Center for Medicare Advocacy

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MEDICARE COVERAGE for INDIVIDUALS UNDER 65 with DISABILITIES

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The Center for Medicare Advocacy is a national, non-profit law organization founded in 1986 that works to advance access to comprehensive Medicare and quality health care. Based in Washington, DC and CT, with additional attorneys in CA, MA, NJ

- Staffed by attorneys, advocates, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic change – Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects

AGENDA

- **Eligibility**
- **Working People with Disabilities**
- **Ways to Supplement Medicare**
- **Selected Access to Care Issues**

ELIGIBILITY for MEDICARE for INDIVIDUALS UNDER 65

MEDICARE ELIGIBILITY

- Age 65 or older
- Disability
  - On Social Security disability (SSDI) or Railroad Retirement disability and collecting benefits for 24 months (waiting period is waived for ALS)
  - End Stage Renal Disease (ESRD) – transplant or 3 months regular dialysis

SSDI & 24-MONTH WAITING PERIOD

Medicare is available for certain people with disabilities who are under age 65

- Must have received Social Security Disability or Railroad Retirement disability benefits for 24 months
- Five month waiting period after a beneficiary is determined to be disabled before a beneficiary begins to collect Social Security Disability benefits
- Entitled to Medicare Part A after being disabled for 29 months

SSDI & WAITING PERIOD

- Months of a previous period of entitlement or deemed entitlement to disability benefits may count toward the 25-month requirement
- Deemed entitlement to disabled widow's or widower's monthly benefits may be used to meet the 25-month requirement or to retain Part A entitlement when they are no longer entitled to monthly disability benefits

EXCEPTIONS TO WAITING PERIOD

- Individuals with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease), in contrast to persons with other causes of disability, do not have to collect benefits for 24 months in order to be eligible for Medicare.

END STAGE RENAL DISEASE (ESRD)

- Exceptions to the Waiting Period for ESRD:
  - Individuals of any age with ESRD who receive dialysis on a regular basis or a kidney transplant are eligible for Part A (and are deemed enrolled for Part B unless such coverage is refused) if they file an application
  - Must also meet certain work requirements
  - Or be entitled to monthly social security benefits or an annuity under the Railroad Retirement Act
  - Or be the spouse or dependent child of an insured or entitled person

ALS

- Persons with Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease) can qualify for Medicare immediately upon collecting Social Security Disability benefits, without the 24-month waiting period, effective July 1, 2001
- See Benefits Improvement and Protection Act (BIPA), Pub. L. 106-554 (December 21, 2000), §115

MEDICARE & WORK

ELIGIBILITY FOR WORKING PEOPLE WITH DISABILITIES

- Distinct sets of rules in Medicare concerning
  - How Medicare coordinates with other types of insurance including employer-based insurance (Medicare Secondary Payer)
  - Rules concerning continuing eligibility for individuals with disabilities who are working

COORDINATION OF BENEFITS

- If a person's other insurance is a group health plan (GHP) provided by an employer based on *current, active* employment then:
  - If the person is eligible for Medicare due to age:
    - The GHP is primary if there are **more than 20 employees** at the company where the beneficiary or their spouse works
    - Medicare is primary is there are fewer than 20 employees
  - If the person is eligible for Medicare due to disability:
    - The GHP is primary if there are **more than 100 employees** at the company where beneficiary, spouse or other family member works
- Retiree coverage is secondary to Medicare

WHEN DISABILITY ELIGIBILITY ENDS

- When a person is no longer considered to be disabled, Medicare eligibility stops at the end of the month following the month of notification, UNLESS
- The reason is eligibility would end only because of work - then Medicare may continue

ELIGIBILITY FOR WORKING PEOPLE WITH DISABILITIES

- Three distinct time frames:
  - Trial work period: for 9 months after obtaining a job
  - 93 months after end of trial work period
  - Indefinite period: following those 93 months
    - Note: Medicare eligibility during each of these periods applies only while the individual continues to meet the medical standard for being considered disabled under Social Security rules

SUPPLEMENTING MEDICARE

THE MEDICARE PROGRAM

Four Parts

1. Part A (Traditional Medicare)
2. Part B (Traditional Medicare)
3. Part C (Private Medicare - known as Medicare Advantage)
4. Part D (Prescription Drug Coverage)

PARTS A & B AND OTHER INSURANCE

- Employer based coverage
  - Through current work
  - COBRA
  - Retiree coverage
- Medicare Supplemental Insurance Policies (Medigaps)
- Military coverage
  - Veterans Administration, TriCare
- Medicaid
  - Medicare Savings Programs (MSPs)
- Medicare Advantage (MA) plans
- Medicare Part D prescription drug benefit

MEDICARE ADVANTAGE (MA)

- MA plans are another way to access Medicare benefits
- A company offering an MA plan contracts with and is approved by CMS to administer Medicare benefits
- MA plans combine Part A, Part B, and, sometimes Part D (prescription drug) coverage (one stop shopping)
- MA have essentially the same coverage rules as traditional Medicare

MA

- MA plans are not supplemental insurance
  - Not in addition to or "on top of" regular Medicare
  - MA plans paid a monthly capitated fee by Medicare to provide all Part A & Part B services
- An individual cannot be sold a Medigap policy while she is in an MA plan
- Care is often subject to pre-approval by the MA plan

MA CONSIDERATIONS

- If considering enrolling in an MA plan, individuals under 65 should consider several factors, including:
  - Quality outcomes in MA plans are mixed; people with greater health needs more likely to return to trad. Medicare
  - 99% of MA plans use some type of prior authorization for 1 or more services
  - HHS OIG (2018) found "widespread and persistent problems related to denials of care and payment in Medicare Advantage plans"

MEDIGAP PLANS

- Medigap insurance is meant to work in tandem with the original Medicare program by paying for beneficiary cost-sharing and some other services not usually covered by Medicare
- Must have Parts A and B to buy a Medigap plan
- Beneficiary pays monthly premiums
- Federal law provides rights to purchase policies at certain times, state law can expand such rights
  - Default rule: Companies don't have to sell /can medically underwrite applicants

MEDIGAP RIGHTS

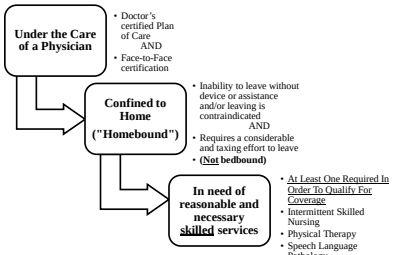
- For Medicare beneficiaries under 65, there are no federal rights to purchase a Medigap plan; look to rights individual states may have added to state law

SELECTED ACCESS to CARE ISSUES

HOME HEALTH BENEFIT

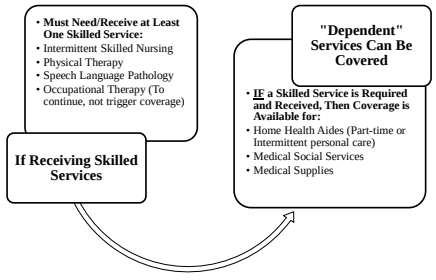
- Increasing access to care problems, particularly for individuals with chronic conditions
  - Benefit is misunderstood, inaccurately articulated, and narrowly implemented
  - Changing financial incentives, e.g. higher payments for individuals who are admitted to home care after an inpatient hospital or skilled nursing facility (SNF) stay and lower payments for those who start home health from the community

Home Health Coverage Criteria



Reference: 42 C.F.R. § 409.40 et seq

Home Health Covered Services



JIMMO & THE MYTH OF IMPROVEMENT

- Pervasive belief among health care professionals, providers, Medicare reviewers, and contractors that Medicare pays for skilled nursing and therapy services only if beneficiary is expected to improve
- Not true and never has been true

WHAT *JIMMO* SETTLEMENT MEANS: NO DENIALS BASED ON IMPROVEMENT STANDARD

- Medicare coverage is improperly denied for skilled nursing or rehabilitation services when the denial is based on:
  - Individual's stable or chronic condition
  - No expectation of improvement in a reasonable period of time
- Services can be skilled and covered even when:
  - Individual has "plateaued"
  - Services are "maintenance only"

CARE SETTINGS *JIMMO* APPLIES TO

- Skilled nursing facility (SNF)
- Home health (HH)
- Outpatient therapy
- Inpatient rehabilitation facilities (IRFs)
  - (To a lesser extent)

BIGGEST OBSTACLES TO IMPLEMENTATION

- Continuing belief among providers and adjudicators that beneficiary must be improving before Medicare will pay (we still get frequent calls about patient who has "plateaued")
- SNFs, HH agencies, therapists in outpatient setting refusing to provide therapy, regardless of what surgeon or other physician says

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