When evaluating the impact of work on a beneficiary’s Medicare, there are three (3) key topics that a CWIC must evaluate:

1. The impact of work on Medicare entitlement;
2. The impact of work on Medicare Part A & B financial assistance; and
3. The impact of work on Medicare Part D financial assistance.

This guide provides a summary of the core concepts, a decision tree, and some frequently asked questions for each topic listed above. The purpose of the decision trees is to help CWICs think through the impact of a work goal on an individual’s Medicare entitlement and the Medicare financial assistance programs. Since this is only intended to be a guide, CWICs will need to read Module 4, unit 2, of the CWIC manual to get more details on these topics.

Medicare Entitlement and Work

As a CWIC you need to explain what impact work will have on a beneficiary’s Medicare entitlement, which includes access to Part A, Part B, and Part D. In summary, when a person begins working Medicare entitlement can continue indefinitely, as long as the person continues to have a qualifying disabling condition. But, the rule under which it will continue varies depending upon the person’s situation. The two key situations are:

1. **Beneficiary continues to receive Title II disability when working**: Medicare simply continues because the beneficiary is in pay status. In this situation a beneficiary does not need a Medicare work incentive.

2. **Beneficiary’s Title II disability will be suspended or terminated when working**: The work incentive called Extended Period of Medicare Coverage (EPMC) can provide ongoing Medicare entitlement for at least 93 months after the TWP ends. When the EPMC is exhausted, Premium-HI for the Working Disabled can provide ongoing Medicare eligibility. The following decision tree is designed to help you personalize the information you give a beneficiary about EPMC and/or Premium-HI for the Working Disabled. It’s important to point out that only Social Security can determine the end date for the EPMC.
In order for Medicare to be extended, the beneficiary must continue to have a disability throughout this period.

See POMS HI 00820.025 Termination of Disability HI for more information.

Reminder: If the beneficiary is earning below SGA and receiving their Title II disability benefit when EPMC is exhausted, Medicare continues based on the ongoing receipt of the cash benefit. However, if after EPMC is exhausted the beneficiary is not receiving the Title II disability benefit due to earnings, they may be able to use Premium-HI for the Working Disabled to maintain Medicare.
Medicare Entitlement Frequently Asked Questions

My beneficiary just recently became entitled to SSDI. What do I say in the BS&A about Medicare? If the beneficiary is still in the 24-month Medicare Qualifying Period (MQP) you may want to briefly cover the following:

1. Identify the month and year that Medicare will begin (25th month after date of entitlement listed on the BPQY)
2. Advise the beneficiary to watch for important notices from Social Security in the months prior to Medicare entitlement that explain:
   - Automatic enrollment in premium-free Part A and Part B, which involves a premium. Beneficiary can opt out of Part B unless state requires they take it, although beneficiaries may face a premium penalty if they wish to enroll later in Part B. Through state “buy-in” agreements with CMS, certain people do not have the option of refusing Part B. States will automatically enroll these individuals in Part B and may pay the premium, co-insurance and deductibles. See HI 00815.001 for a description.
   - Eligibility for financial assistance for the Part B premium as well as the Part A and B deductibles and co-insurance, depending upon the beneficiary’s income
   - Enrollment in a Part D Prescription Drug Plan is voluntary; financial assistance is possible through a low-income subsidy.
3. Encourage the beneficiary to contact you when Medicare begins, so you can update the BS&A and determine if premium assistance is available
4. Encourage the beneficiary to contact a counselor at the State Health Insurance Assistance Programs (www.shiptalk.org) to understand the details and options around Medicare coverage and assist with choosing a Part D plan.
5. Explore other health care coverage options before Medicare starts. The beneficiary may be eligible for Medicaid depending on their income, resources, and the Medicaid eligibility groups available in their state. They also may purchase a health insurance plan on the Marketplace, and potentially be eligible for the Advanced Premium Tax Credit and Cost Sharing to reduce out of pocket costs.1

What are some of the important topics to cover regarding Medicare in the BS&A?

1 Not all states have created a state-specific Marketplace, nor have they elected to extend Medicaid coverage to higher income adults. CWICs need to research their state action at https://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap. Find out if your state has implemented a state exchange at obamacarefacts.com/state-health-insurance-exchange/
• **ALWAYS** state that Medicare continues *as long as cash benefits continue* (e.g. during TWP/grace period or if earnings goal will not result in a decision of SGA).

• Briefly discuss the **Extended Period of Medicare Coverage (EPMC)** if the earnings goal will likely result in a decision of SGA, or the beneficiary is undecided or concerned about increasing earnings.

• If the beneficiary has, or will be, ceased, use decision trees to provide the beneficiary with a general idea of when the EPMC will end (e.g. “at least 93 months after TWP ends”)

• Employers may require beneficiaries to enroll in or retain Medicare Parts B and D, so they should check with their employer before opting out. Some employers will pay the Medicare premiums.

### Medicare Part A & B Financial Assistance and Work

As a CWIC you need to identify whether a person will maintain, obtain, or lose financial assistance with their Medicare Part A & B out-of-pocket expenses when working. Medicare Part A has deductibles and coinsurance. There is no Part A premium, unless the person is using Premium-HI for the Working Disabled. Part B has a number of out-of-pocket expenses: a monthly premium, an annual deductible, and approximately 20% coinsurance on most services. You can find the current out-of-pocket costs for Medicare at the Medicare website here: [https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html](https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html)

There are 5 potential financial-need based programs that can help with some of these Part A & B expenses, all of which could be impacted by earnings. The first three are called **Medicare Savings Programs (MSP)**.

• Qualified Medicare Beneficiary (QMB) (100% FPL income limit): helps with Part B premium, as well as the Part A and B deductibles and coinsurance.

• Specified Low Income Medicare Beneficiary (SLMB) (120% FPL income limit): helps with Part B premium only

• Qualified Individual (QI) (135% FPL income limit): helps with Part B premium only. (not an option if Medicaid eligible)

• Medicaid as secondary insurance: pays Part A & B deductibles and coinsurance:

• Medicaid and Part B premium: Medicaid agencies in some states pay the Part B premium for those over income for QMB and SLMB but who fall into specific categories defined by the state (you must research in your state which Medicaid groups, if any, that can get this help)
The state must use the SSI methodology (income exclusions) to determine countable income for MSPs, and then compare it with the state’s Federal Poverty Level (FPL) for the applicable family size. A spouse’s income is counted. There can also be a resource limit (some states do not have a resource limit for MSPs). The FPL and resource limits will change every year.


If a beneficiary will be using Premium-HI for the Working Disabled to maintain Medicare entitlement after exhausting the EPMC there are a few key factors to keep in mind:

- They will be responsible for paying the Medicare Part A premium
- They may be eligible for the MSP called Qualified Disabled Working Individual (QDWI) to pay that Part A premium
- They cannot get QMB, SLMB, or QI to help with Part A and B out of pocket expenses

The following decision tree provides a process for thinking through the impact of work on these financial assistance programs and suggested language for the BS&A:
Medicare Part A & B Financial Assistance Decision Tree

**Will the person be eligible for Medicaid when working?**
- **No**
- **Yes**

**Will the person have countable income below 100% FPL and resources below state’s QMB limit?**
- **No**
- **Yes**

**Will they have countable income below 120% FPL and resources below state’s QMB/SLMB limit?**
- **No**
- **Yes**

**No Part A or B out-of-pocket expenses:** “It appears you’ll be eligible for QMB to pay your Part B premium, as well as your Part A & B deductible and coinsurance.”

**Some Part A & B out-of-pocket expenses:** “It appears you’ll be eligible for a Medicare Savings Program to pay your Part B premium, but you’ll need to pay your Part A & B deductible and coinsurance.”

**Must pay all Part A & B out-of-pocket expenses:** “You aren’t eligible for a Medicare Savings Program or Medicaid. As a result will need to pay your Part B premium, as well as you Part A & B deductibles and coinsurance.”

**No Part A or B out-of-pocket expenses:** “It appears you’ll be eligible for a Medicare Savings Program to pay your Part B premium, plus Medicaid can pay your Part A & B deductible and coinsurance.”

**May have to pay Part B premium:** “Medicaid can pay your Part A & B deductible, and coinsurance. It appears you aren’t eligible for a Medicare Savings Program to pay your Part B premium. I checked with the state and they [will/will not] pay that premium for you.”

**NOTE:** If the beneficiary will use Premium-HI for the Working Disabled to maintain Medicare, they **will** have a Part A premium. Explore whether they could be eligible for Qualified Disabled Working Individual to pay that Part A premium.
Medicare Part A & B Frequently Asked Questions

How do I know which MSP my beneficiary has? You can get some idea by looking at their countable income, both earned and unearned. To verify the MSP, contact the Medicaid agency, or ask the beneficiary to bring the most recent correspondence from the Medicaid agency to the intake meeting.

The BPQY says my beneficiary has “buy-in” of Medicare Part B. What does that mean? It means one of two things:

1. The person is eligible for and enrolled in a Medicare Savings Program, or
2. The state has opted to pay the Part B premium for certain groups of people who are over income for MSP, and the person falls into one of those groups.

What is “QDWI”? QDWI stands for Qualified Disabled Working Individual. QDWI is another Medicare Savings Program, but it’s different from the other three in that it doesn’t pay for Part B or cover the deductibles and co-insurance. QDWI is financial assistance for the Part A premium for individuals who have exhausted the EPMC, are buying into Medicare through the “Premium HI for the Working Disabled”, and have countable income below 200% of the Federal Poverty Level. The resource limit for QDWI is lower than the other MSPs as well, $4,000 for a single person and $6,000 for a couple. People eligible for Medicaid are not eligible for QDWI.

QDWI only helps with the Part A premium; the beneficiary must pay the Part B and Part D premiums.

A CWIC would only mention QDWI in the BS&A if the beneficiary 1) is likely to use Premium-HI for the Working Disabled in the near future, 2) does not have Medicaid, 3) has expressed concern about not having health care when the EPMC ends, and 4) has/will have countable earnings (using the SSI income exclusions) below 200% of the applicable Federal Poverty Level. Because the Federal Poverty Level changes every year, only an estimate will be possible to determine future eligibility for QDWI.

Medicare Part D Financial Assistance and Work

As a CWIC you need to identify whether a person will maintain, obtain, or lose financial assistance with their Medicare Part D out-of-pocket expenses when working. Medicare Part D is prescription drug coverage, but it only covers a portion of the medications. Part D has a number of out-of-pocket expenses. Depending upon the prescription drug plan the person chooses, they could have a monthly premium, a deductible, and coinsurance. There is one
financial-need based program that offers 2 levels of help, both of which could be impacted by earnings.

- Full Low Income Subsidy covers all of the Part D premium (up to national average), no deductible, and co-payments.
- Partial Low Income Subsidy (135-150% FPL) covers a percentage of the Part D premium (depending on income), a deductible, and coinsurance of 15% until catastrophic level is reached.

Three groups of beneficiaries are deemed eligible for Full Low Income Subsidy:

- SSI eligible (including 1619b)
- Medicaid eligible
- QMB, SLMB, or QI eligible

These groups do not need to apply for Full LIS, but instead get it automatically. When a person begins working, if they remain or become eligible for one of these groups they will either maintain or become eligible for Full LIS. If a person does not fall into one of these groups, or will not be eligible for any of these groups when working, then their countable income must be calculated. If countable income is below 135% FPL they may be eligible for Full LIS. If countable income is between 135-150% FPL they could get Partial LIS.

Social Security determines LIS eligibility for anyone who is not deemed eligible. They use the SSI methodology (income exclusions) to determine countable income, with 2 exceptions. If a person states they have IRWE an automatic 16.3% deduction is given (unless receipts showing a higher amount can be provided). Similarly, an automatic 25% deduction for BWE is given (unless receipts showing a higher amount can be provided).

The following decision tree provides a process for thinking through which of the above possibilities applies, as well as suggested language for the BS&A:
Medicare Part D Financial Assistance Decision Tree

Will the person be eligible for Medicaid, QMB/SLMB/QI, SSI or have countable income below 135% FPL and countable resources below $8,780 when working?

Yes

Full LIS: “It appears you’ll be eligible for full LIS to help pay your Part D premium, deductible, and coinsurance.”

No

Will the person have countable income between 136-150% FPL and countable resources below $13,640 when working?

Yes

Partial LIS: “It appears you’ll be eligible for Partial LIS to help pay some of your Part D premium, deductible, and coinsurance.”

No

All Part D out-of-pocket expenses: “It appears you will not be eligible for LIS when working; as a result you’ll need to pay your Part D premium, deductible, and coinsurance.”
Medicare Part D Frequently Asked Questions

The BPQY doesn’t say anything about Part D. Does that mean the beneficiary is not enrolled in a Part D Prescription Drug Plan? Not necessarily. Verify enrollment in Part D by calling Medicare (1-800-Medicare) with the beneficiary, asking to see the beneficiary’s prescription drug card, or by going on Medicare’s website and enter the beneficiary’s information into the “personalized search” feature (https://www.medicare.gov/find-a-plan/questions/home.aspx). Beneficiaries that are “dually eligible”, meaning they have both Medicare AND full Medicaid benefits, will be required to enroll in a Part D plan, or the state will choose a plan for them.

How do I know if the beneficiary has the Part D Low Income Subsidy (LIS)? You can verify Part D full or partial LIS through Medicare, using the options listed above. If the person has Medicaid you can also verify full LIS through the agency that administers Medicaid in beneficiary’s state.

How does a beneficiary apply for the Part D Low Income Subsidy? If a beneficiary is in one of the deemed eligible categories (SSI, Medicaid, QMB, SLMB, QI), they do not need to apply for LIS, as they will be automatically enrolled. Others will need to apply for the subsidy through Social Security. States are required to screen individuals for LIS eligibility, so Medicaid agencies may provide applications and encourage beneficiaries to apply for LIS. Ultimately, it’s Social Security that will process the application and make an eligibility determination.

If a beneficiary applies for the Low Income Subsidy (LIS), also known as Extra Help, at their local Social Security office, that application effectively starts the application for Medicare Savings Programs unless the beneficiary declines that help. Social Security sends data from the LIS application to the appropriate state agency to begin the MSP application process.

Effective January 2010, the Medicaid agency must consider the data from the LIS application as an application for MSP, even if the LIS application was denied by Social Security. LIS beneficiaries will not have to go into the Medicaid office to apply for MSPs. The state Medicaid agency will contact the beneficiary.

2 DHHS/CMS/Center for Medicaid and State Operations, Letter to State Medicaid Directors, February 18, 2010, re: Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), SMDL #10-003
Who can I refer the beneficiary to if s/he has questions about enrolling in Medicare, choosing a Part D prescription drug plan, or what type of services Medicare covers? Refer the beneficiary to the State Health Insurance Program (SHIP) counselor for help with decisions about enrolling in a Part C plan, choosing a Part D prescription drug plan, or for help with Medicare coverage issues. To find the SHIP counselor in your state, go to https://shiptalk.org. Resources in the community can also be found through http://www.eldercare.gov/ and https://www.benefitscheckup.org/