NewYorkMakesWorkPay

WORKING

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Medicare and Individuals with Disabilities

A Focus on Eligibility, Services and Work Incentives

Medicare is the nation's largest health care program. This federal health insurance program covers several primary classes of persons:

- Persons age 65 or older, including individuals who receive Social Security retirement benefits;
- Persons receiving Social Security Disability Insurance (SSDI) payments, including many adults who receive SSDI through the Childhood Disability Benefits (CDB) program (also known as the Disabled Adult Child or DAC program), and many who receive SSDI as widows or widowers;
- Persons who lose SSDI cash payments through earnings and are in the Extended Period of Medicare Coverage;
- Persons who receive Railroad Retirement benefits based on disability;
- Persons who qualify for Medicare through the End Stage Renal Disease program (based on an advanced stage of kidney failure); and
- Medicare-Qualified Federal Employees.

Inside this issue

An SSDI beneficiary is entitled to Medicare after a 24-month waiting period, (i.e., after 24 months of eligibility for SSDI payments). Two categories of individuals are not subject to a 24-month waiting period: individuals with amyotrophic lateral sclerosis (ALS; also known as Lou Gehrig's Disease); and individuals with End Stage Renal Disease. After the waiting period, eligibility for Medicare Part A is automatic and cost-free. Eligibility for Parts B and D are optional and subject to certain out-of-pocket expenses.

As many readers know, individuals with severe disabilities are often reluctant to work for significant wages because they fear that work activity will lead to a loss of their government-sponsored health insurance, Medicaid or Medicare. A previous newsletter and policy-to-practice brief have focused on Medicaid, including the work incentives known as 1619(b), which allows Medicaid to continue despite the loss of SSI due to wages, and the Medicaid Buy-In for Working People with Disabilities, which allows for Medicaid eligibility to working individuals with no history of SSI receipt. [See our *Working* newsletter and lead article, *New York's Medicaid Buy-In Program for Working People with Disabilities*, available at **http://www.nymakesworkpay.org/docs/MIG_Newsletter_SP09.pdf**; and policy-to-practice brief, *The Medicaid Buy-In for Working People with Disabilities*, available at **http://www.nymakesworkpay.org/docs/MBI%20Brief-2.0.pdf**].

This newsletter will focus on Medicare, with an emphasis on individuals who receive Medicare as SSDI beneficiaries. In the discussion that follows, we summarize: the differences between Medicare and Medicaid; the four parts of Medicare; the Medicare Savings Plans that pay for Part B premiums and other costs; the Part D low-income subsidy program; and the Extended Period of Medicare Coverage for individuals who lose SSDI cash benefits through earnings above the substantial gainful activity level. Extensive details on the four parts of the Medicare program are beyond the scope of this newsletter. Readers are encouraged to go to the Medicare website (**www.medicare.gov**) for more detail on any of the topics that follow.

Medicare & Medicaid Compared

Medicare and Medicaid are two different programs. Medicare is implemented by the federal Centers for Medicare and Medicaid Services (CMS), with eligibility determined by the Social Security Administration (SSA). Since it is not a needs-based program, an individual may have considerable monthly income and assets while retaining eligibility for Medicare. However, several special programs that help pay for out-of-pocket costs associated with Medicare Parts B and D (see below) are based on financial need.

Medicaid is, by contrast, a program primarily targeted to individuals and families with limited income and assets. In most of New York, it is implemented by the County Departments of Social Services except in New York City where it is implemented by the Human Resources Agency. Medicaid provides more extensive funding than Medicare for community-based care. When an individual is dually eligible for both Medicare and Medicaid, Medicare is the primary payer for services that are covered by both programs with Medicaid as the secondary payer.

The Four Parts of Medicare

Medicare Part A (Hospital Insurance)

Medicare Part A pays for inpatient hospital care, skilled nursing facility care, and certain follow-up care. The SSDI beneficiary is automatically eligible for no-cost Part A coverage after the 24-month waiting period.

Part A Deductible and Coinsurance Amounts for 2011. For each calendar year, Medicare pays all covered costs except the Medicare Part A deductible ($1,132 in 2011) during the first 60 days and coinsurance amounts for hospital stays that last beyond 60 days and no more than 150 days. For 2011 the beneficiary pays:

- A total of $1,132 for a hospital stay of 1-60 days;
- $283 per day for days 61-90 of a hospital stay;
- $566 per day for days 91-150 of a hospital stay (Lifetime Reserve Days);
- All costs for each day beyond 150 days; and
- For Skilled Nursing Facility coinsurance, $141.50 per day for days 21 through 100 each benefit period.

Updated figures for 2012 and later years will be available on the **www.medicare.gov** website. If an individual is dually eligible for Medicare and Medicaid, Medicaid will normally pay the beneficiary's share of the hospital or nursing facility charges.

Medicare Part B (Supplemental Medical Insurance)

Medicare Part B enrollment is optional and subject to monthly premiums, deductibles, and co-payments. The annual Part B deductible is $162. The beneficiary pays 20% of the Medicare-approved amount for services after meeting the $162 deductible. Some or all of those out-of-pocket expenses can be paid by the Medicaid agency if the individual qualifies for one of three Medicare Savings Plans.

Part B pays for doctor's services and a variety of other medical services and supplies that are not covered by Part A. For example, Part B will cover home health services (with less extensive coverage than Medicaid), durable medical equipment (including wheelchairs and scooters), prosthetic and orthotic devices. When Medicare Part B does cover an item or service, it covers 80% of Medicare's approved rate for the item, with the individual responsible for the remaining 20%. Therefore, if Medicare covers an $8,000 power wheelchair, payment will be made for $6,400 (80%) with the individual responsible for the remaining $1,600 (20%). The Medicaid program can pick up the copayment if the individual is also eligible for Medicaid or eligible for the Qualified Medicare Beneficiaries (QMB) program (discussed below).

Part B premiums. To enroll in Part B, a Medicare beneficiary must pay a monthly premium. The premium is $96.40 for most individuals in 2011, but $110.50 if the individual first became eligible in 2010 or $115.40 if the individual first became eligible in 2011. A very small number of Medicare beneficiaries with higher income levels (i.e., annual income of $85,000 for individuals or $170,000 for couples) will pay higher Part B premiums.

Part B and late enrollment costs. If an individual declines Medicare Part B, and then later decides to enroll, he or she is usually required to pay a significant penalty. The enrollment penalty is 10% of the premium for each 12-month period he or she could have had Part B cover-

age, but did not take it. The penalty is for life, and the individual will always pay more for Part B coverage than others.

If an individual or a spouse is actively employed and covered by an employer's group health plan, they may not need Part B until they are no longer covered under the employer's plan due to the end of employment. If the person signs up for Medicare Part B within eight months after the employer benefits end, they will not be penalized for late enrollment. Retirement coverage and Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits do not count as employer coverage.

Medicare Savings Plans. Three different Medicare Savings Plans provide for payment of the monthly Part B premium by the Medicaid agency. The following explains these programs as implemented in New York State.

- *Qualified Medicare Beneficiary (QMB) program:* The QMB program requires Medicaid agencies to pay for Part B premiums, deductibles, and copayments for individuals who meet certain financial guidelines. In 2011, the monthly countable income limit is $908 for an individual ($1,226 for an eligible couple), based on 100% of the federal poverty level. In the power wheelchair example above, the QMB program would pay both the monthly Part B premium and the $1,600 copayment for the wheelchair.

- Effective April 1, 2008 the asset test for QMB was eliminated in New York. This means, for example, that an SSDI beneficiary with $60,000 invested in a 401k retirement account from previous employment would be eligible for QMB based only on countable monthly income.

- *Selected Low-Income Medicare Beneficiary (SLMB) program*: The SLMB program requires Medicaid agencies to pay for Part B premiums, but not deductibles or copayments, for individuals with countable income up to $1,089 per month in 2011 ($1,471 for an eligible couple), based on 120% of the federal poverty level. Like QMB, there is no asset test in the SLMB program.

- *Qualified Individuals (QI-1) program:* The QI-1 program requires Medicaid agencies to pay for Part B premiums, but not deductibles or copayments, for in-

Medicare Resources on the Internet

Medicare agency resources:

- Medicare's site – **www.medicare.gov**
- Medicare and You, 2012 Edition – **http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf**

Advocacy agency resources:

- Center for Medicare Advocacy – **www.medicareadvocacy.org** (excellent resources on Medicare Part D)
- Medicare Rights Center – **www.medicarerights.org** (based in New York City, their Medicare Helpline can be reached at 1-800-333-4114)
- National Senior Citizens Law Center – **www.nsclc.org**
- Kaiser Family Foundation – **www.kff.org** (in addition to great Medicare resources, a good source of policy papers on Medicare and other health related topics)

dividuals with countable income up to $1,226 per month in 2011 ($1,655 for an eligible couple), based on 135% of the federal poverty level. Like QMB and SLMB, there is no asset test in the QI-1 program. An individual cannot be both Medicaid eligible and QI-1 eligible.

Medicare Saving Programs are required to follow the Supplemental Security Income (SSI) program's rules for determining countable income. This means that the following income will not count when determining monthly countable income: the first $20 of unearned income, the first $65 of gross earned income ($85 if no unearned income), impairment related work expenses, 50% of remaining earned income, and blind work expenses.

Example. *Carmen receives $740 in monthly SSDI benefits, earns $765 gross monthly at a part-time job she recently started, and has $38,000 in a 403(b) retirement account. She is about to become eligible for Medicare after 24 months of SSDI eligibility and is concerned about the $115.40 per month Part B premium she must pay if she enrolls in this optional program.*

Carmen should be eligible for the SLMB program since her countable income is less than the $1,089 monthly income limit. She has $1,070 in countable monthly income, including $720 in countable SSDI ($740 – 20) and $350 in countable wages ($765 – 65 = 700 ÷ 2 = $350). Her $38,000 in retirement assets will not be counted.

NOTE: If a benefits practitioner was working with Carmen he or she should also tell her about the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program as Carmen should be eligible for the MBI-WPD based on the facts presented. Her countable monthly income, $1,070, is significantly less than the $2,269 countable income limit in New York for the MBI-WPD program in 2011. Importantly, effective October 1, 2011, the countable resource limit for New York's MBI-WPD has increased from $13,800 to $20,000 and retirement accounts are now exempt meaning that Carmen's 403(b) retirement savings, $38,000, will not count against her. Given the facts in this example, Carmen would not be eligible for 1619(b) Medicaid even if she was a former SSI beneficiary who lost SSI due to wages. Under 1619(b), her countable resources must remain below the $2,000 SSI resource limit and the $38,000 retirement account is a countable resource.

Medicare Part C (Medicare Advantage Programs)

Part C is an optional, managed care alternative. There are a wide range of Medicare Advantage Programs offered by Medicare-approved private companies, with all offering the same benefits available through Parts A and B and many offering additional services not typically covered through Part B (such as eyeglasses or dental care). In some cases, the extra services offered through these managed care plans means that the monthly premium will be higher than the current Part B premium would be. Most Medicare Advantage Plans will also cover the prescription drug plan normally covered by Part D, with premium costs that reflect this additional coverage.

There are several types of Medicare Advantage Plans, with no guarantee that the plan an individual wants or needs will be available in their community. Individuals who are considering a Medicare Advantage Program, as an alternative to traditional Medicare, must be careful to make sure this is really a better alternative.

Agencies such as the Health Insurance Information, Counseling and Assistance (HICAP) program can help individuals through this difficult decision making process (call toll free, 1-800-701-0501 for information on HICAP assistance in your region of the state).

Medicare Part D (the Prescription Drug Program)

This optional program provides prescription drug coverage subject to monthly premiums and other out-of-pocket expenses. As explained below, many if not all of the out-of-pocket expenses associated with Part D can be avoided if an individual qualifies for the Part D Low-Income Subsidy program. Although Part D is optional, if an individual is dually eligible for both Medicare and Medicaid he or she must obtain their prescription coverage through the Part D program. In fact, the Centers for Medicare and Medicaid Services will "auto enroll" into Part D any individual who has been identified as dually eligible for Medicare and Medicaid.

Medicare-only individuals (i.e., those not also eligible for Medicaid) must actively enroll in a Part D plan if they wish to have prescription drug coverage through Part D. If they fail to enroll, they can later be charged a premium penalty of 1% of their premium cost for every month of delayed enrollment. If the beneficiary is receiving drug benefits through another health insurance program and receiving "creditable coverage" (prescription drug benefits that are at least as good as the Medicare drug benefit), then he or she does not have to enroll in the Part D program. These individuals should receive a letter from the insurance program indicating if their plan is creditable. **These individuals should also save that letter to use should they need it in the future.**

Potential Part D out-of-pocket costs. Individuals who enroll in Part D and are not eligible for the low-income subsidy (full or partial) will be responsible for significant out-of-pocket expenses. In 2012, these expenses will typically include:

- Monthly premiums which average about $35 to $40 (with premiums considerably higher for some plans);
- The first $320 (a $320 deductible) before the Part D plan starts to pay its share;
- A 25% copayment for the next $2,610 ($652.50) in drug costs;
- Once the plan and beneficiary have paid a combined $2,930 ($320 + $2,610), the beneficiary enters the coverage gap, referred to as the "donut hole";
- The beneficiary then pays 100% of the next $3,725.50 in drug costs (subject to donut hole discounts that started in 2011);
- Once the beneficiary has spent a total of $4,700 in "true out of pocket costs," he or she enters the catastrophic coverage period, with the beneficiary now paying the higher of 5% of the cost of drugs, or $2.60 for generic drugs/$6.50 for brand name drugs.

The donut hole will be gradually be phased out between 2011 and 2020.

Part D's Low-Income Subsidy Program (also known as "Extra Help"). Through the low-income subsidy program, the federal government will provide "extra help" with monthly premiums, deductibles and copayments to financially needy individuals. Individuals qual-

ify for the low-income subsidy in one of two ways: automatically, if they are considered dually eligible for Medicare and Medicaid; or by separate application if they are eligible for Medicare only.

Dually eligible beneficiaries include Medicare recipients who receive Medicaid of any kind, including Medicaid through section 1619(b) or the Medicaid Buy-In for Working People with Disabilities (MBI-WPD). Individuals who are enrolled in one of the Medicare Savings Programs, QMB, SLMB or QI-1, are also considered Medicaid recipients and would automatically qualify for the low-income subsidy program as dually eligible.

Full Extra Help and Partial Extra Help. All dually eligible beneficiaries and Medicare only beneficiaries who meet income and asset criteria are eligible for full extra help. In 2011, a Medicare-only beneficiary qualifies for full extra help (i.e., the full low-income subsidy) if their monthly income is less than 135% of the federal poverty level ($1,226 per month for an individual in 2011), and their assets are less than $8,180. Individuals with full extra help will pay no monthly premiums (if enrolled in a benchmark plan), have no annual deductible costs, and pay minimal copayments for drug purchases. (A "benchmark plan" is a basic Medicare Part D plan that has a premium below the weighted average of Part D plan premiums in a region. This weighted average premium is determined each calendar year and the plans that qualify are announced by CMS).

A Medicare-only beneficiary will qualify for partial extra help if monthly income is between 135% and 150% of the federal poverty level (i.e., between $1,226 and $1,362 per month in 2011) and assets are below $12,640 in 2011. An individual with partial extra help will qualify for a reduced monthly premium based on a sliding scale; have an limited annual deductible; and have lower out-of-pocket expenses related to the amount they pay toward drugs and drug copayments.

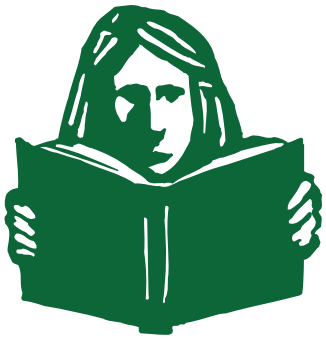
Significant changes to the Part D program are expected for 2012. A broader discussion of Part D and the 2012 changes is beyond the scope of this article. A good source of information on Part D and 2012 changes is the website of the Center for Medicare Advocacy (**www.medicareadvocacy.org**).

When is Medicare Eligibility Terminated?

All good things can come to an end and such is the case with Medicare coverage for the SSDI beneficiary. Medicare will stop if, following a medical continuing disability review, Social Security determines that an individual no longer meets SSDI's medical criteria for disability based on a medical improvement. However, both the SSDI payments and Medicare coverage will continue in two instances. First, an individual who appeals this SSDI termination decision and requests continuing benefits is entitled to continued SSDI cash payments and Medicare coverage until an administrative law judge has heard the case and rendered a decision. Second, pursuant to the work incentive known as section 301, if the beneficiary had started participation in an approved vocational rehabilitation (VR) program before the date of the medical improvement finding, both SSDI

payments and Medicare coverage will, in most cases, continue until the VR program is completed. For example, an individual attending a college program under ACCES-VR (formerly VESID) sponsorship could have his or her SSDI payments and Medicare coverage continued for four years or longer (i.e., until the completion of the college degree).

SSDI, Medicare and Work



We have previously published a newsletter and policy-to-practice brief dealing with SSDI and work. Those publications explain the circumstance under which an SSDI beneficiary is entitled to a nine-month trial work period, a 36-month extended period of eligibility, and expedited reinstatement of benefits. [See our *Working* newsletter and lead article, S*ocial Security Disability Insurance and Work,* available at **http://www.nymakesworkpay.org/docs/MIG_Newsletter_3.0.pdf**; and policy-to-practice brief, *Social Security Disability Insurance, Medicare and Work*, available at **http://www.nymakesworkpay.org/docs/SSDI%20Brief-2.0.pdf**.] Although we cannot restate all the rules that apply to SSDI cash payments when an individual works for substantial wages, it is important to discuss where Medicare eligibility would fit in as the beneficiary works and takes advantage of these SSDI work incentives.

The Trial Work Period (TWP) and Medicare. The TWP is an SSDI work incentive. In all cases, SSDI cash benefits will continue throughout the nine-month TWP. Medicare coverage will also continue under the same conditions as discussed above (Part A continues with no premium; Parts B and D continue subject to monthly premiums and other out-of-pocket expenses).

The Extended Period of Eligibility (EPE) and Medicare. The 36-month EPE is an SSDI work incentive. It begins immediately after the ninth trial work month and continues for 36 consecutive months. If the beneficiary never performs substantial gainful activity (SGA) during the EPE, by virtue of countable monthly earnings of more than $1,000 in 2011 ($1,640 if statutorily blind), SSDI continues and Medicare will continue as well. Part B premiums will continue to be deducted from the SSDI payment unless it is paid through a Medicare Saving Plan. In fact, SSDI payments and Medicare coverage will continue under the usual rules if the EPE ends and the beneficiary continues to earn less than the SGA level.

The first time the beneficiary earns above the SGA level during the EPE, he or she will receive SSDI payments for that month and the next two months (the three-month grace period). Thereafter, SSDI benefits are paid for each month that countable earnings are at or below the SGA level; benefits are not paid for months that countable earnings are above the SGA level. During any EPE months when SSDI payments are suspended, the Part B premium can no longer come out of the SSDI payment. At that point, the beneficiary will be billed directly, on a quarterly basis, for any Part B premiums that are owed.

Even if SSDI payments are suspended for one month or many months during the EPE, Medicare coverage will always continue because these months will be part of the Extended Period of Medicare Coverage which is discussed next.

The Extended Period of Medicare Coverage (EPMC). This work incentive allows a benefi-

ciary to retain premium-free Part A (and optional Parts B and D, subject to payment of premiums and other out-of-pocket expenses) if the beneficiary loses cash payments due to work activity. If the SSDI beneficiary works despite a continuing disability, this incentive allows Medicare eligibility to continue for at least 93 months after the nine-month TWP. A trained benefits practitioner can help the beneficiary determine if their unique circumstances allow the EPMC to be longer than 93 months after the TWP.

This is a very powerful work incentive as it allows Medicare to continue no matter how much the beneficiary earns during the EPMC. High earnings, however, could have an impact on whether the beneficiary qualifies for a Medicare Savings Plan or the Part D low-income subsidy plan. Also, keep in mind that for any months during this extended period that the beneficiary does not receive SSDI payments, Medicare premiums will be billed directly to the beneficiary on a quarterly basis.

Optional Coverage after the Extended Period of Medicare Coverage Ends - The Premium HI Program. An individual who exhausts the EPMC may be able to continue Medicare coverage through the "Premium HI for the Working Disabled" program. He or she must continue to be disabled, be under age 65, and the loss of SSDI must be due solely to earnings that exceed the SGA amount. Medicare eligibility can continue indefinitely so long as the individual continues to be disabled and pays the enrollment premiums. An individual can opt for only Part A coverage, but cannot opt for Part B coverage or part D unless he or she takes Part A.

The Medicaid program is required to pay the required Part A premiums, but not Part B premiums through the Qualified Disabled and

Important Changes in the Medicaid Buy-In for Working People with Disabilities Program

Resource Limits Increased, Retirement Accounts Now Exempt

Our NY Makes Work Pay project has invested considerable resources promoting the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) during each of the last three years. The MBI-WPD allows individuals to earn up to $54,476 per year (if they have no other income) and still qualify for Medicaid. This is important because many jobs do not provide employer-funded private insurance and private insurance plans often do not meet all the health-related needs of individuals with severe disabilities.

Resource limits increased. Effective October 1, 2011, countable resources are now allowed up to $20,000 for an individual and $30,000 for an eligible couple. Prior to this, the resource limit was $13,800 for an individual and $20,100 for an eligible couple.

Retirement accounts are now exempt. Effective October 1, 2011, all retirement accounts are now exempt when determining countable resources. This includes retirement accounts such as pensions, Individual Retirement Accounts (IRAs), 401(k) plans, 403(b) plans, and Keough plans. Even if the MBI-WPD beneficiary could technically access funds in one of these accounts (with or without a penalty), they remain an exempt asset. This is an amazingly positive and important change as it encourages and allows individuals with disabilities to plan for retirement like all citizens.

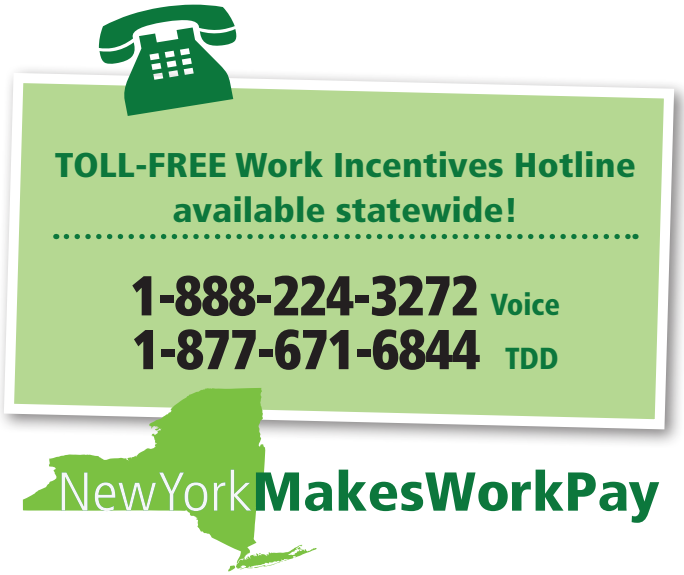
Working Individuals (QDWI) program. To be eligible for Part A premium payment as a QDWI, the individual must meet the following requirements:

- Not otherwise eligible for Medicaid;
- Countable family income may not exceed 200% of the federal poverty level (i.e., monthly income up to $1,816 per month in 2011); and
- Countable resources must be less than $4,000 (twice the SSI standard).

QDWI is considered a Medicare Savings Plan and, as such, is required to follow the SSI rules for counting of income and resources.

Conclusion

Medicare often runs smoothly without a hitch. At other times, it can be very challenging – even downright frustrating. For some individuals, it is full of potholes that can cost them thousands of dollars out of their own pockets. The bottom line is that in the Medicare world what you don't know can hurt you. We hope that Benefits Practitioners use this article as a starting point to assist individuals that return to work with Medicare and the many ways to avoid Medicare-related out-of-pocket expenses.



New York Makes Work Pay Partnering Organizations

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New York State Office of Mental Health

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Notes

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