

Counseling Beneficiaries on Private, Group and Employer-Sponsored Health Coverage Options

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Training Sections

1. Overview – “Debunk Current Myths”
2. Assessment: What Health Coverage Does the Beneficiary Have Now?
3. When and How do Beneficiaries Access Private Health Coverage Options?
4. What are the Main Types of Private Health Coverage Plans?
5. CWIC Health Care Counseling Tips & Tools

Information Resources

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Training Section 1 Overview – “Debunk Current Myths”

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Health coverage options when beneficiaries plan employment

Primary payer rules and the type of the health coverage affects how they interact and who pays the medical bills first.

No one type of health coverage may be the comprehensive coverage a beneficiary needs to live independently or engage in paid work.

When a beneficiary uses two or more types at the same time, complexity and beneficiary “need-to-know” factors usually increase.

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1. Means-Tested Programs

- ❑ The level of personal or family assets, resources and monthly income restrict who is eligible for the program.
- ❑ Benefits most often paid from general tax revenues subject to annual budgets and changes at state and federal legislative levels.
- ❑ The payer of last resort when beneficiary uses other health coverage at the same time alongside a means tested health coverage program

Common examples: Supplemental Security Income (SSI), most Medicaid categories, TANF, Section 8 Housing Vouchers are all means tested programs.

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2. Social Insurance

- ❑ Family members (wage earners and the self-employed) pay into Trust Funds on a monthly basis year in and year out.
- ❑ Benefits awarded when a family member meets the terms in a category, e.g., becomes disabled according to certain rules, retired, a qualified widow or child, or a disabled child
- ❑ Social insurance is public or government insurance; monthly contributions made from the widest possible pool from those not receiving a benefit
- ❑ Benefits paid first from a dedicated Trust Fund, which can also be supported by general tax revenues; Medicare funding today is from both of these funding sources.

Social insurance examples: Social Security Disability Insurance (SSDI), Childhood Disability Beneficiary (CDB), Social Security Old-Age Insurance, Medicare, State Disability Insurance (in some states); Unemployment Insurance

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3. Private Sector Health Coverage

- ❑ Private insurance and non-insurance types of health coverage are often accessed by connections to paid work, membership in a group association or a union, or to family health coverage plans.
- ❑ Initial and ongoing eligibility rules and what the plan covers differ markedly per plan.
- ❑ Some plans are insurance, some are defined benefits; for example, user members pre pay monthly into a pool in a Health Maintenance Organization, HMO. HMOs are not classic insurance.

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Private Sector Health Coverage

- ❑ States regulate private health coverage plans, not the federal government; wide state-by-state variance in private plan rules, protections and how public and private health coverage plans interact
- ❑ Private plans are available in group coverage plans and individual private health coverage plans
- ❑ Eligibility rules and health coverage protections in group vs. individual health plan policies are very different.

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Group Coverage vs. Individual Private Health Coverage

Group Health Coverage or Plan: group health coverage is offered in a range of health plans as an employee benefit, or offered by a union or a professional association, for **groups** of eligible people, to provide medical services to employees and possibly to their dependents. The employee may pay a monthly premium or other costs out of pocket as a portion of the health plan's cost (cost sharing).

Individual health insurance: An insurance or health coverage plan purchased on the private market for an individual by that individual, that can also provide coverage for the individual's family. Monthly premiums, which can be expensive, in addition to co-payments, coinsurance and deductibles. The insurer or health plan can refuse to sell a policy to an individual because of their current health status or their medical history over the recent past.

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Medical Underwriting in Health Coverage

- ❑ **"Medical underwriting"** is a serious review of someone's past medical services received or prescribed, to assess eligibility for a health coverage policy or plan.
- ❑ Access to **group** health coverage has federal and some state protections that Social Security beneficiaries can use to offset medical underwriting practices.
- ❑ A significant majority of Social Security disability beneficiaries will have a very difficult time qualifying for individual health insurance on the private market due to legal medical underwriting practices in the individual market.

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Key factors to Plan in Place

The **beneficiary's understanding** of the interactions between:

- 1) The beneficiary's current benefit profile,
- 2) Current opportunities and/or employment plans,
- 3) The health coverage options available in that context,
- 4) Primary payer rules, and
- 5) Out of pocket costs (cost sharing) for the beneficiary in these contexts.

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TAKEAWAY: Primary Payer Rules

*The **type** of health coverage can determine which plan or program pays medical bills first.*

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Primary Payer Rules and Guidelines

General federal rule:

Private health coverage pays the medical bills first, Medicare pays the medical bills second, and Medicaid pays last or third. Medicaid is often termed the “payer of last resort”.

“Coordination of benefits” is the term used by Medicare, group and private insurance when deciding who pays for services first.

With employers with 100 or more employees, Medicare pays the bills after employer-sponsored health coverage pays bills.

With employers with less than 100 employees, Medicare will be primary payer, then the employer-sponsored group plan.

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Primary Payer Rules and Guidelines

Examples:

Employer-sponsored health coverage, Medicare and Medicaid all provide and pay for the same services x, y, z. The General Federal Rule applies.

Medicare provides and pays for services x, y, z but employer-sponsored coverage does not cover those services; Medicare provides and pays for the service.

Medicaid is the only provider for the service or equipment x, y, z. Even if the person has employer-sponsored coverage and Medicare, Medicaid pays for the service or equipment.

The Social Security beneficiary should inform providers when they have multiple types of health coverage; be proactive in avoiding billing problems.

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When a Beneficiary has both Medicaid and Private Health Coverage

State Example (California):

When the provider accepts both private insurance and Medi-Cal (Medicaid) for the same service, the beneficiary must access the service via the private insurance.

- ❑ Medi-Cal is secondary payer and will not pay for the service provided.

If the health care provider accepts both Medicaid and Private Insurance, the patient cannot be charged co-pays and other cost sharing higher than the standard allowable Medicaid co-pays and other cost sharing.

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Primary Payer Rules and Guidelines

TAKEAWAY:

Beneficiaries need to be careful about what type of coverage (Private, Medicaid, or Medicare) is accepted by the medical providers they use.

- ❑ This can determine how high their co-pays and other coinsurance payments will be.

Payment problems can occur if a beneficiary with Medicaid and private health insurance uses a provider that doesn't accept their private health insurance.

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Out of Pocket Costs and Health Coverage

- ❑ A beneficiary can share in the costs of health coverage provided by Medicaid, Medicare and private health coverage
- ❑ Beneficiary out of pocket costs are usually much less in Medicaid programs.
- ❑ Costs can come in different forms depending on plan or program and the beneficiary profile.
- ❑ **Cost sharing** terms and what they mean are important.

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Cost Sharing Terms

Premium: An amount paid often in monthly installments to purchase an insurance policy, or access to medical services in a Medicaid Buy-In Program (MBI)

Deductible: An initial specified amount that an enrollee has to pay **before** the health coverage plan or program **begins** to contribute towards or pay for medical costs

Coinsurance: A set percentage of medical costs that an enrollee must pay towards the cost of medical care in an ongoing way

Co-payment: A fixed fee that an enrollee of a health coverage plan must pay for use of or purchase of specific medical services provided by the plan

Example: a beneficiary may pay a small co-payment at the pharmacy for prescription drugs covered in most prescription drug plans in Medicare and private prescription drug plans

Out of pocket maximum: the ceiling, or maximum costs paid by a beneficiary per year after which the plan pays 100% of costs

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TAKEAWAY: *Plan in Place*

Teach beneficiary how to Plan in Place.

Plan to the job situation at hand, its benefit package options and both the beneficiary's current benefit profile and understanding of it.

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Training Section 2 Assessment: What Health Coverage Does the Beneficiary Access Now?

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Possible Current Health Coverage

- Employer-sponsored group health coverage
- Family coverage – based on family member's coverage
- Medicaid: Which Medicaid category or program?
 - "Categorically eligible" or Low Cost Medicaid
 - Medicaid based on SSI eligibility (SSI-linked)
 - Medically Needy Medicaid
 - Medicaid Buy-In (MBI) Program in at least 32 states
 - Medicaid through a Health Maintenance Organization
- Medicare -- and no Medicaid? Assess Medicaid eligibility options
- Other health coverage
 - VA or Military health coverage, State Children's Health Insurance Program (SCHIP), Federal Employee Health Benefits Program (FEHBP), Indian Health Service, Student health insurance

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Assessing Health Coverage: Medicare

What Parts of Medicare is the beneficiary enrolled in now?

Parts of Medicare

- Part A Hospital Insurance
- Part B Medical Insurance
- Part C Medicare Advantage Plan
- Part D Prescription Drug Coverage

Medicare Advantage Plans or Original Medicare; Medigap option

It is possible to only have Part A; most have both Parts A and B.

Beneficiaries may not know what are their best options in terms of possible Medicare Plans. State Health Insurance Programs can help beneficiary make educated choices of plans.

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Training Section 3

When and How do Beneficiaries Access Private Health Coverage Options?

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When Do Beneficiaries Access Employer-sponsored Health Coverage?

Timelines accessing Group Health Coverage

Service wait: a set period of time all employees must work at a job before health coverage plans start

- Between 1-6 months, 3 months is an average service wait

Affiliation Periods (HMOs only)

- HMOs may require an employee to work for a certain period of time – an affiliation period – before health coverage under the HMO will begin.
- HMOs can have either an affiliation period or a pre-existing condition exclusionary period – not both.
- Maximum affiliation period: 2 months (3 months for late enrollees)

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Employer-sponsored Group Health Coverage Protections

Federal Health Coverage Protections: HIPAA and COBRA

The Health Insurance Portability and Accountability Act

When starting a job, what are the protections?
When do HIPAA protections apply?

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Employer-sponsored Group Health Coverage Protections Continued

Medical underwriting: investigating the prior medical history of a beneficiary

HIPAA can exempt beneficiary from medical underwriting and pre-existing condition exclusionary periods when employer-sponsored health coverage becomes available, and the beneficiary has had prior health coverage.

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Private Health Coverage Protections Starting, Ending or Changing Jobs

HIPAA

- ❑ HIPAA provides employer-sponsored group health coverage protections when beneficiary starts a job, and during the job.
- ❑ If beneficiary had prior health coverage before signing up for a group health plan, the individual can use that previous coverage to reduce or eliminate a pre-existing condition exclusionary period.

HIPAA can solve the problem of pre-existing conditions exclusionary periods for Social Security disability beneficiaries.

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Employer-sponsored Health Coverage Protections Under HIPAA

Nondiscrimination

HIPAA prohibits employer-sponsored group health plans from denying coverage due to prior health status, disability, or medical history.

- ❑ Dependents also cannot be denied coverage for these reasons.

Pre-existing condition exclusionary period: the amount of time that a beneficiary is excluded from coverage of benefits for a preexisting condition

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Pre-existing condition exclusionary periods

Under HIPAA:

- ❑ Pre-existing condition exclusionary periods generally cannot last longer than 12 months; or 18 months if employee is late enrolling in the health plan.
- ❑ "Pre-existing condition" is defined by HIPAA as any health condition for which the beneficiary received (or was recommended) advice, care, diagnosis, or treatment, within the six months prior to enrollment in a new health plan.

Creditable coverage: a period of prior health coverage which can be used to reduce the length of a preexisting condition exclusionary period.

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Creditable coverage

- ❑ The beneficiary receives credit for previous coverage from these types of health coverage if they have had health coverage without a break of more than 63 days prior to enrolling in the new employer-sponsored group coverage.
- ❑ Creditable coverage includes coverage under a group health plan, HMO, individual health insurance policy, COBRA continuation coverage, **Medicaid paid services or any Part of Medicare.**
- ❑ State law can extend this period beyond the federal 63 day limit.

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Special Enrollment Periods

Enrollment periods

- ❑ **Initial Enrollment Period:** when health coverage is first offered by an employer at start of employment
- ❑ **Annual open enrollment period:** the time of the year when the employee can make changes to health coverage
- ❑ **Special Enrollment Period:** a 30-day period in which a beneficiary can enroll in or change group health coverage

HIPAA requires group health plans to allow beneficiaries and family members to enroll in coverage without having to wait until the plan's annual open enrollment period.

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Special Enrollment Periods

A special enrollment opportunity occurs if an individual with other health insurance loses that coverage or if a person becomes a new dependent through marriage, birth, or adoption.

- ❑ **Qualifying events:** events that allow a beneficiary to have a Special Enrollment Period in which they can change their group health coverage

NOTE: HIPAA protections apply in the Initial Enrollment Period and Special Enrollment Periods but *may not apply* in later subsequent enrollment periods.

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Protections under COBRA

Consolidated Omnibus Budget Reconciliation Act (1986)

When leaving a job, what are the protections?
When does COBRA apply?

COBRA gives employees the right to choose to continue their employer-sponsored health coverage, for the employee and for dependents, if the coverage has ended for certain reasons.

Coverage can continue for up to 18 months for anyone, and for up to 29 months if disabled according to Social Security rules.

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Protections under COBRA

- ❑ To qualify for COBRA continuation coverage, an employee must have lost group health coverage because of:
 - voluntary or involuntary termination of employment, for reasons other than gross misconduct, or
 - a reduction in the hours they work.
- ❑ Employers with 20 or more employees are subject to federal COBRA rules.
- ❑ The employer must give the employee at least 60 days notice after losing group health coverage to elect continuation coverage under COBRA.

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COBRA premiums

COBRA premiums are expensive

- ❑ The employee must pay a monthly premium for the health coverage – up to 102% of the plan's total cost of coverage.
- ❑ During extended COBRA coverage, the beneficiary can be asked to pay a premium of up to 150% of the plan's cost.

Some beneficiaries stop working because of a sudden disability and use up their savings paying premiums for COBRA coverage.

These individuals need other ways to access health coverage when COBRA coverage ends or becomes unaffordable.

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State Continuation Coverage Laws

State COBRA Continuation coverage options

- ❑ 40 States have COBRA expansions
- ❑ State Continuation coverage laws can establish:
 - maximum duration of continuation coverage.
 - minimum benefits that conversion policies must cover
 - maximum rates that can be charged.

Information on State coverage laws at:
<http://www.statehealthfacts.org/comparetable.jsp?cat=7&ind=357&typ=5&gsa=1>

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Training Section 4 What are the Main Types of Private Health Coverage Plans?

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Health Maintenance Organization (HMO)

Features of HMOs

- A contract for services from one group of doctors.
Example: Kaiser Permanente is a well known HMO
- Monthly premiums and usually small co-payments per doctor visit or for services
- Medical services provided from and via a referral by a primary care provider physician in the network
- Preventative health care services and check-ups available
- Less paperwork for the beneficiary accessing services

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Indemnity Plans

Features of Indemnity Plans

- "Fee for service" insurance for any doctor who will accept payment from the plan
- No select network of doctors and no primary care physician
- Cover illness and injury after their onset
- Usually does not cover preventative services as well as HMOs
- Monthly premium, a deductible and coinsurance
- Added paperwork for the beneficiary

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Point of Service Plans (POS)

Features of Point of Service Plans

- Offer coverage that is a combination of coverage types of HMOs, PPOs, and Indemnity plans
- Usually have an annual deductible, in addition to coinsurance and co-pay costs.
- Have networks of providers. Cost of service is lowest if beneficiary sees a primary care provider (PCP) in the network, and if they have an in-network referral for a specialist.
- If a beneficiary goes out of the network to see a health care provider, co-payments, coinsurance, and deductibles will be higher. Increased choice comes with higher out of pocket costs.
- POS plans offer the most flexibility in choice of medical providers – this may be important to some beneficiaries.

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Preferred Provider Organizations (PPOs)

PPOs are a type of health insurance plan that has a network of providers that the insurance company has contracts with.

Features of PPOs:

- Monthly premium and generally low costs for medical services once the annual deductible has been met
- Beneficiaries pay a higher portion of medical costs if they see a doctor that is not in the PPO network.
- The beneficiary doesn't need a referral from a primary care provider (PCP) to see a specialist.
- PPO's offer more choice of providers than HMOs. They require minimal paperwork if you stay in the network of providers.

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Self-Insured Trusts/Self-Funded Plans

Self-insured trusts or self-funded plans are plans in which a large company or union covers an individual's medical expenses with funds set aside to pay claims.

Features of Self-Insured Trusts:

- Plans vary greatly because they are less regulated than other types of health coverage.
- May have monthly premiums, a deductible, co-payments and coinsurance
- Typically have a twelve-month exclusionary period for pre-existing conditions

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Other Health Coverage Programs

Other Health Coverage Programs can interact with private plans

- ❑ **High Risk Pools** – set up by States to provide coverage to individuals who have no other health coverage and have been denied private individual coverage because of their health status or medical history
- ❑ **State run HIPP** – Health Insurance Premium Payment Programs
States can use federal and state Medicaid and SCHIP funds to purchase private coverage for individuals.
Must be “cost effective” – it must cost less for the state to pay for the private coverage than to pay for the individuals medical costs under Medicaid.
- ❑ **County Health Care Programs**
Counties may have programs that provide health care for low-income individuals and which are separate from Medicaid.

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Other Health Coverage Programs

- ❑ **VA coverage** – health coverage for veterans and families through the Veterans Administration health program
- ❑ **Military health coverage**
TRICARE provides civilian health benefits for military personnel, military retirees, and their dependents
- ❑ **Indian Health Service**
Provides medical and public health services to members of federally recognized Tribes and Alaska Natives
- ❑ **Foreign National Coverage** – health coverage by any type of health program in another country, but which covers the individual in the U.S.

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Other Health Coverage Programs

- ❑ **Federal Employees Health Benefits (FEHBP)** – provides health coverage to Federal employees, retirees and their survivors.
- ❑ **Student health insurance** – coverage for students under a school health program.
Example: College or university health insurance

Private health coverage plans

- ❑ Wide range of private health coverage types
- ❑ Plan benefits and cost structures vary;
- ❑ Regulated at the state level

More details on types in Module 4 of CWIC Manual, pages 59-63

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Training Section 5 CWIC Health Care Counseling Tips & Tools

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Health Care Counseling

This knowledge area is complicated for all Americans.

- ❑ Because of complexity of rules in health care systems, beneficiaries can be confused about coverage, bills, appeals and other issues.
- ❑ Beneficiary may have difficulty knowing their right questions to ask; beneficiary may not get questions fully answered by the health care plan or government program.

CWICs help beneficiaries 1) to understand program rules and to help the beneficiary better organize access to accurate information and 2) get to their question about their own situation.

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The Benefits and Work Binder

Encourage beneficiaries to buy, organize and use a thick three ring binder:
“My Benefits and Work Binder”

- ❑ File and retain in one place all benefits information related to work and benefits, the BPQY, original wage stubs, health care plan materials, Notices of Action.
- ❑ The Binder is a portable, organizational tool – it should include a spiral notebook for note taking at all beneficiary appointments at Medicaid offices, employer HR departments, and the Social Security Field Office.

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Issues, Strategies, and Priorities With Health Coverage Planning

Document health coverage options after initial assessment, analysis and discussion, using the suggested Check List.

- Review the reporting requirements of the benefit programs the beneficiary is on now.
- Resolve immediate problems with transition to new job and its benefits package.
- As the beneficiary expands health care options with paid work, remind beneficiary that new plans may have further reporting requirements and procedures.

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Issues, Strategies, and Priorities With Health Coverage Planning

Use Active Listening Skills

Recognize expressions or symptoms of frustration
Be sensitive to beneficiary's current knowledge levels and capacities to express concerns or understanding of program rules

Your typical customer wants a life, not a career as a paralegal or health care attorney.

- A beneficiary will need tools to manage information that works for him or her.
- Communicate in a language register and with terms the beneficiary can understand and use.
- Ask beneficiary to repeat what you are explaining.
Example: "What are the options available after our current health care assessment with the new job offer?"

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Health Care Counseling Tips

Teach beneficiaries self advocacy tips with health coverage programs (e.g., contact available experts for help, do their own Internet research).

- Beneficiaries who learn self-advocacy and improved organizational skills, patience and persistence will be able to safely access more health coverage and benefit options and feel confident in doing this.
- Advise beneficiaries about their right to speak directly with a health plan or program representative and/or a supervisor if they are not getting the help they need to resolve a problem.
- Advise and encourage beneficiary to use health coverage planning "terms of art" – the legal terms that programs use to explain their features, costs and how they deliver services.

Examples: "fee for service" "HMO" "premium" "share of cost" "co-pay" -- as opposed to making up terms that no one else uses.

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Health Care Counseling Tips

Health Coverage Rights and Appeals

- Explain what a Notice of Action is from Medicaid or Social Security and the immediate steps to take if the beneficiary disagrees with the Notice.
- An appeal filed timely in response to a Notice of Action filed will keep the benefits whole (unchanged) until the Appeal is exhausted and decided on.
- Help beneficiaries learn how to exercise rights, including rights to appeal and rights to a second medical opinion.

Working with Experts

- Establish relationships with experts on various health care and government health programs such as state SHIP programs
- Experts may be in community and advocacy organizations, or in government organizations such as local Medicaid offices.

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Health Care Counseling Tips

When to find other experts to network with, work with locally, and refer beneficiaries to

- When complex health coverage issues occur**
 1. that could result in loss or changes to health coverage
 2. that involve an appeal to improve medical services
 3. involve an appeal to dispute a health coverage decision that the beneficiary disagrees with

States have agencies that can help beneficiaries with serious access problems with their health coverage.

Examples: Departments Of Managed Health Care or State Medicaid Ombudsman Offices

These organizations can help when the beneficiary cannot resolve a problem with a health care provider (e.g. HMO) or government program such as Medicaid.

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Health Care Counseling Tips

Working with Other Experts

- State Health Insurance Counseling and Assistance Programs (SHIPs)**
State Health Insurance Programs provide links to SHIP counselors that can answer questions and help all Medicare beneficiaries with health care choices, choosing a Medicare plan and/or additional health insurance, and help understand rights and protections.

Your state:
<http://www.medicare.gov/LongTermCare/Static/Counseling.asp>

- Legal aid organizations, and PABSS (Protection and Advocacy for Beneficiaries of Social Security) programs provide free expert advice on Medicaid and help with appeals that also relate to paid employment situations.
- Organizations targeting specific populations can offer excellent help with health care and benefits issues (for example, state and local HIV and AIDS organizations).

Tip: Experts on health coverage, such as SHIP, Medicaid or Protection and Advocacy staff are often willing to come and give presentations to staff and consumers; some offer free training programs.

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Health Care Counseling Tips

Employer-sponsored group health coverage plans

- ❑ Large employer's have a Human Resources department or an assigned benefits coordinator; small employers may have one dedicated staff person (with other duties).
 - ❑ They can explain health plans, worker's compensation rules and other personnel and benefit matters. They are the primary source of information and resource for employer health plan disputes, coverage questions, initial enrollment periods, service waits, etc.
 - ❑ CWICs may be able to help assess the appeals process in a private group health coverage plan.
- ❑ Protection and Advocacy organizations may be able to help in some private health care plan disputes.

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Social Security Work Credits and New Employment

Paid work and paying FICA taxes changes a benefits profile over time, including the health coverage profile!

- ❑ Social Security Work Credits
 - \$1,090 in gross earnings in a three month period, or one quarter of a year = 1 Work Credit
 - All wage earners who pay FICA payroll taxes earn four (4) Work Credits per year, maximum, when they pay FICA taxes.
 - Young and all SSI workers can work their way into a different beneficiary category by working and paying FICA taxes.

See SSDI Program Description on www.dbio.org which explains Social Security work credits for all age categories.

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Social Security Work Credits and New Employment

New work can change SSI recipient benefit profile over time

Example:

An SSI worker below the age of 24 earns 6 work credits for 1.5 years of work; 6 work credits can earn that recipient a new SSDI eligibility in a month that the SSI recipient's wages fall below SGA; this can be a big surprise. **Plan in Place**

TAKEAWAY: Work credits can change an SSI or an SSDI beneficiary's benefit profile over time.

Expedited Reinstatement of Benefits (EXR)

Because of work credits and for other reasons, the Social Security Field Office can best explain the pros and cons of EXR vs. filing a new application for disability benefits when a beneficiary requests EXR.

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Information Resources

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Information Resources

- ❑ **Medicare and You 2009**, Medicare's Summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>
- ❑ **Center for Medicare Advocacy** – Wide range of current Medicare information from a respected, non profit advocacy organization, www.medicareadvocacy.org
- ❑ **"Your Health Plan And HIPAA ... Making The Law Work For You"**, U.S. Department of Labor, July 2007, <http://www.dol.gov/ebsa/publications/yhphipaa.html>
- ❑ **State Health Insurance Counseling and Assistance Programs (SHIPs)** State Health Insurance Programs provide links to SHIP counselors that can answer questions and help all Medicare beneficiaries with health care choices, choosing a Medicare plan and/or additional health insurance, and help understand rights and protections.
 - ❑ Your state: <http://www.medicare.gov/LongTermCare/Static/Counseling.asp>

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Additional Resources

- **U.S. Department of Labor (DOL) on COBRA** <http://www.dol.gov/dol/topic/health-plans/cobra.htm>
- **An Employee's Guide to Health Benefits Under COBRA**, U.S. Department of Labor, <http://www.dol.gov/ebsa/pdf/cobraemployee.pdf>
- **Health and Disability Advocates Materials Library**, search by health care topic: <http://hdadvocates.org/library/index.asp>
- Social Security website, "Questions and Answers on Extended Medicare Coverage for Working People with Disabilities", <http://www.socialsecurity.gov/disabilityresearch/wi/extended.htm>
- **Protecting Your Health Insurance Coverage**, U.S. Department of Health and Human Services Health Care Financing Administration, Publication No. HCFA 10199, September 2000, www.cms.hhs.gov/HealthInsReformForConsume/Downloads/protect.pdf

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SUPPLEMENTAL SLIDES

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Overview Publicly Funded Health Coverage

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Categorically Eligible Medicaid

States are required to offer Medicaid to certain mandatory populations, called “categorically eligible” groups.

Categorically eligible populations include:

- ❑ Children under age 6 with family income below 133 percent of the federal poverty line
- ❑ Children aged 6-18 with family income below the poverty line
- ❑ Pregnant women with family income below 133 percent of the poverty line
- ❑ Most elderly persons and persons with disabilities who receive Supplemental Security Income (SSI)

Offers low costs for health care and medications

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Medically Needy Medicaid Programs

States have the option to offer Medicaid to “optional” groups, including:

- ❑ Pregnant women, children, and parents with income above “mandatory” coverage income limits
- ❑ Elderly persons and persons with disabilities with income below the poverty line
- ❑ “Medically needy” people with high medical expenses

If a beneficiary has income that is too high to qualify under the low cost Medicaid program, they may qualify for the “Medically Needy” Medicaid program.

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Medically Needy Medicaid Programs

To qualify for Medically Needy Medicaid, individual must be in one of the mandatory or optional categories and have income above the Medicaid eligibility limits.

Beneficiaries can “spend down” their income

Income is reduced by medical expenses to fall below Medically Needy Income Limit (MNIL).

Spend down or share of cost

Beneficiary pays a portion of their medical expenses each month before Medicaid will pay for the rest of their medical bills.

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SSI and Medicaid

States handle the interaction between SSI and Medicaid in differently ways:

- ❑ 32 states and the District of Columbia: SSI recipients qualify for Medicaid through their SSI applications
- ❑ 8 states – “SSI eligibility states”: a separate Medicaid application is required for SSI beneficiaries.
- ❑ 11 states - Section 209 (b) states: Medicaid eligibility is not automatic for SSI recipients

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Medicaid Buy-In Programs (MBI)

Disabled individuals who are working can pay a premium and receive full, low-cost Medicaid coverage

- ❑ 32 States have Medicaid Buy-In Programs
 - ❑ Eligibility and premium rules for Medicare Buy-In Programs vary widely per state
 - ❑ Income to qualify must be less than 250% of federal poverty level. States can use a higher income limit (up to 450%)
- For information on Medicaid Buy-In-programs, SCHIP, and 1619(b) see Module 4 of the CWIC Training Manual.

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Medicare Eligibility

Who is eligible for Medicare?

When will Medicare start?

- SSDI beneficiary, in the 25th month of cash benefits
- Over 65, on the 65th birthday of wage earner who paid FICA taxes
- Under age 65, right away with award because of End-Stage Renal Disease (ESRD)

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Parts of Medicare

- ❑ **Part A Hospital Insurance** – covers inpatient care, including care in a skilled nursing facility or hospice, and home health care
- ❑ **Part B Medical Insurance** – covers medically-necessary services, including doctors' services and outpatient care usually after a hospital stay
- ❑ **Part C Medicare Advantage Plans** – a way to receive Medicare benefits from private health maintenance organizations (HMOs)
- ❑ **Part D Prescription Drug Coverage** – offered through a maze of private insurers and providers to all Medicare beneficiaries who do not have creditable coverage in some other prescription drug plan

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Medicare Plan Options

- ❑ Original (Fee For Service) Medicare vs. Medicare Advantage plan?
- ❑ Private Medigap Insurance policies
- ❑ Prescription Drug Coverage Plans (Part D)
- ❑ Dual eligible categories – Medicaid and Medicare
- ❑ Special Needs Plans

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Accessing Drug Coverage with Medicare

Creditable coverage: In this context, coverage as good as or better than Medicare Part D plans. All other drug plans, upon request, must provide a creditable coverage statement.

Formulary: a list of prescription drugs that a health plan or health care program covers

- ❑ Beneficiaries can request non-formulary medications (if medically necessary) in many drug plans in Medicare and Medicaid and elsewhere
- ❑ Each State Medicaid program and each Medicare Part D plan has a process and a form for a doctor to sign to request non-formulary medications.

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Extended Medicare Coverage

Other Medicare programs

- ❑ Low Income Subsidy and Medicare Part D
- ❑ Medicare Savings Programs – help with out of pocket Medicare costs for some Medicare beneficiaries with low income and low assets

Extended Medicare Coverage (SSDI)

- ❑ After loss of SSDI entitlement because of paid work
- ❑ SSDI beneficiaries can receive at least 7 years and 6 months of free Medicare Part A after their Trial Work Period ends, as long as they remain disabled under Social Security rules.

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