Part I Chapter 2 – Understanding Medicare

Contents

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Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the basic operations of the federal Medicare program including Medicare Parts A (Hospital), B (Medical), C (Medicare Advantage Plans), and D (prescription drug coverage).
2. Describe the eligibility requirements for Medicare for persons with disabilities and the Medicare Qualifying Period (MQP).
3. Describe the options for enrolling in the various parts of Medicare, options for declining coverage, and the premium penalties for delaying enrollment.
4. Identify and describe programs that help Medicare beneficiaries pay for out-of-pocket costs, including Medigap plans, Medicare Savings Programs (MSPs), and the Part D Low-Income Subsidy (LIS).
5. Describe the interaction of Medicare with other public and private health insurance.
6. Describe the effect of work on Medicare coverage and two work incentives that allow individuals to retain Medicare coverage after cash payments ceases; the Extended Period of Medicare Coverage (EPMC) and Premium Hospital Insurance (HI) for the Working Disabled.

Acronyms

- ACEP - Annual Coordinated Election Period
- CMS – Centers for Medicare and Medicaid Services
- EPMC - Extended Period of Medicare Coverage
- EXR – Expedited Reinstatement
- FPL – Federal Poverty Level

- FICA - Federal Insurance Contributions Act taxes
- GEP – General Enrollment Period
- GHP – Group Health Plan
- HI - Medicare Part A Hospital Insurance
- IEP - Initial Enrollment Period
- LGHP – Large Group Health Plan
- LIS - Low-Income Subsidy
- MA - Medicare Advantage Plans
- PDP - Medicare Part D Prescription Drug Plan
- POMS – Program Operations Manual System
- QDWI – Qualified Disabled Working Individual
- QI – Qualified Individual
- SEP – Special Enrollment Period
- SHIP – State Health Insurance Program
- SLMB – Specified Low-Income Medicare Beneficiary
- SMI - Part B Supplemental Medical Insurance

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 does not cover all medical expenses or the cost of most long-term care. Along with Federal Insurance Contributions Act (FICA) taxes that workers and their employers pay, workers pay a Medicare tax. This tax and monthly premiums finance the Medicare program. The Centers for Medicare and Medicaid Services (CMS) is the federal agency in charge of the Medicare program, but Social Security determines who is eligible for Medicare, enrolls people in the program, and provides 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 health care program designed primarily to help those with low income and few resources. Medicare is an entitlement earned by someone who has paid into the Medicare trust fund through taxes on earned income; it is not needs based. The federal government helps pay for Medicaid and sets broad program guidelines states must follow, but each state has its own rules about who is eligible and what services the programs cover. In contrast, original Medicare is a federal 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 coverage. CMS refers to these people as "dual eligible." We will provide detailed information about Medicaid programs available to individuals with disabilities in Chapter 5.

Medicare Parts

There are three core parts to Medicare coverage: 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, CMS refers to them as "Original Medicare." Medicare Part D is prescription drug coverage. It was added to the Medicare program in 2006. Part C Medicare Advantage (MA) Plans are another health plan choice available to individuals who are eligible for Medicare. Part C Medicare Advantage Plans are offered by private companies approved by Medicare.

Medicare Part A

- When Title II disability beneficiaries first become eligible for Medicare, they are automatically enrolled in Medicare Part A Hospital Insurance (HI). Part A covers inpatient care in a hospital or limited time at a skilled nursing facility (following a

hospital stay). It also pays for some home health care and hospice care.

- Social Security beneficiaries who are eligible for Medicare Part A do not have the option of declining this coverage.
- 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. Medicare processes claims and payments to cover what Medicare rules allow.

Medicare Part B

- Anyone who is eligible for premium-free Medicare Part A can also enroll in Medicare Part B Supplemental Medical Insurance (SMI). Part B pays for services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services.
- When Title II disability beneficiaries become eligible for Medicare, they are automatically enrolled in Part B, unless they tell Social Security that they want to decline this coverage. It is possible to enroll in Part A, but decline Part B.
- Under the original Medicare model, using Part B works the same as using Part A. The beneficiary locates a medical provider that accepts Medicare and receives medical services from that provider; then, the provider bills Medicare.

Medicare Part D

- Medicare Part D helps pay the costs of prescription drugs for Medicare beneficiaries in the United States.
- Anyone who is enrolled in Medicare Part A or Part B can also enroll in Part D. Enrollment in Part D is optional for everyone except those who are also eligible for Medicaid. States automatically enroll beneficiaries who are eligible for Medicaid into a Part D plan when Medicare begins, unless they choose a plan themselves.
- Unlike with Parts A and B, Social Security does not 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 below). Private insurance companies that contract with CMS to participate in the Medicare Part D program develop and operate the prescription drug plans.

Medicare Advantage Plans (Part C)

- CMS often refers to Part C of Medicare 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. To join a Medicare Advantage Plan, individuals must have both Medicare Part A and Part B.
- 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 vary widely. Individuals who join one of these plans generally get all of their Medicare-covered health care through that plan. Depending on the plan the beneficiary purchases, MA may include prescription drug coverage. Medicare Advantage plans often offer extra benefits that people enrolled in the Original Medicare Plan do not receive.
- 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.

Medicare Eligibility for Individuals with Disabilities

Social Security disability beneficiaries (SSDI, CDB or DWB) are eligible to enroll in all parts of Medicare after they serve a 24-month 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 disability benefit payment. Medicare coverage begins the first day of the 25th month of Title II disability benefit entitlement, with a few exceptions.

The Medicare Qualifying Period (MQP)

CWICs need to understand how the Medicare Qualifying Period (MQP) works so they can answer questions beneficiaries may pose about when Medicare coverage will begin. Here are some important facts about the MQP:

- In some cases, Social Security approves a beneficiary's disability benefit many months or even years after that person applied. When that happens, it is possible that an individual may have met all or part of the MQP by the time cash benefit payments begin. The 24 months start with the month in which disability benefits were first payable – even if that is in the past.
- Most individuals who qualify for SSDI and DWB have to serve a five-month waiting period before benefit payments begin. For these beneficiaries, the MQP begins after the five-month waiting period ends.
- Childhood Disability Beneficiaries (CDBs) do not have to serve a five-month waiting period before entitlement, but entitlement cannot begin prior to age 18. Because of this, CDBs will not meet the MQP before their 20th birthday.
- The MQP does not have to be served consecutively within one period of entitlement. If Social Security terminates an individual's entitlement to cash benefits and re-entitles them 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 is possible that the time period for re-entitlement without a new qualifying period could be indefinite.
- Beneficiaries continue to serve the MQP even when they are not in cash payment status due to Substantial Gainful Activity (SGA) level earnings during the Extended Period of Eligibility (EPE). Even though a cash benefit may not be payable for a particular month, all months of disability

benefit entitlement are counted in determining when the person meets the MQP requirement.

Most disability beneficiaries have to serve the MQP before they can enroll in Medicare, but there are some specific exceptions to this general rule. This is particularly the case for people who were on disability benefits at some point in the past and subsequently became re-entitled to benefits. These complicated exceptions are not usually part of a CWIC's counseling. To learn more about these exceptions, you may refer to **POMS HI 00801.152 - Counting Months in Reentitlement Cases** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801152).

Enrolling in Medicare

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. Social Security automatically enrolls disability beneficiaries living in the U.S. (except Puerto Rico) in Medicare Parts A and B when they first become eligible for Medicare.

Initial Enrollment Period (IEP)

The initial enrollment period is the first opportunity a person has to enroll in Medicare based on disability benefits. It is 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, they need only keep the card and Medicare Parts A and B coverage will begin automatically. If a person does not want Medicare Part B, the individual returns the signed card to the sender. Returning the card indicates refusal of Part B coverage. If entitled, beneficiaries cannot decline Part A. Beneficiaries can also choose to enroll in a Medicare Advantage Plan (Part C) or a Prescription Drug Plan (Part D) during the IEP.

General Enrollment Period (GEP) or Open Enrollment Period

Each calendar year eligible individuals who do not 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 the month following the month they enroll. For Medicare Parts C and D, the annual Open Enrollment Period occurs October 15 through December 7.

Special Enrollment Period (SEP)

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

There are several circumstances that can trigger SEPs. One of the most common SEPs used by working (or formerly working) beneficiaries covers individuals enrolled in a group health plan. To be eligible for this SEP, the individual must be currently or previously enrolled in a group health plan (GHP) or large group health plan (LGHP). The coverage must be based on either the individual's employment or the employment of a spouse. This SEP allows the individual to sign up for Part B during any month that they are still covered by the GHP or LGHP and continues for an eight-month period 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.

The SEP for Part C and D involves a different set of circumstances. The list of circumstances is available in the CMS Publication **Understanding Medicare Part C and D Enrollment Periods** (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. The ACEP lasts from October 15 through December 7.

Opting out of Medicare Parts B or D

Social Security beneficiaries who are eligible for Medicare Part A do not have the option of declining this coverage. All eligible individuals are enrolled in Part A. Medicare Parts B and D are optional. When a person is first enrolled in Medicare, the packet of information they receive in the mail includes instructions on how to decline Part B coverage. Basically, individuals simply return the signed Medicare card to the sender. Returning the card indicates refusal of Part B coverage. Medicare Part C (Medicare Advantage) plans are optional, but they require a beneficiary to be enrolled in Parts A and B. To find out more about **how to enroll in a Medicare Advantage Plan** refer to the Medicare website (https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan).

Enrollment in Part D is not automatic in most cases as there are many different plans from which to choose. Beneficiaries select a plan that meets their needs and then complete the enrollment paperwork. If someone does not want Part D prescription drug coverage, they simply need to not enroll in a Part D plan. For more information about **enrolling in a Part D plan** go to the Medicare website (https://www.medicare.gov/drug-coverage-part-d/how-to-get-prescription-drug-coverage).

Beneficiaries who decline Part B or Part D when they first become eligible to enroll may have to pay a higher monthly premium if they decide to enroll later. CMS refers to this as the premium penalty or premium surcharge. The monthly Part B premium increases 10 percent for each full 12-month period the beneficiary could have had Part B but did not sign up for it. Because of the Special Enrollment Period provisions, beneficiaries are protected from that penalty for any month the beneficiary had employer-sponsored health insurance (through their own employer or their spouse's employer). To learn more about **the Part B premium penalty,** refer to the Medicare website

(https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-late-enrollment-penalty).

Beneficiaries who elect to enroll in Part D late, and who do not have other creditable coverage, may also experience an increased premium. To find out more about the **Part D late enrollment penalty**, go to the Medicare website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d-late-enrollment-penalty).

Medicare and Other Forms of Insurance

When beneficiaries have Medicare and other health insurance (like from a group health plan, retiree coverage, or Medicaid), each type of coverage is called a "payer." When there is more than one payer, "coordination of benefits" rules decide who pays first. The "primary payer" pays what it owes on medical bills first, and then sends the rest to the "secondary payer" (supplemental payer) to pay. 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 process medical bills correctly. Beneficiaries also need to let Medicare know if they have any other forms of insurance to make sure benefits are coordinated between the payers.

It is important to understand how Medicare interacts with other forms of insurance because it may affect decisions beneficiaries make about enrolling in the various parts of Medicare. Beneficiaries may ask questions about these issues, and CWICs need to be prepared to provide answers or referrals to reliable sources of information. The most common forms of insurance you are likely to encounter include Medicaid, Veterans Administration (VA) Healthcare, TRICARE, and employer group health insurance or other group insurance. When you encounter a beneficiary who has other forms of health insurance, be sure to research how that form of insurance may interact with Medicare. An excellent source of information about this topic is **Medicare and Other Benefits: Your Guide to Who Pays First** (https://www.medicare.gov/sites/default/files/2021-10/02179-Medicare-and-other-health-benefits-your-guide-to-who-pays-first.pdf).

Medicare Out-of-Pocket Costs

Like most forms of health insurance, Medicare involves certain out-of-pocket costs. These consist of premiums, co-insurance, co-payments, and deductibles.

- **Premiums:** In the Medicare program, Part A is premium-free in most cases. Medicare Parts B, D, and C all require payment of a monthly premium. Monthly premium amounts vary and they typically change at the beginning of each calendar year. You can find details about **the Medicare premiums for the various parts of Medicare** (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance).

Social Security automatically deducts Part B premiums for beneficiaries who receive a Social Security disability payment. Beneficiaries may also elect to have Part C and D premiums withheld from the monthly Social Security payment, but that is not automatic. Eligible individuals who no longer get a monthly payment will receive a bill for their Medicare premiums. You can learn more about **paying Medicare bills** (https://www.medicare.gov/basics/costs/pay-premiums).

- **Co-insurance and Co-payments:** Co-insurance is the percentage of a medical bill that the individual pays. A co-payment is a fixed fee that subscribers to a health plan pay for their use of specific medical services. All parts of Medicare require these types of out-of-pocket costs and these costs vary by part. You can find **detailed information about Medicare co-insurance and co-payments** for the current year by referring to the Medicare website (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance).
- **Deductibles:** A deductible is the amount of money an individual is responsible for paying before the health plan will start helping to pay for covered items or services. You can find **detailed information about Medicare deductibles** for the current year by referring to the Medicare website

(https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance).

Medicare Supplements or Medigap Plans

Because Medicare involves deductibles and coinsurance payments, some people end up with many out-of-pocket expenses. Medicare supplemental insurance policies, also called "Medigap Plans," 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 must 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 must sell "standardized" Medigap policies, so that individuals can compare them easily. 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 the **Medicare Plan Finder Tool** (https://www.medicare.gov/medigap-supplemental-insurance-plans/#/m?lang=en&year=2024) to find interactive electronic tools that compare various Medicare and Medigap plans. For additional information on Medigap policies, including how to decide if a Medigap policy makes sense, and what Medigap policies cover, you can refer to the publication titled **Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare** (https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf).

Getting Help Paying Medicare Out-of-Pocket Costs

While Medigap plans are a valuable resource for Medicare beneficiaries, some beneficiaries will find this form of supplemental insurance unaffordable. Fortunately, there are several additional options for helping low-income Medicare beneficiaries get help paying Medicare out-of-pocket expenses.

Option 1: Establishing Eligibility for Medicaid

Medicare enrollees who are also eligible for Medicaid have an effective way to cover out-of-pocket costs without enrolling in a Medigap plan. 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, within the limits of the items and services included in the State Medicaid Plan. Medicaid will cover most costs associated with copayments, coinsurance or deductibles. Depending on the state Medicaid plan, Medicaid may also pay the Medicare Part B premium. We provide detailed information about Medicaid in Chapter 4.

Option 2: Medicare Savings Programs

Medicare Savings Programs (MSPs) are Medicaid-administered programs for people on Medicare who have limited income and resources. These programs help certain qualified individuals to afford Medicare coverage by paying some or all of the Medicare Part A and B out-of-pocket expenses (premiums, copayments, co-insurance or deductibles). MSPs do help with Part D costs.

At the federal level, CMS provides regulatory oversight of the MSPs (e.g., guidance and policy interpretation). A designated state agency, usually the agency administering Medicaid, is responsible for operating the MSPs at the local level. These agencies accept applications for MSPs, determine who is eligible, and conduct eligibility redeterminations. In some states, this program may not be called the Medicare Savings Program but may instead go by a different name.

Since MSPs are intended to help people who have low income and few, if any, assets, eligibility determinations involve means tests. To be eligible for MSPs, beneficiaries must have countable income and resources below limits set by the state Medicaid agency. The term "countable income" refers to the income left after all applicable deductions and exclusions have been applied. The laws enacting the Medicare Savings Program established specific percentages of the Federal Poverty Level (FPL) as the income limits for the MSPs, but some states have opted to use higher amounts. In addition, some states have opted to use higher or no resource limits.

Note about the FPLs: The U.S. Department of 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. 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 FPLs (or percentages of them) are consistently used as a standard for income eligibility for various Medicaid programs so we reference them repeatedly throughout this. More **information about the FPLs** is available at the DHHS web site (https://aspe.hhs.gov/poverty-guidelines).

The Medicare Savings Program includes four separate programs. Each program has different income and resource limits. Not all MSP programs cover the same Medicare expenses. We will cover three MSPs in this section as they are the ones CWICs will encounter the most. The fourth MSP is covered in the section in the chapter about Medicare and work.

Qualified Medicare Beneficiary (QMB)

Of the four Medicare Savings Programs, QMB (sometimes referred to as "quimby") provides the most financial costs support. If a Title II disability beneficiary is eligible for QMB, the state Medicaid agency will pay their Part B premium as well as any Part A and B deductibles and co-insurance. To be eligible, a beneficiary must have Medicare Part A, have countable income up to 100 percent of the current FPL (or a higher limit set by the state), have countable resources below certain prescribed limits and meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency).

Specified Low-Income Medicare Beneficiaries (SLMB)

Individuals eligible under SLMB (also referred to as "slimby") will get help paying their Part B premium. SLMB does not cover other Medicare expenses such as co-payments, co-insurance, or deductibles. To be eligible for SLMB, beneficiaries must have Medicare Part A, have countable income that exceeds 100 percent but is less than 120 percent

of the current FPL (or a higher limit set by the state), have countable resources below certain prescribed limits, and meet the general nonfinancial requirements or conditions of eligibility for Medicaid in their state (e.g., citizenship, residency).

Qualified Individual (QI)

Individuals eligible under QI will get help paying their Part B premium. Like SLMB, QI does not cover other Medicare expenses such as co-payments, co-insurance, or deductibles. To be eligible, beneficiaries must have Medicare Part A, have countable income that is at least 120 percent but below 135 percent of the current FPL (or a higher limit set by the state), have countable resources below certain prescribed limits, meet the general nonfinancial requirements or conditions of eligibility for Medicaid in their state (e.g., citizenship, residency), and be ineligible for Medicaid.

Many CWICs wonder what the difference is between SLMB and QI, aside from the income limit, since both programs only pay Part B premiums. From the beneficiary's perspective, there is one key difference. A person who has Medicaid can use SLMB but cannot 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.

We will provide you with more detailed information about how state Medicaid agencies determine countable income for MSP eligibility determinations in Chapter 5. For more information about the **Medicare Savings Programs** and their current eligibility requirements, refer to Medicare's MSP web page (https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs). You can also read detailed information about the MSPs by referring to a resource document on the NTDC website entitled **Understanding Medicare Savings Programs** (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=133).

Option 3: Part D Low-Income Subsidy

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 (LIS), but CMS and Social Security also

call this program "Extra Help." Unlike the MSPs, LIS is not a state-administered program. CMS administers the LIS while Social Security has primary responsibility for taking LIS applications and making determinations on those applications.

With LIS, beneficiaries generally do not have to pay a monthly Part D premium. 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. LIS eligible individuals who choose to participate in a more expensive plan are responsible for the difference. Those eligible for LIS also do not have co-payments and do not have to meet an annual deductible. To be eligible for the LIS, an individual must:

- Be entitled to benefits under Medicare Part A or entitled to Medicare Part B or both; and
- Reside in one of the 50 states or the District of Columbia; and
- Have countable income up to 150 percent of the FPL and resources at or below certain prescribed limits; or
- Be "deemed eligible". The following groups are deemed LIS eligible: Medicaid recipients, SSI beneficiaries, QMBs, SLMBs, or QIs. Individuals who are deemed eligible do not have to apply for LIS; instead, CMS automatically enrolls them.

Individuals who are not deemed eligible may apply for LIS by submitting an online application on Social Security's website; calling 1-800-772-1213 to apply over the phone; or applying in person at a local Social Security office. Once Social Security receives the application, the agency determines if the countable income is at or below the applicable percentage of the FPL and if countable resources are below the applicable limits.

Part D coverage and eligibility rules can be complex. To learn more about Part D and the LIS, refer to a resource document on the NTDC website **Medicare Part D and the Low-Income Subsidy** (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=132). There is also helpful information about **Part D and the LIS** on Social Security's website (https://www.ssa.gov/benefits/medicare/prescriptionhelp.html). Finally, refer to the **Part D Extra Help webpage** on CMS's website

(https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/find-your-level-of-extra-help-part-d). We will provide you with more detailed information about how Social Security determines countable income for LIS eligibility determinations in Chapter 5.

Medicare and Work

Beneficiaries remain eligible for all parts of Medicare as long as they remain eligible for cash payments. This means that beneficiaries who are working, but still eligible for disability benefits, will experience no interruption in their Medicare coverage. Beneficiaries of the Title II disability programs often believe that Medicare entitlement stops when cash payments stop due to SGA level work. 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 entitlement to Title II disability 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, until at least 93 months after the end of the Trial Work Period (TWP). In many cases, the period will be longer.

Once beneficiaries exhaust the EPMC, they may continue Medicare coverage through the second work incentive called 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. Under the EPMC provision, when an

individual's entitlement to disability benefits ends because they engaged in, or demonstrated the ability to engage in SGA after the 36 months following the end of the Trial Work Period (TWP), Medicare entitlement continues until the earlier of the following:

- The last day of the 78th month following the first month of SGA 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.

While this might sound complicated, in practice it is actually fairly straightforward. The EPMC involves several key time periods:

- The end of the TWP;
- The first 16 months of the Extended Period of Eligibility (EPE);
- The cessation month; and
- The 78 months of the EPMC.

The EPMC provides at least 93 months of coverage after the end of the TWP. It is not coincidental that the 15 months plus the 78 months listed above equals 93. Historically, Medicare coverage only extended to 15 months of the EPE. Congress extended this original 15-month rule several times over the years. Social Security has to use this original limit when counting months for EPMC purposes. Because of this, under the current EPMC rules, the EPMC counting period will never begin earlier than the 16th month of the EPE.

Ninety-three months is the least amount of time beneficiaries will have Medicare if their cash benefit stops due to work and they continue 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:

- If SGA also occurs in the 16th month of the EPE, EPMC will end at least 93 months after the TWP. The beneficiary must continue to have a disability throughout this period.
- If the beneficiary does not perform SGA in the 16th month of the EPE, the EPMC will end 78 months from the first time the beneficiary performs SGA 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, the EPMC will end 78 months after the Grace Period. The beneficiary must continue to have a disability throughout this period.

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

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

It is impossible to know exactly when a beneficiary's EPMC time period would end if the beneficiary has not yet engaged in SGA. The EPMC months do not begin to count until the TWP is over, SGA work has occurred, and Social Security has established the cessation month.

The EPMC is a work incentive for Title II disability beneficiaries. It is NOT a way to keep Medicare when beneficiaries lose benefits due to medical recovery. Individuals using the EPMC as the basis for their continued eligibility for Medicare must continue to meet the Social Security disability requirement, even though their entitlement to Title II disability benefit payments has ended.

Discussing EPMC with Beneficiaries

The EPMC can be very complex. When advising beneficiaries about this work incentive, remember that Social Security is the only place to find out how long the coverage will last. The EPMC depends on when the TWP ended, whether cessation occurred, or even if work caused benefit termination. Some beneficiaries' EPMC time period may have partially or completely passed without the beneficiary even realizing it. A CWIC

may not have enough information about the person's work history to determine the exact end of the EPMC. In addition, a CWIC cannot predict the future. Will the person again become entitled to cash benefits and thus regular Medicare? Will Social Security decide the beneficiary has medically improved? 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 entitlement to Title II disability benefits.

Premium-HI for the Working Disabled

At the end of the EPMC, if a person is still not receiving Title II cash benefits because of SGA level work, it is possible for former beneficiaries who still have a disability to continue Medicare coverage by "buying into" the Medicare program. This provision is referred to as "Premium-HI for the Working Disabled."

Essentially, this work incentive allows disabled and 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 Part A premium for the Working Disabled is not 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 surcharge rules. If an individual were paying an increased Part B premium during the last month of premium-free Part A, but enrolls in Part B under the Working Disabled provision during his or her Initial Enrollment Period, the Part B premium reverts to the standard rate, and the surcharge stops.

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

- The end of the month following the month Social Security notifies the individual that they no longer have a disabling impairment;
- The end of the month following the month the individual files a request for termination of Premium-HI;
- The end of the month before the month the individual becomes re-entitled to premium-free HI, such as when the beneficiary becomes entitled to Medicare Part A due to age or becomes entitled to Title II disability benefits again without a requirement to serve another qualifying period. 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.);

- The end of the grace period for non-payment of premiums; or
- Date of death.

Paying Medicare Premiums during Premium HI for the Working Disabled

Individuals who buy into Medicare through premium HI are billed for their Part A and B premiums on a quarterly basis. A special feature of the Premium HI program is that certain individuals are eligible for reduced Part A premiums if they have sufficient work history. In addition, states are required to pay Part A (but not Part B) premiums for certain people under a special type of Medicare Savings Program called Qualified Disabled and Working Individuals (QDWI). QDWI is a benefit designed for individuals who are under age 65, disabled, and no longer entitled to free Medicare Hospital Insurance Part A solely because they successfully returned to work. To be eligible for this help, an individual must:

- Continue to have a disabling impairment;
- Sign up for Premium Hospital Insurance (Part A);
- Have countable income up to200 percent of the current Federal Poverty Level (FPL);
- Have countable resources worth less than a prescribed amount; and
- Not already be eligible for Medicaid.

Detailed information about **Premium HI for the Working Disabled** is available on Social Security's Program Operations Manual System (POMS) (https://secure.ssa.gov/poms.nsf/lnx/0600801170).

More information about the **QDWI eligibility requirements** is available on Medicare's website (https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs).

Effect of Work on Medicare Savings Programs and the Low-Income Subsidy

Because the MSPs and the LIS are financial needs-based programs, when a person begins working, the increased income could cause their eligibility to change from one level to another or end altogether. In some cases, going to work may actually allow a beneficiary to establish eligibility for MSP or LIS coverage if the wages are high enough to cause the Title II disability payment to stop. To evaluate the effect of work on MSPs and the LIS, CWICs use special calculation sheets to determine total countable income (including the actual wages or earnings goal) and then compare that figure to applicable FPL levels. Calculating countable income for MSP and LIS determinations is complicated and is based on methods we introduce later in the chapter on the Supplemental Security Income (SSI) program. We will cover the MSP and LIS income calculation processes in detail in Chapter 6, after you have learned about the SSI income determination methodologies.

When Medicare Ends

Medicare coverage ends under the following circumstances:

1. Medicare coverage will stop if Social Security decides the person no longer meets the disability standard. Medicare coverage will stop the month after the month the person receives the notice that Social Security has terminated their disability benefits. There is no retroactivity to the Medicare termination.

2. Medicare eligibility will also cease after the EPMC ends for individuals who work their way off cash benefits unless the person purchases Premium HI for the Working Disabled.

3. To retain Parts B and D Medicare coverage (and Part A under Premium HI for the Working Disabled), beneficiaries must pay applicable premiums. Failure to pay Medicare premiums may result in termination of the applicable Part of Medicare.

4. When Title II disability beneficiaries turn 65 years of age, Medicare entitlement based on disability ends and Medicare eligibility based on age begins. There is no break in coverage, and beneficiaries do not have to re-enroll in Medicare. If the beneficiary had any premium penalties, those wouldn't carry into this new period of entitlement. Employment does not affect Medicare entitlement based on age.

Medicare Referrals

Medicare beneficiaries have to make many choices that will determine how they receive their Medicare. They may choose 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 may require the CWIC to 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** is available (https://www.shiphelp.org).

Next Steps

This chapter provides a basic overview of the Medicare concepts CWICs encounter in their day-to-day work. It does not provide sufficient information for you to provide in-depth and comprehensive counseling to beneficiaries about complex Medicare issues – particularly issues

related to the effect of work on Medicare coverage and programs that help pay Medicare out-of-pocket expenses.

To develop greater expertise in Medicare, you will need to complete additional training, conduct research, and consult with your VCU Technical Assistance (TA) Liaison. To deepen your understanding of the Medicare program and improve the quality of the counseling you provide, we recommend that you take the following next steps:

1. VCU's NTDC offers a wide range of **resource materials about Medicare** on their website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=5#Medicare). In particular, there are detailed documents that cover some of the more complex topics introduced in this chapter.
2. VCU offers a four-week web course on the Medicare program several times each year. We recommend that all CWICs complete this web course within the first year of employment to reinforce the concepts they learned during initial training and strengthen their understanding of how paid employment affects Medicare coverage and programs that help pay Medicare out-of-pocket expenses. Once you achieve provisional CWIC certification, you will start receiving email notices when registration for NTDC web courses opens.
3. The VCU NTDC website contains numerous archived training sessions that cover various Medicare concepts. You can find a listing of **archived supplemental training sessions** on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm).
4. This chapter contains links to excellent resources for more information about Medicare. You should keep these in mind when you need to learn more.