



The Ticket to Work and Self-Sufficiency Program

The Social Security Administration SSDI/SSI And Medicare/Medicaid Programs

**Reference Guide for Employment Networks and State Vocational
Rehabilitation Agencies**

January 2007

Ticket to Work and Self-Sufficiency Program
Employment Network Training—Module 2 The Social Security Administration SSDI/SSI and Medicare/Medicaid Programs





The Social Security Administration SSDI/SSI And Medicare/Medicaid Programs

This unit provides background information on Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI), as well as the Medicare and Medicaid programs. A basic understanding of these programs is essential for understanding the incentives that are a part of the Ticket to Work and Work Incentives Improvement Act.



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Learning Objectives

The learning objectives of this module are to:

- Define disability according to Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI),
- Define Substantial Gainful Activity (SGA),
- Define SSDI and eligibility requirements,
- Define SSI and eligibility requirements,
- Describe the basic elements of Medicare, and
- Describe the basic elements of Medicaid.



PART I - DISABILITY DEFINED

Both Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) define disability as the inability to engage in any Substantial Gainful Activity (SGA) because of a medically determinable physical or mental impairment(s):

- That can be expected to result in death; or
- That has lasted or, that Social Security Administration can expect to last for a continuous period of not less than 12 months.

The Social Security Administration's definition of disability also factors in the individual's inability to work at certain levels. An individual will be considered disabled if he/she cannot do the work he/she did before and SSA decides that the individual cannot adjust to other work because of his/her medical condition(s).

Substantial Gainful Activity

The Social Security Administration evaluates the work activity of persons claiming or receiving disability benefits under SSDI and/or claiming benefits because of a disability (other than blindness) under SSI. Under both programs, the Social Security Administration uses earnings guidelines to evaluate an individual's work activity to decide if it is at SGA and whether the Social Security Administration may consider an individual disabled under the law. While this is only one of the tests used to decide if an individual is disabled, it is a critical threshold in disability evaluation.

For SSDI, SGA is used as a factor to decide if an individual has a disability when applying for benefits. SGA is also used as a factor to decide if the disability continues when an individual is already receiving benefits (except during the Trial Work Period).

For SSI, SGA is used as a factor to decide if an individual has a disability when applying for benefits based on a condition other than blindness. (SGA is not a factor for SSI applicants who are blind.) The Social Security Administration uses the same SSDI SGA level for SSI for applicants with impairments other than blindness.

For SSI, the Social Security Administration does **NOT** use SGA as a factor to decide if an individual's disability continues when an individual is already on the rolls. SSI eligibility continues until an individual recovers medically or eligibility is ended for a non-disability related reason.

PART II - SOCIAL SECURITY DISABILITY INSURANCE

Definition of SSDI

Social Security Disability Insurance (SSDI), authorized by Title II (T2) of the Social Security Act, provides benefits to individuals with a physical or mental impairment or blindness who are unable to work for a year or more. Individuals qualify based on their contributions to the Social Security Trust Fund. These contributions are the Federal Insurance Contributions Act (FICA) social security tax paid on their earnings or those of their spouses or parents. The amount of monthly disability benefits is based on an individual's lifetime average earnings covered by Social Security.

Eligibility Requirements for SSDI

In order to be eligible for SSDI the worker must have been employed and paid Social Security taxes for enough years to be covered under Social Security insurance. Some of the taxes must have been paid in recent years and the individual must be:

- The worker or the worker's adult child or widow(er),
- Considered medically disabled, and
- Not working or working but earning less than the Substantial Gainful Activity (SGA) level.

In order to be considered for SSDI as a worker's adult child an individual must:

- Be unmarried,
- Is or was dependent on the parent,
- Be 18 years of age or older, and
- The disability must have begun before age 22.

PART III - SUPPLEMENTAL SECURITY INCOME

Definition of SSI

The Supplemental Security Income Program (SSI), authorized by Title XVI of the Social Security Act, makes cash assistance payments to the aged, blind individuals and individuals with disabilities (including children under age 18) who have limited income and resources. The Federal Government funds SSI from general tax revenues. Some states pay benefits to some individuals to supplement their Federal benefits. Some of these states have arranged with Social Security Administration to combine their supplementary payment with the Federal payment into one monthly check to the beneficiary. Other states manage their own programs and make their payments separately. Title XVI of the Social Security Act authorizes SSI benefits. SSI is a needs based program.

Eligibility Requirements for SSI

To be eligible for SSI the individual must have a financial need and be:

- Aged (65+), or
- Blind (20/200 vision or less with the use of corrective lenses or tunnel vision), or
- Disabled (either not working or working, but unable to demonstrate SGA).

Once an individual is on the rolls, his/her eligibility will continue until he/she medically recovers or no longer meets a non-disability-related requirement.

PART IV - MEDICARE

Overview of Medicare

Medicare is Title XVIII of the Social Security Act and is designated "Health Insurance for the Aged and Disabled." As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise non-covered aged persons who elect to pay a premium for Medicare coverage.

Medicare has traditionally consisted of two parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), also known as Part B. A third part of Medicare, sometimes known as Part C, is the Medicare+Choice program. It was established by the Balanced Budget Amendment (BBA) of 1997 and expanded beneficiaries' options for participation in private-sector health care plans. A new fourth part, Part D, offers prescription drug coverage.

Individuals Covered Under Medicare

Hospital Insurance (HI) is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in Federal, state, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are entitled to HI benefits. HI coverage is also provided to insured workers with end-stage renal disease (ESRD) and to insured workers' spouses and children with ESRD. HI coverage is also available to some otherwise ineligible beneficiaries who voluntarily pay a monthly premium for their coverage.

Services Covered Under Medicare Part A – Hospital Insurance

- **Inpatient hospital care** coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care (LTC) hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital.
- **Skilled nursing facility care** services are similar to those for inpatient hospital but also include rehabilitation services and appliances.
- **Home health agency care**, including care provided by a home health aide, may be furnished part-time by a home health agency (HHA) in the residence of a homebound beneficiary if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care are necessary. Certain medical supplies and durable medical equipment (DME) may also be provided.
- **Hospice care** is a service provided to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits receive only hospice care for treatment of their illness. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management.

Services Covered Under Medicare Part B – Supplementary Medical Insurance

All citizens (and certain legal aliens) age 65 or over and all persons with disabilities entitled to coverage under Hospital Insurance (HI) are eligible to enroll in the Supplementary Medical Insurance (SMI) program on a voluntary basis by payment of a monthly premium. Almost all persons entitled to HI choose to enroll in SMI, which covers the following services and supplies:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists. Also covered are the services provided by Medicare-approved practitioners who are not physicians, such as clinical psychologists, clinical social workers, physician assistants, and nurse practitioners.
- Services in an emergency room or outpatient clinic, including same-day surgery and ambulance services;
- Laboratory tests, X-rays, and other diagnostic radiology services, as well as certain preventive care screening tests;
- Most physical and occupational therapy and speech pathology services;
- Comprehensive outpatient rehabilitation facility services and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it;
- Approved durable medical equipment for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, and casts.

Medicare Financing

The HI program is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by the HI program and pay taxes to support the cost of benefits for aged and disabled beneficiaries.

The HI trust fund also receives income from the following sources: (1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries; (2) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily; (3) reimbursements from the general fund of the U.S. Treasury for the cost of providing HI coverage to certain aged persons who retired when the HI program began and thus were unable to earn sufficient quarters of coverage (and those Federal retirees similarly unable to earn sufficient quarters of Medicare-qualified Federal employment); (4) interest earnings on its invested assets; and (5) other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

The SMI program is financed through premium payments and contributions from the general fund of the U.S. Treasury. Beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Therefore, the contributions from the general fund of the U.S. Treasury are the largest source of SMI income. The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. Beneficiary premiums and general fund payments are pre-determined annually, to match estimated program costs for the following year.

Medicare Part C (+Choice) and MediGAP Insurance and Medicare Part D

Medicare Part C was established under the Balanced Budget Act of 1997. Under Medicare Part C, individuals who are eligible for Medicare Parts A and B can choose to get their Medicare benefits through a variety of risk-based plans. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. The primary Medicare Part C plans include:

- Medicare managed care plans, such as Health Maintenance Organizations (HMOs), Provider Sponsored Organizations (PSOs), Preferred Provider Organizations (PPOs) and other certified public or private coordinated care plans that meet the standards under the Medi-

care law.

- Medicare private, unrestricted fee-for-service plans that allow the beneficiary to select certain private providers. These providers accept the plan's payment terms and conditions.
- Medical Savings Account (MSA) plan that allows the beneficiary to enroll in a plan with a high deductible. After the deductible is met, the MSA plan pays providers. Money remaining in the MSA can be used to pay for future medical care, including some services not usually covered by Medicare Part A and Part B, such as dentures.

Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of both HI and SMI. These liabilities may be paid (1) by the Medicare beneficiary, (2) by a third party, such as an employer-sponsored retiree health plan or private "Medigap" insurance, or (3) by Medicaid, if the person is eligible. The term "Medigap" is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Part A or B of Medicare. These policies, which must meet Federally imposed standards, are offered by Blue Cross and Blue Shield (BC/BS) and various commercial health insurance companies.

Medicare offers prescription drug coverage that is voluntary to everyone with Medicare and the costs are paid for by the monthly premiums of enrollees and Medicare. This is called Medicare Part D. This coverage may help lower prescription drug costs and help protect against higher costs in the future.

In order to receive Medicare Part D, a beneficiary with Medicare Parts A and B must voluntarily enroll in a Prescription Drug Plan or Medicare Advantage plan with prescription drug coverage. These plans are approved and regulated by the Medicare program, but are actually administered by private health insurance companies.

Administration

Department of Health and Human Services (DHHS) has the overall responsibility for administration of the Medicare program. Within DHHS, responsibility for administering Medicare rests with the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA). The Social Security Administration assists, however, by initially determining an individual's Medicare entitlement, by withholding Part B premiums from the Social Security benefit checks of beneficiaries, and by maintaining Medicare data on the master beneficiary record, which is Social Security Administration's primary record of beneficiaries. The Internal Revenue Service in the Department of the Treasury collects the HI payroll taxes from workers and their employers.

PART V - MEDICAID

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 and is managed by the states. 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 establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and 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, Medicaid eligibility and/or services within a state can change during the year.

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; these groups are known as "categorically needy." The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which Federal matching funds are provided:

- Individuals whom meet the requirements for the Aid to Families with Dependent Children (AFDC) program, also known as Temporary Assistance for Needy Families (TANF);
- 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;
- 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;
- 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 under age 19, in families with incomes at or below the FPL.

States may also elect to provide Medicaid to "medically needy" persons. 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 a state-specified income level that would qualify them for Medicaid benefits.

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. A state may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services within its MN program. Currently, thirty-eight states have elected to have a MN program and are providing at least some MN services to at least some MN recipients. All remaining states utilize "special income level" options to extend Medicaid to the "near poor" in medical institutional settings.

Services Under Medicaid

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 basic services generally include services such as inpatient hospital services, outpatient hospital services, physician services, nursing facility services for persons aged 21 or older, rural health clinic services, home health care for persons eligible for skilled-nursing services, and laboratory and x-ray services.

States may also receive Federal-matching funds to provide certain optional services. The most common of the 34 currently approved optional Medicaid services are diagnostic services, clinic services, intermediate care facilities for the mentally retarded, prescribed drugs and prosthetic devices, transportation services, and rehabilitation and physical therapy services.

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 limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. The Medicare program pays for any services that are covered by Medicare 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 states' Medicaid programs. 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). According to CMS estimates, Medicaid currently provides some level of supplemental health coverage for 5 million Medicare beneficiaries within the above three categories.

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.

PART VI: KEY POINTS

The key points of this unit include the following:

- Social Security Disability Insurance (SSDI) provides benefits to individuals with disabilities or blind individuals who are "insured" by workers' contributions to the Social Security Trust Fund (FICA).
- To be eligible for SSDI the worker must have been employed and paid Social Security taxes for enough years to be covered under Social Security insurance, some of the taxes must have been paid in recent years, and an individual must be (1) the worker or the worker's adult child or widow(er), (2) considered medically disabled, and (3) not working or working but earning less than the substantial gainful activity (SGA) level;
- Title II of the Social Security Act authorizes SSDI benefits;
- The Supplemental Security Income Program (SSI) makes cash assistance payments to aged, blind and individuals with disabilities (including children under age 18) who have limited income and resources;
- Title XVI of the Social Security Act authorizes SSI benefits;
- Both SSDI and SSI define disability as the inability to engage in any Substantial Gainful Activity (SGA) because of a medically determinable physical or mental impairment(s), that can be expected to result in death, or that has lasted or that Social Security Administration can expect to last for a continuous period of not less than 12 months;
- Medicare is authorized by Title XVIII of the Social Security Act and covers most persons age 65 or over, along with persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise non-covered aged persons;
- Medicare consists of four parts: Hospital Insurance (HI), Part A; Supplementary Medical Insurance (SMI), Part B; private sector health care plans, Part C; and prescription drug benefits, Part D;
- Medicaid is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources;
- Beneficiaries of SSDI receive Medicare after a 24-month waiting period following their determination for eligibility.
- Beneficiaries of SSI receive Medicaid.
- Beneficiaries of SSDI who have demonstrated a financial need or a significant medical need and meet the eligibility requirements may also receive SSI.