From Expansion
Medicaid to Medicare

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• Centralized program managed within the Louisiana Department of Insurance/Office of Consumer Advocacy and Diversity and SHIIP
• Director and (3) statewide coordinators
• (8) Aging and Disability Resource Centers
• Federally Qualified Health Centers (FQHC’s)
• Vietnamese Initiative in Economic Training (VIET)
• 68 counselors statewide
• Governor’s Office of Elderly Affairs (GOEA) is MIPPA state lead
About Medicare Rights

❖ **National helpline:** Answers 20,000+ questions per year, with top issues affordability, appealing denials, and enrollment and coordination

❖ **Education:** Online resources receive 3 million visits per year, with training and certification offered to Medicare counselors nationally

❖ **Policy:** Array of materials influence Medicare policy, with a focus on defending Medicare and strengthening it for future generations
The project

❖ Medicare Rights worked in partnership and with funding from NCOA

❖ Surveyed Medicaid expansion states to learn how they help Medicaid expansion enrollees transition to other Medicaid programs, Medicare, and MSPs

❖ Looking for promising practices, challenges, themes, and trends
Why this matters

❖ Enrollment is one of the top issues on our helpline annually

❖ Many of our most intractable caller problems revolve around enrollment

❖ Delays in enrollment (or mistaken disenrollment) can lead to loss of or gaps in coverage, late enrollment penalties, and missed care
Types of transitions

❖ Adult Group Medicaid → Medicare + ABD Medicaid
❖ Adult Group Medicaid → Medicare + Medicare Savings Program (MSP)
❖ Adult Group Medicaid → Medicare only
About Medicaid expansion

❖ 32 states (including DC) expanded Medicaid eligibility to adults 19-64 (Adult Group Medicaid) under 138% of the federal poverty level (FPL), which is $16,753 in most states. Maine will make 33.

❖ A person cannot be dually enrolled in expansion Medicaid and Medicare…

❖ … so those who become eligible for Medicare must transition from one program to another
Financial help for people with Medicare

❖ 57 million Medicare beneficiaries

❖ Median Medicare income $26,200 in 2016, with bottom quartile below $15,250

❖ From the federal government: The Low-Income Subsidy (LIS)—also called “Extra Help”—assistance paying for the Medicare drug benefit

❖ From the state: Medicare Savings Programs—funded through Medicaid—assistance paying other Medicare costs
More on Medicare Savings Programs

❖ **Qualified Medicare Beneficiary (QMB):** Pays Medicare Part A and B premiums, deductibles and coinsurances or copays, usually <100% FPL

❖ **Specified Low-income Medicare Beneficiary (SLMB):** Pays Medicare’s Part B premium, usually 100-120% FPL

❖ **Qualifying Individual (QI) Program:** Pays Medicare’s Part B premium, usually 120-135% FPL
## Income and asset limits compared

<table>
<thead>
<tr>
<th>Program</th>
<th>Income limit</th>
<th>Asset limit</th>
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<tbody>
<tr>
<td>Adult Group</td>
<td>138% FPL ($1396/month)</td>
<td>None</td>
</tr>
<tr>
<td>ABD Medicaid*</td>
<td>73% FPL ($739/month)</td>
<td>$2000</td>
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<tr>
<td>QMB</td>
<td>100% FPL ($1012/month)**</td>
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* Aged, Blind, and Disabled Medicaid. States vary in their income limits for ABD Medicaid, but 73% of FPL is the most common.

** Several states have raised the income limits for MSPs.

*** Several states have eliminated the asset limit for MSPs.
The “Medicaid cliff”

- Medicaid historically has had no premiums or deductibles
- Medicare has monthly premiums and annual deductibles
- Switching from Medicaid to Medicare can be a major financial shock if there are no subsidies available
More on the “Medicaid cliff”

- Average out-of-pocket costs for Medicare enrollees excluding premiums = $3,024 per year ($252/month)
- With average premiums = $4,632 per year ($386/month)

“Medicaid cliff” example: Terry

- Terry has Adult Group Medicaid and is turning 65 in a month.
- His income is $804/month (80% of the FPL).
- If Terry spent the average on his Medicare expenses, he would have only $418/month left over for all other expenses.
“Medicaid cliff” example: Terry

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Big picture

❖ States that do not view this as a primary concern may not be willing to take steps to ease transitions, even when failing to do so may cause harm to beneficiaries, headaches for the state, and hassles for caseworkers and advocates

❖ Most interview subjects did not feel their states were doing a good job preparing Medicaid enrollees to transition to Medicare, or getting eligible Medicare enrollees into MSPs
Project methods

❖ Conducted initial online research into how and if states post information on Medicaid, Medicare, and MSPs

❖ Developed a short questionnaire through an iterative process with feedback from CMS, NCOA, and advocates

❖ Launched the survey and interview process

❖ Kept the survey in the field for six months
Who responded?

❖ Targeting all 31 expansion states (at that time), plus DC

❖ Good information from 22 states

❖ State employees, SHIP employees, and advocates all provided their unique perspectives
Who responded?

❖ One of the most exciting states is Louisiana
❖ From Louisiana’s information, we developed the “ideal” process map
“Ideal” process map

- State has process to ID enrollees approaching Medicare eligibility
- State evaluates eligibility for other programs including MSP & ABD Medicaid
- State only contacts enrollee for more information if necessary
- State mails notice & IDs other eligible programs if possible
- Individual transitions out of Adult Group Medicaid into Medicare
Promising practices

❖ Moving toward earlier identification of individuals approaching Medicare eligibility

❖ Providing pre-notice assessment (ex parte) of eligibility, ex parte redetermination, and assessment for eligibility via data match

❖ Eliminating asset test and increase income eligibility for MSPs
More promising practices

- Providing a soft transition landing while applications/determinations are pending
- Aligning redetermination schedules among multiple benefits
- Request advocate and consumer input on notices and incorporate feedback
And more promising practices

❖ Multiple types of applications

● One-stop/one-door multi-purpose applications, especially when applicant is not yet enrolled in any programs or when eligibility is unknown

● Targeted, streamlined applications for single programs when eligibility is known to avoid irrelevant information collection
Challenges

❖ Computer systems
  ● Combination of new and legacy systems causing incompatibility
  ● Systems with errors, missing data, or inadequate capabilities

❖ Lack of data on SSDI eligibility
More challenges

❖ Staffing, training, and state budgets
❖ Short redetermination periods
  ● Some states moving to 6 month cycles
❖ Notice issues
  ● Adequacy = Timeliness and readability
  ● Language access
Key takeaways

❖ The Adult Group program is in its infancy

❖ Some processes take a while to implement or perfect

  ● Computer systems in particular may be a matter of waiting out kinks under some circumstances

❖ Political uncertainty may be playing a role

  ● States that perceive expansion as temporary may not invest in finding solutions
For more information

❖ Read the issue brief at

https://www.ncoa.org/resources/toward-seamless-coverage/

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