

**MEDICARE AND MEDICAID AS RELATED TO  
WORK ISSUES**

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### What is Medicare?

Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with end-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Medicare has two parts. Part A is hospital insurance. Most people do not have to pay for Part A. Part B is medical insurance. Most people pay monthly for Part B.

### Will a beneficiary get Medicare coverage?

Everyone eligible for Social Security Disability Insurance (SSDI) benefits is also eligible for Medicare after a 24-month qualifying period. The first 24 months of disability benefit entitlement is the waiting period for Medicare coverage. During this qualifying period for Medicare, the beneficiary may be eligible for health insurance through a former employer. The employer should be contacted for information about health insurance coverage.

### How months are counted?

SSA counts one month for each month of disability benefit entitlement.

### When do previous periods of disability count?

Months in previous periods of disability may be counted

towards the 24-month Medicare qualifying period if the new disability begins:

- Within 60 months after the termination month of the workers' receiving disability benefits; or
- Within 84 months after the termination of disabled widows' or widowers' benefits or childhood disability benefits; or
- At any time if the current disabling impairment is the same as, or directly related to, the impairment which was the basis for the previous period of disability benefit entitlement.

#### **What happens to Medicare coverage if a beneficiary works?**

A beneficiary may receive at least 93 months of hospital and medical insurance after the trial work period as long as she/he still has a disabling impairment. This provision allows health insurance to continue when a beneficiary goes to work and engages in substantial gainful activity. The beneficiary does not pay a premium for hospital insurance. Although cash benefits may cease, the beneficiary has the assurance of continued health insurance.

After premium-free Medicare coverage ends due to work, beneficiaries can purchase Medicare hospital and medical insurance if they continue to have a disability at the end of the 93-month period.

#### **Who is eligible to buy Medicare coverage?**

Beneficiaries are eligible to buy Medicare coverage if:

- They are not 65
- Have a disabling impairment
- Their Medicare stopped due to work

#### **What type of Medicare can a beneficiary buy?**

A beneficiary can buy Premium Hospital Insurance ( HI Part A) at the same monthly cost which uninsured eligible retired beneficiaries pay (\$316.00 per month for 2003 or \$174.00 per month if the beneficiary has earned 30 quarters of coverage); and

A beneficiary can buy Premium Supplemental Medical Insurance (SMI Part B) at the same monthly cost which uninsured eligible retired beneficiaries pay (\$58.70 per month for 2002); or

A beneficiary can buy Hospital Insurance separately without Supplemental Medical Insurance. A beneficiary can buy Supplemental Medical Insurance only if they buy Hospital Insurance.

#### **When can a beneficiary enroll?**

During their initial enrollment period (the month they are notified about the end of their premium-free health insurance and the following seven months);

During the annual general enrollment period (January 1 through March 31 of each year); or

During a special enrollment period if they are covered under an employer group health plan.

Some beneficiaries with low incomes and limited resources may be eligible for State assistance with these expenses. Please refer to [Qualified Disabled Working Individual](#) for more information.

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### **Medicare for Working Beneficiaries with Disabilities**

**Question: How long will I get to keep Medicare if I go to work?**

**Answer:** As long as your disabling condition still meets our rules, you can keep your Medicare coverage for at least 8 ½ years after you return to work. (The 8 ½ years includes your nine month trial work period.)

**Question: I have Medicare hospital insurance (Part A) and medical insurance (Part B) coverage. Will I get to keep both parts?**

**Answer:** Yes, as long as your disabling condition still meets our rules. Your Medicare hospital insurance (Part A) coverage is premium-free. Your Medicare medical insurance (Part B) coverage will also continue. You or a third party (if applicable) will continue to pay for Part B. If your Social Security Disability Insurance cash benefits stop due to your work, you or a third party (if applicable) will be billed every 3 months for your medical insurance premiums. If you are receiving cash benefits, we will continue to deduct your medical insurance premiums from your check.

**Question: I have Medicare (Part A) but I did not take Part B coverage when it was first offered to me. Can I get Part B now?**

**Answer:** Yes. If you did not sign up for Part B, you can only sign up for it during a general enrollment period (January 1st through March 31st of each year) or a special enrollment period.

The special enrollment period is available if you have been covered under a group health plan based on your own or a family member's current employment status since the month you were first eligible for Part B.

You can sign up for Part B during any month you are covered under the group health plan based on current employment status, or during the 8-month period that begins the first full month after the employment or the group health plan coverage ends, whichever comes first.

**Question: When I return to work and get medical coverage through my employer, will this change my Medicare? Do I need to notify anyone?**

**Answer:** Medicare may be the "secondary payer" when you have health care coverage through your work. See the information under "Coordination of Medicare and Other Coverage for Working Beneficiaries with Disabilities" about when Medicare is a "secondary payer or primary payer". Notify your Medicare contractor or the Coordination of Benefits Contractor at 1-800-999-1118 right away. Prompt reporting may prevent an error in payment for your health care services.

**Question: After my Trial Work Period, how long will I have Medicare coverage?**

**Answer:** You will get at least 7 years and 9 months of continued Medicare coverage, as long as your disabling condition still meets our rules.

Promptly report any changes in your work activity. This way you can be paid correctly, and we can tell you how long your Medicare coverage will continue after you return to work.

**Question: I plan to continue working. Will I be able to purchase Medicare after my premium -free Medicare Part A (hospital insurance) coverage ends?**

**Answer:** Yes. As long as you still have a disabling condition, you can purchase Medicare Part A (hospital insurance). If you purchase Part A, you may purchase medical insurance (Part B). You cannot purchase Part B in this situation, unless you also purchase Part A.

**Question: Do I need to apply for premium Medicare Part A (hospital insurance)? If so, when?**

**Answer:** Yes. Once your premium free Medicare Part A coverage ends, you will get a notice that will tell you when you can file an application to purchase Medicare coverage.

**Question: How much are the premiums if I decide to purchase Medicare Part A?**

**Answer:**  
Part A (Hospital Insurance) premium for 2003  
· \$174.00 per month if you or a spouse has at least 30 quarters of Medicare covered employment. (Note: If an individual works in covered employment during the 8 ½ year premium-free Medicare period, 38 quarters of coverage would be earned.)  
· \$316.00 per month if you have less than 30 quarters of Medicare covered employment).

Part B (Medical Insurance) premium for 2003  
· \$58.70 per month.

There is a program that may help you with your Medicare Part A premiums if you decide to purchase Part A after your extended coverage terminates. To be eligible for this help, you must be:

- Under age 65.
- Continue to have a disabling impairment.
- Sign up for Premium Hospital Insurance (Part A).
- Have limited income.
- Have resources worth less than \$4,000 for an individual and \$6,000 for a couple, not counting the home where you live, usually one car, and certain insurance.
- Not already be eligible for Medicaid.

To find out more about this program, contact your county, local or State Social Services or medical assistance office. Ask about the Medicare buy-in program for Qualified Disabled and Working Individuals.

**Question: Where can I find publications on Medicare?**

**Answer:** You can view, print, or order publications online or by calling 1-800-MEDICARE (1-800-633-4227). The fastest way to get a publication is to use our search tool and then view and print it. If you order online or through 1-800-MEDICARE, you will receive your order within 3 weeks. The link to search publications is at:

<http://www.medicare.gov/Publications/home.asp>

**Question: If I have additional question on my Medicare coverage, who do I call?**

**Answer:** 1-800-MEDICARE (1-800-633-4227) or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired)

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**Coordination of Medicare and Other Coverage for Working Beneficiaries with Disabilities**

**Question: I am under age 65, disabled, working and have both Medicare and group health coverage. Who pays first?**

**Answer:** It depends. If your employer has less than 100 employees, Medicare is the primary payer if:

- you are under age 65, and
- have Medicare because of a disability.

If the employer has 100 employees or more, the health plan is called a large group health plan. If you are covered by a large group health plan because of your current employment or the current employment of a family member, Medicare is the secondary payer (see example below).

Sometimes employers with fewer than 100 employees join other employers in a multi-employer plan. If at least one employer in the multi-employer plan has 100 employees or more, then Medicare is the secondary payer for disabled

Medicare beneficiaries enrolled in the plan, including those covered by small employers. Some large group health plans let others join the plan, such as a self-employed person, a business associate of an employer, or a family member of one of these people. A large group health plan cannot treat any of its plan members differently because they are disabled and have Medicare. A large group health plan must offer the same benefits to plan members and their spouses that are over 65 and disabled as are offered to employees and their spouses under 65.

**Example:** Mary works full-time for GHI Company, which has 120 employees. She has large group health plan coverage for herself and her husband. Her husband has Medicare because of a disability. Therefore, Mary's group health plan coverage pays first for Mary's husband, and Medicare is his secondary payer.

**Question: If I have additional question on my Medicare coverage, who do I call?**

**Answer:** 1-800-MEDICARE (1-800-633-4227) or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired)

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### **Medicare and Group Health Coverage for People with End-Stage Renal Disease (ESRD) (Permanent Kidney Failure)**

**Question: I have ESRD and group health coverage. Who pays first?**

**Answer:** If you are eligible to enroll in Medicare because of End-Stage Renal Disease (permanent kidney failure), your group health plan will pay first on your hospital and medical bills for 30 months, whether or not you are enrolled in Medicare and have a Medicare card. During this time, Medicare is the secondary payer. The group health plan pays first during this period no matter how many employees work for your employer, or whether you or a family member are currently employed. At the end of the 30 months, Medicare becomes the primary payer. This rule applies to all people with ESRD, whether you have your own group health coverage or you are covered as a family member.

**Example:** Bill has Medicare coverage because of permanent kidney failure. He also has group health plan coverage through the company he works for. His group health coverage will be his primary payer for the first 30 months after Bill becomes eligible for Medicare. After 30 months, Medicare becomes the primary payer.

**Question: Can a group health plan deny me coverage if I have permanent kidney failure?**

**Answer:** No. Group health plans cannot deny you coverage, reduce your coverage, or charge you a higher premium because you have ESRD and Medicare. Group health plans

cannot treat any of their plan members who have ESRD differently because they have Medicare.

**Question: If I have additional question on my Medicare coverage, who do I call?**

**Answer:** 1-800-MEDICARE (1-800-633-4227) or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired)

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### **Medigap Policies for People Under Age 65 With a Disability or End-Stage Renal Disease**

A Medigap policy is a health insurance policy sold by private insurance companies to help you pay the medical costs the Original Medicare Plan does not cover.

**Question: If I have Medicare and I want to enroll in mine or my spouse's employer group health plan, can I stop my Medigap policy?**

**Answer:** The Ticket to Work and Work Incentive Improvement Act of 1999 gives you the right to suspend a Medigap policy. If you are under 65, have Medicare, and have a Medigap policy, you have the right to suspend your Medigap policy. This lets you suspend your Medigap policy benefits and premiums, without penalty, while you are enrolled in your or your spouse's employer group health plan.

If, for any reason, you lose your employer group health plan coverage, you can get your Medigap policy back. You must notify your Medigap insurance company that you want your Medigap policy back within 90 days of losing your employer group health plan coverage.

Your Medigap benefits and premiums will start again on the day your employer group health plan coverage stopped. The Medigap policy must have the same benefits and premiums it would have had if you had never suspended your coverage. Your Medigap insurance company can't refuse to cover care for any pre-existing conditions you have. So, if you are disabled and working, you can enjoy the benefits of your employer's insurance without giving up your Medigap policy.

**Question: If I have additional question on my Medicare coverage, who do I call?**

**Answer:** 1-800-MEDICARE (1-800-633-4227) or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired)

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### **Medicare and Veteran's Benefits**

**Question: I have Medicare and Veteran's benefits. Who pays first?**



**Answer:** If you have or can get both Medicare and Veterans benefits, you can get treatment under either program. When you get health care, you must choose which benefits you are going to use. You must make this choice each time you see a doctor or get health care, like in a hospital. Medicare cannot pay for the same service that was covered by Veterans benefits, and your Veterans benefits cannot pay for the same service that was covered by Medicare. You do not have to go to a Department of Veterans Affairs (VA) hospital or to a doctor who works with the VA for Medicare to pay for the service. However, to get services paid by VA, you must go to a VA facility or have the VA authorize services in a non-VA facility.

**Question: Are there any situations when both Medicare and VA can pay?**

**Answer:** Yes. If the VA authorizes services in a non-VA hospital, but doesn't pay for all of the services you get during your hospital stay, then Medicare may pay for the Medicare-covered part of the services that the VA does not pay for.

**Example:** John, a veteran, goes to a non-VA hospital for a service that is authorized by the VA. While at the non-VA hospital, John gets other non-VA authorized services that the VA refuses to pay for. Some of these services are Medicare-covered services. Medicare may pay for some of the non-VA authorized services that John received. John will have to pay for services that are not covered by Medicare or the VA.

**Question: Can Medicare help pay my VA co-payment?**

**Answer:** Sometimes. The VA charges a co-payment to some veterans. The co-payment is your share of the cost of your treatment, and is based on income. Medicare may be able to pay all or part of your co-payment if you are billed for VA-authorized care by a doctor or hospital that is not part of the VA.

**Question: I have a VA fee basis ID card. Who pays first?**

**Answer:** The VA gives fee basis ID cards to certain veterans. You may be given a fee basis card if:

- You have a service connected disability;
- You will need medical services for an extended period of time;

or

- There are no VA hospitals in your area.

If you have a fee basis ID card, you may choose any doctor that is listed on your card to treat you for the condition. If the doctor accepts you as a patient and bills the VA for services, the doctor must accept the VA's payment as payment in full. The doctor may not bill either you or Medicare for any charges. If your doctor doesn't accept the fee basis ID card, you will need to file a claim with the VA yourself. The VA will pay the approved amount to either you or your doctor.

**Question: Where can I get more information?**

**Answer:** You can get more information on Veterans' benefits

by calling your local VA office, or the national VA information number 1-800-827-1000. Or, you can use a computer to look on the Internet at [www.va.gov](http://www.va.gov). If you do not have a computer, your local library or senior center may be able to help you get this information using their computer.

**Question: If I have additional question on my Medicare coverage, who do I call?**

**Answer:** 1-800-MEDICARE (1-800-633-4227) or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired)

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### **Medicare and COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)**

**Question: What is COBRA?**

**Answer:** COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions. This is called continuation coverage. You may have this right if you lose your job or have your working hours reduced, or if you are covered under your spouse's plan and your spouse dies or you get divorced. COBRA generally lets you and your dependents stay in your group health plan for 18 months (or up to 29 or 36 months in some cases), but you may have to pay both your share and the employer's share of the premium. Some state's laws require employers with less than 20 employees to let you keep your group health coverage for a time, but you should check with your State Department of Insurance to make sure. In most situations that give you COBRA rights, other than a divorce, you should get a notice from your benefits administrator. If you don't get a notice, or if you get divorced, you should call your benefits administrator as soon as possible.

**Question: What happens if I have COBRA and enroll in Medicare?**

**Answer:** If you already have group health coverage under COBRA when you enroll in Medicare, your COBRA may end.

The length of time your spouse may get coverage under COBRA may change when you enroll in Medicare. For more information about group health coverage under COBRA, call your State Department of Insurance.

**Question: What happens if I am in Medicare and choose to get COBRA coverage?**

**Answer:** If you elect COBRA coverage after you enroll in Medicare, you can keep your COBRA continuation coverage. If you have only Medicare Part A when your group health plan coverage based on current employment ends; you can enroll in Medicare Part B during a Special Enrollment Period without having to pay a Part B premium penalty. You need to enroll in Part B either at the same time you enroll in Part A or during a

Special Enrollment Period after your group health plan coverage based on current employment ends. However, if you have Medicare Part A only, sign-up for COBRA coverage, and wait until the COBRA coverage ends to enroll in Medicare Part B; you will have to pay a Part B premium penalty. You do not get a Part B special enrollment period when COBRA coverage ends. State law may give you the right to continue your coverage under COBRA beyond the point COBRA coverage would ordinarily end. Your rights will depend on what is allowed under the state law.

Remember, enrolling in Medicare Part B will also trigger your Medigap open enrollment period. To make sure you understand about this, you should call  
1-800-MEDICARE (1-800-633-4227, TTY/TDD:  
1-877-486-2048 for the hearing and speech impaired) and ask for your free copy of the Guide to Health Insurance for People with Medicare.

**Question: Who pays first, Medicare or my COBRA continuation coverage?**

**Answer:** If you are age 65 or older and have Medicare and COBRA continuation coverage, Medicare pays first. If you or a family member has Medicare based on a disability and COBRA coverage, Medicare is the primary payer. However, if you or a family member has Medicare based on ESRD, the COBRA coverage is the primary payer and Medicare is the secondary payer for the first 30 months.

**Question: If I have additional question on my Medicare coverage, who do I call?**

**Answer:** 1-800-MEDICARE (1-800-633-4227) or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired)

For more information about Medicare go to:  
<http://www.medicare.gov>

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Medicaid is a jointly funded, Federal-State health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments.

Thirty-two states and the District of Columbia provide Medicaid eligibility to people eligible for Supplemental Security Income (SSI) benefits. In these States, the SSI application is also the Medicaid application. Medicaid eligibility starts the same months as SSI eligibility.

The following jurisdictions use the same rules to decide eligibility for Medicaid as SSA uses for SSI, but require the filing of a separate application: Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, Utah, Northern Mariana Islands

The following States use their own eligibility rules for Medicaid, which are different from SSA's SSI rules. In these States a separate application for Medicaid must be filed: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, Virginia.

What happens to Medicaid coverage if a SSI recipient works?

If a recipient's State provides Medicaid to people on SSI, the recipient will continue to be eligible for Medicaid. Please refer to [Work Incentives](#) for more information about SSI work incentives.

Medicaid coverage can continue even if a recipient's earnings along with other income become too high for a SSI cash payment.

How does a recipient qualify?

To qualify a recipient must:

- Have been eligible for an SSI cash payment for at least one month;
- Still be disabled;
- Still meet all other eligibility rules, including the resources test;
- Need Medicaid in order to work; and
- Have gross earned income that is insufficient to replace SSI, Medicaid, and any publicly funded attendant care. (Refer to Red Book for the "threshold amount" section.)

The Center for Medicare and Medicaid Services (formerly HCFA) oversees State administration of Medicaid. You may go to HCFA's web site at: <http://www.cms.hhs.gov>

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To find information of interest to you, view the sections above for [Professional](#), [Government](#), and [Consumer](#) audiences.

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### HIPAA Compliance

October 16, 2003 is the deadline for HIPAA compliance. If you have questions on HIPAA compliance, please see the following resources:

1. [HIPAA Administrative Simplification website](#)
2. [HIPAA Administrative Simplification Frequently Asked Questions \(FAQs\)](#)
3. Call the CMS HIPAA Hotline at 1-866-282-0659
4. [Submit HIPAA Questions Electronically](#)
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7500 Security Boulevard, Baltimore MD 21244-1850

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## Welcome to Medicaid

### Site for Consumer Information

**Origins of Medicaid:**

The Medicaid Program provides medical assistance for certain individuals and families with low incomes and resources. Medicaid eligibility is limited to individuals who fall into specific categories. Although the Federal government establishes general guidelines for the program, the Medicaid program requirements are actually established by each State. Whether or not a person can be eligible for Medicaid will depend on the State where he or she lives. **[Read more about Medicaid](#)**

**Medicaid State Programs**

Medicaid is a state administered program and each state sets its own guidelines regarding eligibility and services. To get information regarding Medicaid in your state, [click here](#) or select your state from the list below:

**Eligibility:**

Medicaid eligibility is limited to individuals who fall into specified categories. The federal statute identifies over 25 different eligibility categories for which federal funds are available. These categories can be classified in to five broad coverage groups:

- Children;
- Pregnant Women;
- Adults in Families with Dependent children;
- individuals with disabilities;
- and individuals 65 or over

Read general information regarding [Medicaid eligibility](#) or to find specific information regarding eligibility in your state, or [select your state](#) from the list of states in the Medicaid State Programs section.

**What Medicaid Covers:**

Medicaid is a state administered program and each state sets its own guidelines. Certain services must be covered by the states and other services are optional and are elected by states. Read general information about

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[Medicaid Services](#) or to find specific information regarding services in your state, [select your state](#) from the list of states in the Medicaid State Programs section.

### **State Children's Health Insurance Programs (SCHIP)**

The Balanced Budget Act of 1997 created a new children's health insurance program called the State Children's Health Insurance Plan (SCHIP). This program gave each state permission to offer health insurance plans for children, up to age 19, who are not already insured. Families who earn too much to qualify for Medicaid may be able to qualify for SCHIP. **[Read more about SCHIP](#)**

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## Medicaid: A Brief Summary

**NOTE: The following are brief summaries of complex subjects. They should be used only as overviews and general guides to the Medicare and Medicaid programs. The views expressed herein do not necessarily reflect the policies or legal positions of the Centers for Medicare & Medicaid Services or the Department of Health and Human Services (DHHS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.**

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### Overview of Medicaid

**Title XIX** of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, State legislatures may change Medicaid eligibility and/or services during the year.

### Basis of Eligibility and Maintenance Assistance Status

Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the Federal statute, Medicaid does *not* provide health care services even for very poor persons *unless* they are in one of the groups

designated below. Low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels (as determined by each State within Federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, States are *required* to provide Medicaid coverage for certain individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are *not* provided for State-only programs. The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which Federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996, or--at State option--more liberal criteria.
- Children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL).
- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).
- Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL.
- Certain Medicare beneficiaries (described later).

States also have the *option* of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which States will receive Federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each State).

- Children under age 21 who meet the AFDC income and resources requirements that were in effect in their State on July 16, 1996.
- Institutionalized individuals eligible under a "special income level" (the amount is set by each State--up to 300 percent of the SSI Federal benefit rate).
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
- Recipients of State supplementary income payments.
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs).
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides these women with medical assistance and follow-up diagnostic services through Medicaid.
- "Optional targeted low-income children" included within the State Children's Health Insurance Program (SCHIP) established by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33).
- "Medically needy" persons (described below).

The medically needy (MN) option allows States to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. Persons may qualify immediately or may "spend down" by incurring medical expenses that reduce their income to or below their State's MN income level.

Medicaid eligibility and benefit provisions for the *medically needy* do not have to be as extensive as for the *categorically needy*, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a State elects to have a MN program, there are Federal requirements that certain *groups* and certain *services* must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A State may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services within its MN program. As of August 2002, thirty-six States have elected to have a MN program and are providing at least some MN services to at least some MN beneficiaries. All remaining States utilize the "special income level" option to extend Medicaid to the "near poor" in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193)-- known as the "welfare reform" bill--made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are State options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of the new restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstated by Public Law 105-33, the BBA.

In addition, welfare reform repealed the open-ended Federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides States with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits States to impose a wide range of other requirements as well--in particular, those related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

**Title XXI** of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a new program initiated by the BBA. In addition to allowing States to craft or expand an existing State insurance program, SCHIP provides more Federal funds for States to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options from which States may select to provide health care coverage for more children, as prescribed within the BBA's Title XXI program.

Medicaid coverage may begin as early as the third month prior to application --if the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows States to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provides or continues Medicaid coverage to certain disabled beneficiaries who work despite their disability. Those with higher incomes may pay a sliding scale premium based on income.

### **Scope of Medicaid Services**



Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program *must* offer medical assistance for certain *basic* services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive Federal matching funds to provide certain *optional* services. Following are the most common of the thirty-four currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facilities for the mentally retarded (ICFs/MR).
- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Home and community-based care to certain persons with chronic impairments.

The BBA included a State option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 or older who require a *nursing facility level* of care. The PACE team offers and manages *all* health, medical, and social services and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both Titles XVIII and XIX, without amount, duration, or scope limitations and without application of any deductibles, copayments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

### **Amount and Duration of Medicaid Services**

Within broad Federal guidelines and certain limitations, States determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, States are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) Medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under Federal law, must be covered even if those services are not included as part of the covered services in that State's Plan; and (2) States may request "waivers" to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, States have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, States may not provide room and board for the beneficiaries). With certain exceptions, a State's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

### **Payment for Medicaid Services**

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within Federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid

beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. During 1988-1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing Federal expenditures for Medicaid. Under legislation passed in 1991, 1993, and again within the BBA of 1997, the Federal share of payments to DSH hospitals was somewhat limited. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554) increased DSH allotments for 2001 and 2002 and made other changes to DSH provisions that resulted in increased costs to the Medicaid program.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services.

The Federal Government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In 2002, the FMAPs varied from 50 percent in eleven states to 76.09 percent in Mississippi, and averaged 57 percent overall. The BBA also permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent and raised the FMAP for Alaska from 50 percent to 59.8 percent through 2000. The BIPA of 2000 further adjusted Alaska's FMAP to a higher level for 2001-2005. The Federal Government pays States a higher share for children covered through the SCHIP program. This "enhanced" FMAP averages about 70 percent for all States, compared to the general Medicaid average of 57 percent.

The Federal Government also reimburses States for 100 percent of the cost of services provided through facilities of the Indian Health Service, provides financial help to the twelve States that furnish the highest number of emergency services to undocumented aliens, and shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the SCHIP program, the Qualifying Individuals (QI) program (described later), and DSH payments, Federal payments to States for medical assistance have no set limit (cap). Rather, the Federal Government matches (at FMAP rates) State expenditures for the mandatory services, as well as for the optional services that the individual State decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into Public Law 106-113, the appropriations bill for the District of Columbia for fiscal year

2000) increased the amount that certain States and the territories can spend on DSH and SCHIP payments, respectively. The BIPA set upper payment limits for inpatient and outpatient services provided by certain types of facilities.

### **Medicaid Summary and Trends**

Medicaid was initially formulated as a medical care extension of Federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of Federal mandates, population growth, and the earlier economic recession. In recent years Medicaid enrollment has declined somewhat.
- The expanded coverage and utilization of services.
- The DSH payment program, coupled with its inappropriate use to increase Federal payments to States.
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very low-birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care.
- The increase in drug costs and the availability of new expensive drugs.
- The increase in payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. National data for 1999 (excluding Hawaii), for example, indicate that Medicaid payments for services for 20.5 million children, who constitute 51 percent of all Medicaid beneficiaries, average about \$1,170 per child (a relatively small average expenditure per person). Similarly, for 8.4 million adults, who comprise 20 percent of beneficiaries, payments average about \$1,935 per person. However, certain other specific groups have much larger per-person expenditures. Medicaid payments for services for 4.1 million aged, constituting 10 percent of all Medicaid

beneficiaries, average about \$10,335 per person; for 7.3 million disabled, who comprise 18 percent of beneficiaries, payments average about \$9,000 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 1999 payments to health care vendors for 40 million Medicaid beneficiaries average \$3,825 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 40 percent of the total cost of care for persons using nursing facility or home health services in 2000. National data for 1999 (excluding Hawaii) show that Medicaid payments for nursing facility services (excluding ICFs/MR) totaled \$33.1 billion for more than 1.6 million beneficiaries of these services--an average expenditure of \$20,690 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled \$2.9 billion for more than 800,000 beneficiaries--an average expenditure of \$3,625 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow Statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided States a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 57 percent in 2001.

More than 40 million persons received health care services through the Medicaid program in fiscal year (FY) 1999 (the last year for which beneficiary data are available). In FY 2001, total outlays for the Medicaid program (Federal and State) were \$227.8 billion, including direct payment to providers of \$162.6 billion, payments for various premiums (for HMOs, Medicare, etc.) of \$37.6 billion, payments to disproportionate share hospitals of \$15.9 billion, and administrative costs of \$11.7 billion. Outlays under the SCHIP program in FY 2001 were \$3.8 billion. With no changes to either program, expenditures under Medicaid and SCHIP are projected to reach \$394 billion and \$7.2 billion, respectively, by FY 2007.

### **The Medicaid-Medicare Relationship**

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eligible for *full* Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their State's Medicaid program, according to

eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort."

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the SMI premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to the Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare HI and SMI coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their HI premiums as Qualified Disabled and Working Individuals (QDWIs).

For Medicare beneficiaries with incomes that are above 120 percent and less than 175 percent of the FPL, the BBA establishes a capped allocation to States, for each of the 5 years beginning January 1998, for payment of all or some of the Medicare SMI premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The payment of this QI benefit is 100 percent Federally funded, up to the State's allocation.

When all these categories are taken into account, Medicaid is estimated to provide some level of supplemental health coverage for about 6.5 million Medicare beneficiaries.

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**NOTE:**

Medicaid data are based on the projections of the Mid-Session Review of the President's Fiscal Year 2003 Budget and are consistent with data received from the States on the Forms HCFA-2082, HCFA-37, and HCFA-64.

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## The Medicaid Buy-in

### 1. How can a State structure the buy-in so that, once a person with a disability buys in, the person does not lose HCBS waiver services by virtue of being over-income?

The question really is how the State can structure its HCBS waiver to ensure that persons eligible under a work incentives group can receive waiver services. This can be done by either amending an existing waiver, or applying to CMS for approval of a new waiver, to cover the work incentives group under the waiver. Once the work incentives group is covered under a waiver, a person can receive HCBS waiver services as long as he or she continues to be eligible for Medicaid under the work incentives group.

### 2. Must all working persons with disabilities, as determined by SSA criteria, be included for Medicaid coverage? If not, may the State limit the program to specific disability groups?

The buy-in may not be limited to a single disability group. Also, even though any one individual may be eligible for Medicaid through a variety of eligibility options including the buy-in, the State must enroll each individual in the manner that does the least harm.

For example, if Joe is eligible for 1619(b) and therefore Medicaid, and also eligible for the buy-in, Joe should be enrolled in 1619(b). 1619(b) "does the least harm" because Joe's ties to SSI are preserved and he would receive Medicaid premium-free. The only question would be if Joe makes an alternative choice not to participate in 1619(b) but rather to enroll in the buy-in instead.

### 3. Concerning disability determinations, can the State designate an entity other than the Social Security Administration to perform disability determinations? If so, under what circumstances and special conditions?

The State may designate another agency. However, the same protocols must be used statewide. For the Medicaid Buy-in these protocols must match the SSA protocols (except for people covered under a Medical Improvement option selected by the State.)

For the Demonstration to Maintain Independence, the protocols would of course be different from SSA's and would be designed by the State and approved by CMS.

### 4. The BBA (or TWWIIA) group can have higher resource levels than

**the \$2000/\$3000. What happens to that person who has accumulated higher assets when they retire? Also, with the earnings, comes the potential for higher retirement income & that too may make them ineligible?**

A person who is fully retired admittedly is likely to lose Medicaid if the person could qualify only under one of the work incentives groups. Eligibility could be lost for a variety of reasons, including the person no longer being employed, or having too many resources, or too much unearned income because he or she is receiving a pension, to qualify. Some of these problems may be avoidable; for example, the person may continue to be employed in some capacity, even if his or her work effort is reduced from the level before retirement.

However, it must be emphasized that the work incentives groups under both the BBA and TWWIIA are designed to assist individuals with disabilities who want to work. The work incentives groups were never intended to provide Medicaid to a person indefinitely regardless of whether that person continues to meet the requirements for eligibility under the program.

**5. How is a recipient covered by a HCBS waiver affected by TWWIIA?**

As explained previously, a State can provide HCBS waiver services to persons eligible under one or both of the TWWIIA groups by amending an existing waiver, or applying to CMS for approval of a new waiver, to cover the group or groups under the waiver.

**6. Can the state limit the buy-in option to persons working at least 40 hours per month? Can the State limit the options to persons working at least 40 hours per month but less than 80 hours per month or any other monthly work threshold?**

While States must require that applicants have earnings in order to establish eligibility for the Medicaid Buy-in, there is no provision of the law which permits States to establish minimum thresholds on the amount of hours a person must work in order to be eligible.

**7. Can the buy-in be limited to individuals with no other insurance coverage or available coverage? (Example: Medicare eligibles)**

No. You may require that individuals access available private insurance coverage (including Medicare) so long as Medicaid pays the premiums and cost-sharing. However, there is no authority under the Medicaid statute to restrict eligibility for any of the work incentives groups to individuals with no other health insurance. If an individual has other health insurance, Medicaid would become wrap-around coverage that would only pay for those services the individual's medical insurance does not cover.

**8. What is the recommended length of time for transitional coverage/eligibility for a previously covered person within the categorical group should he/she lose their job?**

CMS has no recommendations to make on this subject.

**9. How will the SSA consider disability income (SGA) for those persons between the age of 16-18?**

The basic rules for considering income earned by a disabled individual are the same regardless of the individual's age. Under the BBA group, all earned income is disregarded in determining eligibility. Also, the SGA limit of \$700 a month must be ignored in determining whether the individual is disabled. Under the TWWIIA work incentives groups States may, but are not required to, disregard earned income beyond the standard SSI earned income disregard in determining eligibility. However, as with the BBA group the SGA limit must be ignored in determining whether the individual is disabled.

Last Modified on Friday, May 03, 2002



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# **MEDICAID BUY-IN ELIGIBILITY GROUPS**

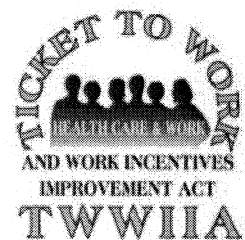
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## Medicaid Buy-In Eligibility Groups

### I. BBA Eligibility Group

Section 4733 of the Balanced Budget Act of 1997 (BBA) allows States to provide Medicaid coverage to working individuals with disabilities who, because of their earnings, cannot qualify for Medicaid under other Statutory provisions. Section 4733 allows States to provide Medicaid coverage to these individuals by creating a new optional categorically needy eligibility group.

In response to BBA, many States implemented more liberal income and resource methodologies than are used by SSI and have premium payments and cost sharing charges set on a sliding scale based on income.

#### A. Rules that Apply to All States Implementing BBA Eligibility Group

- Family Income Standard – Net family income below 250 percent of the Federal poverty level for a family of the size involved.
- Except for earned income (which is completely disregarded) the individual must meet all SSI eligibility criteria, including:
- Unearned income not exceeding the SSI income standard (currently \$512 a month for an individual; \$769 for a couple).
- Resources not exceeding SSI resource standard (\$2,000 for an individual; \$3,000 for a couple).
- Disabled as defined under the SSI program.
- SSI income and resource methodologies are used to determine eligibility.

#### B. Options Available to States under BBA

- Use of more liberal income and resource methodologies than are used by SSI (Section 1902(r)(2) of the Act).
- Use of more restrictive eligibility criteria than are used by SSI (209(b) States).
- States can require payment of such premiums or other cost-sharing charges, on a sliding scale based on income, as the State may

determine.

## **II. TWWIIA Eligibility Groups**

Similar to the BBA Group, the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), created two new optional categorically needy Medicaid eligibility groups: (1) the Basic Coverage Group; and (2) the Medical Improvement Group.

The Basic Coverage Group is similar to the BBA group, except that there is no 250 percent of the Federal poverty level family income limit, there is an age limit (at least 16 but not more than 64 years of age), AND under these new groups States are free to establish their own income and resource standards, or have no income and resource standards if they choose.

### **A. Rules that Apply to All States Implementing Basic Coverage Group**

- Individuals covered must be at least 16 but not more than 64 years of age.
- Individuals covered must be disabled as SSI defines the term.
- Earned income is not automatically disregarded.
- No federally required income and resource standards.
- If States establish income and resource standards, SSI income and resource methodologies are used to determine eligibility.

### **B. Rules that Apply to All States Implementing Medical Improvement Group**

- Individuals covered must be 16 but not more than 64 years of age.
- Individual covered must have a medically improved disability.
- Individual covered must have been eligible under the Basic Coverage Group but lost that eligibility because his or her medical condition has improved to the point where it is determined at the time of a regularly scheduled continuing disability review that he or she is no longer disabled as SSI defines the term.
- Earned income is not automatically disregarded.
- No federally required income and resource standards.
- If States establish income and resource standards, SSI income and resource methodologies are used to determine eligibility.

### **C. Options Available to States under TWWIIA**

- States are free to establish their own income and resource standards, or have no income and resource standards if they choose.
- Use of more liberal income and resource methodologies than are used by SSI (Section 1902(r)(2) of the Act).
- Use of more restrictive eligibility criteria than are used by SSI (209(b) States).
- States can require payment of such premiums or other cost-sharing charges, on a sliding scale based on income, as the State may

determine.

To assist States in their implementation of the work incentives eligibility groups, the following provides information about the eligibility rules and policies each State covering the BBA or TWWIIA eligibility groups has adopted in three areas; income, resources, and payment of premiums or other cost-sharing charges. Using the rules that apply to all States as the baseline, these three constitute the areas in which States can exercise eligibility options.

States that have Implemented a Work Incentives Eligibility Group under BBA or TWWIIA - [Link to map](#)

### **Medicaid Buy-In Questions and Answers**

Last Modified on Friday, April 18, 2003



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Your Medicare Coverage Home

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## Your Medicare Coverage

Welcome to the Medicare Coverage section of www.medicare.gov. This section provides information about your health care in the Original Medicare plan (sometimes referred to as "service"). By searching this database you will find:

- Some of the services and supplies the Original Medicare covers;
- The conditions that must be met for some services and supplies to be covered;
- How often services or supplies are covered (limits);
- How much you pay;
- Who you can contact if you have additional questions;
- Some of the services and supplies the Original Medicare does not currently cover.

The information contained in this database is also available in a CMS publication titled **Your Medicare Benefits**.

It is important for you to understand that Medicare does not pay for everything, and it does not pay the total cost for most services and supplies that are covered. You should talk to your doctor to be sure you are getting the service or supply that best meets your health care needs.

The amount of your coverage is also dependent on whether you have coverage under Medicare Part A, Medicare Part B, or Medicare Part D. **Medicare Part A** typically pays for your inpatient hospital expenses and **Medicare Part B** typically covers your outpatient health care expenses including doctor fees.

A benefit is a health care service or supply that is paid for or in full by Medicare.

**Note:** If you belong to a Medicare + Choice plan, it may have at least the same benefits covered under Medicare Part A and Part B. However, your costs may be different, and you may have additional benefits, like coverage for prescription drugs or extra help with hospital. You should contact your Medicare + Choice plan administrator for specific coverage information for the plan which you are enrolled. If you are interested in seeing if Medicare + Choice and Medigap plans are available in your area, please visit the **Medicare Personal Plan Finder** section of our website.

Select Search Criteria

1. Please **select a state/territory** where you would like to search for Medicare Coverage information.

**State / Territory:**

Select a State

2. **Please select up to five coverage topics from the list below:**

Alternative Therapies  
 Ambulance Services  
 Anesthesia (Inpatient)  
 Anesthesia (Outpatient)  
 Artificial Limbs and Eyes

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Centers for Medicare & Medicaid Services



Department of Health and Human Services

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## What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities under age 65.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has Two Parts:

### • **Part A (Hospital Insurance)**

Most people do not have to pay for Part A.

### • **Part B (Medical Insurance)**

Most people pay monthly for Part B.

## **Part A (Hospital Insurance)**

### **Helps Pay For:**

Care in hospitals as an

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inpatient, critical access hospitals (small facilities that give limited outpatient and inpatient services to people in rural areas), skilled nursing facilities, hospice care, and some home health care.

Information about your coverage under Medicare Part A can be found in the **Your Medicare Coverage** database.

**Cost:**

Most people get Part A automatically when they turn age 65. They do not have to pay a monthly payment called a premium for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not sure you have Part A, look on your red, white, and blue Medicare card. It will show "Hospital Part A" on the lower left corner of the card. You can also call the Social Security Administration toll free at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

**For More Information About Medicare Part A Coverage:**

Visit the **Your Medicare Coverage** database.

Call your Fiscal Intermediary about Part A bills and services. The phone number for the Fiscal Intermediary in your area can be found in the **Helpful Contacts** section.

## **Part B (Medical Insurance)**

### **Helps Pay For:**

Doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are **medically necessary**. Information about your coverage under Medicare Part B can be found in the **Your Medicare Coverage** database.

### **Cost:**

You pay the Medicare Part B premium of \$58.70 per month in 2003. This amount may change January 1, 2003. In some cases this amount may be higher if you did not choose Part B when you first became eligible at age 65. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did

not sign up for it, except in special cases. You will have to pay this extra 10% for the rest of your life.

Enrolling in part B is your choice. You can sign up for Part B anytime during a 7-month period that begins 3 months before you turn 65. Visit your local Social Security office, or call the Social Security Administration at 1-800-772-1213 to sign up. If you choose to have Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. If you do not get any of the above payments, Medicare sends you a bill for your part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you do not get your bill by the 10th, call the Social Security Administration at 1-800-772-1213, or your local Social Security office. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

**For More Information About Medicare Part B Coverage:**

Visit the **Your Medicare Coverage** database.

Call your Medicare Carrier about bills and services. The phone number for the

Medicare Carrier in your area can be found in the **Helpful Contacts** section.

You may have choices in how you get your health care including the Original Medicare Plan, Medicare Managed Care Plans (like HMOs), and Medicare Private Fee-for-Service Plans.



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**Department of Health and Human Services**

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### Origins of Medicare

In 1965, the Social Security Act established both Medicare and Medicaid. Medicare was a responsibility of the Social Security Administration (SSA), while Federal assistance to the State Medicaid programs was administered by the Social and Rehabilitation Service (SRS). SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW). In 1977, the Health Care Financing Administration (HCFA) was created under HEW to effectively coordinate Medicare and Medicaid. In 1980 HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).  
[Read more about Medicare](#)

### Centers for Medicare & Medicaid Services

CMS is the federal agency, which administers the Medicare Program. Currently, Medicare, provides coverage to approximately 40 million Americans. Medicare is the national health insurance program for:

- People age 65 or older
- Some people under age 65 with disabilities
- People with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant

[Read more about the history of the agency...](#)

- ★ [Consumer Information](#) is the resource to find Medicare beneficiary information.
- ★ [Provider Information](#) is the resource to find Medicare provider information.

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## CMS / HCFA History

In 1965, the Social Security Act established both Medicare and Medicaid. Medicare was a responsibility of the Social Security Administration (SSA), while Federal assistance to the State Medicaid programs was administered by the Social and Rehabilitation Service (SRS). SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW). In 1977, the Health Care Financing Administration was created under HEW to effectively coordinate Medicare and Medicaid. In 1980 HEW was divided into the Department of Education and the Department of Health and Human Services (HHS).



The first U.S. President to propose a prepaid health insurance plan was Harry S. Truman. On November 19, 1945, in a special message to Congress, President Truman outlined a comprehensive, prepaid medical insurance plan for all people through the Social Security system. The plan included doctors and hospitals, and nursing, laboratory, and dental services; it was dubbed "National Health Insurance." Furthermore, medical insurance benefits for needy people were to be financed from Federal revenues.

Over the years, lawmakers narrowed the field of health insurance recipients largely to social security beneficiaries. A national survey found that only 56 percent of those 65 years of age or older had health insurance. President John F. Kennedy pressed legislators for health insurance for the aged. However, it wasn't until 1965 that President Lyndon B. Johnson signed H.R. 6675 (The Social Security Act of 1965; PL 89-97) to provide health insurance for the elderly and the poor.

On July 30, 1965, President Johnson signed the Medicare and Medicaid Bill (Title XVIII and Title XIX of the Social Security Act) in Independence, Missouri in the presence of former President Truman, who received the first Medicare card at the ceremony; Lady Bird Johnson, Vice-President Hubert Humphrey, and Mrs. Truman also were present. President Johnson remarked: "We marvel not simply at the passage of this Bill but that it took so many years to pass it."

Medicare extended health coverage to almost all Americans aged 65 or older. About 19 million beneficiaries enrolled in Medicare in the first year of the

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program. Medicaid provided access to health care services for certain low-income persons and expanded the existing Federal-State welfare structure that assisted the poor.

The 1972 Social Security Amendments expanded Medicare to provide coverage to two additional high risk groups—disabled persons receiving cash benefits for 24 months under the social security program and persons suffering from end-stage renal disease.

Last Modified on Wednesday, September 24, 2003



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Helping you compare health plan options (including Medicare + Choice and supplemental insurance plans) in your area.

**[Medicare Eligibility Tool](#)**  
Determine your Medicare eligibility and enrollment status.

**[Your Medicare Coverage](#)**  
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
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Identify programs that may assist with your prescription drug and other health care costs.

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**[Supplier Directory](#)**



coverage in the Original Medicare Plan.

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**Department of Health and Human Services**

## **209(b) STATES**

## 209(b) States

### *DEFINITION*

<http://www.cms.gov/medicaid/welfareref/factsh2.asp>

Under 209(b) of the Social Security Disability Act Amendments of 1973, states may use Medicaid eligibility criteria that differ from SSI standards as long as the criteria are not more restrictive than the state's approved standards when the SSI law was enacted in 1972. Some §209(b) states do use SSI's definition of disability in determining the Medicaid eligibility of disabled individuals in their state.

### *STATES*

[http://www.cms.gov/manuals/45\\_smm/sm\\_07\\_7199\\_to\\_exhibit\\_2.asp](http://www.cms.gov/manuals/45_smm/sm_07_7199_to_exhibit_2.asp)

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2. New Hampshire

#### Region 2

None

#### Region 3

1. Virginia

#### Region 4

1. North Carolina

#### Region 5

1. Illinois
2. Indiana
3. Minnesota
4. Ohio

#### Region 6

1. Oklahoma

#### Region 7

1. Missouri
2. Nebraska

#### Region 8

1. North Dakota

#### Region 9

1. Hawaii