THE STATE BAR OF TEXAS
TEXAS YOUNG LAWYERS ASSOCIATION

Medicare, Medicaid, and SSI – A General Guide

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TABLE OF CONTENTS

MEDICARE, MEDICAID, AND SSI – A GENERAL GUIDE

This guide is intended to provide an overview of the federal Medicare, Medicaid and Supplemental Security Income programs and is not intended to be a comprehensive source of information on these programs. The Texas Young Lawyers Association seeks to make Texas residents generally aware of who is eligible for these programs, the benefits available through these programs, and how the benefits can be obtained. This information is not a substitute for the advice of a lawyer, but instead is designed to assist Texans in learning about their legal rights.

Medicare

Medicare is a health insurance program administered by the Centers for Medicare & Medicaid Services (CMS), which is part of the U.S. Department of Health and Human Services. Medicare is available for the following people:

- Individuals who are age 65 or older;
- Some individuals under age 65 who have a disability; and
- Individuals with a medical diagnosis of End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

An individual must also be a citizen or permanent resident of the United States to be eligible for Medicare. The Medicare program consists of two parts – Part A, which provides hospital insurance, and Part B, which provides medical insurance. To receive Medicare benefits, eligible individuals must apply at a local Social Security office.

Medicare Part A

Medicare Part A provides insurance coverage for hospital care. Most people are automatically eligible for Medicare Part A when they reach 65 years of age. Individuals do not have to make monthly premium payments for Part A if either they or a spouse paid Medicare taxes while they were working. Individuals who did not pay Medicare taxes while working may be able to purchase Part A insurance through the Social

Security Administration or local Social Security office for a monthly premium;[1] or if their income and assets are low enough, this premium as well as the Part B premium can be paid by the Qualified Medicare Beneficiary Program discussed on page 5 of this brochure.

Medicare Part A helps individuals to pay for the following care and services, provided they are medically necessary:

- Inpatient hospital care (including inpatient mental health care and care in critical access hospitals that provide limited services to people in rural areas) – Medicare helps to pay for up to 90 days of inpatient hospital care during each benefit period. (Note: A benefit period begins on the first day the individual receives services in a hospital or skilled nursing facility and ends after the individual has been discharged from the hospital or skilled nursing facility and has not been a patient in any other facility for 60 consecutive days. There is no limit on the number of benefit periods an individual can have.)

- Care in skilled nursing facilities – Medicare helps to pay for up to 100 days in a skilled nursing facility in each benefit period for individuals meeting certain conditions. Medicare will pay all approved charges for the first 20 days in the skilled nursing facility, but the individual must pay a coinsurance amount for days 21 through 100.

- Hospice care – Medicare helps to pay for hospice care for terminally ill individuals who select the hospice care benefit. These individuals only pay limited costs for drugs and inpatient respite care.

- Some home health care – Medicare pays the full approved cost for covered home health care, including part-time or intermittent skilled nursing services prescribed by a doctor for treatment or rehabilitation of homebound patients, if certain conditions are met. Eligible individuals must, however, pay a 20% coinsurance charge for medical equipment.

- Blood received at a hospital or skilled nursing facility during a covered stay.

Medicare Part B

Medicare Part B provides medical insurance coverage. Part B is not automatic like Part A, thus eligible individuals must enroll in Part B. Individuals can sign up for Part B at any time during the seven-month period that begins three months before they turn 65 years of age. Individuals enrolled in Part B must pay monthly premium payments.[2] In some cases, Medicaid will pay for an individual to have Medicare Part B insurance coverage. For more information about Medicaid, please refer to the Medicaid section of this brochure.

Individuals who do not elect to enroll in Part B when they are first eligible can only sign up for Part B once a year, between January 1 and March 31. Part B insurance coverage for individuals enrolling during this period will begin on July 1 of the year in which they enroll. Individuals should be aware that if they do not choose Part B when they are first eligible at age 65, the cost of Part B may increase 10% for each 12-month period they could have enrolled in Part B but did not do so. Except in special cases, individuals will be required to pay this 10% increase as long as they are enrolled in Part B. An eligible individual can delay enrolling in Part B, however, if the individual or his or her spouse continues to work *and* the individual is covered under a group health plan from that current employment. Individuals who delay enrolling in Part B because they are covered under a group health plan may avoid the 10% premium increase by signing up for Part B while they are still enrolled in the group health plan or within eight months after either the employment or the group health coverage ends, whichever occurs first.

Medicare Part B helps individuals pay for the following services and supplies, provided they are medically necessary:

- Doctors' services;
- Outpatient hospital care (including emergency room care);
- Ambulance transportation;
- Diagnostic tests;
- Laboratory services;
- Outpatient physical and occupational therapy;
- Outpatient mental health care;
- Durable medical equipment, such as wheelchairs and hospital beds, and supplies; and
- Some home health care for which Part A does not pay.

In addition to these specific services and supplies, Medicare Part B helps pay for a variety of other medical services and some preventive care, such as mammograms and Pap smear screening. Part B generally does *not* pay for most prescription drugs, routine physical exams, services not related to the treatment of illness or injury, dental care or dentures, cosmetic surgery, routine foot care, hearing aids, routine eye care, eyeglasses, or health care received while traveling outside the United States.

Individuals enrolled in Part B must pay a $100 deductible each calendar year as well as 20% of the Medicare approved charges for medical and other services and for durable medical equipment. Under Part B, Medicare pays 80% of the Medicare-approved charges for most covered services. For outpatient mental health care, however, individuals must pay 50% of the charges, and outpatient hospital services require individuals to pay coinsurance or copayment amounts depending on the services. Under Part B, individuals pay nothing for Medicare-approved clinical laboratory services or for Medicare-approved home health care services. Finally, individuals whose doctors do not accept the Medicare-approved charges will also pay the limited additional charges.

Supplemental Insurance and Health Plan Options

The traditional Medicare option is known as the Original Medicare Plan. Under the Original Medicare Plan, individuals make payments for services, as has been previously described in this brochure. With this plan, an individual may go to any doctor or hospital that accepts Medicare. The individual pays his or her portion and Medicare pays its portion.

Private insurance companies also sell Medicare supplemental insurance policies (Medigap or Medicare SELECT) to help pay the costs individuals are required to pay under the Original Medicare Plan, such as coinsurance amounts and deductibles or other health care costs. An individual must have both Part A and Part B to purchase a supplemental insurance policy. There is an open enrollment period that is available for individuals to purchase supplemental insurance for the six-month period after they first enroll in Part B. Individuals should consider purchasing supplemental insurance policies during this open enrollment period because during this period, insurance companies cannot refuse to cover

individuals or charge individuals higher premiums based on their health status. Individuals who enroll after the open enrollment period could be denied supplemental insurance or charged higher premiums.

In addition, the Medicare program offers other ways for individuals to receive their Medicare health insurance benefits if they are enrolled in both Part A and Part B. Individuals may be able to enroll in Medicare managed care plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider sponsored organizations (PSOs), private fee-for-service plans, or Medicare medical savings account plans. These other Medicare plans provide insurance coverage for all of the services covered by Part A and Part B. Most of these other Medicare options also offer benefits not covered by the Original Medicare Plan, such as preventive care, prescription drugs, dental care, hearing aids, and eyeglasses.

Qualified Medicare Beneficiary (QMB) and Other "Medicare Savings Programs"

Under the Qualified Medicare Beneficiary (QMB) Program, the Texas Department of Human Services will pay Medicare Part A and B premiums, copayments, and deductibles for persons whose incomes are below the poverty line and whose countable assets do not exceed $4,000 for an unmarried individual or $6,000 for a married couple.[3] There are QMB income limits for individuals and for couples who are both eligible for QMB.[4] Income from certain sources is exempt, including the first $65 of earned income and half the rest of earned income.

The Specified Low-Income Medicare Beneficiaries (SLMB) program pays the Medicare Part B premiums[5] of Medicare beneficiaries who meet the asset requirements for QMB and whose incomes fall within certain ranges.[6] Those amounts include the $20 per month that is "exempt" but do not take into account other possible exemptions such as part of earned income (as discussed above.)

The "Qualifying Individuals-1" program also pays the Medicare Part B premium. The only difference is that it is available only to persons who are *not* certified for any other Medicaid funded program in the same month. Income eligi-

bility requirements are also applicable.[7] Those amounts include the $20 per month that is "exempt" but do not take into account other possible exemptions such as part of earned income as discussed above. Asset requirements are the same as for QMB.

Although these "Medicare Savings Programs" can make a big difference to people struggling to pay medical expenses, about half the persons who are eligible for QMB are not receiving it. For information on how to apply, contact any office of the Texas Department of Human Services.

Helpful Contact Information

The following offices can provide more information about enrolling in Medicare or the Medicare options in Texas:

Social Security Administration:
1-800-772-1213
1-800-325-0778 (TTY number for the deaf and hard of hearing)

Centers for Medicare and Medicaid Services (CMS), Dallas regional office:
1-214-767-6401

Texas Department on Aging's State Health Insurance Program (SHIP):
1-800-252-9240
1-800-252-9108 (TDD)

Texas Department of Insurance (TDI) Consumer Help Line: (can provide information about Medicare supplemental insurance policies available in Texas)
1-800-252-3439
1-512-332-4238 (TTY)
www.tdi.state.tx.us/consumer/medsup.html

In addition, for Medicare information on the Internet, visit www.medicare.gov.

Medicaid

Medicaid is a broad, need-based medical assistance program serving certain individuals who are unable to pay for necessary healthcare. In the State of Texas, Medicaid eligibility is usually determined by the Texas Department of Human

Services ("TDHS").[8] Medicaid consists of two primary components: Community Medicaid and Long-Term Care Medicaid. Community benefits are provided for younger, disabled persons and families receiving public assistance. Medicaid for persons in nursing homes and assisted living facilities and for those needing care at home is called Long-Term Care Medicaid. The distinction is important because the regulations for each program are very different. The discussion of Medicaid in this section of the brochure will be limited to Long-Term Care Medicaid. For more information regarding other Medicaid programs, contact TDHS or go to its website at www.dhs.state.tx.us.

Requirements

In order to receive Long-Term Care Medicaid in a nursing home, the general requirements are that the person must:

- Be at least 65 years of age or be blind or disabled;
- Be a citizen or permanent resident of the United States;
- Have a medical condition requiring nursing care; and
- Meet certain financial requirements (discussed below).

In addition, a determination of medical necessity must be made. TDHS contracts with the National Heritage Insurance Company to determine medical necessity. Professionally developed written criteria are used to evaluate the medical necessity for admission and continued stay of Medicaid recipients based on each recipient's need for care under daily supervision of licensed nurses. The director of nurses at a nursing facility can determine whether the recipient will meet medical necessity criteria upon request of a "pre-admission assessment of a medical necessity" by a Medicaid applicant or a family member. Finally, an applicant must reside in a Medicaid-contracted nursing facility or skilled nursing facility for a period of 30 consecutive days before being certified for Medicaid. Medicaid coverage may be retroactive to the date of entry, however, if all eligibility requirements were met on that date.

Financial Limits

Individuals must meet certain financial requirements to be eligible for the long-term care benefits provided by Medicaid. The financial limits apply to both an individual's income and assets.

Income is defined as the receipt of any property or service an individual can use, either directly or by sale or conversion, to meet basic needs for food, clothing, and shelter.[9] Gross income, not net income, is used for determining eligibility. Countable income includes, but is not necessarily limited to, the following:

Social Security Benefits	Railroad Benefits
Veteran's Benefits	State and Local Retirement Benefits
Private Pension Benefits	Royalty and Rental Payments
Interest and Dividends	Gifts and Contributions
Earnings and Wages	
Civil Service Annuities	

An individual's income is applied to the cost of his or her nursing care and Medicaid pays the difference. Before applying an individual's income to the costs of his or her nursing care, TDHS allows certain deductions, which include but are not necessarily limited to the following:

- A personal spending allowance;[10]
- An allowance for a spouse and/or dependent living outside the nursing facility, if certain criteria are met;
- All medical and dental expenses not covered by Medicare, Medicaid or insurance;
- Cost of Medicare Part A and/or Part B premiums and all other health insurance premiums, such as Medicare supplemental insurance; and
- Court-approved fees paid to a guardian,[11] if applicable.

In some cases, an individual may have too much income to qualify for the Long-Term Care Medicaid Program, but too little income and assets to pay the private pay rate for his or her nursing care. In these cases, a specialized trust known as a "Miller Trust" or "Qualified Income Trust" may be used to qualify the individual for the Long-Term Care Medicaid Program. This specialized trust is designed only to hold the income of the Medicaid recipient and should not be confused with other types of trusts that are created for different purposes. Furthermore, this trust should not be confused with a special/supplemental needs trust, the purpose of which is to hold and apply assets that would otherwise be given to or inherited by individuals receiving government assistance.

Individuals seeking eligibility for Long-Term Care Medicaid must also satisfy certain asset limitation require-

ments.[12] A larger amount of assets may be excluded where one spouse is in a long-term care facility and the other lives in the community; however, a qualified attorney should be consulted for assistance in determining the amount of assets which can be excluded in such a circumstance.

In determining eligibility, some assets are counted and others are excluded. Countable assets include, but are not necessarily limited to:

Bank Accounts	Stocks and Bonds
Certificates of Deposits	Oil/Gas/Mineral Rights
Real Estate	Jewelry and Antiques
Life Insurance	Cars and Other Vehicles
Burial Plots and Funds	

Assets excluded by TDHS in determining an unmarried individual's eligibility are:

- Homestead where the individual intends to return, including all adjacent land;
- Life insurance, if the face value is $1,500 or less;
- Burial funds of $1,500, less any excluded life insurance;
- Car worth less than $4,500, or more if needed for medical transportation;
- Burial spaces for the individual, spouse, and close relatives;
- Irrevocable pre-paid burial policy;
- Wedding rings;
- Certain business property (sometimes including farms and ranches); and
- Tangible property worth not more than $6,000 that produces income of at least 6% per year.

Transferring Assets

Transfers of an individual's assets can cause him or her to be ineligible for Medicaid. Generally, a person must be very careful about making uncompensated transfers of assets ("gifts") within a 36-month period preceding his or her application for the Long-Term Care Medicaid Program. This period is known as the "look back period." The look back period for gifts to an irrevocable trust is 60 months. TDHS will examine any transfers made during the look back period and, in many circumstances, the transfers will result in a period of ineligibility for the Medicaid program. The rules in this area

are very complex, and a qualified attorney should be consulted prior to making any gifts or transfers of assets for less than fair market value. A law passed by Congress in 1997 that purported to make it a criminal offense for an attorney to advise a client about the Medicaid "transfer rules" has been declared unconstitutional. Because such transfers can result in unintended consequences, an attorney's advice is often crucial to transferring property wisely if at all. Failure to report a transfer can result in criminal penalties for fraud, as can any fraudulent statement in the application process.

Medicaid Programs for Care at Home and in Assisted Living Facilities

The Community-Based Alternatives Program provides an alternative to institutionalization in a long-term care facility. Although the applicant must meet the criteria for nursing home care in the Long-Term Care Medicaid Program, he or she may receive personal care services provided in the home or in an assisted living facility. Unfortunately, enrollment in this program is limited, and the long waiting list for this program frequently causes applicants to seek long-term nursing care instead. Other programs that provide some home care (and are more likely to be available) are referred to generally as "Community Care." They include Primary Home Care, Family Care, and others.

Program for All-Inclusive Care of the Elderly

The Program for All-Inclusive Care of the Elderly (PACE) provides health care and related services to persons who are over 55, indigent, and have been certified as requiring nursing home care. PACE is an alternative service delivery system that focuses on preventative care and assisting individuals to remain in the community and outside an institutional setting as long as possible. PACE provides all health or health related services, such as primary medical care, dentistry, podiatry, social services, in-home care, meals, transportation, and housing assistance, in addition to other services. Services are provided through staff members or through third party providers receiving payment through the program. Participants in the program agree to accept health care and related services only through the PACE site. Services provided through PACE are funded by payments from Medicare and Medicaid. The PACE program is currently available only in El Paso, but it is being expanded to other parts of Texas.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal program administered by the Social Security Administration with help from the states to provide a minimum income for people who meet certain requirements.

Requirements

In order to receive SSI, the general requirements are that a person must:

- Be at least 65 years of age or blind or disabled;
- Be a U.S. citizen or qualified alien and resident (for at least 30 days) of the United States;
- Meet certain financial requirements (discussed below); and
- File the necessary applications.

Additionally, a person will typically not be eligible if he or she is residing in a public institution, such as a mental institution or prison. Residency in some public institutions will not cause ineligibility but may instead result in a reduction of SSI benefits or no adverse effect at all. A person may also be denied SSI benefits if he or she fails to apply for other benefits for which he or she may be entitled, or if he or she fails to accept rehabilitation or treatment if offered.

Financial Limits

Eligibility for SSI depends on financial requirements as well as the requirements mentioned earlier. The applicant must qualify in both the income category and the asset category. To be eligible for SSI, an individual's "countable" income must be below a certain level.[13] The calculation of income a person may have and qualify for SSI will depend on whether the income is "earned" or "unearned." There is also a limit on the value of assets a person may have and qualify for SSI.[14] Not all assets are considered in this limit. The same assets are exempt as those listed for an unmarried individual applying for nursing home Medicaid (even if the applicant for SSI is married).

Benefits

SSI pays meager benefits. An eligible individual can receive from the SSI program a maximum amount[15] depending on

the types and amounts of income he or she is receiving. The benefit amount is increased slightly each year due to a cost of living increase.

Applying for SSI

Applicants should visit their local Social Security office or call the Social Security Administration at 1-800-772-1213 to schedule an appointment. They can also obtain information from the Internet by visiting www.ssa.gov. The parents or guardians of blind or disabled children and of adults needing assistance can typically complete the application for their children or wards. To give assistance to an adult who does not have a guardian, one must be appointed his or her "representative" on an "Appointment of Representative" form. This and other forms are available at www.ssa.gov/online/forms.html.

Receiving SSI Payments

SSI payments will begin later of the month after the month in which the applicant has become eligible for SSI or has completed the application for SSI. After that, payments will be made on the first day of the month. Payments to an eligible couple are made by sending each spouse a separate check. An individual or couple may also receive payments in advance of regular SSI payments in special situations. To do so, the individual or couple must present evidence of eligibility and must be faced with a financial emergency, such as inability to obtain food, shelter, or medical care.

Appealing an SSI Determination

A person who receives an adverse determination regarding SSI benefits may appeal the determination. Such a situation is normally handled similarly to a Social Security Disability Insurance case. It should be noted, however, that if SSI benefits are being lowered, suspended, or terminated, the person must be given prior written notice before such action can be taken. Also, if an appeal is filed within 10 days from receipt of the notice, the SSI benefits must continue unreduced until the appeal is resolved. If, however, the denial of benefits was valid and the appeal is denied, any payments received after the initial notice of denial must be repaid to the Social Security Administration.

ENDNOTES

1 This amount was $319 in 2002.

2 In 2002, the monthly premium amount was $54, but this amount typically increases each year.

3 The same assets are exempt (not "countable") as those listed for unmarried individuals applying for Medicaid nursing home care (discussed in the Medicaid section of this brochure).

4 The QMB income limit for 2002 was $759 per month for an individual and $1,015 per month for a couple in which both were eligible for QMB. Those amounts included the $20 per month that is "exempt."

5 This amount was $54 per month in 2002.

6 In 2002, the eligibility ranges were as follows: unmarried individuals with monthly incomes greater than $759 and not more than $906, and couples with monthly incomes greater than $1,015 and not more than $1,214.

7 In 2002, it was available to unmarried individuals with monthly incomes greater than $906 and not more than $1,017; and couples with monthly incomes greater than $1,214 and not more than $1,364.

8 Note that eligibility for Community Medicaid is determined by the Social Security Administration in SSI cases because all SSI beneficiaries are eligible for that type of Medicaid.

9 The maximum amount of countable income a single person may have and still qualify for Medicaid is $1,635 as of January 1, 2002.

10 In 2002, the amount was $60 per month, or more if it was for VA Aid & Attendance.

11 This generally does not include attorney fees or court costs associated with a guardianship.

12 In 2002, single persons could not have countable assets in excess of $2,000. A married couple, both of whom apply for Medicaid, could not have countable assets in excess of $3,000.

13 This amount was $545 per month in 2002.

14 In 2002, a single individual could have assets worth up to $2,000 and a married couple could have up to $3,000.

15 The amount was $545 per month in 2002 (or no more than $847 for an eligible individual with an eligible spouse).

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