.html>

IMPORTANT NOTE: The CHIP Program is based on legislation that Congress must re-authorize on a periodic basis. In February 2009, President Obama signed the Children Health Insurance Program Reauthorization Act of 2009, extending CHIP through 2013. The Affordable Care Act (ACA) extended CHIP an additional two years through 2015. In 2015, the law was reauthorized again. Among many provisions, the law extended the authorization of the federal CHIP program for an additional two years, through September 30, 2017. As of this writing, the CHIP legislation had not been re-authorized. While the CHIP legislation expired in September 2017, the legislation financed services until September 2019. Congressional action is required for CHIP to continue. For more information about the re-authorization process, refer to the National Conference of State Legislatures web site at:
<http://www.ncsl.org/research/health/childrens-health-insurance-program-overview.aspx>

Appealing Medicaid Decisions

Under federal Medicaid law, a Medicaid applicant or recipient is entitled to an administrative hearing after any decision that affects his or her right to Medicaid or to any service for which he or she is seeking Medicaid funding. This is known as a “fair hearing” and is available in all states.

A person whose Medicaid benefits or right to services funded by Medicaid the state either denies or terminates is entitled to a written notice of that

decision. In most cases, the letter will read: NOTICE OF ACTION. The notice must explain the action the state is taking, the reason for the action, the right to a hearing to appeal the decision, and the availability of free services from a legal services, legal aid, or similar program (such as a Protection & Advocacy program). States may establish their own time limits for requesting hearings. Typically, states will permit the Medicaid recipient a time limit (to 60 days) for requesting the hearing. However, if the notice indicates that the state will terminate an ongoing benefit, such as funding for home health care services, on a certain date, the recipient will need to request the hearing before the termination date if he or she will request continued services pending the appeal. Federal Medicaid law provides that state continue benefits pending the appeal (a concept often referred to as “aid continuing”) if the beneficiary requests a hearing before the effective termination date and the recipient (or advocate working on his or her behalf) specifically requests the continuation of benefits.

Conducting Independent Research

1619(b) Chartered Thresholds:

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302200!opendocument>

Social Security’s Program Operations Manual section on Special Medicaid Beneficiaries:

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0501715015>

Additional Resources

A handout CWICs may use to help explain 1619(b) titled “What will Happen to My Medicaid When I go to Work” is attached on the following page. CWICs may personalize this handout by adding their State Threshold figure.

What Will Happen to my Medicaid When I go to Work?

Continued Medicaid Eligibility - Section 1619(b)

This incentive continues Medicaid coverage for most working SSI beneficiaries even after earnings become too high to allow a cash benefit. To qualify for this incentive the person must:

- Have been eligible for SSI cash payment for a least one month.
- Still meet the disability requirement.
- Meet the Medicaid "needs" test.
- Have GROSS annual earned income less than the current state "threshold amount" (enter amount here).
- Have countable unearned income of less than the current FBR and resources under the current limit for SSI recipients.

What does the 1619(b) provision do?

- Enables people who are ineligible for continued Medicaid coverage because earnings exceed the threshold amount to get SSI cash payments again if earnings fall below the break-even point within 12 months.
- Allows people who are ineligible for continued Medicaid coverage because earnings exceed the threshold amount to regain Medicaid eligibility if earnings drop below the threshold amount within 12 months.
- Allow eligible 1619(b) recipients to get SSI cash payments at any time earnings fall below the break-even point.
- Enables people to maintain eligibility for SSI cash payments or continued Medicaid coverage after a period of ineligibility without filing a new application.

Competency Unit 2 – Understanding Medicare

What is Medicare?

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65, and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care. A portion of the Federal Insurance Contributions Act (FICA) taxes that workers and their employers pay finances the Medicare program. It's also financed in part by monthly premiums that beneficiaries pay. The Centers for Medicare and Medicaid Services (CMS) is the federal agency in charge of the Medicare program. However, the Social Security Administration determines who is eligible for Medicare, enrolls people in the program, and disseminates general Medicare information.

Medicare Versus Medicaid

Many people think that Medicaid and Medicare are two different names for the same program. Actually, they are two very different programs. Medicaid is a state-run program designed primarily to help those with low income and few resources. Medicare, by comparison, is an entitlement earned by someone who has paid into the Medicare trust fund through taxes on earned income; it's not needs based. The federal government helps pay for Medicaid, but each state has its own rules about who is eligible and what is covered under Medicaid. In contrast, original Medicare is a federally run program that has the same eligibility standards and coverage rules across all 50 states. Medicaid coverage is typically free (with some exceptions in some states), while Medicare coverage involves premiums, co-payments, and deductibles. Some people receive both Medicaid and Medicare. CMS refers to these people as "dual eligible." Unit 1 of this module offers in-depth explanations of the various Medicaid programs available to individuals with disabilities.

Medicare Basics

There are three core parts to Medicare: Parts A, B, and D. Medicare Part A (hospital insurance) and Part B (supplemental medical insurance) were the original parts to Medicare; as a result, they are referred to as “Original Medicare.” Medicare Part D (prescription coverage) was established in 2006. You may be wondering, “What about Part C?” Part C is a way for beneficiaries to get their Part A and B benefits, and even Part D, through a private health insurance company.

This unit will provide details about each part of Medicare, but keep in mind CWICs aren’t expected to be experts on what Medicare does or doesn’t cover. When beneficiaries have questions about Medicare coverage, CWICs should refer them to the State Health Insurance Assistance Program (SHIP). SHIP is a national program that offers one-on-one counseling and assistance to people with Medicare and their families. Through federal grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face meetings. SHIP counselors may be paid employees or volunteers and complete a thorough training process to help address a number of Medicare coverage questions. Details about SHIPs are provided further on in this unit.

NOTE: The annual CMS publication “Medicare and You” provides an easy-to-understand overview of the parts of Medicare. This publication is an invaluable reference guide for CWICs on Medicare program rules. You can ask Medicare to mail you a copy by calling 1-800-MEDICARE or download it at:
<https://www.medicare.gov/medicare-and-you/medicare-and-you.html>

The following chart outlines the parts of Medicare:

Medicare Part	Overview	Out of Pocket Expenses
Part A: Hospital Insurance (HI)	Inpatient hospital care Post-acute rehabilitation	Deductibles, plus co-insurance based on length of stay

Medicare Part	Overview	Out of Pocket Expenses
Part B Supplemental Medical Insurance (SMI)	Doctor’s services and outpatient care	Monthly premiums, plus typically 20% of approved customary outpatient charges after an annual deductible
Part D Prescription Drug Coverage	Prescription drug costs	Varies by Part D Plan, usually has monthly premiums, deductible, co-pays, and coinsurance

Medicare Part A

Medicare “Part A” (also known as Hospital Insurance or HI) helps pay for care in a hospital and skilled nursing facility, home health care, and hospice care. When a Title II disability beneficiary becomes eligible for Medicare, he or she is automatically enrolled in Medicare Part A. Part A hospital insurance is premium-free for these individuals and isn’t optional. Social Security beneficiaries who are eligible for Medicare Part A don’t have the option of declining participation. Social Security manages the enrollment process for Part A. While there is no Part A monthly premium for Title II disability beneficiaries, there are deductibles and co-insurance. Details of the Part A deductibles and co-insurance can be found at the following Medicare website: <https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>

Under the original Medicare model, to use Part A the beneficiary locates a medical provider that accepts Medicare and receives medical services from that provider; then, the provider bills Medicare (generally a contractor of Medicare who processes claims and payments) to cover what is allowable within Medicare rules.

Medicare Part B

Medicare “Part B” (also known as Supplemental Medical Insurance or SMI) helps pay for doctors, outpatient hospital care, and other medical services. Anyone who is eligible for premium-free Medicare hospital insurance (Part A) can also enroll in Medicare supplemental medical insurance (Part B). When a Title II disability beneficiary becomes eligible for Medicare, he or she is automatically enrolled in Part B. Social Security manages the enrollment process for Part B. The standard monthly premium for Part B was \$134.00/month in 2017. If a beneficiary’s yearly income were more than \$85,000 (\$170,000 for a couple), he or she would have a higher premium. Social Security generally deducts the Part B premium from the beneficiary’s Title II benefit. Part B also has an annual deductible of \$183 (in 2017) and co-insurance of approximately 20 percent. The 2018 Medicare premiums and other out-of-pocket costs were not published in time for inclusion in the 2018 WIPA Training Manual. However, CMS posts these figures on the Medicare website as soon as they are announced. Details of the Part B premium, deductible, and co-insurance can be found at the following Medicare website: <https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>

Beneficiaries do have the choice to opt out of Part B, but it’s important they understand the consequences of that decision. Beneficiaries who decline Part B may have to pay a premium penalty (a higher monthly premium) if they decide to enroll in Part B later on. The monthly Part B premium will increase 10 percent for each full 12-month period the beneficiary could have had Part B but didn’t sign up for it. There is no premium penalty for any month the beneficiary had employer-sponsored health insurance (through their own employer or their spouse’s employer). Months of coverage under COBRA don’t qualify as coverage under an employer-sponsored health plan.

Information will be provided further on in this unit about financial assistance called Medicare Savings Programs (MSPs) that can help pay the Part B premium and other Medicare out-of-pocket costs. Some beneficiaries say they don’t want to enroll in Part B because they feel they can’t afford it. When this happens, CWICs should provide information about the Medicare Savings Programs and refer the person to a SHIP counselor to talk through their options. If a beneficiary is subject

to a higher Part B premium because of the premium penalty, it's possible to eliminate the penalty if the beneficiary is found eligible for a new period of Medicare entitlement (such as when turning 65) or if the state finds him or her eligible for the Medicare Savings Program. Just as with Part A, to use Medicare Part B under the original model, the beneficiary locates a medical provider that accepts Medicare and receives medical services from that provider; then the provider bills Medicare (generally a contractor of Medicare who processes claims and payments) to cover what is allowable within Medicare rules.

Medicare Part D

Medicare Part D is the newest part of Medicare; it helps pay the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006. Anyone who is enrolled in Medicare Part A or Part B can also enroll in Part D. Unlike with Parts A and B, Social Security doesn't process Part D enrollments. Beneficiaries must enroll directly with a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Plan (Part C – described later). Private insurance companies that contract with CMS to participate in the Medicare Part D program develop and operate the prescription drug plans. Depending on the Prescription Drug Plan, beneficiaries may have a monthly premium, an annual deductible (no more than \$405 a year in 2018), and co-insurance payments.

With regard to the premium, beneficiaries who opt out of Part D may have to pay a premium penalty (a higher monthly penalty) if they decide to enroll in Part D later. A premium penalty would be due if the beneficiary goes for a continuous period of 63 days or longer without "creditable coverage". The monthly Part D premium would increase 1 percent of the "national base beneficiary premium" times the number of full, uncovered months the beneficiary could have had Part D but chose not to enroll. Months the beneficiary had creditable coverage won't count in calculating the penalty. There is a financial assistance program, Low Income Subsidy (also known as Extra Help), which can help pay the Part D premium. That program will be discussed later in this unit.

For more information about what CMS considers to be “creditable coverage”, refer to <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index.html?redirect=/creditablecoverage/>

For more information about the Medicare premium penalty and ways to avoid incurring this cost, refer to the Medicare website here: <https://www.medicare.gov/part-d/costs/penalty/ways-to-avoid-part-d-late-enrollment-penalty.html>

A PDP could have a deductible and three phases of coinsurance:

- **Deductible:** No more than \$405 a year in 2018
- **Phase 1 - Initial Coverage:** A beneficiary could be charged up to a 25 percent co-insurance. This phase ends when the beneficiary and his or her drug plan pay \$\$3,750 in drug costs in 2018.
- **Phase 2 - Coverage Gap:** If a plan has a coverage gap, the beneficiary will pay 35 percent for brand-name drugs and 44 percent for generic drugs in 2018. The coverage gap used to be called the “donut hole” because beneficiaries, historically, had to pay 100 percent of their drug costs. Under the Affordable Care Act (ACA) the coverage gap is phasing out. By 2020 the beneficiary’s co-insurance will reduce to 25 percent for generic and brand names, until he or she reaches catastrophic coverage level.
- **Phase 3 - Catastrophic Coverage:** After a beneficiary has paid \$5,000(2018) in drug costs, he or she moves into this catastrophic coverage. Once a beneficiary moves into catastrophic coverage, he or she only pays a small coinsurance amount or copayment for covered drugs for the rest of the year.

Beneficiaries who are eligible for the Low income Subsidy (LIS) program will receive financial help to pay these Part D out-of-pocket expenses. Details about when the coverage gap begins and ends can be found at the following Medicare website at: <https://www.medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html>

CWICs should refer beneficiaries to SHIP if they are thinking about declining Part D or need help choosing a plan. States will automatically enroll beneficiaries who are eligible for Medicaid into a Part D plan when Medicare begins, unless they choose a plan themselves.

Medicare Advantage Plans (Part C)

Part C of Medicare is also known as Medicare Advantage (MA). MA Plans provide an option for Medicare beneficiaries to get their Medicare Part A and Part B services, and in some cases, Part D, through a private health plan. These health plan options are part of the federal Medicare program, but private insurance companies operate them. A wide range of MA plans are available in many areas of the country. Different MA plans cover different services, and costs for these plans also vary widely. Individuals who join one of these plans generally get all of their Medicare-covered health care through that plan, and coverage can include prescription drug coverage.

Medicare Advantage Plans include:

- Medicare Health Maintenance Organization (HMOs)
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service Plans
- Medicare Special Needs Plans

Individuals who join a Medicare Advantage Plan use the health insurance card that they receive from the plan for all health care items or services. In many of these plans, there are extra benefits and lower co-payments than in the Original Medicare Plan. However, some individuals may have to see doctors that belong to the plan or go to certain hospitals to get services.

To join a Medicare Advantage Plan, individuals must have both Medicare Part A and Part B. In addition to the regular Part B premium, participants in some Medicare Advantage Plans might have to pay an additional monthly premium to their Medicare Advantage Plan for the extra benefits that their plan offers. Individuals who join a Medicare Advantage Plan don't need a Medigap policy (described below), because Medigap plans

won't pay any deductibles, co-payments, or other cost-sharing under a Medicare Advantage Health Plan. Therefore, individuals who decide to join a Medicare Advantage Plan may want to drop Medigap policies.

Medicare Advantage plans often offer extra benefits that people enrolled in the Original Medicare Plan don't receive. CMS assesses the quality of services provided through Part C plans using a "star rating system" that can assist individuals in evaluating different plans. More information on plans, services, and ratings is available at: <http://www.medicare.gov>

Medicare Supplements or Medigap Plans

Although Medicare is a valuable resource, it doesn't cover all medical items or services an individual might need. In addition, because Medicare involves deductibles and coinsurance payments, some people end up with large out-of-pocket expenses. Medicare supplemental insurance policies, also called "Medigap Plans," may help fill gaps in services and cover certain out-of-pocket expenses. These are private insurance policies that are optional for Medicare beneficiaries to purchase but are mandated to exist in each state. A wide array of plans is available, and plans vary significantly in the amount of coverage they provide and how much they cost. Insurance companies can only sell "standardized" Medigap policies, which are required to provide specific benefits so that individuals can compare them easily. It's important to compare Medigap policies, because costs and coverage can vary significantly.

If a beneficiary has Medicaid, generally the insurance companies are prohibited from selling the individual a Medigap plan. This is because Medicaid will act as a secondary insurance to Medicare and cover the types of costs Medigap would normally cover. Another consideration is that Medicare beneficiaries may also reduce their out-of-pocket costs by enrolling in a Medicare Advantage Plan. For some beneficiaries, this may be a better option than purchasing a Medigap policy, depending on their specific health care needs.

Beneficiaries can go to www.medicare.gov to find interactive electronic tools that compare various Medicare and Medigap plans. CWICs can also refer beneficiaries to a SHIP counselor for help deciding whether a Medigap plan would be useful. For additional information on Medigap policies, including how to decide if a Medigap policy makes sense, and

what Medigap policies cover, CWICs are advised to read the publication titled "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," which can be found online at:

https://www.medicare.gov/pubs/pdf/02110-medicare-medigap_guide.pdf

Medicare Eligibility

These specific groups of people are eligible for Medicare:

- Individuals age 65 and older who are insured for retirement benefits under Social Security, either through their own work or through a spouse's work.
- Individuals receiving Social Security Disability Insurance (SSDI) who have met the 24-month qualifying period for Medicare.
- Individuals receiving benefits as a Childhood Disability Beneficiary (CDB) who have met the 24-month qualifying period.
- Individuals who meet the Social Security disability standards and who are either entitled to Disabled Widow(er)s benefits (DWB) or Medicare on a deceased worker's record and who have met the 24-month qualifying period.
- Individuals who lost Title II disability benefits due to work and are in the Extended Period of Medicare Coverage (EPMC).
- Individuals with disabilities who have exhausted their Extended Period of Medicare Coverage (EPMC) and are eligible to purchase Medicare Parts A, B, and D coverage through Premium-HI for the Working Disabled.
- Individuals who have End-Stage Renal Disease (ESRD) who have been receiving dialysis for three months, or who have been performing self-dialysis for one month, or who have received a kidney transplant. Note that people receiving Medicare under the End Stage Renal Disease (ESRD) provisions don't have to meet a 24-month qualifying period.

- Government employees who paid Medicare taxes and meet any of these above categories.
- People who are age 65 or older, aren't insured for Social Security retirement benefits, and pay a premium for Part A as well as the other parts of Medicare.

The majority of the beneficiaries WIPA projects serve are eligible for Medicare based on their entitlement to a Title II disability benefit (SSDI, CDB, or DWB). There are two other ways to get Medicare that CWICs may run across: Medicare for People with End Stage Renal Disease and Medicare Qualified Government Employees.

Medicare for People with End Stage Renal Disease (ESRD)

ESRD is a condition of the kidneys caused by many factors that require dialysis or a kidney transplant. It's possible for a person to become eligible for Medicare based on having this diagnosis if he or she meets other criteria, including:

- Has been receiving dialysis for three months, or has been performing self-dialysis for one month, or has received a kidney transplant; and
- Is entitled to a monthly benefit under Title II or the Railroad Retirement Act, or is fully or currently insured, or has a spouse or is a dependent child of person who is entitled to a monthly benefit or is fully or currently insured.

To access Medicare based on the ESRD diagnosis, the person doesn't need to receive a cash benefit from Social Security, meet the Social Security disability definition, or be a certain age. As a result, the requirements for establishing insured status for ESRD Medicare are much easier to meet than the requirements for cash disability benefits.

ESRD Medicare also has different rules for when the coverage begins and when it ends. ESRD Medicare usually begins with the third month after dialysis begins. Coverage can begin earlier if the person self-administers dialysis or was previously entitled to Medicare under the ESRD provisions. Coverage ends 12 months after dialysis stops or 36 months after a

successful transplant. An important point for CWICs to know is that work activity doesn't affect a person's ongoing eligibility for ESRD Medicare.

For more detailed information on ESRD coverage, refer to Medicare Coverage of Kidney Dialysis & Kidney Transplant Services published by CMS, which can be found online at:

<https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf>

Medicare Qualified Government Employees (MQGE)

Medicare Qualified Government Employees (MQGEs) are people who worked and paid taxes into the Medicare trust fund, but didn't pay taxes into the Social Security trust fund. Medicare benefits for these individuals follow all of the same disability benefit rules that apply to benefits for people who paid Social Security taxes. For example, these individuals must wait 29 full calendar months from their disability onset date to become eligible for Medicare. This represents the five full months of the benefit waiting period plus the 24-month Medicare Qualifying Period (MQP). In addition, certain dependents may become entitled on MQGE work records. These dependents don't receive cash payments, but if they meet the appropriate requirements for Medicare coverage, they may receive Medicare. People who receive Medicare coverage under the MQGE can continue this coverage if they pass medical reviews and pay the Medicare premiums.

Unlike ESRD Medicare, work can affect Medicare eligibility for a MQGE. When the beneficiary's Medicare entitlement begins, he or she is given a 9-month Trial Work Period (TWP). During the TWP the beneficiary keeps Medicare regardless of the amount he or she earns. After the TWP, if the beneficiary's countable earnings are below the Substantial Gainful Activity (SGA) level, Medicare eligibility simply continues. If Social Security determines that the beneficiary is performing SGA, the Extended Period of Medicare Coverage (EPMC) extends the MQGE Medicare eligibility as it would for someone receiving SSDI payments. The EPMC is a work incentive that we will explain later in this unit.

Medicare Qualifying Period

The Medicare Qualifying Period (MQP) is different from the five-month Social Security disability benefit waiting period. The 24-month MQP begins with the first month the person is entitled to a payment after the five-month waiting period. Medicare coverage generally begins the first day of the 25th month of Title II disability benefit entitlement, with a few exceptions.

Example of a Qualifying Period for a SSDI beneficiary:

Denny had a spinal cord injury on November 10, 2015. Because the disability waiting period must be full calendar months, Denny's five-month disability waiting period for SSDI was December 2015 through April 2016. His entitlement to SSDI began May 2016. Medicare coverage and entitlement begin for Denny on May 1, 2018, provided that Denny still has a disability that meets the Social Security rules.

When Social Security approves a beneficiary's disability benefit years after applying, it's possible that an individual may have met all or part of the 24-month qualifying period by the time cash benefits start being paid.

Example of a Qualifying Period for a SSDI beneficiary: Frieda received the approval letter for her Social Security disability benefits in December 2017, after appealing her initial denial. The Disability Determination Service in the state where she lived determined that Frieda became disabled on March 15, 2015. Frieda's five-month disability waiting period was April through August 2015. As a result, her first month of entitlement was September 2015. Even though Frieda didn't receive cash payments until January 2017, the Medicare qualifying period began in September 2015, her first month of entitlement to payments. Frieda will be due Medicare coverage effective September 1, 2017, the first day of the 25th month after her entitlement to SSDI began.

The 24-month qualifying period doesn't have to be served consecutively. If Social Security terminates an individual's entitlement to cash benefits and re-entitles him or her within five years of the termination, the earlier months of entitlement may fully or partially meet the qualifying period for

Medicare entitlement. If the disability is the same as or related to that of the earlier entitlement, it's possible that the time period for re-entitlement without a new qualifying period could be indefinite.

Example of earlier entitlement helping to meet qualifying period:

Dorothy developed breast cancer and was entitled to Social Security Disability Insurance. Her date of onset was April 15, 2017. Her five-month disability waiting period was May through September 2017, and she became entitled to SSDI beginning in October 2017. In September 2018 Dorothy's cancer was in complete remission, and she reported medical improvement. Social security terminated her benefits in October 2018. At that point she had served 12 months of her Medicare Qualifying Period. If Dorothy becomes entitled to disability payments again within five years from the date Social Security terminated her benefits, she would only need to serve the last 12 months of the qualifying period for her Medicare coverage to begin.

Example of individual with same disability becoming re-entitled to benefits:

Frances was born with a severe physical disability. When she was 25, she became entitled to SSDI. She received benefits for five years, before working off of benefits in January 2011. In May 2018, Frances became re-entitled to SSDI based on the same disability. Because Frances was entitled to SSDI under the same disability, she didn't have to again meet the 24-month Medicare Qualifying Period.

Beneficiaries continue to serve the MQP even when the beneficiary isn't in cash payment status due to SGA level earnings during the Extended Period of Eligibility (EPE). There is a common misperception that if cash payments cease, beneficiaries also stop serving the MQP. In fact, there is no relationship between receipt of cash payments during the EPE and serving MQP months.

Example of qualifying period and the EPE:

Gary became disabled on January 1, 2016 due to an auto accident. Gary's disability is permanent. His waiting period for SSDI benefits was January through May 2016. He became entitled to SSDI effective with the month of June 2016. In July 2017, Gary returned

to work. He wasn't performing SGA, but worked steadily. In October 2017, Gary received a raise and an increase in his hours, making his earnings substantial. His Trial Work Period ended January 2018, and his cash benefits stopped after his Grace Period (February 2018 – April 2018) due to SGA. Although Gary wasn't due payments effective May 2018, his MQP was still running. His Medicare coverage began effective June 2018.

Medicare Qualifying Period for Childhood Disability Beneficiaries (CDB)

A Childhood Disability Beneficiary (CDB) can't meet the MQP before his or her 20th birthday. Remember, the earliest CDB eligibility can begin is the month of the individual's 18th birthday. That means the 24-month MQP clock can't begin ticking until the month of the 18th birthday, at the earliest. As a result, the soonest the 24 month MQP could end for a Childhood Disability Beneficiary is the 20th birthday. Individuals who lose entitlement to CDB and whom Social Security re-entitles to CDB later won't have to serve another 24-month qualifying period if the re-entitlement occurs within seven years.

Example of qualifying period for CDBs:

Michael has been disabled since birth. He turned 18 in January 2016. He was entitled to regular child's benefits until December 2015, and became entitled to CDB benefits in January 2016. Even though Michael had a disability that began earlier, the qualifying period can't begin until the month he turned 18. Michael will receive Medicare coverage in January 2018. (Note: There is never a five-month waiting period for CDB benefits.)

Medicare Qualifying Period for Disabled Widow(er)s Benefits (DWB)

Disabled Widow(er) Beneficiaries may meet the MQP through current entitlement to DWB benefits, or they may meet the MQP with prior entitlement to SSI benefits. People who receive DWB may continue to receive Medicare based on DWB eligibility, even if they are entitled to a different type of Title II cash benefit, such as early retirement, that doesn't provide Medicare eligibility.

When a current or former SSI recipient becomes entitled (or deemed entitled for Medicare purposes only) to DWB, the DWB will receive credit toward the 24-month MQP for all months in an SSI period of eligibility beginning with the first month for which the individual received any payment up to the month of (deemed) DWB entitlement. All months count, including months of nonpayment, suspension, and termination. The same months of SSI/SSP that Social Security credits toward the five-month DWB waiting period the agency may also credit toward the 24-month MQP.

Example of qualifying period for DWB with no prior SSI entitlement:

Marge had a spinal cord injury on May 5, 2016. Marge became entitled to DWB benefits in November 2016, after serving her five-month disability waiting period. Marge's Medicare began in November 2018.

Example of qualifying period for DWB with prior SSI entitlement:

Linda received SSI for several years then her ex-husband died in May 2017. Social Security used her prior SSI entitlement to meet the qualifying period for Medicare. Linda's Medicare coverage began in May 2017.

Example of qualifying period with DWB Medicare and Child-in-Care or Mother's benefits:

Jane was 58 when her husband died in February 2016. Their youngest child was 15. Although Jane had a disability, it was financially to her advantage to receive benefits as a mother of a child under age 16, called Mother's benefits or "Child-in-Care" benefits. Jane applied for Child-in-Care benefits and for Medicare under DWB. Even though Jane wasn't previously entitled to Social Security benefits, Social Security was able to establish that her disability began nine months prior to application. Thus, Jane served her five-month waiting period prior to applying for both Mother's and DWB benefits. Even though the disability began in the past, her cash benefits couldn't be retroactive, since the month her husband died was the first possible month of payment for this benefit. Her MQP began with the first month of entitlement to

Mother's benefits, and her Medicare became effective two years later, in February 2018.

Exceptions to the Medicare Qualifying Period (MQP)

Individuals who become entitled to Title II disability benefits must complete the MQP before Medicare coverage may begin. There are some specific exceptions to this general rule, especially for people who were on disability benefits at some point in the past and subsequently Social Security re-entitled to benefits.

The 1980 Amendments to the Social Security Act made some important changes to the MQP rules. Beginning with December 1980, Social Security may count months from previous periods of disability benefit entitlement in determining when beneficiaries meet the 24-month MQP requirement under certain circumstances. This exception applies when one of the following situations occurs:

- A prior period of DIB entitlement ended no more than five years (60 months) before the month of current disability onset. This means that if an individual terminated from DI benefits no more than five years ago, and is now re-entitled to benefits, he or she can apply whatever months he or she served of the MQP from the previous period of entitlement to the current period of entitlement. For many people, that means they have already served the MQP, and Medicare can start right away.
- A prior period of DWB or CDB entitlement ended no more than seven years (84 months) before the month of current disability onset. Again, this exception allows these individuals to apply any MQP months they served under the prior period of entitlement to the current period of entitlement. In many cases, the individuals will have served the full MQP in the past, and Medicare may begin immediately upon re-entitlement to benefits.
- The current disabling impairment is the same as, or directly related to, the impairment that served as the basis for disability during a previous period of disability benefit entitlement. This exception only applies to individuals whose prior period of entitlement ended after February 29, 1988.

- An individual whose previous disability entitlement ended for non-disability reasons prior to March 1, 1988 and is re-entitled to disability benefits with the same disability onset date. If the individual's previous period of entitlement ended after February 29, 1988, prior months of entitlement may count under the preceding rule.

This information can be found at POMS HI 00801.152 - Counting Months in Reentitlement Cases. This citation also gives some good examples that make these situations a little easier to understand. This citation is available online at:

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801152>

There are also some additional circumstances when the MQP is either waived entirely or shortened for people who haven't had a previous period of entitlement:

- Individuals with End Stage Renal Disease (ESRD) can apply for and receive Medicare coverage without waiting for a full disability review and entitlement to cash payments. This Medicare eligibility group is specifically designed for people with ESRD and has its own set of rules.
- Public Law 106-554 amended section 226 of the Social Security Act to waive the 24-month waiting period for Medicare coverage for disabled individuals medically determined to have Amyotrophic Lateral Sclerosis (ALS), better known as Lou Gehrig's disease. The date of Medicare entitlement is the date of entitlement to DIB, DWB, or CDB based on a diagnosis of ALS, or July 1, 2001, whichever is later. This provision affects both new and current beneficiaries.
- When a current or former SSI recipient becomes entitled (or deemed entitled for Medicare purposes only) to DWB, the DWB will receive credit toward the 24-month MQP for all months in an SSI period of eligibility beginning with the first month for which the individual received any payment up to the month of (deemed) DWB entitlement. All months count, including months of nonpayment, suspension, and termination. The same months of SSI/SSP that Social Security credits toward the five-month DWB waiting period the agency may also credit toward the 24-month MQP.

WARNING: There are some intricate Medicare rules for DWBs that aren't described in this unit because they are relatively obscure. Remember, CWICs should always verify exactly what type of Title II disability benefits a person is receiving. When CWICs encounter DWBs with Medicare issues, they should contact their VCU NTDC Technical Assistance Liaison for assistance.

Medicare Enrollment Periods

Eligible individuals may enroll in Medicare only at specific times. The Initial Enrollment Period (IEP) occurs when people first become eligible for Medicare. The General Enrollment Period (GEP) occurs annually, and a Special Enrollment Period (SEP) is provided to eligible individuals when certain changes occur with other health coverage. States automatically enroll Social Security disability beneficiaries in Medicare Parts A and B when they first become eligible for Medicare, except for residents of Puerto Rico and foreign countries.

Initial Enrollment Program (IEP)

The initial enrollment period is the first opportunity a person has to enroll in Medicare based on disability benefits or attainment of age 65. It's a seven-month period beginning three months before the first month of potential Medicare coverage and ending three months following that month. CMS sends out a Medicare card automatically. If an individual wants both parts of Medicare, he or she need only keep the card and Medicare Parts A and B coverage will begin automatically. If a person doesn't want Medicare Part B, the individual returns the signed card to the sender. Returning the card indicates refusal of Part B coverage. During this time, an individual can choose to enroll in a Medicare Advantage Plan (Part C) and a Prescription Drug Plan (Part D).

General Enrollment Period (GEP) or Open Enrollment Period

Each calendar year eligible individuals who don't have Medicare Part A or B may enroll during the General Enrollment Period (GEP). The GEP lasts from January 1 through March 31 of each year. When people enroll during the GEP, Medicare coverage begins the first day of July of the year

in which the beneficiary made the request. Remember, if more than 12 months have elapsed between the time the person first could have received Medicare Part B and the time the beneficiary actually enrolls, the premium may be higher. For Medicare Parts C and D, an Open Enrollment Period occurs October 15 through December 7. And as with Part B, if a beneficiary doesn't opt to enroll in Part D when he or she is first eligible, he or she could have a higher premium if he or she enrolls in Part D during this period.

Special Enrollment Period (SEP)

Once a beneficiary's Initial Enrollment Period ends, he or she may have the chance to sign up for Medicare during a Special Enrollment Period (SEP). The SEP allows certain individuals to sign up for Part A and/or Part B at any time as long as they meet certain criteria.

To be eligible for a Special Enrollment Period, the individual must be enrolled in a group health plan (GHP) or large group health plan (LGHP) based on employment (the individual's employment or the employment of a spouse). Individuals also have an 8-month SEP to sign up for Part A and/or Part B that starts at the earliest of these times:

- The month after the employment ends, or
- The month after group health plan insurance based on current employment ends.

In most cases, individuals who enroll in Medicare during an SEP do not have to pay a premium surcharge.

The SEP for Part C and D involves a different set of circumstances. The list of circumstances can be found in the CMS Publication "Understanding Medicare Part C and D Enrollment Periods" which can be found online at: <https://www.medicare.gov/Pubs/pdf/11219-Understanding-Medicare-Part-C-D.pdf>

Annual Coordinated Election Period

Medicare uses an additional annual election period for changes to Medicare Part D and Medicare Part C (Medicare Advantage plans). This is called the Annual Coordinated Election Period (ACEP). During the ACEP, Medicare beneficiaries may change prescription drug plans, change Medicare Advantage plans, return to original Medicare, or enroll in a

Medicare Advantage plan for the first time. Starting in the fall of 2011, the ACEP each year will last from October 15 through December 7.

NOTE: If a beneficiary has Medicare and Medicaid, or is enrolled in the Part D Low-Income Subsidy Program (also known as “Extra Help”), he or she can join, switch, or drop a Medicare Advantage plan or a Medicare Part D plan at any time. More information about the Low- Income Subsidy Program is provided later in this unit.

Medicare Work Incentives and When Medicare Ends

Medicare entitlement for individuals with disabilities begins when the MQP is over. This is generally the first day of the 25th month of entitlement to cash benefits. That is the first month for which medical services providers can bill Medicare. Medicare offers no retroactivity of coverage, which means that beneficiaries can’t use Medicare to cover medical bills they incur prior to the initial month of coverage.

When Medicare Ends

Medicare coverage will stop if an individual ceases to meet the Social Security disability standard. In most cases, the earliest Medicare coverage can stop is the month after the month the person receives the notice that Social Security has terminated his or her disability benefits. There is no retroactivity to the Medicare termination. Medicare coverage will also end if a beneficiary fails to pay premiums.

When Title II disability beneficiaries turn 65 years of age, the Medicare entitlement based on disability ends and Medicare eligibility based on age begins. There is no break in coverage, and beneficiaries don’t have to re-enroll in Medicare. If the beneficiary had any premium penalties, those wouldn’t carry into this new period of entitlement. Medicare entitlement based on age isn’t affected by employment.

Medicare and Work

Beneficiaries of the Title II disability programs often believe that Medicare entitlement stops when cash payments stop. In fact, there are two work

incentives built into the Medicare program that, when combined, permit beneficiaries to retain Medicare for an indefinite period if they continue to have a disability after cash payments stop due to work activity.

The first Medicare work incentive is called Extended Period of Medicare Coverage (EPMC). Provided that the disabling condition continues, individuals who lose cash payments due to SGA-level work can use EPMC to retain premium-free Medicare Part A, as well as the option to have Part B, Part C, and Part D coverage, for at least 93 months after the end of the Trial Work Period. In many cases, the period will be longer.

Once beneficiaries exhaust the EPMC, they may continue Medicare coverage through the second work incentive, Premium-HI for the Working Disabled. This second work incentive has no time limit, but the individual must continue to have a disability and must begin paying (or get assistance paying) the Part A premium.

Extended Period of Medicare Coverage (EPMC)

The Ticket to Work and Work Incentives Improvement Act of 1999 made an important change to the Medicare program for working beneficiaries with disabilities. It significantly extended the amount of time beneficiaries who lose entitlement because of substantial work may receive Medicare. The rule, referred to as the Extended Period of Medicare Coverage (EPMC), applies to anyone who currently has Medicare coverage based on disability benefits, provided that the disabling condition continues. Social Security made some additional changes to and clarifications of the EPMC several years after the Ticket legislation passed. The following rules became effective on November 23, 2004:

“If an individual’s entitlement to disability benefits ends because he or she engaged in, or demonstrated the ability to engage in Substantial Gainful Activity after the 36 months following the end of the trial work period, Medicare entitlement continues until the earlier of the following:

- *The last day of the 78th month following the first month of Substantial Gainful Activity occurring after the 15th month of the individual’s re-entitlement period or, if later,*

- *The end of the month following the month the individual's disability benefit entitlement ends."*

Centers for Medicare & Medicaid Services 42 CFR, Part 406, Federal Register: September 24, 2004 (Volume 69, Number 185, Pages 57224-57225).

While this might sound complicated, in practice it's actually fairly straightforward. To begin with, CWICs need to understand that the EPMC involves several key time periods:

- The end of the TWP;
- The first 15 months of the EPE;
- The cessation month; and
- The 78 months of the EPMC.

In the opening paragraph the statement was made that the EPMC provides at least 93 months of coverage after the end of the TWP, and this 93-month figure is derived from the time periods listed above. Historically, Medicare coverage only extended to 15 months of the EPE. Congress has extended this original 15-month rule several times over the years, but because of the way the laws are written, Social Security has to use this original limit when counting months for EPMC purposes. Because of this, under the current EPMC rules, the EPMC period will never begin earlier than the 16th month of the EPE.

The current rules added 78 months of Medicare coverage after this original 15 months for a total of at least 93 months. The 93-months number represents the fewest number of months a person will have Medicare if his or her cash benefit stops due to work and he or she continues to have a disability. The period can be longer (and often is much longer) depending on when the Cessation month occurs.

Cessation prior to 14th month of EPE: If cessation occurs prior to the 14th month of the EPE, there are two possibilities for when the EPMC will end:

1. If SGA also occurs in the 16th month of the EPE, EPMC will end 93 months after the TWP. The beneficiary must continue to have a disability throughout this period.
2. If SGA doesn't also occur in the 16th month of the EPE, EPMC will end 78 months from the first SGA month that occurs after that 16th month. The beneficiary must continue to have a disability throughout this period.

Cessation on or after the 14th month of the EPE: If cessation occurs on or after the 14th month of the EPE, EPMC will end 78 months after the Grace Period. The beneficiary must continue to have a disability throughout this period.

A decision tree is provided at the end of this unit that provides a visual representation of the EPMC process. Additionally, you can refer to the requirements in POMS HI 00820.025 Termination of Disability HI found online at:

<https://secure.ssa.gov/poms.nsf/lnx/0600820025>

Example of EPMC lasting for the minimum of 93 months: Kali goes to work in January 2017. Kali completes his TWP nine months later in September 2017. His cessation month occurs in December 2017, prior to 14th month of the EPE. Kali continues to earn above SGA for the next 10 years. Kali's SSDI benefits terminate after the 36-month EPE, but he has EPMC coverage for 93 months from the end of his TWP.

What would make Kali's Medicare continue past those first 93 months?

- If Kali became entitled to payments again during the EPE, and continued to be due payments indefinitely, his Medicare would also be indefinite.
- If Kali stopped working and requested Expedited Reinstatement, or reapplied for benefits within five years of termination, his Medicare would also last longer than 93 months.

Predicting the exact end of the EPMC is impossible unless three events have occurred:

1. The TWP has ended;
2. Cessation has occurred; and
3. The person is past the 16th month of the EPE.

An important point for CWICs to emphasize is that as long as a beneficiary remains entitled to Title II disability payments, Medicare coverage will continue. If an individual completed his or her TWP and more than 15 months have passed since that time, then Medicare eligibility will continue for at least 78 months after the last cash payment is due.

Examples of EPMC lasting longer than 93 months:

- **Example 1:** Connie started working in March 2016 earning above the Trial Work Period threshold but below SGA. In month 30 of her EPE she began doing SGA-level work. Connie's Medicare will last at least 78 months after the last grace month. If she is re-entitled, however, she will have Medicare as long as she is due a payment, even if it's for the rest of her life.
- **Example 2:** Kelly completed her Trial Work Period in 2001. She has worked since then, but has never performed Substantial Gainful Activity. Kelly will continue to have Medicare as long as she is entitled to a disability payment. When she performs SGA, she would be due payments for her cessation and grace months, and then she would have Medicare at least another 78 months through the EPMC.

Keep in mind that it's impossible to know exactly when a beneficiary's EPMC would end if the beneficiary hasn't yet engaged in SGA. The EPMC months don't begin to count until the TWP is over, SGA work has occurred, and Social Security has established the cessation month.

It's important to understand that the EPMC is a work incentive for Title II disability beneficiaries. It's afforded to individuals who have lost cash benefits due to work. It's NOT a way to keep Medicare when beneficiaries lose benefits due to medical recovery. People in the EPMC must still meet the Social Security disability requirement, even though these individuals may not be due cash payments.

EPMC Complications

When advising beneficiaries about Medicare continuation, remember that Social Security is the only place to find out how long the coverage will last. The beneficiary may not know when or if the TWP ended, whether cessation has occurred, or even that work should have caused benefit termination. Some beneficiaries may have used most or all of their EPMC in the past without even realizing it.

Because performance of Substantial Gainful Activity is so important to the length of time someone has EPMC, CWICs should always remember that SGA is a decision, and work that appears to be SGA may not end up being SGA. For example, someone may begin performing work at a high enough level that, at first, may appear to be SGA. SGA, however, represents sustained work effort valued above a certain amount. Thus, if the work effort is short, and ends because of the person's disability, the person may actually have an Unsuccessful Work Attempt. In these situations, Social Security may go back and reverse the cessation, because the person wasn't performing SGA, which could have a direct effect on calculating the end of the EPMC.

Extended Medicare and Expedited Reinstatement

Because the EPMC is a work incentive, people must still meet the medical disability criteria for Social Security to entitle them. This creates a potential risk for individuals who request Expedited Reinstatement (EXR). There are two standards Social Security uses to determine disability status. One, used for new applications, is tougher because the burden of proof lies with the applicant. The other standard, called the Medical Improvement Review Standard (MIRS), Social Security uses in both medical Continuing Disability Reviews and EXR.

A request to Social Security for Expedited Reinstatement when Social Security has medically denied the beneficiary is the same as the beneficiary having a medical CDR when receiving benefits and Social Security finding that person to have medically improved. When medical improvement occurs, all work incentives, including the EPMC, stop. If losing Medicare is a concern, the person may want to reapply for benefits instead of requesting EXR. Denial of a reapplication wouldn't affect

Medicare entitlement, because the application process uses a different disability standard. The decisions aren't equivalent. For a further discussion of this topic, refer to unit 9 of Module 3.

Medicare Premiums during the EPMC

Under the EPMC provision, Medicare Part A continues to be premium-free, while Medicare Parts B, C, and D continue to have a monthly premium. Beneficiaries usually pay their Medicare Part B premiums by having Social Security deduct them from cash benefits. When no cash benefits are payable, the person receives a bill for Medicare premiums. There are four ways to pay the Medicare bill. The beneficiary can:

1. Pay directly from his or her bank account through the bank's online bill payment service.
2. Sign up for Medicare Easy Pay <https://www.medicare.gov/your-medicare-costs/paying-parts-a-and-b/medicare-easy-pay.html>, which is a free service that automatically deducts the premium payments from the beneficiary's savings or checking account each month.
3. Pay by check or money order to: Medicare Payment Collection Center, P.O. Box 790355, St. Louis, MO, 63179-0355.
4. Pay by credit or debit card by providing account information on the payment coupon on the Medicare bill.

You can read more about the payment options at:

<https://www.medicare.gov/your-medicare-costs/paying-parts-a-and-b/pay-parts-a-and-b-premiums.html>

If a beneficiary has an employer group health plan, or is covered by an employer group health plan from a spouse's work, he or she may wish to opt out of the Medicare Part B coverage until:

- The beneficiary's or spouse's employment stops;
- The beneficiary's or spouse's insurance becomes secondary to Medicare; or,
- The insurance coverage terminates.

In these circumstances, eligible individuals can re-enroll for Medicare Part B coverage during the Special Enrollment Period (SEP). Individuals who are not eligible for the SEP may be subject to a premium surcharge penalty. The beneficiary should check with the employer-sponsored health plan before opting out of Part B, as some plans require a person to keep Part B.

Another common scenario is that the person may be eligible for financial assistance with the Part B premium, such as through a Medicare Savings Program. A person using EPMC to maintain Medicare will have lost the Title II benefit check, which means he or she potentially has countable income low enough to continue getting help through the Medicare Savings Program. In this case, the beneficiary won't have to pay the Part B premium.

CWIC Responsibilities in EPMC Cases

EPMC can be very complex. A CWIC may not have enough information about the person's work history, nor sufficient expertise to determine the exact end of the EPMC. In addition, a CWIC can't predict the future. Will the person again become entitled to benefits? Will there be a decision of medical improvement? Will the individual keep working? The best plan is to stress the positive aspects of the EPMC in general terms. The points CWICs need to make are:

- Medicare will continue for AT LEAST 93 months after the TWP ends no matter how much a beneficiary earns. CWICs should communicate this to beneficiaries who are still within the first 15 months of their EPE.
- Beneficiaries currently entitled to Medicare will have AT LEAST 78 months of Medicare coverage after cash benefits end due to SGA level employment. CWICs should communicate this to beneficiaries who are outside the first 15 months of the EPE and didn't cease during the first 15 months.
- Individuals who work but who never engage in SGA will maintain their Medicare coverage simply because of ongoing receipt of the cash benefit.

Premium-HI for the Working Disabled

Keep in mind that during the EPMC, Medicare Part A continues to be premium-free. At the end of the EPMC, if a person is not receiving the Title II cash benefit because of SGA level work, it's possible for eligible individuals to continue Medicare coverage (all parts) by "buying into" the Medicare program. This provision is referred to as "Premium-HI for the Working Disabled."

Essentially, this work incentive allows disabled, working individuals to enroll in Medicare Part A alone, or in both Part A and Part B, as well as Part D, by paying the monthly premiums. An individual who qualifies for this provision may continue to "buy into" Medicare for as long as he or she continues to have a disabling impairment.

To enroll in Premium-HI for the Working Disabled, an individual must be under age 65, and:

- Have lost entitlement to premium-free Medicare Part A solely because he or she was engaging in SGA;
- Continue to have a disabling physical or mental impairment; and
- Be ineligible for Medicare on any other basis.

An individual may not enroll in Medicare Part B under this provision without also enrolling in Part A. There is no provision that allows individuals to only purchase Medicare Part B. Individuals may purchase Part A by itself, or may purchase both Part A and Part B.

An individual may enroll in Premium-HI for the Working Disabled during any Medicare enrollment period: the Initial Enrollment Period, the General Enrollment Period, or during a Special Enrollment Period. The Part A premium for the Working Disabled isn't subject to increases for late enrollment. The Part B premium under the Premium-HI for the Working Disabled provision is subject to increases for late enrollment following normal Part B premium increase rules. If an individual were paying an increased Part B premium during the last month of premium-free Part A, but enrolls for SMI under the Working Disabled provision during his or her Initial Enrollment Period, the Part B premium reverts to the standard rate, and the surcharge disappears.

Premium-HI for the Working Disabled continues until the earliest of the following points in time:

- End of the month following the month Social Security notifies the individual that he or she no longer has a disabling impairment;
- End of the month following the month the individual files a request for termination of Premium-HI;
- End of the month before the month the individual becomes re-entitled to premium-free HI. In this case Part B coverage continues without interruption. (The amount of the Part B premium reverts to the standard amount, effective with the first month of re-entitlement to premium-free HI, if the individual was paying a rate increased for late enrollment.);
- End of the grace period for non-payment of premiums; or
- Date of death.

IMPORTANT: Re-entitlement to disability benefits by an individual required to serve a new 24-month MQP doesn't result in termination of Premium-HI for the Working Disabled. Premium-HI entitlement continues until the individual becomes re-entitled to premium-free Part A based on meeting the 24-month qualifying period requirement.

The 2017 Medicare Part A premium is \$413 per month. The Part A premium reduces by 45 percent (\$185.85 in 2017) if beneficiaries:

- Have 30 or more quarters of coverage on their own earning record; or
- Have been married for at least 1 year to a worker with 30 or more quarters of coverage; or
- Were married for at least 1 year to a deceased worker with 30 or more quarters of coverage; or
- Are divorced, after at least 10 years of marriage, from a worker who had 30 or more quarters of coverage at the time the divorce became final.

States are required to pay Part A (but not Part B) premiums under a type of Medicare Savings Program called Qualified Disabled and Working Individuals (QDWI). To be eligible for this program the individual must have limited income and resources and not meet qualifications for Medicaid. The QDWI resources standard is twice the SSI standard (\$4,000 for an individual and \$6,000 for an eligible couple), and countable family income may not exceed 200 percent of the current federal poverty guidelines. Resources and income are usually counted according to the SSI rules.

Medicare and Other Forms of Insurance

When individuals have multiple forms of insurance, Medicare usually operates as the primary insurer, paying all possible medical expense first. In some circumstances Medicare is the secondary payer.

Medicare and Medicaid

Medicare almost always pays first when an individual has both Medicare and Medicaid coverage, because Medicaid is considered the payer of last resort. Medicaid pays for the remaining expenses that are within the confines of the Medicaid coverage rules for that state. For example, if both Medicare and Medicaid cover a service, then Medicare would pay for its approved portion and Medicaid would pick up the remaining amount, assuming it's within the coverage rules for that state. Given the nature of this arrangement, Medicaid often ends up paying the Medicare deductible and co-insurance for Part A and B. If Medicaid doesn't pay the full amount of the co-insurance, healthcare providers may not seek remaining payment from beneficiaries.

Medicare and VA Health Benefits

Most of the veterans who are under the age of 65 and who receive Medicare have become eligible for Medicare through the SSDI program. SSDI beneficiaries become eligible for Medicare in the month after receiving 24 months of SSDI cash benefits. Veterans with both Medicare and VA health benefits can choose which health coverage to use when they receive care. The veteran can either receive care at a VA facility or choose to use Medicare by seeing a provider outside of the VA system. In

general, the two health care programs are independent, and there is no coordination of benefits. Medicare can't pay for the same service that was covered by Veterans' benefits, and the VA can't pay for the same service that Medicare covered. When a veteran uses Medicare, he or she is responsible for all Medicare premiums, deductibles, and coinsurance. When the veteran receives care through the VA, Medicare won't pay anything. The only instance in which both Medicare and the VA can pay for services is when the VA authorizes services in a non-VA hospital. In this case, if the VA doesn't pay for all of the medical services the veteran received during the stay, Medicare can pay for the Medicare-covered part of the services for which the VA doesn't pay. Also, if a doctor or hospital that isn't part of the VA system bills a veteran for VA-authorized care, Medicare may pay all or part of the co-pays for these services.

When veterans are considering whether to decline or unenroll from Medicare Part B, they should carefully explore all options before making a decision. If a veteran doesn't enroll in Medicare Part B when it's first available, the veteran will have to pay a late enrollment penalty if he or she later decides to enroll in Part B. Having VA healthcare benefits won't make him or her exempt from this penalty. However, if a veteran declines Part B coverage because he or she is covered by a group health plan based on current employment, there will be no late enrollment penalty if he or she enrolls in Part B later.

REMEMBER: The Part B late enrollment penalty is 10 percent of the current Part B premium for every 12-month period that the veteran delays enrollment. In addition, the veteran may have to wait to enroll in Part B. As a rule, beneficiaries can only enroll in Part B during the General Enrollment Period (January 1 to March 31). Part B coverage will then become effective on July 1 of that year. For this and other reasons, the VA strongly encourages veterans with VA healthcare benefits to maintain other types of health insurance, including Medicare and Medicaid. Funding set aside by Congress for the VA changes each year. It's possible that veterans in lower priority groups could lose their eligibility for VA healthcare benefits when this funding decreases. Veterans should be careful about choosing to end other health insurance solely because they have VA healthcare benefits. For more information about healthcare options for veterans, see unit 3 of this module.

Medicare Part D is a different story. VA healthcare is considered “creditable coverage” for Part D. As a result, the veteran could choose to opt out of Part D and avoid paying a penalty if he or she decides to take it at some point in the future. In making this decision the veteran will need to decide whether the VA prescription drug coverage is sufficient to meet his or her needs.

Medicare and Other Forms of Health Insurance

A beneficiary may have other forms of health insurance in addition to Medicare. For example, a young adult receiving SSDI and Medicare may still be eligible for his or her parents’ health insurance, or an SSDI beneficiary who is married may be eligible based on his or her spouse’s employer-based health insurance. In some cases Medicare will pay first, and in other cases it will be the secondary payer. Other forms of insurance that may pay first include the following:

- Employer or union group health plan coverage (when coverage is based on the beneficiary’s or a family member’s current employment):
 - If the beneficiary is under age 65 and disabled, Medicare is secondary if the employer has 100 or more employees.
 - If the beneficiary is over age 65 and still working, Medicare will be secondary if the employer has 20 or more employees.
- Employer or union group health plan coverage (as described above), regardless of size and regardless of current employment status, for 30 months if the individual has Medicare because of ESRD.
- No-fault insurance (including automobile insurance)
- Liability insurance (including automobile insurance)
- Black-lung benefits
- Workers’ compensation

Individuals who have other forms of insurance in addition to Medicare need to inform their healthcare providers (i.e., doctors, hospitals, and

pharmacies) to make sure that they pay medical bills correctly. Rules about which insurance pays first are called primary payer rules, but Medicare also uses the term Coordination of Benefits when referring to this issue. For questions about who pays first, individuals can read “Medicare and Other Health Benefits: Your Guide to Who Pays First” at <https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf>. This is an easy-to-read publication by CMS that explains Coordination of Benefits between Medicare and other types of health coverage. Beneficiaries can also contact Medicare’s Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

IMPORTANT POINT: If a beneficiary’s employer offers health insurance, you should advise the beneficiary to talk with the human resources department at his or her place of employment about the coordination with Medicare. Some employer health insurance policies require enrollees to keep or take Medicare if they can get it, while other employers don’t have such a requirement. CWICs should be prepared to refer beneficiaries to SHIP to talk through their options.

Medicare Savings Programs - Financial Assistance Program #1

As explained in the first part of this unit, there are a number of out-of-pocket expenses for Part A and B. Congress created the jointly funded (federal and state) Medicare Savings Programs (MSPs) to help low income Medicare beneficiaries pay for some or all of the Part A and B out-of-pocket expenses.

At the federal level, CMS provides regulatory oversight of the MSPs (e.g., guidance and policy interpretation). A designated state agency, that is, usually the agency administering Medicaid, is responsible for administering the MSPs. That means if a beneficiary were interested in applying for a Medicare Savings Program, he or she would generally do so the same way he or she applies for Medicaid in his or her state. The Medicaid agency is also the agency that generally conducts redeterminations to evaluate ongoing eligibility. It’s important to note

that in some states this program isn't called the Medicare Savings Program, but may instead go by a different name.

Because the federal government partially funds the MSPs, the state must follow certain federal regulations. Federal regulations require states (including 209(b) states) to use the SSI income and resource methodologies to determine countable income and countable resources. States may choose to use less restrictive rules, but aren't allowed to use more restrictive rules than SSI. Because states have some discretion in setting eligibility rules, CWICs must locate the state-specific details of the MSP eligibility criteria. Most states have a policy manual outlining the MSP eligibility details. CWICs are advised to locate a copy of that manual (online or paper).

To be eligible for a MSP, beneficiaries must have countable income below income limits set by the state Medicaid agency. The laws enacting the Medicare Savings Program established the FPL as the income limits for the MSPs, but some states have opted to use higher amounts.

Understanding Federal Poverty Levels (FPLs)

The U.S. Department for Health and Human Services (DHHS) establishes annual poverty guidelines that are widely used as a poverty measure for administrative purposes — for instance, when determining financial eligibility for certain federal or state programs. The poverty guidelines are often loosely referred to as the “federal poverty level” (FPL).

The FPL amounts are based on family size. For example, in 2017 the FPL for a family size of one was \$12,060 (\$1,005 per month) and for a family size of two it was \$16,240 (\$1,353 per month). Each year, there is one set of FPL figures for the 48 contiguous states and another set with higher figures for Alaska and Hawaii. The PFLs (or percentages of them) are consistently used as a standard for income eligibility for various Medicaid programs so we reference them repeatedly throughout this Module. The examples in this Module use the 2017 FPLs because DHHS doesn't publish updated FPLs until January or February of each year. CWICs will need to research the 2018 FPLs at that time. More information about the FPLs is available at the DHHS web site here: <https://aspe.hhs.gov/poverty-guidelines>

In addition to countable income falling below the required limits, countable resources must be below certain limits. Beginning January 2010, as a result of the Medicare Improvements for Patients and Providers Act (MIPPA), three of the MSP resource limits aligned with the resource limits for the Low Income Subsidy (LIS) program. Some states have opted to use higher resource limits than those used by the LIS program, while other states have no income limit at all. As a result, CWICs must research the details about MSP eligibility in their states.

The MSP includes four separate programs:

1. Qualified Medicare Beneficiary (QMB),
2. Specified Low-Income Medicare Beneficiary (SLMB),
3. Qualifying Individual (QI), and
4. Qualified Disabled Working Individual (QDWI).

As a reminder, a given state may use different names for some or all of these programs, so CWICs need to research the appropriate term to use. Below is a chart summarizing the basic details of these programs for 2017.

Program	Income Limit	Resource Limit	How It Helps
Qualified Medicare Beneficiary (QMB)	100% Federal Poverty Level	\$7,390 single, \$11,090 couple	Pays Part A and B premiums, deductibles, co-insurance, and co-payments
Specified Low-Income Medicare Beneficiary	120% Federal Poverty Level	\$7,390 single, \$11,090 couple	Pays Part B premium only

Program	Income Limit	Resource Limit	How It Helps
(SLMB)			
Qualifying Individual (QI)	135% Federal Poverty Level	\$7,390 single, \$11,090 couple	Pays Part B premium only
Qualified Disabled Working Individual (QDWI)	200% Federal Poverty Level	\$4,000 single, \$6,000 couple	Pays Part A premium only

It's important to point out these programs don't help with the Medicare Part D out-of-pocket expenses; a separate program called Low Income Subsidy, which will be covered later in this unit, covers those. Additionally, Medicare Savings Programs don't cover Medigap or Medicare Advantage premiums.

Qualified Medicare Beneficiary (QMB)

Of the four Medicare Savings Programs, QMB (sometimes referred to as "quimby") provides the most support. If a Title II disability beneficiary is eligible for QMB, the State Medicaid agency will pay his or her Part B premium as well as any Part A and B deductibles and co-insurance. To be eligible, the beneficiary must:

- Have Medicare Part A;
- Have countable income at or below 100 percent of the current FPL (or a higher limit set by the state);
- Have countable resources below \$7,390 for a single person, \$11,090 for a couple in 2017 (or a higher limit set by the state); and
- Meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency)

NOTE: Those eligible for Medicare under Premium-HI for the Working Disabled can't use QMB.

As noted earlier, to determine countable income the state Medicaid agency must use the SSI income methodology, unless CMS has approved a more liberal method. That means applying the \$20 General Income Exclusion to determine countable unearned income, and applying all the SSI earned income exclusions when calculating countable earned income. If the resulting total countable income is below 100 percent of the FPL (or a higher limit set by the state), then the individual would get QMB. Below is an example of how the State Medicaid agency would calculate countable income using the SSI income and resource methodology.

Example of person who is eligible for QMB:

Sylvia receives \$874 per month of SSDI, has \$2,500 in resources, and has just been notified she has completed her Medicare Qualifying Period and her eligibility for Medicare will start in three months. She explains that she can't afford to have the Part B premium deducted from her SSDI check and doesn't think Medicare will be useful because she won't be able to pay the deductible and co-insurance. Could Sylvia be eligible for QMB?

Using the SSI deductions, it appears Sylvia will be below 100 percent of the FPL. Her unearned income is \$874; after deducting the \$20 General Income Exclusion, her countable unearned income is \$854. She doesn't have any earned income, so her total countable income is \$854 per month. One hundred percent of the FPL for a single person is \$1,005 per month (2017 rate). Sylvia's countable income is below that level. Because her resources are below \$7,390 she would likely be eligible for QMB, assuming she meets all the nonfinancial requirements of the State's Medicaid program.

The Department of Health and Human Services (DHHS) publishes the FPL figures annually, usually by mid-February. Cost of Living Adjustments (COLAs) go into effect in January. As a result, COLAs for Title II benefits are disregarded in determining countable income for QMB purposes at least through the month following the month in which the annual FPL update is published. In regard to resources, the MSPs use the same resource methodology as SSI, unless CMS has approved a more liberal

method. For summary information about countable resources and what resources Social Security excludes under SSI, refer to Unit 5 of Module 3.

When the State Medicaid agency finds a beneficiary eligible for QMB, the state records that information in a data system (known as the SDX) that is shared with Social Security. Social Security will then stop deducting the beneficiary's Part B premium from his or her Title II disability benefit check. As a QMB, the beneficiary will also get help paying his or her Part A and Part B deductibles, co-insurance, and co-payments. Generally, the State Medicaid agency will issue the beneficiary a Medicaid card. This doesn't mean the beneficiary has full Medicaid coverage. Instead, the beneficiary receives this card to give to medical providers, so they know to bill the state for the Part A and B deductibles and co-insurance. Given this involvement by the Medicaid agency, some states refer to QMB eligible individuals as "Limited Medicaid Beneficiaries." It's very important to understand that MSPs don't give beneficiaries access to the full array of Medicaid State Plan services or long-term care waivers. Instead, they have access to Medicare-covered services, and the state Medicaid agency is using the Medicaid billing system to pay the Part A and B deductible, co-payments, and co-insurance. A person must meet the criteria for a Medicaid eligibility group to get Medicaid State Plan services. See unit 1 of this module for information about Medicaid eligibility.

A determination that an individual is a QMB is normally effective for a period of 12 months. However, a state may make redeterminations more frequently than every 12 months, as long as the state doesn't make them more frequently than every six months. This limitation on the frequency of redeterminations doesn't apply in situations where the state becomes aware of an actual change in the beneficiary's situation that could affect eligibility.

QMB and Medicaid: It's important to understand that beneficiaries receiving QMB may also have full Medicaid coverage because they meet the eligibility criteria for a Medicaid eligibility group. In fact, many concurrent beneficiaries getting both SSI and Title II disability benefits have Medicare, Medicaid, and QMB coverage. QMB and Medicaid are similar in some ways and different in other ways:

Program	Full Medicaid State Plan Services	Pays Part A and B deductibles and co-insurance	Part B Premium
QMB	No	Yes	Yes
Medicaid	Yes	Yes	Maybe (see the note below)on below)

NOTE: In some states, if a person is over the income limits for the Medicare Savings Programs but is Medicaid eligible, the state will pay the Part B premium. Some states impose an income limit on providing this assistance or limit this assistance to select Medicaid eligibility groups. When a state chooses to pay the Part B premium for someone over the MSP income limit, the state is sometimes using 100 percent state funds to do so because the person isn't eligible for the jointly funded federal and state Medicare Savings Programs. Some states have determined that it's financially worthwhile to pay the Part B premium with state funds because it will assure the person has Medicare Part B, which reduce Medicaid costs. Other states haven't made that determination and choose not to offer this assistance.

It's critical that CWICs clarify if their state pays Part B premiums for dual eligible individuals (Medicare or Medicaid eligible) who are over the income limits for MSP eligibility. If that's the case, when a beneficiary goes to work, if he or she remains or becomes eligible for Medicaid (such as through the Medicaid Buy-In), he or she will experience no loss in financial assistance for Part A and B when his or her eligibility for QMB ends. Looking at the chart above, all the financial assistance QMB provides is provided by Medicaid.

Specified Low - Income Medicare Beneficiaries (SLMB)

Someone eligible under SLMB (also referred to as "slimby") will get help paying his or her Part B premium. To be eligible, the beneficiary must:

- Have Medicare Part A;
- Have countable income above 100 percent but at or below 120 percent of the current FPL (or a higher limit set by the state);
- Have countable resources below \$7,390 for a single person, \$11,090 for a couple in 2017 (or a higher limit set by the state); and
- Meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency).

NOTE: Those eligible for Medicare under Premium-HI for the Working Disabled can't use SLMB.

To determine eligibility for SLMB, the states must use the SSI income methodology, unless they have been approved to use a more liberal method. That means applying the \$20 General Income Exclusion to determine countable unearned income, and applying all the SSI earned income exclusions when calculating countable earned income. If the resulting total countable income were above 100 percent but at or below 120 percent of the FPL (or a higher limit set by the state), then the individual would get SLMB. Below is an example of how the states would calculate countable income, using the SSI income and resource methodology.

Example of person who is eligible for SLMB:

Bruce receives \$1,126-per month of SSDI, has \$5,500 in resources, and has just been notified Medicare will be starting. Could Bruce be eligible for SLMB?

Using the SSI deductions, it appears Bruce's countable income will be below 120 percent of the FPL. His unearned income is \$1,126; after deducting the \$20 General Income Exclusion, his countable unearned income is \$1,106. He doesn't have any earned income, so his total countable income is \$1,106 per month. A hundred twenty percent of the FPL for a single person is \$1,206 per month (2017 rate). Bruce's countable income is below that level. Because his resources are below \$7,390, he would likely be eligible for

SLMB, assuming he meets all the nonfinancial requirements of the state's Medicaid program.

The COLA deduction explained under QMB also applies to SLMB. Additionally, when a beneficiary is eligible for SLMB, the state records that information in a data system that is shared with Social Security. Social Security will then stop deducting the beneficiary's Part B premium from his or her Title II disability benefit check.

Qualifying Individuals (QI)

Someone eligible under QI will get help paying his or her Part B premium. To be eligible, the beneficiary must:

- Have Medicare Part A;
- Have countable income above 120 percent but at or below 135 percent of the current FPL (or a higher limit set by the state);
- Have countable resources below \$7,390 for a single person, \$11,090 for a couple in 2017 (or a higher limit set by the state); and
- Meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency); and
- Be ineligible for Medicaid.

Note: Those eligible for Medicare under Premium-HI for the Working Disabled can't use QI.

To determine eligibility for QI, the states must use the SSI income methodology, unless CMS has approved a more liberal method. That means applying the \$20 General Income Exclusion to determine countable unearned income, and applying all the SSI earned income exclusions when calculating countable earned income. If the resulting total countable income were above 120 percent but at or below 135 percent of the FPL (or a higher limit set by the state), then the individual would get QI. Below is an example of how the states calculate countable income, using the SSI income and resource methodology.

Example of person who is eligible for QI :

Andrew receives \$1,300 per month of SSDI, has \$6,000 in resources, and has just been notified Medicare will be starting. Could Andrew be eligible for QI?

Using the SSI deductions, it appears Andrew's countable income will be below 135 percent of the FPL. His unearned income is \$1,300; after deducting the \$20 General Income Exclusion, his countable unearned income is \$1,280. He doesn't have any earned income, so his total countable income is \$1,280 per month. One hundred thirty-five percent of the FPL for a single person is \$1,357 per month (in 2017). Andrew's countable income is below that level. Because his resources are below \$7,390, he would likely be eligible for QI, assuming he meets all the nonfinancial requirements of the state's Medicaid program.

The COLA deduction explained under QMB and SLMB also applies to QI. Additionally, when a beneficiary is eligible for QI, the state records that information in a data system that is shared with Social Security. Social Security will then stop deducting the beneficiary's Part B premium from their Title II disability benefit check.

Many CWICs wonder what the difference is between SLMB and QI, aside from the income limit. From the beneficiary's perspective, there is one key difference. A person who has Medicaid can use SLMB but can't use QI. The other differences are all administrative. QI is a federal block grant program, so funding is based on availability of grant funds. If a state runs out of the block funds, it could close enrollment in QI until new grant funds are available. Another administrative difference is the match rate; the percentage the federal government pays for the QI program is different from the SLMB program.

QMB, SLMB, QI , and Earnings

Because QMB, SLMB, and QI are all financial needs-based programs, when a person begins working, his or her eligibility could change from one level to another or end altogether. To evaluate the effect of work on MSPs, CWICs should take the following steps:

1. Calculate total countable income (including the earning goal).
2. Compare total countable income to QMB, SLMB, and QI income levels.
3. Identify if the beneficiary will remain in same coverage level, move to a lower coverage level (QMB to SLMB or QMB to QI), or lose MSPs altogether.
4. Determine if the person will keep or become eligible for Medicaid.

Once those steps are complete, CWICs may use the charts below to help clarify how the help with Medicare Part A and B out-of-pocket expenses will change. The first chart outlines the change in coverage that will occur for beneficiaries who won't be eligible for full Medicaid when they begin working. The second chart outlines the change in coverage that will occur for beneficiaries who will maintain or become eligible for full Medicaid when they begin working.

Scenarios for beneficiaries who aren't, nor will become, Medicaid eligible:

Scenario once the work goal is achieved	Part A and B deductibles and co-insurance will be paid?	Part B Premium will be paid?
Has QMB, will have QMB	Yes	Yes
Has QMB, will have SLMB/QI	No	Yes
Has QMB, won't have MSPs	No	No
Has SLMB/QI , will have QMB	Yes	Yes
Has SLMB or QI , will have SLMB/QI	No	Yes
Has SLMB/QI , won't have MSPs	No	No

Scenarios for beneficiaries who will continue to be eligible for Medicaid or will become eligible when they begin working:

Scenario once the work goal is achieved:	Part A and B deductibles and co-insurance will be paid?	Part B Premium will be paid?
Has QMB, will have QMB	Yes	Yes
Has QMB, will have SLMB	Yes (Medicaid)	Yes
Has QMB, won't have QMB/SLMB	Yes (Medicaid)	Maybe (Medicaid)
Has SLMB, will have QMB	Yes	Yes
Has SLMB, will have SLMB	Yes (Medicaid)	Yes
Has SLMB, won't have QMB/SLMB	Yes (Medicaid)	Maybe (Medicaid)

As a reminder, someone who is Medicaid eligible can't get QI; as a result, there is no option in the chart directly above showing the option of QI. Because this second chart reflects the beneficiaries who will maintain or obtain full Medicaid when working, the individual will have more help paying Medicare Part A and B out-of-pocket expenses. In every scenario the person is getting help paying their Part A and B co-insurance and deductibles. That's possible because full Medicaid naturally covers those expenses if QMB isn't available. Remember, Medicaid operates as a secondary insurance to Medicare. The only potential change in assistance is with the groups that lose eligibility for MSP altogether. In that situation, if the state won't pay the Part B premium for dual eligible individuals (Medicare and Medicaid eligible) with income over the 120 percent income limit, then the beneficiary will need to begin paying that premium. In states that pay the Part B premium for dual beneficiaries

over 120 percent FPL, the beneficiaries will see no effective change in their coverage.

Let's look at a few examples of how earned income would affect coverage of Medicare Part A and B out-of-pocket expenses.

Example of person who is eligible for QMB, doesn't have Medicaid, and begins working:

Sylvia receives \$874 per month of SSDI, has \$2,500 in resources, has Medicare, and has QMB. She has been offered a job making \$1,100 per month in gross wages. What will happen to Sylvia's eligibility for QMB?

Her unearned income is \$874; after deducting the \$20 General Income Exclusion, her countable unearned income is \$854. Her earned income is \$1,100; after deducting the \$65 Earned Income Exclusion and dividing the remaining earnings in half, her countable earned income is \$517.50. That means her total countable income is \$1,371.50 per month.

Sylvia's income isn't only over the QMB income limit (100 percent FPL is \$1,005 – 2017 rate); it's also over the SLMB (120 percent FPL is \$1,206 – 2017 rate) and QI income limit (135 percent FPL is \$1,357 – 2017 rate) for a single person. She will have to begin paying her Part A and B co-insurance and deductibles, as well as her Part B premium.

As an option, Sylvia could explore her eligibility for Medicaid (e.g., Medicaid Buy-In). If she is eligible for Medicaid, that program would pay her Medicare Part A and B deductibles and co-insurance. Depending on the state she lives in, Medicaid may also pay her Part B premium. Another option is to explore Impairment Related Work Expenses (IRWEs) or Blind Work Expenses (BWEs). If Sylvia has enough of these deductions, her countable income may fall below the QI, SLMB, or even QMB limit.

Example of person who is eligible for QMB and Medicaid, and begins working:

Ericka receives \$789 per month of SSDI, has \$1,000 in resources, has Medicare and Medicaid, and has QMB. She has been offered a job making \$600 per month in gross wages. What will happen to Ericka's eligibility for QMB?

Her unearned income is \$789; after deducting the \$20 General Income Exclusion, her countable unearned income is \$769. Her earned income is \$600; after deducting the \$65 Earned Income Exclusion and dividing the remaining earnings in half, her countable earned income is \$267.50. That means her total countable income is \$1,036.50 per month.

Ericka's income is over the QMB income limit (100 percent FPL is \$1,005 – 2017 rate), but it's below the SLMB limit (120 percent FPL is \$1,206 - 2017 for a single person). That means she'll continue getting help paying for her Part B premium, but through SLMB rather than QMB. While Ericka doesn't have the QMB program to pay her Part A and B deductible and co-insurance, she does have full Medicaid coverage. If she maintains her eligibility for Medicaid when she begins working, she would continue to get help paying the Part A and B deductibles and coinsurance. In effect, Ericka will continue to have the same coverage she has now. If Ericka can't maintain Medicaid when working, you should explore IRWEs or BWEs to see if her countable income could fall below the QMB limit.

Qualified Disabled and Working Individuals (QDWI)

The last Medicare Savings Program is very different from the other three. Qualified Disabled Working Individual (QDWI) only pays the Part A premium for those who are "buying-into" Medicare under "Premium HI for the Working Disabled."

To be eligible for QDWI, an individual must:

- Be using Premium-HI for the Working Disabled to maintain Medicare;

- Have countable income below 200 percent of the current FPL;
- Have countable resources below \$4,000 for a single person, \$6,000 for a couple;
- Be not otherwise eligible for Medicaid; and
- Meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency).

As with the other MSPs, QDWI uses the SSI income and resource methodologies to determine countable income and resources. With QDWI, states aren't allowed to use more liberal income and resource methodologies, an option they have with the QMB, SLMB, and QI program. While 200 percent of the FPL may not seem high, an individual can have a relatively high monthly income and use this program. There are two key factors that make that possible: The individual no longer has a Title II benefit check when he or she is using this program, and the earned income disregards allow him or her to have wages of more than twice the income limit. Let's look at an example.

Example of person who is likely eligible for QDWI :

Frank has \$3,200 per month in gross wages, and his EPMC is about to end. He'd like to maintain Medicare through Premium-HI for the Working Disabled but is concerned about affording the Part A premium. He has \$3,500 in resources. Could Frank be eligible for QDWI?

His unearned income is \$0, because he's no longer receiving his SSDI benefit. His gross wages are \$3,200 per month; after deducting the \$20 General Income Exclusion and the \$65 Earned Income Exclusion, and dividing the remaining amount in half, he has \$1,557.50 in countable earned income. Because he has no unearned income, his total countable income is \$1,557.50 per month.

Two hundred percent of the FPL for a single person is \$2,010 per month (2017 rate). Frank's total countable income is below that level. Because his resources are below \$4,000, he would likely be

eligible for QDWI, assuming he meets all the nonfinancial requirements of the state's Medicaid program.

As this example demonstrates, an individual can have a substantial amount of earned income and still use QDWI.

Low Income Subsidy (Extra Help) - Financial Assistance Program #2

As explained in the first part of this unit, there are a number of Part D out-of-pocket expenses, which vary based on the private prescription drug plan the beneficiary chooses. For many beneficiaries, these costs are unaffordable. When Congress created Part D, it also created a financial assistance program to help low-income beneficiaries pay for the Part D out-of-pocket expenses. The formal name for this financial assistance program is Low Income Subsidy, but it's also called "Extra Help." LIS isn't a state program, which is often a point of confusion. LIS is a program administered by CMS. The LIS program provides two levels of help: Full Low Income Subsidy and Partial Low Income Subsidy.

To be eligible for LIS, some groups must have income below certain FPLs. When an individual applies for LIS, Social Security will apply the FPL that corresponds to the individual's state of residence in the month that the individual applied.

In addition to some groups having income limits, some groups must have resources below the current year's resource limit. If a beneficiary indicates he or she would use some or all of his or her resources for funeral or burial expenses, then Social Security will allow a \$1,500 exclusion for an individual and \$3,000 for a couple. As a result, publications about LIS resource limits often inflate the current year's limit by \$1,500 for an individual and \$3,000 for a couple, to account for this allowance. The resource limits listed in this unit don't include the allowance for funeral or burial expenses. If a beneficiary expected those expenses, his or her resource limit, in effect, would be higher (\$1,500 for an individual and \$3,000 for a couple).

Full Low Income Subsidy

Full LIS provides critical support to beneficiaries. With Full LIS the beneficiary generally won't have to pay a monthly premium. The CMS pays subsidized premiums to the prescription drug provider (PDP) or the Medicare Advantage prescription drug plan (MA-PDP) based on the service area's regional benchmark premiums. Full LIS eligible individuals who choose to participate in a more expensive plan are responsible for the difference. Those eligible for Full LIS don't have to pay an annual deductible. Additionally, they aren't subject to the initial coverage, coverage gap, or catastrophic coverage payment rules. Instead, these individuals pay small co-payments, if any.

To be eligible for the Full LIS, an individual must:

- Be entitled to benefits under Medicare Part A or entitled to Medicare Part B or both;
- Reside in one of the 50 states or the District of Columbia; and
- Have countable income at or below 135 percent of the FPL and resources at or below \$7,390 for single or \$11,090 for couples in 2017; **OR**
- Be deemed eligible (the following groups are deemed Full LIS eligible: Medicaid recipients, SSI beneficiaries, QMBs, SLMBs, or QIs)

Deemed Eligible:

Those whom CMS deems eligible don't have to apply for Full LIS; instead, CMS automatically enrolls them. CMS determines if an individual is deemed eligible for Full LIS based on monthly data from state Medicaid agencies and Social Security's records of SSI participation. CMS then automatically enrolls deemed eligible beneficiaries who haven't yet enrolled with a PDP or MA-PDP. Beneficiaries whom CMS deems eligible can switch plans at any time. Many beneficiaries don't realize that once they are eligible for Part D, Medicaid will no longer cover most, if not all, of their prescriptions, because they are the payer of last resort. To assure beneficiaries don't inadvertently go without prescription coverage, CMS automatically enrolls Full LIS deemed eligible beneficiaries into a plan.

Not Deemed Eligible:

Those whom CMS deems not eligible, but instead who have income and resources below the limits noted above, have to apply for the Low Income Subsidy program. While CMS is administering the LIS program, it doesn't have the infrastructure to accept and process applications; it doesn't have field offices in towns across the country where beneficiaries can go and apply. As a result, CMS established an agreement with Social Security to accept and process LIS applications for those who aren't deemed eligible. That means an individual who doesn't fall into one of the deemed eligible categories will need to apply for LIS at Social Security. Individuals may apply for the LIS program in three ways:

1. Submitting an online application on Social Security's website;
2. Calling 1-800-772-1213 to apply over the phone; or
3. Applying in person at a local Social Security office.

Once Social Security receives the application, the agency will need to determine if the countable income is at or below 135 percent of FPL and if countable resources are below the applicable limits.

In determining eligibility for the non-deemed group, Social Security will use the SSI income and resource methodology, with some modifications. To begin, Social Security doesn't use deeming, but will count the following people's income and resources in determining LIS eligibility:

- Countable income of the Medicare beneficiary and living- with spouse (if any) measured against a percentage of the annual FPL for the beneficiary's family size (this includes dependent relatives living with the beneficiary); and
- Resources of the Medicare beneficiary and living-with spouse (if any).

In counting income, effective January 1, 2010, Social Security won't count in-kind support and maintenance as income. The agency will also exclude interest and dividends, regardless of the source. Also worth noting, Social Security won't approve a Plan to Achieve Self Support whose sole purpose is to exclude income and resources for LIS eligibility.

In regard to resource exclusions, there are a few differences from the SSI rules:

- Social Security doesn't consider transfers of resources when making LIS determinations. Therefore, Social Security doesn't ask an applicant if he or she transferred resources.
- Non-liquid resources, other than non-home real property, aren't resources for purposes of determining eligibility for the subsidy. For purposes of determining eligibility for the subsidy, the following non-liquid assets aren't countable resources: all vehicles (autos, trucks, motorcycles, boats, snowmobiles, etc.), household goods and personal effects, irrevocable burial trusts, and irrevocable burial contracts.
- If the individual alleges that he or she expects to use some of his or her resources for funeral or burial expenses, Social Security excludes \$1,500 from that individual's countable resources. For a married couple who live together, Social Security will exclude up to \$3,000. Social Security won't ask the individual for the actual value of the funds that he or she expects to use. Therefore, the exclusion is always \$1,500 unless the individual alleges that he or she doesn't expect to use any of his or her resources for burial or funeral expenses.

In determining countable income, Social Security applies the basic SSI deductions. When determining countable unearned income, Social Security applies the \$20 General income Exclusion to any unearned income first, then to earned income, if unused. The agency applies the \$65 Earned Income Exclusion and divides earnings in half to determine countable earned income. Additionally, Social Security can deduct impairment Related Work Expenses (IRWE) and Blind Work Expenses (BWE). If a beneficiary indicates to Social Security he or she has IRWEs, Social Security will deduct an automatic 16.3 percent of gross wages. If a beneficiary with statutory blindness indicates he or she has BWEs, Social Security will deduct an automatic 25 percent of gross wages. Social Security will deduct the actual amount of the IRWE or BWE if it's more advantageous than the standard percentage. To use these deductions, the Title II disability beneficiary must be under age 65. If his or her spouse is under age 65 and receiving Title II disability benefits, he

or she may also use these work incentives. Below is an example calculation.

Example of a person who is likely eligible for Full LIS:

Sherry has \$1,212 per month in SSDI, \$7,000 in resources, and is single. She tells you she is unable to pay for her prescriptions each month.

Could Sherry be eligible for Full LIS?

Step	Calculations
Unearned Income	\$1,212
General Income Exclusion (GIE) \$20	– \$20
Countable Unearned Income	= \$1,192
Gross Earned Income	\$0
Student Earned Income Exclusion	–
Remainder	–
GIE (if not used above) \$20	–
Remainder	–
Earned Income Exclusion (EIE) \$65	–
Remainder	–
Impairment Related Work Expense (IRWE) (16.3% of gross wages or actual amount if higher)	–
Remainder	–
Divide remainder by 2	–
Blind Work Expense (BWE) (25% of gross wages or actual amount if higher)	–

Step	Calculations
Total Countable Earned Income	= \$0
Total Countable Unearned Income	\$1,192
Total Countable Earned Income	+ \$0
PASS Deduction	- \$0
Total Countable Income	= \$1,192

Her unearned income is \$1,212, but after deducting the \$20 General Income Exclusion, her countable unearned income is \$1,192. She doesn't have any earned income, so her total countable income is \$1,192 per month. One hundred thirty-five percent of the FPL for a single person is \$1,357 per month (2017 rate). Sherry's countable income is below that level. Because her resources are below \$7,390, she would likely be eligible for Full LIS. The CWIC should let her know she is likely eligible for a Medicare Savings Program, QI, and once she applies and is found eligible for QI, the State Medicaid agency will automatically enroll her in full LIS.

As a reminder, this calculation isn't used for individuals who are deemed eligible for Full LIS and will continue to fall under a deemed eligible category when working. For example, if a beneficiary is eligible for Full LIS right now because he or she has full Medicaid coverage, and when he or she begins working, he or she will maintain Medicaid, then there is no need to do a calculation worksheet because he or she will remain deemed eligible for Full LIS. Conversely, if a beneficiary will lose his or her deemed eligible status due to a change in income, then the calculation would be appropriate. For example, if a beneficiary is eligible for Full LIS because he or she has QMB, but when he or she begin working, he or she will lose eligibility for QMB, SLMB, and QI, then the beneficiary would need a calculation worksheet to determine whether he or she meets the income criteria, unless he or she fell under one of the other deemed eligible categories (e.g., Medicaid or SSI).

Partial Low Income Subsidy

Partial LIS provides slightly less support than Full LIS. With Partial LIS the beneficiary either has no premium or will have a premium based on a sliding fee scale. As with Full LIS, CMS pays subsidized premiums to the prescription drug provider (PDP) or the Medicare Advantage prescription drug plan (MA-PDP) and base them on the service area's regional benchmark premiums. Partial LIS eligible beneficiaries who choose to participate in a more expensive plan are responsible for the difference. Those eligible for Partial LIS have a \$83 annual deductible (2018 rate) Additionally, they aren't subject to the initial coverage, coverage gap, or catastrophic coverage payment rules. Instead, these individuals pay lower co-insurance or co-payments over the course of the year.

To be eligible for the Partial LIS, an individual must:

- Be entitled to benefits under Medicare Part A or entitled to Medicare Part B or both;
- Reside in one of the 50 states or the District of Columbia; and
- Have countable income at or below 150 percent of the FPL and resources at or below \$12,320 for single or \$24,600 for married in 2017.

As with the non-deemed eligible Full LIS beneficiaries, Partial LIS beneficiaries must apply for LIS through Social Security. Individuals apply for Partial LIS in the same manner as for full LIS as described earlier. The same countable income and resource methodologies explained under Full LIS also apply under Partial LIS. The difference is merely that the income and resource limits are higher.

Example of a person who is likely eligible for Partial LIS:

Sophia has \$1,425 per month in SSDI, \$10,000 in resources, and is single. She tells you she is having a hard time paying for her prescriptions each month. Could Sophia be eligible for Partial LIS?

Step	Calculations
Unearned Income	\$1,425
General Income Exclusion (GIE) \$20	- \$20
Countable Unearned Income	= \$1,405
Gross Earned Income	\$0
Student Earned Income Exclusion	-
Remainder	
GIE (if not used above) \$20	-
Remainder	
Earned Income Exclusion (EIE) \$65	-
Remainder	
Impairment Related Work Expense (IRWE) (16.3% of gross wages or actual amount if higher)	-
Remainder	
Divide by 2	
Blind Work Expense (BWE) (25% of gross wages or actual amount if higher)	-
Total Countable Earned Income	= \$0
Total Countable Unearned Income	\$1,405
Total Countable Earned Income	+ \$0
PASS Deduction	- \$0
Total Countable Income	= \$1,405

Her unearned income is \$1,425, but after deducting the \$20 General Income Exclusion, her countable unearned income is \$1,405. She doesn't have any earned income, so her total countable income is \$1,405 per month. One hundred fifty percent of the FPL for a single person is \$1,507 per month (2017 rate). Sophia's countable income is below that level. Because her resources are below \$12,320, she would likely be eligible for Partial LIS.

With Partial LIS there are no deemed eligible individuals. Instead, every Partial LIS beneficiary must meet the income and resource limits. Given that, the calculation that Social Security must use to estimate eligibility when a beneficiary begins working, unless he or she will fall under a Full LIS deemed eligible group when working (e.g., Medicaid Buy-In).

LIS and Earnings

To estimate the effect of earnings on a beneficiary's LIS eligibility, the first step is to clarify which category he or she falls into: deemed eligible for Full LIS, eligible for Full LIS (not deemed eligible), or eligible for Partial LIS. Once you have identified the category, the next step is to clarify whether the individual will lose eligibility for that category once he or she is working. If the beneficiary won't lose eligibility for the category he or she is in, then CWICs can tell the beneficiary that his or her eligibility should continue. If the beneficiary will lose eligibility for the category he or she is in, the CWICs must communicate that expected change and provide options, if any.

Example of a person the CWIC expects to maintain deemed eligibility for Full LIS:

Devin has \$320 per month in SSDI, \$450 per month in SSI, Medicare, QMB, and Medicaid. She has been deemed eligible for Full LIS. Devin will begin working next month making \$3,000. She has several expensive prescriptions, which she relies on LIS to help her cover. What will happen to Devin's Full LIS when she begins working?

1. The first step is to clarify which category Devin falls into, which is deemed eligible for Full LIS. She is deemed eligible because she has Medicaid, plus she has SSI and QMB.

2. The second step is to clarify whether Devin will lose eligibility for all these deemed categories once she begins working. While Devin will likely lose her eligibility for QMB, she will continue to be eligible for Medicaid and SSI (using the 1619(b) work incentive). That means the CWIC expects Devin to continue to be eligible for Full LIS as a deemed eligible beneficiary. Because the CWIC expects her to remain deemed eligible, there is no need to do the LIS countable income calculation.

Example of a person who is deemed eligible for Full LIS but whom the CWIC expects will lose that deemed status:

Tom has \$1,080 per month in SSDI, Medicare, and SLMB. He has been deemed eligible for Full LIS because he gets SLMB. Tom will begin working next month making \$850. He has several expensive prescriptions that he relies on LIS to help him cover. What will happen to Tom's Full LIS when he begins working?

1. The first step is to clarify which category Tom falls into. He is deemed eligible for full LIS because he has SLMB.
2. The second step is to clarify whether Tom will lose eligibility for all these deemed categories once he begins working. After reviewing the SLMB eligibility rules, the CWIC determines he won't be eligible for SLMB, nor will he be eligible for QMB or QI. He will also not be an SSI recipient. The only way Tom could continue to be considered deemed eligible for Full LIS is if he became eligible for Medicaid. In many states there is a Medicaid Buy-In program, which may be a way for Tom to become eligible for Medicaid. Because Medicaid Buy-In programs have a premium, he'd need to decide if it's financially worthwhile for him. If Tom doesn't become eligible for Medicaid when he begins working, then the CWIC must use the LIS calculation to determine if he can maintain eligibility for Full LIS as a non-deemed eligible individual or for Partial LIS.

Step	Calculations
Unearned Income	\$1,080
General Income Exclusion (GIE) \$20	– \$20
Countable Unearned Income	= \$1,060
Gross Earned Income	\$850
Student Earned Income Exclusion	– \$0
Remainder	\$850
GIE (if not used above) \$20	– \$0
Remainder	\$850
Earned Income Exclusion (EIE) \$65	– \$65
Remainder	\$785
Impairment Related Work Expense (IRWE) (16.3% of gross wages or actual amount if higher)	– \$0
Remainder	\$785
Divide by 2	\$392.50
Blind Work Expense (BWE) (25% of gross wages or actual amount if higher)	– \$0
Total Countable Earned Income	= \$392.50
Total Countable Unearned Income	\$1,060
Total Countable Earned Income	+ \$392.50
PASS Deduction	– \$0
Total Countable Income	= \$1,452.50

Tom's countable income, \$1,452.50, will be over 135 percent of the FPL (\$1,357 - 2017 rate), which means he wouldn't be eligible for Full LIS. But, his income does fall below 150 percent of the FPL (\$1,507 - 2017 rate), which means he would likely be eligible for Partial LIS. To support Tom in pursuing his work goal, it will be important for him to know his options. He will be able to use Partial LIS instead of Full LIS, or if Medicaid eligibility is an option for Tom in his state, he will be able to maintain Full LIS by enrolling in Medicaid.

Reporting Income and Resource Changes and LIS Redeterminations

To determine subsidy eligibility and whether the individual qualifies for a full or partial subsidy, Social Security considers all of the countable income the individual and living-with spouse receive (or expect to receive) for a period of 12 months. Although Social Security computes subsidy eligibility based on income projected for 12 months, the computation isn't linked to a particular calendar year. The subsidy determination system uses the 12-month projection of income because Social Security issues the FPL income limits as annual income limits. At the point when an individual files for subsidy, Social Security compares the 12-month projection to the current year's FPL income limit. If the individual's projected income is under the limit, he or she will continue to be eligible for subsidy until Social Security processes a redetermination or a subsidy-changing event.

Example of determining subsidy eligibility:

Ms. Smith files for subsidy in August. The subsidy determination system uses the income reported on her application in August and projects it for 12 months starting from the subsidy computation month without regard to the expected increase in her income due to the January COLA), or the expected increase in the FPL limits due to the annual FPL update (usually in February). The subsidy determination system needs this type of computation because the individual's income for next January and next year's FPL amount aren't known in August when Social Security is processing the claim.

Social Security makes LIS determinations for a calendar year and won't change them during the year unless the individual:

- Appeals the determination;
- Reports a subsidy-changing event; or
- Becomes eligible for SSI, Medicaid, or the MSP and is therefore deemed eligible for the subsidy.

Social Security doesn't require LIS beneficiaries to report changes. There are NO mandatory reporting rules in the LIS program. In addition, there is no distinction between how the agency processed first- and third-party reports. Beneficiaries, relatives, friends, or other agencies may report events that affect a beneficiary's subsidy. The source of information doesn't affect how Social Security processes the report of change.

Two types of events can affect the subsidy determination or amount:

- Subsidy Changing Events, which are effective the month after the month of report, and
- Other Events, which are events that may change the subsidy determination, but do not become effective until the January following the report (or later in some cases).

There are six Subsidy Changing Events. These events result in the re-determination of subsidy amount or eligibility for the beneficiary. Once Social Security receives and inputs a report of a subsidy changing event, the agency sends a redetermination form (SSA-1026-OCR-SM-SCE) to the beneficiary.

These changes become effective the month after the month the beneficiary reports them:

1. Beneficiary marries
2. Beneficiary and living-with spouse divorce
3. Beneficiary's living-with spouse dies
4. Beneficiary and living-with spouse separate

5. Beneficiary and living-with spouse annul marriage
6. Beneficiary and previously separated spouse resume living together

Example of Subsidy Changing Event:

Mary Smith, a beneficiary, contacts Social Security in May 2018. She reports that she married in March 2018. This is a subsidy changing event or SCE. Any change becomes effective in June 2018. Mrs. Smith says that she doesn't have time to complete the screens immediately. The 800-number agent will input the event on the Changing Event screen in MAPS, which will generate a re-determination form. The agent asks Ms. Smith if her spouse is eligible for a subsidy as well. He is. The agent then asks if Ms. Smith is reporting the change for him as well. She says she is, so the agent enters an SCE for the spouse. He will receive a re-determination form as well. Mrs. Smith and her spouse must return both forms, even though the information on the forms should be identical. When they return the forms with the updated income and resource information, the Social Security agent will process them in MAPS. The system will then determine the new subsidy amounts, which will be effective in June 2018 for Ms. Smith and her new spouse.

Events other than the six subsidy changing events listed above may affect a beneficiary's subsidy eligibility or amount, but any changes resulting from the report of an "Other Event" are generally effective the following January. Typically "other events" include changes in income and resources such as getting a job, becoming eligible for unemployment insurance, receiving a large insurance settlement or inheritance, etc.

Example of an "Other Event":

In late August 2017, Social Security mails a scheduled re-determination to Mr. Jones. He completes the form that indicates a change in his income and sends it back to Social Security on September 19, 2017. Social Security re-determines Mr. Jones' eligibility based on the income he reported on September 19, 2017. The subsidy determination system uses the income on this report, projects it for 12 months, and compares this annualized amount to the 2017 FPL income limits to determine his subsidy percentage. If the change he reported affects his eligibility or the amount of his subsidy, the effective date of the change will be January 2018.

There are some differences in eligibility changes for those deemed eligible for LIS. For an individual deemed eligible between January 1 and June 30 of a calendar year, the individual is deemed eligible for Full LIS for the remainder of the calendar year, regardless of changes in his or her situation. For an individual deemed eligible between July 1 and December 31 of a calendar year, the individual is deemed eligible for the remainder of the calendar year and the following calendar year. For more information about the Part D LIS, refer to POMS HI 03001.005 Medicare Part D Extra Help (Low-Income Subsidy or LIS): <https://secure.ssa.gov/apps10/poms.nsf/lnx/0603001005>

Medicare Counseling and Referrals

Medicare beneficiaries have to make many choices that will determine how they receive their Medicare. They have the choice to keep Original Medicare or to enroll in a Medicare Advantage Plan. Beneficiaries also choose a specific provider for their Medicare Advantage Plan and their Part D plan.

CWICs need to have a basic understanding of these Medicare options, but will also need to work with organizations that provide in-depth Medicare counseling services. Some beneficiaries will have questions or problems that lie outside of the CWIC's area of knowledge or experience. In these cases, CWICs should refer the beneficiary to an outside organization for assistance.

State Health Insurance Counseling and Assistance Programs (SHIPs)

In each of the 50 states, a State Health Insurance Counseling and Assistance Program (SHIP) provides free one-on-one Medicare counseling to seniors and people with disabilities. SHIPs help beneficiaries make informed choices about their Medicare and can answer questions about Medicare bills, appeals, and Medicare consumer rights. More information on the services that SHIPs provide and a link to state SHIP websites can be found at: <https://www.shiptacenter.org>.

Counseling Beneficiaries on Medicare

This unit covers important parts of the Medicare program that CWICs need to understand in order to assist beneficiaries. Here are some additional points to remember:

- Medicare beneficiaries may be eligible for, but not enrolled in, the Low Income Subsidy program. Some beneficiaries aren't automatically enrolled in LIS and need to apply for this program.
- SSDI beneficiaries may not know that they could qualify for Medicaid. CWICs need to ask these beneficiaries if they have considered Medicaid as a health coverage option, in addition to Medicare.
- Medicare beneficiaries may qualify (and need to apply) for the MSP that will help to pay their Medicare premiums and coinsurance.
- Medicare beneficiaries may have their Part B premiums paid for by the state if they are enrolled in Medicaid or in the MSP.
- Dual eligible individuals (with Medicare and Medicaid) have additional options under Medicare. For example, these individuals may change their Medicare Advantage Plan or Part D plan in any month of the year.

Conclusion

While many Title II disability beneficiaries are concerned about how paid employment will affect their cash payments, it's often the medical coverage afforded by Medicare that individuals are most worried about losing. This unit provided specific information to CWICs about how the federal Medicare program operates and offers detailed explanations on how to get help paying the premiums and other out-of-pocket expenses Medicare beneficiaries incur. Finally, this unit described exactly how paid employment affects Medicare coverage and under what circumstances Medicare coverage can continue even after cash benefits cease due to SGA-level work.

Conducting Independent Research

Medicare and You - CMS Publication:

<https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf>

Medigap Plan Information: <http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html>

Medicare and Other Health Benefits: Your Guide to Who Pays First:

<https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf>

Questions and Answers on Extended Medicare Coverage for Working People with Disabilities:

<http://www.socialsecurity.gov/disabilityresearch/wi/extended.htm>

SSA POMS DI 40510.140 Premium Medicare for the Working Disabled – General:

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0440510140!opendocument>

SSA POMS HI 03001.005 Medicare Part D Extra Help (Low Income Subsidy or LIS):

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0603001005>

SSA POMS HI 03020.000 Income (Low Income Subsidy):

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0603020000>

SSA POMS HI 03030.000 Resources (Low Income Subsidy):

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0603030000>

Cornell University, ILR School, Employment & Disability Institute Policy & Practice Brief #27 - Overview of Medicare Part D, John Coburn and Barbara Otto, Health and Disability Advocates, April 2006: http://www.ilr.cornell.edu/edi/publications/PPBriefs/PP_27.pdf

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services. This booklet has information about Medicare coverage for people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant) (56 pages):

<https://www.medicare.gov/pubs/pdf/10128-Medicare-Coverage-ESRD.pdf>

Additional Resources

We included templates CWICs can use to calculate countable income for the purposes of determining the effect of earned income on Medicare Savings Programs and the Part D LIS eligibility. We have also provided a decision tree CWICs can use to map out the end of a beneficiary's EPMC.

MSP Calculation Sheet

Beneficiary Name _____ Date _____

CWIC: _____

Scenario Description:

(Customize chart based on any additional deductions allowed in your state)

Step	Calculations
Unearned Income	
General Income Exclusion (GIE) \$20	-
Countable Unearned Income	=
Gross Earned Income	
Student Earned Income Exclusion	-
Remainder	
GIE (if not used above) \$20	-
Remainder	
Earned Income Exclusion (EIE) \$65	-
Remainder	
Impairment Related Work Expense (IRWE)	-
Remainder	
Divide by 2	
Blind Work Expenses (BWE)	-
Total Countable Earned Income	=
Total Countable Unearned Income	
Total Countable Earned Income	+
PASS Deduction	-
Total Countable Income	=
Result based on comparison of countable income to MSP income limits: QMB: No more than 100% FPL SLMB: No more than 120% FPL QI: No more than 135% FPL QDWI: No more than 200% FPL	

LIS Calculation Sheet

Beneficiary Name _____ Date _____

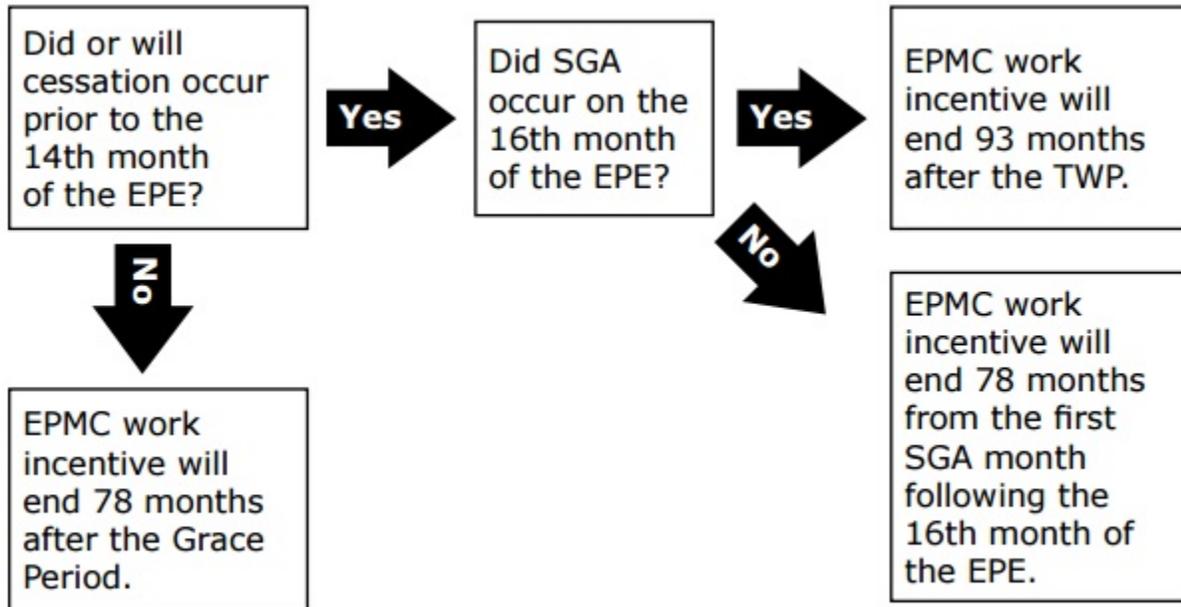
CWIC _____

Scenario Description:

Beneficiaries who are dually eligible (also have Medicaid of any type) are deemed eligible for full LIS with no additional financial assessment. Do not use this chart for those beneficiaries.

Step	Calculations
Unearned Income	
General Income Exclusion (GIE) \$20	-
Countable Unearned Income	=
Gross Earned Income	
Student Earned Income Exclusion	-
Remainder	
GIE (if not used above) \$20	-
Remainder	
Earned Income Exclusion (EIE) \$65	-
Remainder	
Impairment Related Work Expense (IRWE) (16.3% of gross wages or actual amount if higher)	-
Remainder	
Divide by 2	
Blind Work Expenses (BWE) (25% of gross wages or actual amount if higher)	-
Total Countable Earned Income	=
Total Countable Unearned Income	
Total Countable Earned Income	+
PASS Deduction	-
Total Countable Income	=
Results based on comparison of countable income to applicable LIS income limit: Full LIS: No more than 135% FPL Partial LIS: No more than 150% FPL	

Extended Period of Medicare Coverage (EPMC) Decision Tree



Did or will cessation occur prior to the 14th month of the EPE?

- **NO:** EPMC work incentive will end 78 months after the Grace Period.
- **YES: Did SGA occur on the 16th month of the EPE?**
 - **NO:** EPMC work incentive will end 78 months from the first SGA month following the 16th month of the EPE.
 - **YES:** Did SGA occur on the 16th month of the EPE?
 - **YES:** EPMC work incentive will end 93 months after the TWP

Competency Unit 3 – Healthcare Options for Veterans

Introduction

The U.S. Department of Defense (DoD) and the Department of Veterans Affairs (VA) offer comprehensive health coverage to active members of the military and to veterans of the armed forces. The Department of Defense provides coverage through the TRICARE program. The Veterans Health Administration (VHA) administers the VA healthcare system for veterans. CWICs may encounter Social Security beneficiaries who have health coverage through one or both of these programs. Title II disability beneficiaries (SSDI, CDB, DWB) may also enroll in the Medicare program, and some veterans may be eligible for Medicaid. This unit will provide an overview of the TRICARE program and the VA healthcare system, and discuss the interactions between these systems and other healthcare programs such as Medicare and Medicaid.

IMPORTANT DEFINITIONS:

- Certain terms have specific definitions in the context of the U.S. military. “Separating” or “being discharged” means leaving the military. The only individuals who are considered “retired” from the military are: 1) Those who served for 20 years before they left military service, or 2) those who have been certified “medically retired” because they have become disabled. Note that not all injured or disabled service members are “medically retired.”
- A veteran is defined as a person who is a former member of the U.S. Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard), served on active duty, and was discharged under conditions other than dishonorable. This includes current and former members of the Reserves or National Guard.

Overview of Healthcare Benefits for Members of the Military and Veterans

TRICARE

All active duty service members (ADSMs) are covered by TRICARE. TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is a health care program of the United States Department of Defense Military Health System. TRICARE combines the health resources of the military with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide affordable access to high-quality health care services around the world. TRICARE provides health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component.

When a service member leaves the military, he or she may or may not be able to maintain his or her TRICARE coverage. This depends on a number of factors, including if the individual is retiring, voluntarily separating, or being medically discharged. For most service members, TRICARE eligibility ends when they separate from the military.

After being discharged, some service members are eligible to apply for temporary health care through the Transitional Assistance Management Program (TAMP). TAMP can provide transitional TRICARE coverage for up to 180 days. After the 180 days (or immediately for those not eligible for TAMP), the individual can purchase extended health care coverage through a program called Continued Health Care Benefits Program (CHCBP). This program is similar to continuation of private health care coverage under COBRA and requires payment of a monthly premium. CHCBP can be used to extend health coverage for up to 18 months. When TRICARE, TAMP, or CHCBP health care benefits end, veterans may apply for VA health benefits.

The VA Healthcare System

The Veterans Health Administration (VHA) is the branch of the U.S. Department of Veterans Affairs (VA) that provides healthcare for veterans. A veteran is defined as a former member of the American

Armed Forces who served on active duty and was discharged under conditions other than dishonorable. The VHA operates the United States' largest, most comprehensive integrated health care system consisting of 150 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, and Vet Centers. Together these health care facilities and the more than 53,000 independent licensed health care practitioners who work within them provide comprehensive care to more than 8.3 million veterans each year.

After a service member leaves active military service, the VHA becomes responsible for providing medical care for service-related injuries or conditions. At this point, the Department of Defense is no longer responsible for providing care for service-related conditions. The VHA offers a number of different programs as part of the Veterans healthcare system. The most important one is the Medical Benefits Package, which is a standard set of health services the VHA provides to veterans who qualify for VA healthcare benefits. Other VA programs include Readjustment Counseling services, dental care, and home healthcare for homebound veterans. In most cases, VA facilities such as VA hospitals and VA Medical Centers provide the medical services. Civilian medical facilities generally don't provide care under the VA to veterans.

Understanding VA Healthcare Benefits

Because CWICs primarily work with veterans rather than active members of the military, we will begin our discussion of healthcare options with the VA healthcare benefits.

Applying for VA Healthcare Benefits

The VA offers veterans a number of ways to apply for healthcare benefits. Veterans may apply online by filling out the online application and submitting it electronically to the VA for processing. The online application VA Form EZ, Application for Health Benefits, is found online here: <http://www.va.gov/healthbenefits/apply/>

Veterans may also apply in person by going to the local VA health care facility and completing the same VA Form 10-10EZ, Application for Health Benefits. It's also possible to apply by phone with a VA representative by calling 1-877-222-VETS (8387), 8 a.m. to 8 p.m. Mon-Fri, EST. Finally,

applications may be submitted by mail. Detailed information about the application process may be found here:
<http://www.va.gov/HEALTHBENEFITS/apply/index.asp>

Eligibility

Once the VA receives the completed application, it determines whether or not the veteran meets the eligibility requirements for enrollment. The veteran must meet a number of criteria to be eligible for the VA Medical Benefits Package. First, individuals must have served in the active military service and been separated under any condition other than dishonorable. Current and former members of the Reserves or National Guard who were called to active duty by a federal order and completed the full period for which they were called or ordered to active duty may also be eligible for VA health benefits.

Second, veterans must meet minimum duty requirements (generally 24 continuous months of service) unless they were discharged because of a disability related to their service. Because there are a number of other exceptions to the minimum duty requirements, the VA encourages all veterans to apply so that it may determine their enrollment eligibility.

Additional factors determine if a veteran is eligible for VA health benefits and if the veteran is required to pay co-pays for healthcare services. Recent combat veterans are eligible for full VA health benefits for a period of five years after the date of their discharge, regardless of their income and assets. "Recent combat veterans" is defined as veterans who were discharged from active duty after January 28, 2003. Also, veterans who were disabled in the line of duty during active service are eligible for full VA health benefits, including care for illnesses or injuries unrelated to the military service.

Some non-disabled veterans who have incomes above the income thresholds are still eligible for VA health benefits because they meet another criteria for eligibility (such as being eligible for Medicaid or having received a Purple Heart medal). For more information about eligibility requirements, refer to:

<http://www.va.gov/HEALTHBENEFITS/apply/veterans.asp>

Enrollment and Enrollment Priority Groups

The VA operates an annual enrollment system that helps to manage the provision of health care. Once the VA enrolls a veteran, that veteran remains enrolled in the VA health care system and maintains access to certain VA health benefits. During the enrollment process, the VA will use the veteran's VA disability rating and other factors to place the veteran in one of eight Enrollment Priority Groups. Priority Group 1 is considered the highest priority group to receive care, and Group 8 is the lowest.

The VA uses the Enrollment Priority Groups to ensure that veterans who need healthcare the most will be covered if the VA doesn't have enough funding to provide healthcare to all veterans. The number of veterans who can be enrolled in the health care program is determined by the amount of money Congress gives the VA each year. Because funds are limited, the VA set up Priority Groups to make sure that certain groups of Veterans can be enrolled before others.

Some veterans may be eligible for more than one Enrollment Priority Group. In that case, the VA will always place the veteran in the highest Priority Group the individual is eligible for. Under the Medical Benefits Package, the same services are generally available to all enrolled veterans. The Enrollment Priority Groups determine how much a veteran has to pay (in co-pays) when he or she receives medical treatment and medications.

There are many other qualification rules for assignment into the Priority Groups, and this aspect of the VA healthcare system is very complex. The main qualifications are the following:

- **Priority 1:** Veterans with service-connected disabilities rated 50 percent or more; and veterans determined by VA to be unemployable due to service-connected conditions.
- **Priority 2:** Veterans with service-connected disabilities rated 30 percent or 40 percent.
- **Priority 3:** Veterans with service-connected disabilities rated 10 percent and 20 percent; veterans who are former Prisoners of War (POW) or were awarded a Purple Heart medal; and veterans whose

discharge was for a disability incurred or aggravated in the line of duty.

- **Priority 4:** Veterans receiving aid and attendance or housebound benefits; veterans determined by VA to be catastrophically disabled.
- **Priority 5:** Veterans receiving VA pension benefits or eligible for Medicaid programs, and non-service-connected veterans and non-compensable, zero percent service-connected veterans whose gross annual household income and net worth are below the established VA means test thresholds.
- **Priority 6:** Veterans of World War I; veterans with zero percent service-connected disabilities who are receiving disability compensation benefits; and some veterans who served in a theater of combat operations after November 11, 1998.
- **Priority 7:** Veterans with income or net worth above the VA national income threshold and income below the geographic income threshold who agree to pay co-pays.
- **Priority 8:** Veterans with income or net worth above the VA national income threshold and the geographic income threshold who agree to pay co-pays.

For more information about the priority groups, refer to the VHA website here:

http://www.va.gov/HEALTHBENEFITS/resources/priority_groups.asp

VA Health Benefits Co-Pays

Veterans don't have to pay a monthly premium for VA health benefits. Instead, some veterans pay an out-of-pocket co-payment (or co-pay) for services to treat conditions not related to their military service. If a veteran doesn't have a VA-rated disability or other special eligibility factor, he or she will be required to submit financial information to determine if he or she is eligible for free or low-cost VA health benefits. This process is called Financial Assessment (or Means Test). The results of this test determine which Enrollment Priority Group that the veteran

will be placed in, and also how much their co-pays will be at the time of receiving services.

As of March 24, 2014, most veterans are no longer required to complete the annual financial assessment known as a Means Test. Instead, VA will receive income information from the IRS and Social Security, and will contact the veterans only if the information it receives indicates a change in their VA health benefits may be appropriate. The elimination of the annual means test frees enrolled veterans to enjoy their VA health care benefits without worrying about completing annual income assessment forms. Under the new process, veterans will be required to have one financial assessment on file — their current file if they're already enrolled, or the assessment they provide when they apply. The VA will maintain and monitor that assessment and update it only as substantial income changes occur. For more information, go to:

http://www.va.gov/healthbenefits/cost/financial_assessment.asp

There are four types of co-pays in the VA health system:

1. Outpatient co-pays
2. Inpatient co-pays
3. Long-term care co-pays, and
4. Medication co-pays.

Some low-income veterans are eligible for reduced co-pay rates for inpatient care, and veterans in Priority Group 1 are exempt from all co-pays. Primary care services and specialty care services have co-pays of \$15 and \$50 respectively. Medications veterans fill at VA pharmacies cost \$8 for a supply of up to 30 days. For the most up-to-date information on co-pays and other out-of-pocket expenses associated with the VA healthcare benefits, go to:

<http://www.va.gov/healthbenefits/cost/copays.asp>

Medicare and VA Health Benefits

Veterans with both Medicare and VA health benefits can choose which health coverage to use when they receive care. The veteran can either receive care at a VA facility or choose to use Medicare by seeing a provider outside of the VA system. In general, the two healthcare programs are independent and don't coordinate benefits. Medicare can't pay for the same service that was covered by veterans' benefits, and the VA can't pay for the same service that Medicare covered.

When a veteran uses Medicare, he or she is responsible for all Medicare premiums, deductibles, and coinsurance. When the veteran receives care through the VA, Medicare won't pay anything. The only instance in which both Medicare and the VA can pay for services is when the VA authorizes services in a non-VA hospital. In this case, if the VA doesn't pay for all of the medical services received during the stay, then Medicare can pay for the Medicare-covered part of the services that the VA doesn't pay for. Also, if a doctor or hospital that isn't part of the VA system bills a veteran for VA-authorized care, Medicare may pay all or part of the co-pays for these services.

When veterans are considering whether to decline or dis-enroll from Medicare Part B, they should explore all options carefully before making a decision. If a veteran doesn't enroll in Medicare Part B when it's first available, he or she may have to pay a late enrollment penalty if he or she later decides to enroll in Part B. Having VA health coverage won't make the veteran exempt from this penalty. However, if a veteran declines Part B coverage because he or she is covered by a group health plan based on current employment, there will be no late enrollment penalty if the veteran enrolls in Part B later.

The Part B late enrollment penalty is 10 percent of the current Part B premium for every 12-month period that the veteran delays enrollment. In addition, the veteran may have to wait to enroll in Part B. As a rule, beneficiaries can only enroll in Part B during the General Enrollment Period (January 1 to March 31). Part B coverage will then become effective on July 1 of that year. For this and other reasons, the VA strongly encourages veterans with VA health benefits to maintain others type of health insurance, including Medicare and Medicaid. Funding set aside by Congress for the VA changes each year. It's possible that

veterans in lower priority groups could lose their eligibility for VA health benefits when this funding decreases. Veterans should be careful about choosing to end other health insurance solely because they have VA health benefits.

VA Prescription Drug Benefits and Medicare Part D

The VA provides prescription drug benefits to all veterans enrolled in VA health benefits. Under the VA prescription drug program, VA physicians write prescriptions for medications that are on a national list of covered medications (called the VA formulary). Veterans using VA drug coverage can only fill prescriptions at a VA pharmacy or through the VA's prescription drug mail order program, which is called CMOP (Consolidated Mail Outpatient Pharmacy). Note that if the veteran has Medicare Part D, he or she may fill a VA-written prescription at a non-VA pharmacy using his or her Medicare Part D coverage.

Medicare Part D coverage and VA Prescription Drug Benefits are completely separate programs and don't affect each other in any way. Veterans enrolled in both programs effectively have two prescription drug programs that they can use. Veterans access VA drug benefits through VA physicians and VA pharmacies. Veterans may use Medicare Part D through non-VA providers and fill prescriptions at non-VA pharmacies. The VA generally provides comprehensive drug coverage at a low cost to veterans. In some cases, however, the out-of-pocket costs for a drug will be cheaper at a non-VA pharmacy through Medicare than through the VA. In these situations, veterans can save money by using their Part D coverage. If a veteran has Medicare Part D and qualifies for the Low Income Subsidy (LIS) program, he or she will have minimal out-of-pocket costs when using his or her Part D coverage. This is another reason for some veterans to use Medicare Part D coverage instead of VA drug coverage. Veterans who don't qualify for the LIS may pay less for medications if they obtain them through the VA instead of through Medicare. Neither Medicare nor the VA will pay for medications that the other program has paid for.

Choosing Whether or Not to Enroll in Medicare Part D

Veterans with VA health benefits will have to decide whether or not to enroll in a Medicare Part D plan. CWICs should discuss with a veteran the

pros and cons of having Part D coverage in addition to VA prescription drug coverage. Veterans may have to pay a monthly premium when they enroll in a Medicare Part D plan. Some veterans will decide not to enroll in Medicare Part D and only obtain their medications through the VA.

Veterans who have had continuous VA health benefits don't have to pay a late enrollment penalty for Medicare Part D at any later date. A veteran can decline Part D coverage and enroll later without having the penalty of higher monthly Part D premiums. This is because Medicare considers VA prescription drug coverage as creditable coverage for Medicare Part D purposes. Creditable coverage means that Medicare considers the VA drug benefits as good as or better than Part D drug plans (VA health benefits aren't creditable coverage for Medicare Part B. If a veteran declines Part B coverage, he or she will have a late enrollment penalty if he or she enrolls in Part B later).

When deciding whether or not to enroll in Medicare Part D, veterans need to assess how important it is for them to have Part D coverage in addition to VA prescription drug coverage. Factors to consider include the cost of Part D premiums and the additional flexibility of being able to get prescriptions from non-VA doctors and facilities. Veterans can also use their Medicare Part D coverage to obtain medications that aren't on the VA formulary. Another way to receive non-formulary drugs through the VA is to request them through a waiver process. This process, however, can be time consuming and challenging for many veterans. A veteran can sometimes use VA prescription drug coverage to obtain drugs that are too expensive or not available through Medicare.

Two additional considerations may be important to veterans. A veteran who lives in or moves to a geographical area that has limited access to VA facilities may want to maintain his or her Medicare prescription drug coverage to facilitate access to a pharmacy. If a veteran becomes a patient or inmate in a government agency (such as a jail, prison, state veterans home, or state mental institution), the veteran may not be eligible for VA health benefits. While the veteran is in that institution, he or she may not have creditable coverage for Medicare Part D from the VA. Because of this, it may be important to maintain Medicare Part D coverage in order to avoid a break in coverage and a Part D late enrollment penalty. It's important to note that veterans who are incarcerated are ineligible for Medicare Part D. This is because they don't

meet the requirement of permanently residing in the service area of a Part D plan.

TRICARE

TRICARE is the Department of Defense (DoD) health care program for active duty service members (ASDMs) and their family members. TRICARE evolved during the 1990s from the existing military health care program, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). The DoD provides all members in all branches of the U.S. military with health coverage through TRICARE. TRICARE provides health care through a combination of military and civilian medical facilities and providers. TRICARE is designed so that ASDMs and family members can get health care at civilian medical facilities when they are unable (too far away, for example) to get treatment at a military hospital or clinic. The name TRICARE comes from the existence of its three primary programs:

1. **TRICARE Prime** (a managed care plan for all active duty service members);
2. **TRICARE Standard** (a fee-for-service plan for non-active duty beneficiaries, including family members, living in the United States); and
3. **TRICARE Extra** (a savings program that works with TRICARE Standard).

Additional TRICARE programs include:

- **TRICARE For Life** (for Medicare-eligible TRICARE beneficiaries);
- **TRICARE Reserve Select** (for Reservists and National Guard Members);
- **TRICARE Prime Overseas**; and
- **US Family Health Plan** (available only in six areas of the country).

All active duty service members are covered under either TRICARE Prime or TRICARE Prime Remote. Family members and other TRICARE beneficiaries choose between several other TRICARE options. The DoD bases eligibility for the different TRICARE programs on a number of factors, including whether the individual or his or her TRICARE sponsor is on active duty or retired, where he or she lives, and whether he or she is Medicare eligible. Each program differs in terms of out-of-pocket costs and which medical providers and facilities its members can use (military, civilian, or both). In general, TRICARE provides comprehensive health coverage at a low cost to its members.

When a service member leaves the military, eligibility for TRICARE will end unless the individual is retiring from the military. Retirees and their dependents maintain eligibility for TRICARE. Service members can retire after 20 years of service or if they become permanently or temporarily disabled, referred to as medical retirement. It's possible for a beneficiary to have both TRICARE and VA healthcare benefits.

Most Title II disability beneficiaries who have TRICARE and Medicare will be enrolled in TRICARE for Life (TFL). Two other possible TRICARE options for beneficiaries with Medicare are TRICARE Plus and TRICARE Prime. TRICARE Prime is only available to beneficiaries who live in a TRICARE Prime service area. TRICARE Plus is available at some Military Treatment Facilities, and it gives enrollees priority access to primary care appointments at these facilities.

TRICARE Prime care uses a managed care system similar to a civilian HMO. Under TRICARE Prime, a primary care manager coordinates care, and members need referrals and prior-authorizations to access specialty care. For veterans with TRICARE Prime, a Military Treatment Facility (MTF) provides most care. One advantage of choosing TRICARE Prime over TFL is that Prime gives the beneficiary priority access to treatment at MTFs. The disadvantage of choosing TRICARE Prime over TFL is that the beneficiary won't be able to use the wider network of providers that accept Medicare. Also, with TRICARE Prime, the beneficiary will need a referral and authorization to see a specialist. The majority of Medicare-eligible TRICARE beneficiaries that CWICs will encounter will be enrolled in TRICARE for Life.

TRICARE for Life

TRICARE for Life is the TRICARE program option for Medicare-eligible uniformed services retirees, their eligible family members and survivors, and certain former spouses. TFL is available to all Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B. TFL is wraparound coverage for Medicare. This means that for most medical services, TRICARE will pay all out-of-pocket costs that the beneficiary would have incurred with Medicare alone. For medical services covered by both Medicare and TRICARE, TRICARE will cover the full Medicare deductible and coinsurance amounts. Veterans with TFL have a wide choice of providers and minimal out-of-pockets costs. TRICARE for Life is similar to the Original Medicare (that is "fee-for-service" Medicare) in that the veteran can use any Medicare-certified healthcare provider or facility.

Complete information about TRICARE is available at:
<http://www.tricare.mil>

TRICARE and Medicare

When beneficiaries have TRICARE and Medicare, Medicare coverage will generally be the primary payer (will pay bills first). TRICARE is secondary payer for medical services that are covered by both Medicare and TRICARE. Medicare will pay its portion of the claim, and then TRICARE will pay the remaining amount of the bill. TRICARE will pay any Medicare co-insurance and deductible amounts for the Medicare beneficiary. The only exception to this rule is when the beneficiary has used up a Medicare benefit for a medical service. In this case, TRICARE will also make payment as the primary payer. The beneficiary will be responsible for applicable TRICARE deductibles and cost shares.

The beneficiary will usually have no out-of-pocket costs for services covered under both TRICARE and Medicare. For example, if a veteran has both types of health coverage, and needs to stay in a hospital for four months, the veteran will have no out-out-pocket costs. TRICARE will cover all Part B out-of-pocket costs as well, as long as the veteran uses providers that accept Medicare. CWICs should remind veterans to use providers that accept Medicare. If they use a provider that doesn't accept

Medicare, then Medicare won't pay anything. In this case, TRICARE will pay only 20 percent of its allowed rate for the services, and the beneficiary will be responsible for the remainder of the bill.

If Medicare covers a medical service but TRICARE doesn't, then TRICARE won't pay anything. Medicare will be the primary payer. The veteran will have to pay any remaining portion of the bill after Medicare has paid. In this case, the veteran will pay Medicare co-insurance and deductible amounts. When TRICARE covers a medical service but Medicare doesn't, TRICARE will be the primary payer. The veteran will have to pay any TRICARE cost shares and the TRICARE Standard annual deductible (unless the veteran has other health insurance that will pay).

Medicare Part B Enrollment and TRICARE

Title II disability beneficiaries with TRICARE need to understand the importance of enrolling in and maintaining their Medicare Part B coverage. Under federal law, if an individual is a TRICARE beneficiary eligible for premium free Medicare Part A, he or she must enroll in Medicare Part B and pay the monthly premiums in order to remain eligible for TRICARE benefits. There are a few exceptions to this rule, which are discussed below. If a beneficiary doesn't enroll in Part B when it becomes available to him or her, he or she can enroll in Part B later but he or she may have a break in his or her TRICARE coverage and he or she may be required to pay the Part B late enrollment penalty.

There are two main exceptions to the requirement of having Medicare Part B in order to be eligible for TRICARE. The first exception is for active duty service members (ASDMs) and their family members. ASDMs aren't required to purchase Medicare Part B in order to remain TRICARE eligible. ASDMs can enroll in Part B anytime they are on active duty or within the first eight months following the month they separate or retire from the service. This eight-month period is called is a Special Enrollment Period for Medicare Part B. The DoD strongly encourages ASDMs to keep Part B while active so that there is no break in TRICARE coverage after they leave the military. If the SSDI beneficiary is a family member of an ASDM (who is called his or her sponsor), the beneficiary doesn't need to purchase Part B until his or her sponsor retires or separates. The family member will have a Special Enrollment Period: He or she can enroll any

time the sponsor is on active duty and the eight months period after the sponsor separates or retires from service.

TRICARE and Medicare Prescription Drug Benefits

TRICARE provides veterans with low-cost comprehensive prescription drug coverage. TRICARE has a standardized list of covered medications called the Uniform Formulary. TRICARE classifies all medications into three cost tiers:

- **Tier 1:** Formulary – Generic
- **Tier 2:** Formulary – Brand Name
- **Tier 3:** Non-Formulary

TRICARE bases the beneficiary's out-of-pocket costs on the drug's Tier level and on how the beneficiary obtains the drug. If the beneficiary obtains the prescription drug at a Military Treatment Facility pharmacy, there is no cost to the beneficiary. If he or she obtains the medication through the mail or at a "Network" pharmacy, then the co-pays range from \$5 (Tier 1) to \$17 (Tier 2). TRICARE has more than 56,000 Network pharmacies throughout the U.S. and its territories.

How Medicare and TRICARE coordinate benefits between prescription drug coverage is similar to how they coordinate for other types of medical services. Medicare is the primary payer when both TRICARE and Medicare cover the prescription drug. There is no cost to the beneficiary for drugs that both plans cover, up to an annual coverage limit of \$2,250. After the beneficiary reaches this limit, he or she is responsible for standard TRICARE co-pays for medication. This means that initially veterans with both types of health coverage will have no out-of-pocket prescription drug costs. After they have reached \$2,250 in total drug costs, veterans will have to pay the TRICARE Standard co-pays. If a veteran uses MTF pharmacies for drugs on the Uniform Formulary, he or she will have little or no out-of-pocket costs for medications, even after reaching his or her annual coverage limit.

Joining a Medicare Part D plan is voluntary for TRICARE beneficiaries. TRICARE drug coverage is creditable coverage for Medicare Part D purposes. Beneficiaries won't be subject to a Part D late enrollment

penalty as long as they have had no break in TRICARE coverage. The primary advantage for veterans with TRICARE to enroll in a Medicare Part D plan occurs if the veteran is low-income. Low-income veterans may be able to obtain some medications at a lower out-of-pocket cost by using their Medicare instead of TRICARE. For many veterans, however, TRICARE prescription drug coverage will be affordable and meet their healthcare needs. These veterans may choose not to enroll in a Part D plan.

More information about the interaction between TRICARE and Medicare may be found online at:

<http://www.tricare.mil/Plans/Eligibility/MedicareEligible.aspx>

Conducting Independent Research

Veterans Health Administration Home Page:

<http://www.va.gov/health/>

Veterans Health Care information:

<http://www.military.com/benefits/veterans-health-care>

VA Health Benefits Reference Library:

<http://www.va.gov/healthbenefits/resources/publications.asp>

TRICARE for Life Handbook:

https://www.hnfs.com/content/hnfs/home/tn/bene/res/handbooks_and_brochures/tricare_for_lifeandretiree.html

“Comparison of Outpatient Prescription Drug Coverage: Medicare, VA, VA-ChampVA, DoD-Tricare Pharmacy” Centers For Medicare & Medicaid Services:

<http://www.cms.hhs.gov/partnerships/downloads/tricare.pdf>

Important Information for TRICARE (Military Health Benefits):

Beneficiaries Entitled to Medicare Based on Social Security Disability; Social Security Administration, SSA Publication No. 05-10020, June 2014.

<https://www.ssa.gov/pubs/EN-05-10030.pdf>

Competency Unit 4 – Understanding Private Health Insurance Coverage

Introduction

Until recently, many Social Security disability beneficiaries have been unable to access private health insurance. Historically, private health insurance companies could deny coverage due to pre-existing conditions. Because most beneficiaries eligible for Social Security disability benefits have pre-existing conditions, these private health insurance plans were out of reach. As a result of the Affordable Care Act (ACA) of 2010, private health insurance companies may not deny eligibility for a healthcare plan or access to covered services because of pre-existing conditions (effective January 1, 2014). For children, the ACA removed this barrier in September 2010.

Generally, individuals access private health insurance plans through the following means:

- Employer-sponsored health insurance;
- The Marketplace (also known as the Insurance Exchange);
- Individual or family plans purchased directly from private health insurance companies; or
- Union, association, and professional organization sponsored plans.

NOTE: This unit will provide details about each of these pathways to private health insurance as they currently stand. Legislative changes to the ACA could occur in the coming year which would make some information in this unit inaccurate. When in doubt, seek assistance from your VCU NTDC TA Liaison.

Healthcare Terms and Concepts

Healthcare Terms

There are certain terms a CWIC must understand to master the information in this unit.

Initial Enrollment Period:

The first time health coverage is made available is called the initial enrollment period. If the person doesn't sign up during the initial enrollment period, he or she will need to wait for the open enrollment period or a special enrollment period to enroll.

Open Enrollment Period:

With most pathways to private healthcare, after the initial enrollment period expires, there will likely be a designated time frame during which a person can enroll, called an open enrollment period. This is often once a year and will span multiple weeks or months. During open enrollment, an individual can accept or change health plans.

Special Enrollment Period:

When a pathway to health insurance has an initial and open enrollment period, it's common to also have a special enrollment period. This provides a way for people, who meet certain exceptions, to enroll after the initial enrollment period but before the open enrollment period. Take, for example, an individual who opts out of employer-sponsored health insurance because he or she was already on his or her spouse's employer health plan. If that person lost coverage under his or her spouse's employer health plan, he or she could enroll in his or her own employer's health plan (assuming they have and allow this under a special enrollment period), even if the coverage ended before open enrollment.

Premium, Deductibles, Co-Payments, Co-Insurance, and Out-of-Pocket Maximum

- Premium is a monthly amount the individual must pay to be enrolled in a plan.
- Deductible is the amount of money an individual is responsible for paying before the health plan will start helping to pay for covered services.
- Co-insurance is the percentage of a medical bill that the individual pays.
- Co-payment is a fixed fee that subscribers to a health plan pay for their use of specific medical services covered by the plan.
- Out-of-pocket maximum is the maximum amount an individual pays for healthcare services in a calendar year before the insurer begins to pay for services at 100 percent.

The amount of the premium, deductible, co-payments, and co-insurance can vary dramatically from one plan to another.

Example of how each of these expenses comes into play:

Alex has seldom been sick and never spent time in the hospital. Last December Alex broke his leg skiing and was rushed to the local hospital. The break was so bad that he needed surgery. Afterwards he endured several months of physical therapy. The bill for the hospital stay, surgery, and physical therapy amounted to \$60,000.

Alex's health plan is through his employer; he has \$250 deducted from his paycheck each month for the premium. Because Alex had rarely been ill, he hadn't yet paid the required deductible. After the hospital stay and surgery, Alex was responsible for:

- The first \$500 of his medical bills (deductible);
- Twenty percent of the remaining medical expenses up to the out-of-pocket maximum of \$2,000 (co-insurance); and

- Continued payment of the health insurance premium (\$250/month).

The total expenses, not including premiums, Alex will have during any calendar year will be \$2,500.

Broad Insurance Reforms

Under the Affordable Care Act (ACA) of 2010, a number of broad insurance reforms changed some of the rules set by health insurance companies.

Elimination of Pre-Existing Conditions: As of January 1, 2014, insurance companies can no longer deny coverage or deny issuing an insurance plan to individuals because of a pre-existing condition. The elimination of pre-existing conditions for children under the age of 19 went into effect in September 2010.

Community Rating: Community rating is a reform that affects how health insurance companies can set their rates. Historically, health insurance companies have been able to take into consideration the individual's personal health when determining the rate. Under the ACA, health insurance companies can vary their rates but only based on certain characteristics including family size, geographic location, use of tobacco, and age.

Lower Insurance Costs: Health insurance companies are no longer able to have annual or lifetime limits on the amount of covered health care services, with the exception of some plans that the ACA grandfathered in. Additionally, health plans must create limits for the amount a consumer will pay in out-of-pocket costs and provide certain preventative services at no cost.

Extended Access to Parents' Health Insurance: In the past, health plans often dropped children from their parents' plans when they turned 19 or finished college. As of September 2010, children can stay on (or be added to) their parents' insurance policies until they turn 26. This applies to insurance plans that provide dependent coverage, including employer-sponsored health coverage.

Mental Health Parity: The ACA didn't establish Mental Health Parity protections but does extend the applicability of parity to many new insurance plans. Under parity requirements, health plans can't put more restrictive criteria on behavioral health services than on physical or acute care services. This allows greater, and equitable, access to behavioral health services when compared to physical health.

Common Types of Healthcare Plans

Health Maintenance Organization (HMO)

This type of health insurance plan usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Exclusive Provider Organizations (EPO)

These are managed care plans in which services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).

Preferred Provider Organization (PPO) Plans

With this type of health plan you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Point of Service (POS) Plans

With the type of plan you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.

Employer-Sponsored Health Insurance

For many Social Security disability beneficiaries, accessing employer-sponsored healthcare is a work incentive that remains largely untapped. Many individuals consider employment merely as a way to improve their quality of life through increased income. However, accessing employer-sponsored benefits such as health coverage, short-term or long-term disability insurance coverage, and life insurance can allow individuals to

support their healthcare needs as well as those of a spouse or dependents. Many employers offer benefits to an individual who works a specified number of hours and remains employed for a specified period of time.

Active Work Requirements: Employers usually require an employee to work a minimum number of hours per week to be eligible for employee benefits. This active work requirement ranges from 20 to 40 hours per week depending on the employer and health coverage provider.

Service Wait: When an individual accepts employment that offers health coverage, he or she may be required to wait between one to six months to enroll. This period is known as the service wait. The service wait may be different for each benefit the employer offers.

Once the individual meets the eligibility requirement, there will be an initial enrollment period during which time he or she can enroll. Depending on the plan(s) offered by the employer, the individual would likely have a monthly premium. In many cases the employer pays a portion of the premium and the employee pays another portion. In some situations the employer will pay the entire premium.

Types of Employer-Sponsored Healthcare Coverage

Employers may choose to provide a variety of private health plans. Each type provides coverage in different ways with advantages and disadvantages. Individuals should consider the cost associated with the coverage. Although some coverage will enable an individual to have greater access to medical providers, the individual must be able to afford the cost associated with this choice. Most employer-sponsored healthcare benefits use a form of healthcare explained under the "Common Types of Healthcare" above.

It's possible for an employer to use a self-insured trust or self-funded plan as an alternative. These are plans in which a large company or labor union covers an individual's medical expenses with funds set aside to pay claims. Because this type of coverage is less regulated, the policies vary greatly. Individuals who are members of a self-insured trust should thoroughly review the benefits to determine what the self-insured trust covers.

Using Medicaid or Medicare with Employer-Sponsored Health Coverage

Beneficiaries can use private employer-sponsored coverage in conjunction with Medicaid and Medicare. Adding private health coverage can expand access to providers and extend healthcare benefits to family members. Unfortunately, many individuals believe that use of, or eligibility for, private health coverage will make them ineligible for Medicaid or Medicare, when this is generally not the case. As a result, many individuals needlessly deny themselves and their dependents access to employer-sponsored health coverage.

When using employer-sponsored health benefits in conjunction with either Medicaid or Medicare (or both), it's critically important that beneficiaries inform current and new medical providers of multiple types of health coverage to ensure proper billing and to avoid patient liability.

When an individual is eligible for Medicaid and private health coverage simultaneously, the private coverage always becomes primary (pays first) and Medicaid becomes secondary. There are no exceptions to this rule. Medicaid is always the payer of last resort when other forms of health insurance are available.

Medicaid beneficiaries should report to their eligibility worker when they are offered employer-sponsored health insurance. Some states will require the beneficiary to take the employer-sponsored health insurance if it's "cost effective." If it's "cost effective," the Medicaid agency will likely pay the individual's health insurance premium. If it's not "cost effective," the individual won't be required to take the new coverage but will also not receive any assistance in paying for the premium.

When an individual is eligible for both Medicare and employer-sponsored health coverage simultaneously, the employer's coverage becomes primary (pays first) and Medicare becomes secondary, if the individual is under age 65 and the employing company has more than 100 employees. However, Medicare only pays the difference between the employer coverage and the cost of the covered expense up to what Medicare would usually pay for the covered expense.

Employer-sponsored health insurance becomes the secondary payer with Medicare paying first for individuals under age 65 who work for companies with fewer than 100 employees, or for people aged 65 and older who work for companies with fewer than 20 employees.

While Medicare will let a beneficiary opt out of Medicare Part B and D if the beneficiary has employer-sponsored healthcare, it's important that beneficiaries know some employer-sponsored health insurance plans will require the beneficiary to get or keep all parts of Medicare if they are eligible.

If employment ends and the individual has COBRA coverage or retiree coverage with Medicare, then Medicare is the primary payer. More detailed information on COBRA will be provided further on in this unit.

NOTE: If a beneficiary already has COBRA when he or she becomes Medicare-eligible, in most cases he or she will want to enroll in Part B to avoid paying a late enrollment penalty. The beneficiary won't have a Special Enrollment Period (SEP) to enroll in Medicare Part B when COBRA ends. See the unit on Medicare for more information on Medicare Part B and late enrollment penalties.

Social Security Title II disability beneficiaries have eight months after employer coverage stops, regardless of COBRA, to enroll in Medicare Part B without a premium surcharge. For more detailed information about the premium surcharge for Medicare Part B, refer to Unit 2 of this module, "Understanding Medicare."

Example of using Medicare with employer-sponsored health coverage:

Gus has been working for the same small company for 40 years. He enjoys his work, likes his employer, and at age 70 has no intention of retiring. In addition to his employer's health insurance, he has Medicare. Gus had an emergency appendectomy two weeks before his 71st birthday. He was admitted to the hospital, where doctors performed surgery. Instead of billing his primary insurer, Medicare paid for the majority of the surgery and hospital stay. Because Gus received coverage from a small employer (fewer than 20 employees), Medicare covered the surgery as the primary payer, with the private coverage becoming secondary.

Example of using Medicaid with employer-sponsored health coverage:

Michael is an SSI recipient who is now working, making \$20,000 annually, and is enrolled in his employer-sponsored health coverage with a deductible and co-payments. He is also still eligible for Medicaid under 1619(b) provision, which is explained in detail in Unit 1 of this module.

Michael received bills for lab work and consultations that he thought his health insurance covered, so he called the lab and asked to speak to the billing department. The representative explained that he was being billed for co-payments that his primary insurer required. He said he understood, though he didn't. He then called his primary care physician's office and asked to speak to the billing department there. Again he questioned the bill. After a moment the billing representative agreed with him and assured him that the billing department will remind the lab and the physician's office that not only does Michael have private insurance but also that Medicaid that will take care of the co-payments that the lab billed.

He was relieved until the following month when he received a bill from the same lab. He angrily tore into the envelope and yanked out the bill. His concerns were immediately alleviated when he saw at the bottom of the bill, "BALANCE DUE: \$0."

Beneficiaries should take into account some important considerations when combining Medicare or Medicaid with employer-sponsored insurance:

- Determining whether the employer's plan will cover the beneficiary's current physician(s) and specialists.
- Informing new health insurance carrier of Medicare eligibility to establish payment order and avoid patient liability.
- Taking into account special provisions for continued Medicaid and Medicare coverage while working (see Units 1 and 2 of this module).

COBRA Health Coverage Protection between Jobs or Continuation Coverage

Federal and state law allows continued access to employer-sponsored health coverage after employment ends, whether it ends voluntarily or involuntarily. These legal protections apply to health coverage through an employer. The protections are commonly called COBRA, or continuation coverage protections. The acronym COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1986. With the passage of the Affordable Care Act (ACA) of 2010, pre-existing conditions are no longer a barrier to individual health insurance plans, and new pathways exist (e.g., Marketplace) to obtain health insurance. As a result, it's expected that fewer people will use this COBRA option. Because this law still exists, it's important CWICs understand when and how it can help.

Individuals who are working and have health coverage through their employer might lose that coverage for a number of reasons, such as being laid off, quitting, or reducing their work hours. When individuals lose employer-sponsored health coverage for these or similar reasons, the COBRA laws may allow them to keep that coverage for up to three years. Continuation coverage laws, in most situations, also protect spouses and dependents of those on an employer-sponsored health plan.

IMPORTANT NOTE: Under COBRA provisions, employers don't pay for any part of the continuation coverage. The individual who receives coverage entirely pays for COBRA coverage.

To be eligible for continuation coverage, the individual must have lost his or her employer-sponsored group coverage because of a qualifying event. Many events that cause an individual to lose his or her original coverage are qualifying events. For employees, qualifying events include:

- Quitting,
- Being fired for a reason besides gross misconduct,
- Being laid off, or

- Having work hours reduced to a point where the employer doesn't provide health coverage.

To be eligible for continuation coverage, the individual must be on the employer-sponsored health plan on the day before a qualifying event happens. After the qualifying event, the employer has to notify the health plan within 30 days of that event. If the covered individual divorces or legally separates from the spouse, or is someone who reaches an age where he or she is no longer considered a dependent child, those individuals have to notify the health plan within 60 days.

The health plan then has 14 days to send out a notice informing the key people in these cases that continuation coverage is available. They will send an application along with the notice that explains how much the COBRA continuation coverage premium will be. The cost will generally be the entire amount of the premium, including what the employer used to pay, plus a small cost for administrative fees.

A covered individual has 60 days from the day of the qualifying event to enroll in continuation health coverage. If an individual gets a notice after the qualifying event, he or she has 60 days from the day he or she receives the notice. If the individual doesn't get a notice, he or she will need to contact both the employer and the health plan.

In some states, if Medicaid covers beneficiaries, the state's Medicaid health insurance premium payment program may be able to help pay COBRA continuation coverage premiums. CWICs are encouraged to investigate whether this option is available in their home state.

Two laws relate to this continued coverage. They apply to different people for different amounts of time. It can be confusing as to when coverage under one law begins and when another one ends.

- **COBRA is a federal law that covers employees of businesses with 20 or more employees.** It allows up to 18 months of continuation coverage for an employee who loses coverage because of a qualifying event. The premium for these 18 months is up to 102 percent of the premium for current employees with the same plan. The coverage time periods are sometimes different for spouses and dependents. COBRA will last for 36 months if the

individual qualifies for continuation coverage because of the employee's Medicare enrollment, legal separation or divorce, loss of dependent status, or death of the employee.

- **OBRA (Omnibus Budget Reconciliation Act of 1987) is a federal law meant to extend COBRA for a longer period of time to people with disabilities.** If the individual is on COBRA for 18 months and Social Security determines that the individual is disabled within the first 60 days of the COBRA continuation coverage, the individual can extend the coverage for an additional 11 months. The purpose of this law is to protect health coverage during the period between becoming disabled and qualifying for Medicare. The premium can increase to up to 150 percent of the premium for current employees with the same plan.

With continuation coverage, the individual is on the same health coverage policy he or she was on previously and will have the same benefits as other employees on the plan. If the employer increases premiums for those currently on that plan, the continuation coverage premiums will increase accordingly. If the employer offers current employees an opportunity to switch plans, those on continuation coverage will have that opportunity as well. With COBRA, the individual can also choose to continue coverage for dental and vision benefits.

The Marketplace (Insurance Exchange)

The Marketplace, also known as the Insurance Exchange, was a centerpiece of the Affordable Care Act (ACA). The purpose of the Marketplace is to ensure the availability of and access to health insurance for Americans. The heart of the Marketplace is a website that provides a place for people to compare and shop for private health insurance plans. The model fosters competition and facilitates access. The website also provides a way for people to apply for non-disability or non-elderly related Medicaid eligibility groups and the Children's Health Insurance Program (CHIP), as well as the Advanced Premium Tax Credit (APTC), which helps pay health insurance premiums.

Some states have created their own state-specific Marketplace, whereas other states chose not to create a Marketplace; instead, its citizens use

the Marketplace run by the federal government: www.healthcare.gov. A handful of states pursued a hybrid model. To find out what your state is using for the Marketplace, go to the following webpage and select your state: <https://www.healthcare.gov/marketplace/individual/>. CWICs should become familiar with these resources to be able to refer beneficiaries when the time arises.

For individuals who don't have Internet access or who need support in comparing plans, shopping for plans, or applying for Medicaid or the APTC, both phone and in-person assistance is available. Details such as the appropriate phone number and how to find in-person assistance are available on the Marketplace website for each state.

Eligibility and Who Can Use the Marketplace

To use the Marketplace, an individual must:

- Live in the Marketplace service area, and
- Not be incarcerated, and
- Be a U.S. citizen or national, or
- Be a non-citizen who is lawfully present in the U.S. for the entire period for which he or she is seeking enrollment

Important Notes About Medicare and Medicaid Beneficiaries:

Medicare Beneficiaries: It's illegal to sell and issue duplicate coverage to Medicare beneficiaries. As a result, Medicare beneficiaries can't use the Marketplace. The exception is beneficiaries whose employer purchases Small Business Health Options Program (SHOP) coverage, as they are treated the same as any other people with employer coverage.

Medicaid Beneficiaries: While Medicaid beneficiaries aren't prohibited from purchasing a plan on the Marketplace, there doesn't appear to be any situation in which it would make financial sense to purchase a plan on the Marketplace and have Medicaid. The individual would have to pay the monthly premium, because he or

she would be ineligible for the Marketplace financial assistance programs.

Now that you understand the eligibility criteria for purchasing a private plan on the Marketplace and the fact that Medicaid and Medicare beneficiaries are unlikely to benefit from such a plan, it's helpful to look at who could benefit from a Marketplace plan:

- Individuals receiving SSDI who don't qualify for Medicaid and are in the 24-month Medicare Qualifying Period.
- Uninsured individuals currently applying for Social Security.
- SSI beneficiaries who have earned income that exceeds 1619(b) and other options for Medicaid in the state.
- Social Security disability beneficiaries who medically improve.
- Title II disability beneficiaries who were terminated due to SGA-level work and whose Medicare coverage under the EPMC will soon expire.

Enrollment Periods

- **Open Enrollment Period:** Generally this period is November, December, and potentially one or more months in the beginning of the following year. The Marketplace website will specific dates for a state's open enrollment period. **Special Enrollment Period:** When a qualifying life event occurs (e.g., moving to a new state, certain changes in income, marriage, divorce, birth of a child), a Special Enrollment Period will be available.

Qualified Health Plans

Plans on the Marketplace are called Qualified Health Plans (QHPs). The entity running the Marketplace (the state agency or federal government) must review all plans to assure they meet certain requirements. One of the major requirements of QHPs is that they must offer Essential Health Benefits (EHBs). Essential Health Benefits are a minimum package of services that all QHPs have to offer. They create a baseline for plans on

the Marketplace. Essential Health Benefits include at least these 10 categories:

1. Ambulatory patient services,
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorders services (including behavior health treatment)
6. Prescription drugs
7. Rehabilitation and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services, and chronic disease management
10. Pediatric services (including oral and vision care)

The essential health benefits package may vary slightly from state to state. Each state creates a benchmark plan, which provides more specific details about coverage including specific benefit limits, state required benefits, and a list of covered prescription drug categories and classes. State benchmark plans can be found on the following webpage: <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>

To make it easier for consumers to compare plans on the Marketplace, the plans are categorized using a metal grouping: platinum plans, gold plans, silver plans, and bronze plans. The difference between these categories of plans is the actuarial value, which is the overall healthcare cost that each plan covers. Plans with higher actuarial value (the health plan covers more healthcare costs) have a higher monthly premium. The lower the actuarial value, the lower the premium will be.

Levels of Coverage	Plan Pays On Average	Enrollees Pay On Average* (in addition to monthly premium)
Bronze	60 percent	40 percent
Silver	70 percent	30 percent
Gold	80 percent	20 percent
Platinum	90 percent	10 percent

*Based on average cost of an individual under the plan and may not be the same for every enrolled person.

In looking at the plans, for example, an individual may have more out of pocket costs associated with the provision of health care services with a silver plan than he or she would with a gold plan. But, the individual would have less in premium costs with a silver plan than he or she would with a gold plan. Choosing a health plan is a financial decision based in large part on the individual's expected health care needs. The monthly premiums will vary not only by metal category, but also by geographic area, age, family size, and tobacco use.

Two financial assistance programs help those with low income afford coverage through the Marketplace:

- Advanced Premium Tax Credit (APTC)
- Cost Sharing Reduction

Advanced Premium Tax Credit (APTC)

ACA created the Advanced Premium Tax Credit to help those with low income offset the cost of health insurance. A tax credit generally means getting money back during tax time each year. This tax credit works in a very different way. If a person's Modified Adjusted Gross Income (MAGI) is low enough, he or she can get this tax credit in advance, getting a little bit each month. The monthly amount of the tax credit is paid directly to

the health insurance company beneficiaries choose on the exchange, to cover a portion of the monthly premium. The end result is that the person gets a portion of their premium paid, reducing what has to come directly out of his or her pocket each month. It's also important to note that this tax credit is "refundable," which means it's available to a person even if he or she has no tax liability.

Who can get APTC?

The ACA bases eligibility for the APTC, in part, on income. Families with income between 100 percent and 400 percent of the FPL who purchase coverage through an insurance exchange could be eligible for a tax credit. There is no asset test. Income is determined using the MAGI standard. To determine income using the MAGI standard, the first step is to determine taxable income less any allowable IRS deductions, which is what the person reports to the IRS. Add in any Title II Social Security income that you didn't count as taxable income. Unlike the Medicaid eligibility groups who use a MAGI-based income methodology, there isn't a 5 percent disregard of income. For example, George has \$1,200 of SSDI and \$850 of gross wages. He doesn't have Medicare yet and has no tax deductions. His total income, \$2,050, is below 400 percent of the FPL for a single person (\$4,020 – 2017 rate).

A critical concept to understand, in terms of eligibility, is that even if a person's income falls within that range, he or she can't get this tax credit if he or she is eligible for minimum essential coverage. Minimum essential coverage includes public health insurance such as Medicare Part A, Medicaid, the CHIP program, TRICARE, and VA Health Care Benefits. The logic is the federal government is already sponsoring, at least in part, health insurance for those individuals. Minimum essential coverage also includes employer-sponsored health insurance, unless the employer-sponsored plan doesn't cover at least 60 percent of health care expenses or unless the person's share of the premium exceeds 9.5 percent of his or her income. People who have unaffordable employer-sponsored health insurance can enroll in a health insurance plan through the exchange and may receive tax credits to reduce the cost. During the application process on the Marketplace, the person would have to "attest" to having unaffordable employer-sponsored health insurance. The Marketplace then verifies that statement.

If a person is interested in applying for the APTC, he or she will need to do so through the Marketplace for his or her state, whether it's a state-run exchange or the federally run version. During the application process, the person will provide his or her estimated income for the year. If his or her income is low enough, he or she can choose the specific amount of advanced credit he or she wants applied to his or her premiums each month, up to a maximum amount based on his or her income. If the amount of the advanced credit he or she takes for the year is less than the tax credit he or she ends up being due, then he or she will get the difference as a refundable credit when completing his or her tax return at the beginning of the following year. If the advanced payments for the year are more than the amount of credit the person ends up being due, then the extra tax credit will reduce his or her overall refund (if any) or he or she must pay it back when filing the tax return the following year. If a person's income is variable, he or she will potentially want to choose an advanced tax credit amount that is less than the maximum to avoid or minimize having to pay at tax time.

How much does APTC help?

The amount of the tax credit that a person can receive is based, in part, on the premium for the second lowest cost silver plan on the exchange where the person is eligible to purchase coverage. A silver plan covers about 70 percent of health care expense. The amount of tax credit is also based on the household's income. On the lower end of the scale, those with income up to 133 percent of the FPL will pay 2 percent of their income on the premium. On the higher end of the scale, those with income up to 400 percent of the FPL will pay 9.5 percent of their income on the premium.

Example of eligibility for a silver plan:

Debra is 45 years old and has income in 2017 that is expected to be 250 percent of the FPL, which is \$30,150 (2017 rate). Given her income, Debra wouldn't be required to pay more than 8.05 percent of income for a premium, which equals \$2,427 for the year. The second lowest cost silver plan in her area costs \$5,733. Because she's only required to pay \$2,427, she would be eligible for an advanced tax credit of \$3,306. That is simply the difference between the second

When applying for a health plan on the Marketplace, the individual will also be able to apply for the APTC. The Marketplace will calculate the APTC the person is estimated to be eligible for. If an individual is interested in an estimate, the Kaiser Family Foundation has created an estimator tool that can be found on the following web page at: <http://kff.org/interactive/subsidy-calculator/>

Cost Sharing Reduction

The purpose of cost sharing subsidies is to protect those with lower income from the high out-of-pocket costs that can occur when accessing health care services. The ACA provides for reduced cost sharing for families with incomes at or below 250 percent of the FPL by making them eligible to enroll in health plans that pay more of the health care costs. There is no asset test for this assistance.

The way it works is the person must sign up for a silver level plan and must also be eligible for the APTC. If he or she meets those criteria and his or her income is at or below 250 percent of FPL, then he or she can get the out-of-pocket savings of a gold or platinum plan at the price of a silver plan. As noted earlier, the out-of-pocket expenses for a silver plan are around 30 percent, whereas the out-of-pocket costs are only 20 percent with a gold plan and down to 10 percent with a platinum plan. By giving someone the equivalent of a gold or platinum plan at the price of a silver plan, it will reduce his or her out-of-pocket costs.

If the person applying is a member of a federally recognized Indian Tribe, he or she won't have to pay any cost-sharing if his or her household income is less than 300 percent of the federal poverty level. A summary of health reforms for Native Indians and Alaska Natives can be found at the following web site at:

http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2010_Letters/Fact_Sheet.pdf

Catastrophic Plans

The Marketplace may also offer catastrophic plans. Catastrophic plans generally require the person to pay all of his or her medical costs up to a certain amount, usually several thousand dollars. If a person has any costs for essential health benefits that exceed that amount, then the

insurance company generally pays those expenses. These policies usually have lower premiums than a comprehensive plan but cover the person only if the person needs a lot of care. They basically provide protection in worst-case scenarios. In the Marketplace, catastrophic policies cover three primary care visits per year at no cost and cover preventive benefits for free, such as blood pressure screening or alcohol misuse screening.

These plans will only be available on the Marketplace for people under 30 years of age or people over 30 who have received a hardship exemption from the individual mandate fee (explained below). To get a hardship exemption, the person must have household income less than 100 percent of the Federal Poverty Level. For someone with very low income and few health care costs, this could potentially be a useful option.

Individual and Employer Mandate

A highly contested part of the ACA includes the individual and employer mandates. The individual mandate is the part of the law that requires individuals to pay a tax penalty if they don't have health insurance. This piece of the legislation was brought before the Supreme Court and upheld in 2012. The idea behind the individual mandate was that when someone without health coverage gets urgent, often expensive medical care and doesn't pay the bill, it affects the cost of health care for everyone.

In 2017, the fee is \$695 per adult and \$347.50 per child, up to \$2,085 per family, OR 2.5 percent of yearly household income, whichever is greater. The maximum amount is the totally yearly premium for the national average price of a Bronze plan sold through the Marketplace.

To avoid the penalty, a person must have insurance that qualifies as minimum essential coverage, which includes any plan purchased on the Marketplace, any employer-sponsored health plan, Medicare, Medicaid, CHIP, TRICARE, VA Healthcare Benefits, and Peace Corp volunteer plans. Other plans may also qualify. There are some exceptions in who must pay the fee, including:

- People who are uninsured for no more than two consecutive months of the year,

- The lowest priced coverage available, either through a Marketplace or job-related plan, would cost more than 8.05 percent of household income,
- Those who aren't required to file a tax return because their income is too low, and
- People who would qualify for Medicaid under the new income limits, 133 percent of FPL, but who live in a state that chose not to offer the expanded Medicaid.

Additionally, those who are a member of a federally recognized tribe don't have to pay a fee, nor do those participating in a health care sharing ministry and those that are members of a recognized religious sect with religious objections to health insurance.

When CWICs are working with individuals who don't have minimum essential coverage, and those individuals are concerned about the penalty, CWICs should be prepared to refer the individual to the Marketplace's toll-free number or one of the organizations providing in-person assistance. Those entities can help the person clarify if he or she falls into one of the exemption categories.

The ACA also includes a provision for an employer mandate, which imposes a tax penalty if employers with at least 50 full-time employees or full-time equivalents don't offer health insurance coverage that is affordable and meets minimum standards set by the ACA. Affordable means the employee's share of the premium costs for employee-only coverage is less than 9.5 percent of the yearly household income. "Minimum standards" means that the employer-sponsored health plan must cover at least 60 percent of total health care costs. Enforcement of this tax penalty, which is called the Employer Shared Responsibility Payment, began applying in 2016. The amount of the tax penalty is based partly on whether the employer offers insurance or not. The penalties for not providing affordable coverage aren't triggered unless an employee accesses the tax credit on the Marketplace. If just one employee accesses the credit, then it triggers the penalty for all relevant FTEs.

When working with a beneficiary who has questions about his or her employer's responsibility under this mandate, you should refer him or her

to the Marketplace's toll-free number or the organizations providing in-person assistance.

Other Pathways to Private Health Insurance

In addition to accessing private health insurance through an employer or through the Marketplace, it may also be possible for an individual to access coverage through:

- Individual or family plans purchased directly from private health insurance companies
- Union, association, and professional organization sponsored plans

Private health insurance companies will continue to offer individual and family health insurance plans outside the Marketplace. They will likely target those plans to people who are interested in a different benefit package than the state's benchmark plan allows. It's important for individuals to know that the APTC and the Cost Sharing Reduction aren't available to anyone who purchases a plan outside the Marketplace.

Some people get health coverage through unions and professional organizations, or associations such as an association of realtors, artists, or trades people. The laws governing these types of plans depend on a number of factors, including the type of policy, who the participants are, and other variables, so it's impossible to make general statements about which laws apply. But, what can be said is that the broad reforms under the ACA (elimination of pre-existing conditions, community rating, etc.) apply to any new health insurance plan an individual purchases, including those purchased directly from private health insurance companies, through unions, professional organizations, or associations.

Conclusion

The passage of the ACA has changed the landscape of the private health insurance market. CWICs should be knowledgeable about the new Marketplace to help beneficiaries without health coverage explore those options. Additionally, CWICs should be knowledgeable about the interface between employer-sponsored health insurance and public benefits. Addressing those questions is a key part of supporting

individuals with disabilities in recognizing the many benefits of work, without worrying about the effect on their benefits.

Conducting Independent Research

Department of Labor COBRA website:

<http://www.dol.gov/dol/topic/health-plans/cobra.htm>

An Employee's Guide to Health Benefits under COBRA, U.S.

Department of Labor:

<http://www.dol.gov/ebsa/pdf/cobraemployee.pdf>

Medicare and Other Health Benefits: Your Guide to Who Pays First, CMS Publication No. 02179.

<https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf>

Kaiser Family Foundation serves as a non-partisan source of facts, information, and analysis for policymakers, the media, the health care community, and the public: www.kff.org

The National Health Law Program (NHeLP) is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly, and people with disabilities: www.healthlaw.org

Families USA is a consumer focused website on health care, Medicaid, Medicare, private insurance, and prescription drugs, as well as state and national health policy analysis. It's a nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans: www.familiesusa.org

Prescription Drug Patient Assistance Programs (PhRMA) is a site that contains a directory of prescription drug patient assistance programs. Users can find out which pharmaceutical companies participate and how to access low-cost and no-cost medications: www.phrma.org

Georgetown University Health Policy Institute publishes information, which helps consumers understand health care protections provided under federal and state law, including HIPAA:

<http://ihcrp.georgetown.edu>

Federally administered Marketplace: <https://www.healthcare.gov>

The Centers for Medicare and Medicaid website provides information for community organizations on how they can support people in accessing the Marketplace: <http://marketplace.cms.gov>

White House website that provides information about the health reforms under the ACA, tailored to specific populations:
<http://www.whitehouse.gov/healthreform>

Competency Unit 5 – Supporting Individuals with Disabilities in Assessing Healthcare Needs and Options

Introduction

All SSI and Title II disability beneficiaries have significant disabilities or medical conditions. In many instances, these disabilities require a regular course of medical care. Depending on the disability, the individual may need a fairly wide range of medical services and products. The costs associated with these services and products will vary greatly.

In some cases, an individual can obtain all the healthcare and related services needed for under \$200 per year. Other beneficiaries with more significant disabilities may have healthcare needs that will cost in excess of \$10,000 per year. In fact, some individuals who work and have physical disabilities may require several hours of home healthcare services per day. Their annual costs for healthcare may exceed \$50,000. Hopefully, with good healthcare coverage options and high-quality healthcare counseling from a skilled CWIC, beneficiaries can receive the services they need with limited out-of-pocket expenses. In some cases, CWICs will need to make a referral to an agency that can provide expert advocacy and counseling on a specific healthcare program or plan.

This unit will provide a framework for assessing the healthcare needs of beneficiaries and providing counseling to them to guide their decisions related to healthcare. Eligibility details provided in previous units in this module will be referenced, but not explained. To clarify eligibility requirements or obtain more information on the various programs and strategies mentioned in this section, the reader should refer to other sections of this manual or to the resources referenced at the end of this unit.

Counseling on Healthcare Issues: Defining the Role of the CWIC

Social Security beneficiaries often make decisions about seeking work, accepting a job, or working more hours based on the anticipated effect that work and wages will have on their continuing eligibility for Medicaid or Medicare. Similarly, beneficiaries may make these decisions based on the availability of other third-party health insurance options, including private insurance plans, insurance plans sponsored by the Department of Veterans Affairs (VA), or state-specific insurance plans that are publicly funded or subsidized.

Unfortunately, these employment-related decisions made by beneficiaries often are based on incorrect or incomplete information about either the effect of their work on Medicaid or Medicare, or rights they may have to the wide range of other third-party insurance options. Some beneficiaries may wrongly assume that benefits (i.e., insurance coverage) will be terminated, while others may wrongly assume that benefits may continue. Still others may lack the sophistication or insight to realize that these are important issues to consider when planning a move into competitive work or higher-paying work.

A well-trained CWIC works with the beneficiary in a benefits-planning context to guide his or her decisions as related to securing or retaining coverage for his or her healthcare needs. While the experienced CWIC should be competent to deal with the majority of issues presented in this section, every CWIC should have minimum levels of expertise on these topics depending on the topic and the nature of the issues.

Levels of Competency for CWICs

The subject areas for healthcare planning listed below are sorted into primary and secondary categories. In-depth expertise in the primary subject areas will be a challenge during the first six to 12 months after a CWIC is newly certified. However, with close supervision, regular mentoring, and access to technical assistance from the NTDC, the newly certified CWIC should be able to provide competent healthcare planning and counseling services in all the primary subject areas.

Within these subject areas, CWICs should be able to accurately analyze complex beneficiary scenarios with the use of reference materials (such as this manual and relevant websites). In cases involving individualized WIPA services, the Benefits Summary and Analysis (BS&A) report and the Work Incentives Plan (WIP) should comprehensively address each of these issues as relevant.

The following represent primary subject areas related to healthcare planning and counseling:

- The basic framework of the state's Medicaid program, including an understanding of the services covered, the application process, and the appeal process;
- Each Medicaid eligibility group available to people with disabilities, including each group's income limit, resource limit, and the income/resource methodology;
- Thorough knowledge of the Medicaid work incentives, including Section 1619(b) and the state's Medicaid buy-in (MBI) program, if the buy-in is available;
- The basic framework of Medicare, including an understanding of the differences between Parts A, B, C, and D, and an understanding of the Medicare 24-month waiting period;
- The Extended Period of Medicare Coverage (EPMC), allowing Title II disability beneficiaries to retain premium-free Medicare Part A and optional Part B and Part D coverage during the nine-month trial work period and for a minimum of 93 months thereafter;
- The Medicare Savings Programs (MSPs), including what they can help pay for, how to apply, income limits, resource limits, and the income and resource methodology used;
- The Low-Income Subsidy (LIS) Program, including what they can pay for, who has to apply and who is deemed eligible, the income limits, the resource limits, and the income and resource methodology used;
- How SSI's Plan for Achieving Self-Support (PASS) can provide access to Medicaid coverage in many states;

- The Medicaid appeals process and any resources available for handling those appeals, including the state's Protection and Advocacy program;
- Healthcare options available to veterans including TRICARE and the VA healthcare system;
- The basic concepts of employer-sponsored healthcare;
- The basic framework of the Marketplace and which beneficiaries are likely to benefit from a private health insurance plan through this exchange; and
- The interaction of Medicare, Medicaid, TRICARE, VA healthcare benefits, and private health insurance, including primary payer rules.

The following represent secondary subject areas related to healthcare planning and counseling:

- Any Medicaid waivers available that can provide expanded eligibility criteria or expanded services to beneficiaries;
- The framework for selecting a Medicare Part D prescription drug plan including the online resources available to beneficiaries for assisting with plan selection;
- The key provisions of COBRA healthcare continuation coverage as they relate to the right to continued private insurance coverage following an event that results in the termination of that coverage;
- The healthcare-related services, including assistive technology, available through the state's vocational rehabilitation agency or agencies allowing some transition-aged youth and adults some medical services and equipment to support their vocational goal when not otherwise available through Medicaid or a private insurance plan;
- Any state-funded or state-subsidized health insurance plans, including the CHIP program, that may be available to meet the needs of beneficiaries in the state;

- The health insurance benefits offered by the U.S. military and the Department of Veterans Affairs to disabled veterans and their families; and
- Any charitable resources available in your state or regions of the state that the beneficiary can access to meet healthcare needs for individuals not otherwise insured, to meet those needs.

Given the complexity of the many healthcare provisions and considerations, some programs have assigned multiple CWICs the responsibility of developing special healthcare counseling expertise.

Making Referrals

On occasion, beneficiaries will encounter problems and questions about their health coverage that are best served by a referral to an outside agency. The issues may be outside of the CWIC's experience or current level of knowledge. The beneficiary may need expert help with a Medicaid appeal, or help to determine which Medicaid category best meets his or her needs. The state Protection and Advocacy program is an excellent source of help with complex Medicaid problems or appeals. There may also be local legal aid organizations that provide expert assistance with Medicaid. The State Health Insurance Assistance Programs (SHIPs) provide free, expert counseling on Medicare program options, appeals, and other Medicare rules to and for all Medicare beneficiaries in all states regardless of age. To locate a SHIP, go to: <https://www.shiptacenter.org>

For CWICs who are new and still learning about public healthcare programs (such as Medicaid and Medicare), referrals to specific experts and organizations can help the beneficiary get answers to complex questions when he or she needs the help.

Assessing the Healthcare Needs of a Beneficiary

It's crucial that CWICs assess a beneficiary's healthcare needs, including identifying needs that aren't currently being met. Armed with this information, the CWIC can work with the beneficiary to develop both

short-term and long-term plans to meet the beneficiary's healthcare needs.

A sample assessment tool that outlines the key information to be gathered is provided at the end of this unit. Even if the beneficiary isn't getting services in one of these areas, it's important to assess whether these are unmet healthcare needs. For each category on the questionnaire or checklist, the CWIC should address a number of key areas, including:

- **Estimated monthly or annual costs.** This helps to establish what is at stake if, for example, the beneficiary lost eligibility for Medicaid. If the actual cost of medication were \$200 per month, the beneficiary would need \$2,400 per year to cover this cost if he or she lost Medicaid and no other source of prescription drug coverage is identified.
- **How is the item covered?** This will help identify whether there needs to be a plan for continued eligibility for Medicaid or Medicare after starting work. For example, this may prompt the CWIC to explore either 1619(b) or the Medicaid buy-in as part of a long-range benefits plan.
- **What are the total out-of-pocket expenses for the service or product on a monthly and yearly basis?** This is really the bottom-line inquiry for each of the key healthcare areas.

By answering these questions for each service or product, the CWIC begins to see a picture of just what it's costing the beneficiary for healthcare. Armed with this information, the CWIC can then work with the beneficiary to develop a plan to cover as much of the out-of-pocket expenses as possible.

No matter how detailed the interview questionnaire or checklist may be, it can't anticipate every potential healthcare need. CWICs should share with the beneficiary the purpose of the questions and encourage him or her to offer any additional relevant information. If any of the identified healthcare needs are either not covered through some type of insurance or payment source or require significant deductibles or co-payments, this should be a red flag to explore other coverage options.

Keep in mind that the information you gather through the initial interview is just one “snapshot” in the healthcare assessment process. When providing services over an extended period of time, it will be necessary to update the information periodically. For example, the beneficiary may have started taking a new Medicaid-funded medication that is very expensive, making the retention of Medicaid while working a higher priority than it was at the initial interview. To ensure important changes to healthcare needs and coverage aren’t missed, CWICs should make a proactive contact with the beneficiary at least every six months to fully review and update all information collected during the initial interview.

Example of a healthcare issue that goes beyond the typical questionnaire or checklist:

Using an interview checklist containing questions about home healthcare, the CWIC learns that Sally, who has cerebral palsy and uses a wheelchair, receives four hours of personal care services per day (two hours in the morning and two hours in the evening). Although not suggested by the interview checklist, Sally’s CWIC, knowing that she is attending college, asks if these services are sufficient to prepare her to leave for school in the morning. Sally explains that her new morning aide, supplied by the ABC Home Health Agency (a Medicaid contractor), is often unreliable, arriving 15 to 30 minutes late, which results in Sally being late for her morning college classes.

The CWIC provides Sally with self-advocacy tips for addressing the issue with a supervisor at ABC. Additionally, after some follow-up investigation of resources, the CWIC refers Sally to a self-directed home care program run through the local Center for Independent Living. This program will enable Sally to hire and supervise her own Medicaid-funded home health aides.

Assessing Current, Long-Term, and Potential Eligibility for Third-Party Insurance

After completing an assessment of a beneficiary’s healthcare needs, it’s important to explore existing or potential payment sources that will help cover the identified costs. This section will discuss third-party insurance plans, which, for the majority of beneficiaries, will involve Medicaid,

Medicare, or a private insurance. CWICs need to be aware, however, that some beneficiaries will have coverage through lesser-known third-party insurance plans, such as CHIP, the VA healthcare system, or TRICARE.

Medicaid

If the beneficiary is a Medicaid recipient, it's important to verify the Medicaid eligibility group. Eligibility could be through the receipt of SSI, through the medically needy or spend down group, through the Medicaid Buy-in, or through the Home and Community Based Services waiver group. By identifying the source (or sources) of Medicaid eligibility, it will be possible to help the beneficiary plan for the retention of Medicaid when he or she goes to work or increases monthly earnings if retention of Medicaid is critical to him or her.

Example of moving from the Medicaid Spend-Down program to the Medicaid Buy-in program:

Let's go back to Sally, who is 22 years old, has cerebral palsy, and is starting her senior year in college majoring in Spanish education. Sally receives \$820 in CDB and must pay \$100 per month for a spend-down to receive Medicaid, based on the financial criteria unique to her state. The CWIC is meeting with Sally as she begins her last year in college.

Sally explains that her prospects for a teaching job upon graduation are good and that she expects to earn \$24,000 to \$30,000 as starting pay, plus a comprehensive health insurance plan. At her CWIC's urging, Sally has checked around, and it appears that none of the health insurance plans provided by school districts offers coverage for four hours of daily personal care services, which she will continue to need. Based on these facts, both Sally and her CWIC agree that she will need to maintain Medicaid coverage for the indefinite future.

The CWIC explains to Sally that as she starts working, her spend down amount will increase. The CWIC also explains to Sally that she should be eligible for the Medicaid Buy-in, as her state is one of the many states implemented this optional Medicaid eligibility group. The CWIC shares with Sally their state's buy-in criteria: (1) Countable income can be up to 250 percent of the federal poverty

level after applying SSI-related income disregards (allowing for earnings of around \$60,000 gross per year if there is no unearned income); (2) Countable resources of up to \$10,000 are allowed — higher than the resource limit for the state's spend down program; and (3) She'll be required to pay a monthly premium of around \$100. Sally agrees to apply for the buy-in as soon as she starts working. The CWIC summarizes this information in an updated BS&A report.

Based on the stated facts, Sally's need for personal care services may be modest enough that she can have a long-term plan to pay these costs herself once she pays off her student loans and she sees her pay increase. Keep in mind that her personal care services would cost nearly \$1,500 per month if we assume a \$12 per hour rate. As part of long-range planning, the CWIC should urge Sally to look into potential tax savings, through the flexible spending account or medical deductions, as a way to partially subsidize this cost should she assume it at some point in the future.

Retaining Medicaid through 1619(b) provisions

Continued Medicaid under 1619(b) is available to former SSI recipients who lost SSI due to earnings and who currently meet all the criteria for 1619(b) eligibility. Although 1619(b) has been available nationwide for over 30 years, many people are unaware of it. CWICs must be vigilant to make sure that SSI beneficiaries and the agencies that serve them are aware of 1619(b).

One potential pitfall in establishing both initial and continuing eligibility is the "Medicaid use test." To meet this test, the beneficiary must:

- Have used Medicaid in the last 12 months;
- Expect to use Medicaid in the next 12 months; or
- Or would be unable to pay unexpected medical bills in the next 12 months without Medicaid.

Most beneficiaries will meet one of the first two alternatives as active Medicaid users. As a practical matter, everyone should meet the third test as well, as it would be rare to have a private health insurance plan

that would pay for any and all unexpected medical bills no matter what intervening events occurred.

Example of using the PASS work incentive as part of a long-range plan to retain Medicaid:

Let's go back to Sally and change the facts slightly. Her state hasn't opted for the Medicaid Buy-in (MBI) program. Although Medicaid is automatic for SSI recipients in her state, because her level of CDB benefits, \$820, is well over her state's SSI rate, she can't qualify for SSI and can't access 1619(b) Medicaid, which is only available to former SSI recipients who lose SSI due to work and earnings. This creates a major dilemma for Sally, who needs Medicaid and is planning to go to work. To Sally, it appears as if there is no means to retain Medicaid upon securing employment.

When the CWIC meets with Sally during her final year of undergraduate school, she determines that Sally is a good candidate for a Plan for Achieving Self-Support (PASS). Sally can set aside her CDB benefits in a PASS to save toward the purchase of a van to be modified for her use as a wheelchair user. This would support Sally's goal to become a Spanish teacher, as nearly all of the potential school districts that would employ her aren't located near any public transportation line, with some more than 20 miles from her home.

The CWIC explains that an approved PASS would allow Sally to set aside \$800 of her CDB benefits into a dedicated account to save for the down payment on the van, resulting in that income being excluded for SSI purposes. With countable income reduced to \$0, Sally will now be eligible for an SSI check at the full Federal Benefit Rate (FBR) per month and automatic Medicaid, with no spend down. Assuming the PASS is effective in October, with a plan to purchase the van in late July and start teaching in September of the following year, Sally will be able to save more than \$7,000 for a down payment on the van.

NOTE: The CWIC would typically go on to discuss the PASS finances in greater detail, explaining what would happen when Sally loses CDB benefits following her trial work period.

As part of the long-term plan, the CWIC explains: If Social Security approves, Sally can set aside a portion of her wages through the PASS

when she goes to work to pay for van insurance and make van payments. The state Vocational Rehabilitation agency will be able to pay for approximately \$20,000 in modifications to allow Sally to drive the van as a wheelchair user. Sally can expect to lose her CDB benefits because she will have performed SGA following a nine-month trial work period and three-month grace period. Her PASS can continue, following the loss of CDB benefits, with her wages being the only income going into the PASS. Finally, upon losing her SSI at the completion of the PASS, Sally will be eligible for Medicaid through section 1619(b) as she will have lost SSI payments due to having earnings over the allowable limit for an SSI cash payment.

Under her unique circumstances, PASS will enable Sally to reach her employment goal and also retain Medicaid as a payment source for personal care services in her state. Keep in mind that many beneficiaries will need more hours of personal care services than the four hours per day that Sally needs with resulting monthly costs of \$5,000 or more.

As stated previously, CWICs must be familiar with the Medicaid waiver programs available in their state, not just Medicaid eligibility groups. Given the role of CWICs in supporting work, it's particularly important to be aware of any waiver that may allow for vocational services, including job coaching, that could support a beneficiary's work goal. In many states, waivers are available that will provide a range of assistive technology and home modifications, among other things not ordinarily available through the regular Medicaid program. This could greatly help Sally, from the earlier examples, as she moves into her own apartment upon completing college.

Upon graduation, Sally's grandparents, who are moving to Florida, agree to rent to Sally their small, two-bedroom ranch home. The two entrances to the home are already wheelchair-accessible, as Sally's grandmother needed similar access to come and go in either her walker or a three-wheeled scooter.

The CWIC, having researched the current waiver Sally is using, identified a number of other services that may benefit her, including home modifications and a range of assistive technology to maximize independence or to support work goals. Sally identifies the following special items that may increase her independence as she moves into the

ranch home: an environmental control unit, allowing her to answer the phone, open or lock the doors, or operate the TV and appliances from a central unit on her wheelchair; a ceiling track lift, allowing Sally to safely and efficiently travel from the bedroom to the bathroom and back to take care of hygienic needs with minimal assistance from a third person; and a one-time allowance to make her kitchen more accessible to her by lowering countertops and redesigning the kitchen to make it more usable by her. Sally agrees to contact her Medicaid caseworker to determine whether she can take advantage of the home modifications as a renter of the property.

Medicare

Some important Medicare issues that will come up in the CWIC or beneficiary relationship include:

- An understanding of Medicare Savings Programs as a means of paying for Medicare Part A and B premiums and other out-of-pocket expenses;
- The effect of work on eligibility for Medicare Savings Programs;
- An understanding of the Low Income Subsidy Programs as a means of paying for Medicare Part D out-of-pocket expenses;
- The effect of work on eligibility for Low Income Subsidy Programs; and
- The potential eligibility for Extended Medicare Coverage for eight years or more after the Social Security disability beneficiary starts working.

Medicare Savings Programs

As noted above, the Medicare Savings Programs can pay for Part B premiums and, in the case of the QMB program, can also pay for the Part A and Part B co-payments and deductibles. When counseling beneficiaries, it's important to ask questions about Part B premiums, investigate potential eligibility for the Medicare Savings Programs, and identify any co-payments they are paying.

Example of how Medicare Savings Programs can assist:

George currently receives \$960 per month of SSDI, has Medicare, and is enrolled in the Qualified Medicare Beneficiary (QMB) programs (one of the Medicare Savings Programs). George has 4-5 medical appointments each month, which are covered under Part B. The QMB program pays the 20 percent coinsurance for him, which adds up to \$250. The QMB program is also paying the Part B premium. George has been offered a job making \$950 per month, which he'd like to take, but he's questioning whether it would financially make sense given he'd lose all coverage through the Medicare Savings Programs.

At the meeting, the CWIC explains that if George were to apply for the Medicaid Buy-In program, he'd have Medicaid to cover his Part B deductible and co-insurance. The CWIC also explains that in their state the Medicaid agency would pay his Part B premium if he were to become Medicaid eligible, noting George would have to pay approximately \$83 per month to use this program. George, seeing he would financially get ahead and have more healthcare coverage, took the job and enrolled in the Medicaid Buy-In program.

It's important to emphasize that the CWIC was able to help George think through these options by using an interview tool that prompts questions about Part B premium payments and potential eligibility for Medicaid Buy-In. By taking these steps, George's CWIC is able to direct him to a solution that supports him in working, financially getting ahead, and continuing his needed healthcare coverage.

Example of how beneficiaries dually eligible for Medicaid and Medicare must use Part D for Prescription Drug Coverage:

When the CWIC first meets with Sally, she is 19 years old, in her second year of college, and has been receiving CDB benefits since age 18. Sally also explained that she takes two anticonvulsants to control a seizure disorder, which are covered by Medicaid. At the time of their meeting, Sally wasn't yet eligible for Medicare.

In helping Sally to plan for her long-term healthcare needs, the CWIC explains that at age 20, after she has received CDB benefits for 24 months, she will be eligible for Medicare. It's further

explained that when Sally becomes eligible for Medicare she will be required to have her prescription drugs covered by the Medicare Part D prescription drug program, even if she remains eligible for Medicaid.

The CWIC documents this information in Sally's BS&A report. The CWIC also advises Sally that she will need to start the process of choosing a Part D prescription drug plan a few months before her Medicare eligibility begins, and provides links to online resources and tools for doing this.

Wherever possible, the CWIC should help the beneficiary plan for upcoming changes to minimize loss in coverage.

When Sally becomes eligible for Medicare, the CWIC will then provide counseling about eligibility for the Low Income Subsidy program. The CWIC will also help Sally understand the effect of work on LIS and explore strategies for ways to get help paying her prescriptions.

Private Insurance Coverage

Beneficiaries are most likely to be eligible for a private health insurance plan if they are working and coverage is available as an employee benefit, or through their spouse or parents' health insurance plan through work. It's possible a beneficiary may have coverage through the Marketplace, but that would generally only be the case with Title II disability beneficiaries in the 24-month Medicare Qualifying Period who aren't eligible for Medicaid. In regards to private health insurance coverage, CWICs are most likely to encounter beneficiaries who face issues relating to:

- Understanding coordination of benefits (who pays first, second, etc.);
- When private insurance is or isn't financially worthwhile; and
- Rights under private health insurance plans.

While it's simply not possible to maintain expertise regarding private health insurance plans as they relate to Medicaid and Medicare, the CWICs can take steps to help beneficiaries explore their options and understand their rights in this area.

- CWICs should be prepared to explain how it's possible to have employer-sponsored healthcare in addition to Medicare or Medicaid.
- CWICs should be able to help beneficiaries explore when employer-sponsored health insurance may be financially worthwhile (e.g., when state Health Insurance Payment can be available, access to larger pool of medical providers, access to alternative care services).
- CWICs should be able to explain the basic rights beneficiaries have in accessing private health care coverage and refer beneficiaries to the state's health insurance commissioner for details questions.
- If a beneficiary is already covered by a private health insurance plan, the CWIC can urge him or her to obtain a copy of the policy or a summary of what the plan covers. The plan typically provides these summaries to a beneficiary as a routine matter, or the employee can ask his or her human resource department to help him or her get a copy. Often these summaries will make it very clear whether a particular service is covered and under what conditions. If the insurance company declines to cover a particular item or service, the summaries the company provides to the employee generally describe any appeals available through the plan itself.

Assessing Current and Potential Eligibility for Non-Traditional Payment Sources or Strategies for Healthcare

There are numerous non-traditional sources of funding for healthcare (i.e., sources other than Medicaid, Medicare, private health insurance, or lesser known programs that act like third party insurance). This section will briefly comment on the role the CWIC can play with regard to two of

these funding sources or program: special education programs and state Vocational Rehabilitation agencies.

Special Education Programs

When working with a transition-aged special education student, generally 16 to 21 years of age, don't overlook the special education system as a means for funding a wide range of services that we might typically think of as falling into the healthcare area. For example, if necessary to support a student in a special education program, a school could provide: mental health counseling, a private duty nurse, a one-to-one aide, physical therapy, occupational therapy, or speech therapy. A school can also provide a range of equipment under the designation of assistive technology including augmentative communication devices.

While very few CWICs can be expected to be special education experts, nearly every state's Protection and Advocacy agency will devote considerable resources to special education advocacy. It's incumbent on CWICs to establish working relationships with the special education advocates at the Protection and Advocacy agency so that they can call on these contacts for information about special education rights and guidance on when it's appropriate to refer a beneficiary for assistance.

State Vocational Rehabilitation (VR) Agencies

Many of the beneficiaries receiving WIPA services will have active cases with their state VR agency or a separate VR agency for the blind (in many states). Although we don't typically think of the VR agency as a funding source for healthcare services, they are authorized to fund a wide range of services for the "diagnosis and treatment" of physical or mental impairments to reduce or eliminate impediments to employment, to the extent that these services aren't available from other sources such as Medicaid, Medicare, or private health insurance. Just a few examples of these items or services include: therapeutic treatment, dental care, eyeglasses and visual services, personal assistance services while receiving VR services, and rehabilitation technology (including vehicle modifications and telecommunication devices).

Typically, the role of the CWIC on VR issues will be to identify the potential for assistance with healthcare needs and refer the individual to

the VR agency. If the beneficiary encounters a dispute over coverage of an item or service or if he or she anticipates a dispute, the CWIC can also refer the individual to the Client Assistance Program (CAP) advocate who covers their state or region of the state. The CAP program exists in every state and is authorized to assist individuals in their disputes with the VR agency. In many states, the CAP program is located within the Protection and Advocacy agency.

Assessing Case Scenarios to Determine When a Beneficiary Will or Won't Have a Long-Term Need to Retain Medicaid

Some beneficiaries will have significant disabilities but no apparent need for expensive healthcare services on a regular basis. For example, an individual whose only disability is profound deafness may incur no regular healthcare expenses related to the disability. Like all Americans, those individuals should have health insurance to cover the unexpected illness or injury, but the employer-funded health insurance plan may be enough, when available. The decision on whether long-term Medicaid eligibility is important will always depend on individual circumstances, and the CWIC should be able to provide guidance to the beneficiary in making this decision.

Example in which a beneficiary will need long-term

Medicaid: Eric, age 28, has a traumatic brain injury and started receiving SSI benefits at age 18. About three months ago, he became eligible for \$520 in monthly CDB in addition to a reduced SSI benefit. He lives in a state where Medicaid eligibility is automatic for SSI recipients. Eric has no regular healthcare costs and, except for routine medical or dental appointments, doesn't see a doctor unless he is ill. His parents check in with him daily at his apartment, but he is otherwise independent.

Eric starts a job at a local warehouse where he will make \$11 per hour working 15 hours per week. His gross pay will be \$715 in most months (higher in three-paycheck months), meaning he will lose his right to SSI cash benefits but retain CDB benefits. As a 15-hour-per-week employee, he won't be covered by his employer's health insurance plan.

During the CWIC's visit with Eric and his father, they discuss how his wages will affect his SSI and CDB benefits. The CWIC explains that Eric should be eligible for 1619(b) Medicaid upon his loss of SSI eligibility (i.e., his annual wages will be below his state's 1619(b) threshold of \$30,000, his resources will be below SSI's limits, and he will meet 1619(b)'s Medicaid use test as he has used Medicaid in the past year). Eric and his father still wonder if he should bother to keep Medicaid because he so rarely uses it.

While the ultimate decision to retain Medicaid through 1619(b) will always be the beneficiary's to make, the CWIC should advise Eric and his father that there are several good reasons for keeping 1619(b). Keeping Medicaid will insure him against unexpected medical expenses, as he has no other health insurance coverage. Coverage will be cost-free (subject to any modest co-payments if his state has them). If he loses his job or his wages go down significantly while he is eligible for 1619(b), he can transition back to SSI cash benefits without a new application.

Example in which keeping Medicaid may be more important than it first appears:

After Eric worked 15 hours per week at the warehouse for six months, Eric's employer increased his hours to 30 per week and his hourly pay to \$12 per hour. His gross pay will be \$1,500 in most months (higher in three-paycheck months), meaning he will still be ineligible for SSI but can continue his eligibility for 1619(b) assuming he continues to meet all other eligibility criteria. Even though his monthly wages will be well above the current substantial gainful activity amount, he can retain CDB benefits throughout a nine-month trial work period and three-month grace period.

As a 30-hour per week employee, he will now be covered by his employer's health insurance and dental plans as long as he opts for the plan and pays a \$75 per month health insurance premium. The insurance plan is comprehensive, covering doctor visits (\$10 co-payment) and prescription drugs (\$10 co-payment) among its many benefits. Dental insurance is available as well, with a \$5 per month payment toward the premium if he opts for the coverage.

In a follow-up meeting with the CWIC, Eric and his father are looking for guidance on whether Eric should sign up for the health insurance or dental plan. They indicate that Eric's doctor does accept Medicaid but that the nearest dentist who accepts Medicaid is more than 20 miles away. They also discuss the trial work period and expected loss of CDB benefits thereafter. Finally, Medicare eligibility will commence in about 12 months, and they have questions about Medicare Part D coverage and whether the premium for Medicare Part B coverage is worth paying.

Among other things, the CWIC explains:

- That with \$1,500 in monthly gross earnings and no significant impairment-related work expenses or subsidies to bring countable wages below the SGA level, Eric can expect his CDB cash benefit to be suspended after a nine-month trial work period and three-month grace period;
- If he retains Medicaid through 1619(b), he can return to SSI cash benefits status upon losing his CDB benefits;
- Private health insurance coverage and dental coverage at these modest payment rates is a good deal if Eric can work it into his budget;
- He is responsible for reporting to the Medicaid agency that he has the option to take this employer-sponsored health insurance plan. If the Medicaid agency finds it cost-effective, it may pay the premium for him;
- His Medicaid should be able to pay some co-payments on doctor visits and prescription drugs that the employer-sponsored plan doesn't cover;
- Because his Medicare eligibility will begin in about 12 months, he will need to decide whether to enroll in Parts B and D, because he will likely have comparable coverage through the private health insurance plan. He will need to check with his employer to clarify if they will require he take Medicare. If not, he will then need to decide whether to opt out of Part B or D.

Based on this information, Eric and his father decide that he will enroll in the employer-sponsored health insurance and dental plans; he will contact the Medicaid agency to report this private health insurance and find out if Medicaid will pay the monthly premium; he will take whatever steps are necessary to retain Medicaid through 1619(b); and they will meet again in six months to review Eric's updated work status and sort out the issues affecting whether he should enroll in either Medicare Part B or Part D.

In these scenarios, the CWIC has guided Eric and his father through some complex scenarios to enable them to make informed decisions.

Staying Current in Healthcare Policy

CWICs must regularly update their resource materials and attend new trainings to keep up with changes in healthcare policy. In recent years, the Marketplace was started, many states have initiated Medicaid Buy-in (MBI) programs, many states started new Medicaid waiver programs, and the Medicare Part D program was started. Eligibility thresholds for 1619(b), which vary state-by-state, typically go up every year. Similarly, the eligibility levels in state medically needy or spend down programs may change from year to year.

CWICs can expect this manual to be edited on a regular basis as changes occur, but that editing may be no more often than once per year. For this reason, it's essential to regularly reference resources on the VCU NTDC website, review email updates distributed by the NTDC, and attend new and refresher trainings as appropriate. Finally, CWICs must be alert to changes that are specific to their state and regularly check with key resources to keep up with state-related changes.

Conducting Independent Research

The Kaiser Family Foundation's "State Health Facts" site is a perfect example of a relevant resource to supplement CWICs' knowledge on state and federal health care rules and ongoing changes to them. Its website, www.statehealthfacts.org, provides links, state-by-state, and state-specific links to a range of programs within the state, including Medicaid, Medicaid waivers, and the CHIP program.

Additional Resources

On the following page, we have attached a form that CWICs may use to assess a beneficiary's current healthcare coverage and areas of unmet need.

Planning for Health Care Coverage

Name:

Date:

What do you currently use your healthcare coverage for? (check all that apply)

- Doctor visits
- Mental health counseling
- Other therapies (e.g., physical therapy, occupational therapy, and speech therapy)
- Medication
- In-home services
- Residential services (e.g., foster home, group home)
- Day Habilitation (e.g., supported employment)
- Durable Medical Equipment
- Other:

Current healthcare coverage (check all that apply) :

- Medicaid
- Medicare
- MSP
- LIS
- Private
- VA

Average monthly or annual healthcare costs and premiums:

Description of healthcare needs currently unmet:
