Transitioning to Medicare from expansion Medicaid through the Marketplace – Frequently Asked Questions

1. What is Medicaid?

Medicaid is a low-cost federal health insurance program administered by states. It provides health insurance for individuals who have limited income and assets and
- Are 65 years or older
- Have certain disabilities
- Are blind
- Need long-term care
- Are in a medically needy category
- Are former foster care youth

Medicaid covers health care services such as inpatient and outpatient hospital services, physicians’ services, home health services, nursing facility services, and laboratory services, among others. Medicaid does not have a monthly premium, and individuals may pay a small deductible or copayment for care.

Most people with Medicare have Medicaid for the aged, blind, and disabled, which is known as ABD Medicaid or traditional Medicaid. The income limit for traditional Medicaid is generally 87% of the federal poverty level (FPL) and individuals can apply at their local Medicaid office.

2. What is expansion Medicaid?

Under the Affordable Care Act (ACA), some states expanded Medicaid income limits and the categories of people who can receive Medicaid benefits. Individuals enroll in expansion Medicaid through their state’s Marketplace, also known as an Exchange.

Expansion Medicaid covers individuals with incomes below 138% of the FPL who are
- Childless adults ages 19-64 (also called Adult Group)
- Pregnant
  - Income limits are higher for pregnant individuals
- Children up to age 19 (or 21, depending on the state)
- Parent and caretaker relatives

Financial eligibility for expansion Medicaid is determined by an individual’s modified adjusted gross income (MAGI) from their tax return and their household size. For individuals who do not file taxes, eligibility rules match those for tax filers to the maximum extent possible. Spouses, parents, stepparents, and children living together are included in the same household. Certain income is not counted when calculating expansion Medicaid eligibility, including veterans benefits, workers compensation, and child support. Resources/assets are not counted.

Individuals approved for expansion Medicaid may receive expansion Medicaid for up to a 12-month continuous coverage period.
3. How does traditional Medicaid compare to expansion Medicaid?

Individuals who are not part of the expansion Medicaid populations may be eligible for traditional Medicaid (see question 1). Traditional Medicaid is typically not overseen by the Marketplace. Rather, an individual generally receives traditional Medicaid through a local Medicaid office.

Traditional Medicaid eligibility requirements are stricter than those for expansion Medicaid. This means that people receiving expansion Medicaid may be found ineligible for traditional Medicaid when they become eligible for Medicare. Generally, individuals must have an income less than 87% of FPL (compared to 138% of FPL for expansion Medicaid eligibility) to qualify for traditional Medicaid. Resources/assets are counted, meaning there is an asset limit for traditional Medicaid.

Specific budgeting for traditional Medicaid may depend on state rules, and an individual should contact their local Medicaid office for more details.

4. What is Medicare? How does an individual know if they are eligible for Medicare?

Medicare is a federal program that provides health insurance for those who are 65 or older, those who are under 65 and have received Social Security Disability Insurance (SSDI) for a certain amount of time, and those who are under 65 with kidney failure requiring dialysis or transplant. Unlike Medicaid, Medicare does not have income limits.

When an individual turns 65, they are eligible for Medicare if
- They collect or qualify to collect Social Security or Railroad Retirement benefits
- **OR** they are a U.S. resident and either:
  - A U.S. citizen
  - **OR** a permanent U.S. resident having lived in the U.S. for five years in a row before applying for Medicare.

If an individual is under 65, they are eligible for Medicare if
- They are a U.S. citizen or a permanent resident
- **AND** they have lived in the U.S. for five years in a row
- **AND** they have been receiving Social Security Disability Insurance (SSDI) for more than 24 months.

Exception: If an individual has been diagnosed with amyotrophic lateral sclerosis (ALS), there is no waiting period, and they are eligible for Medicare when they start receiving SSDI.

If an individual has been diagnosed with End-Stage Renal Disease (ESRD), they are eligible for Medicare if
- They are getting dialysis treatments or have had a kidney transplant
- **AND** they or a family member have enough Medicare work history to qualify.

5. What do the different parts of Medicare cover? How much does Medicare cost?

Medicare benefits are administered through three parts:** Part A**(hospital/inpatient benefits), **Part B**(doctor/outpatient benefits) and **Part D**(prescription drug benefit). An individual can choose to get their Medicare benefits through Original Medicare or a Medicare Advantage Plan.
• Original Medicare is Medicare coverage through the federal government, and it includes Part A and Part B. An individual with Original Medicare usually gets their prescription drug coverage through a stand-alone Part D plan.

• Medicare Advantage Plans are provided by private insurance companies that contract with the federal government. Medicare Advantage Plans combine Part A, Part B, and usually Part D benefits in the same plan.

**Medicare Part A:** Part A covers inpatient hospital care, inpatient skilled nursing facility care, home health care, and hospice care. There is no Part A premium for individuals with 10 years of Social Security work history based on their or their spouse’s, ex-spouse’s, or deceased spouse’s work history. **Most individuals with Medicare do not pay a premium for Medicare Part A.** Individuals who do not meet the work requirement have to pay a Part A premium, which can be costly.

Regardless of an individual's eligibility for premium-free Medicare Part A, individuals will have to pay a deductible when they are admitted to the hospital, coinsurances for particular hospital days, and coinsurances for particular skilled nursing facility days.

**Medicare Part B:** Part B covers doctor services, including medically necessary outpatient care and preventive care. Medicare Part B also covers durable medical equipment (DME), home health care, X-rays, lab tests, ambulance services, therapy services (physical, occupational, speech), and mental health/substance abuse treatment. Medicare Part B has an annual deductible and a monthly premium, which may be higher for individuals with higher incomes. Typically Medicare pays 80% of the Medicare-approved amount for a doctor’s service, and the beneficiary pays 20% coinsurance.

Medicare does not cover most dental care, most vision care, routine hearing care, most foot care, most long-term care, alternative medicine, most care received outside the U.S., individual care or custodial care if an individual does not also need skilled care, and most non-emergency transportation.

**Medicare Advantage Plans:** MA Plans must cover everything that Original Medicare covers, but may have different costs and restrictions. Medicare Advantage Plans can also cover benefits not covered by Parts A and B, such as limited vision and dental services.

See questions 8 and 9 to learn about Part D plans.

**6. Can an individual have both Medicare and Medicaid? How do they work together?**

Yes. Someone with Medicare and Medicaid is known as a dual-eligible or dually eligible individual. Medicare acts as primary insurance to Medicaid, meaning Medicare pays first for care and Medicaid pays for remaining costs. Those transitioning from expansion Medicaid to Medicare (with or without traditional Medicaid) should understand coverage and cost differences between the two programs. For example, Medicare does not cover dental services but some state Medicaid programs do. See question 8 to learn about how Part D works with Medicaid.

**7. What are Medicare Savings Programs (MSPs)?**

Medicare Savings Programs are Medicaid-administered benefits that help pay Medicare costs for beneficiaries with limited incomes. There are four different types of MSPs: **Qualifying Individual (QI), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Medicare Beneficiary (QMB),** and **Qualified Disabled Working Individual (QDWI).** Note that QDWI will not be discussed.
in this FAQ, but individuals can find more information here:

Each MSP has its own baseline eligibility level set by the federal government. Eligibility
determinations typically involve counting an individual’s income and assets/resources, but states can
choose to have more generous eligibility requirements than those set forth by the federal government.
For instance, some states have higher income eligibility thresholds, and some states do not have asset tests.

**QI, SLMB, and QMB** cover the cost of the monthly Part B premium, can be used to enroll in Part B
outside of a formal enrollment period, and eliminate a beneficiary’s Part B late enrollment penalty if they have one. Additionally, all MSPs automatically enroll an individual in Extra Help, a federal benefit that helps with prescription drug costs (see question 8).

In addition, the **QMB** MSP, which is the most generous of the three, pays for Medicare coinsurances
and deductibles, provides protections against being billed for Medicare-related costs, and may help
enroll an individual in premium-free Part A.

**8. How does Medicare Part D work with Medicaid? How does Extra Help assist with drug coverage?**

Once an individual with Medicaid has Medicare, they will receive most of their prescription drugs through their Medicare Part D plan. Part D covers prescription medications at a pharmacy or through a mail-order service.

**Part D enrollment:** Individuals who are Medicare-eligible and do not have creditable drug coverage should enroll in a Part D drug plan. **Creditable coverage is coverage that is as good as or better than Medicare prescription drug coverage.** Creditable coverage is typically provided through an employer health plan, union plan, or retiree plan. If an individual misses their initial opportunity to enroll in Part D and does not have creditable drug coverage, they may have a gap in coverage when they do sign up, and they may face a late enrollment penalty.

**Part D costs and Extra Help:** Medicare Part D is administered through private drug plans. Each plan has its own premium costs, formularies (list of drugs a plan covers), and coverage restrictions, as well as a deductible in some cases. The Extra Help program (also known as the Low-Income Subsidy [LIS]) assists with an individual’s prescription drug costs.

Extra Help is a federal benefit administered by the Social Security Administration (SSA), and it helps cover the cost of an individual’s Part D premium, copayments, and deductible, if the plan has a deductible. Extra Help also provides individuals with a Special Enrollment Period (SEP), allowing them to change their drug coverage up to once a month. Extra Help also permanently eliminates an individual’s Part D late enrollment penalty, if they have one.

**Extra Help eligibility and enrollment:** If an individual is enrolled in Medicaid, Supplemental Security Income (SSI), and/or a Medicare Savings Program, they automatically qualify for **Extra Help.** If an individual is not enrolled in one of these programs, they will have to fill out an application through SSA. They can do so by calling an SSA office to have an application mailed to them, visiting the SSA website to access the online application, or visiting a local SSA office in person.
Extra Help has both income and asset eligibility limits. Depending on their income and assets, an individual may qualify for either full or partial Extra Help. With either level of benefit, an individual will never have to pay the full cost of their drugs as long as they take medications on their Part D plan’s formulary and get them at a pharmacy in their plan’s network.

9. If an individual has Medicare and Medicaid, will they have to actively enroll in a Part D plan?

Most dually eligible individuals who do not have a Part D plan will automatically be enrolled in a Part D plan once they have Extra Help. Individuals should review their Part D plan to make sure it covers their drugs, since the plan they are automatically enrolled in may not meet their coverage needs. Individuals with Extra Help can change their Part D coverage on a monthly basis if they so choose (see question 8).

For Extra Help to fully cover the Part D premium, the individual must choose a plan that offers basic coverage and has a premium at or below the Extra Help premium amount for their state.

Note that if an individual has Medicaid and certain kinds of employer, union, or retiree prescription drug coverage, they will not be automatically enrolled in a Part D plan. If they will lose their retiree or union health coverage by enrolling in a Part D plan, they may not want to take Medicare drug coverage. An individual should speak with their benefits administrator to learn how their prescription drug coverage may or may not be affected by Medicare Part D.

10. What happens if an individual has expansion Medicaid and becomes Medicare-eligible?

When an individual with expansion Medicaid becomes Medicare-eligible, they should be evaluated for traditional Medicaid and a Medicare Savings Program. Remember, an individual with Medicare cannot have expansion Medicaid. Transitions from expansion Medicaid to Medicare will often look different from transitions for those with traditional Medicaid and Medicare because the Marketplace may be involved. In addition, as discussed in question 3, the budgeting limits for expansion Medicaid are more generous than the limits for traditional Medicaid, so it is possible that an individual with expansion Medicaid will not be eligible for traditional Medicaid—though they may be eligible for an MSP to help with costs.

The timing and agency involved in evaluating an individual for traditional Medicaid and an MSP depends on the state. Individuals may be evaluated for traditional Medicaid at their expansion Medicaid renewal date, or they may be evaluated for traditional Medicaid as soon as they become Medicare-eligible.

Regardless of evaluation status, when an individual has expansion Medicaid and becomes Medicare-eligible they should enroll into Medicare Parts A and B since Medicare is primary and Medicaid is secondary. Depending on their income and assets, the individual may automatically receive full Extra Help, which will automatically enroll them in a Medicare Part D drug plan with a premium below the Extra Help subsidy amount.

11. What happens when an individual’s expansion Medicaid ends?

Before an individual is evaluated for traditional Medicaid, they should receive notices from their Marketplace, local Medicaid office, or other agency about the process. These notices may look like Medicaid renewal notices. Individuals should ask their Marketplace or Medicaid office if they need to complete additional paperwork to be evaluated for traditional Medicaid and an MSP. The specific
paperwork and agency involved in the transition vary depending on the state. All paperwork should be completed by the individual, caregiver, or professional to ensure that the individual is evaluated for traditional Medicaid. Once this paperwork is received, the individual's case should be transitioned to the proper state agency to be processed.

Individuals may be able to receive state reimbursement for their Part B premiums while they transition. Individuals can confirm specific rules with their state Marketplace.

After completing the necessary steps, individuals will be evaluated for traditional Medicaid and an MSP. Individuals should ask their Marketplace whether their expansion Medicaid benefits will be continued (known as continuation of benefits) while their case is being evaluated.

Individuals should receive information from their local Medicaid office about whether they are eligible for traditional Medicaid and/or an MSP.

12. What are the possible outcomes for individuals transitioning from expansion Medicaid to Medicare?

For individuals becoming Medicare-eligible who are no longer eligible for expansion Medicaid, possible outcomes are:

1. Transition from expansion Medicaid to Medicare with traditional Medicaid and a Medicare Savings Program
2. Transition from expansion Medicaid to Medicare with an MSP and without traditional Medicaid
3. Transition from expansion Medicaid to Medicare without traditional Medicaid or an MSP
4. In limited circumstances, receive Medicare and remain in Expansion Medicaid

13. What happens if an individual with expansion Medicaid is found eligible for traditional Medicaid and an MSP?

If an individual is determined eligible for traditional Medicaid and an MSP by their local Medicaid office, Medicare will pay primary on claims and Medicaid will pay secondary. The individual will have additional coverage of services that are not covered by Medicare but are covered by Medicaid (see question 6). The individual should be sure to see providers who accept both Medicare and Medicaid in order to have the best coverage of services.

If the individual is also found eligible for an MSP, they will not have to pay their monthly Part B premium, and they may receive assistance with their Part A premium (if applicable) and Medicare cost-sharing. Individuals who are found eligible for an MSP will be automatically enrolled in Extra Help, which helps cover the cost of an individual's Part D premium, copayments, and deductible, if the plan has a deductible.

14. What happens if an individual with expansion Medicaid is found ineligible for traditional Medicaid and is found eligible for an MSP?

Individuals found ineligible for traditional Medicaid will no longer have Medicaid benefits. In many cases, Medicare may be the individual's only health insurance. The individual may lose coverage of services that only Medicaid covers (depending on the state), like certain vision and dental care.
Individuals in this situation may want to consider enrollment in a Medicare Advantage Plan that covers some of the services Medicare does not cover. Beneficiaries may also wish to consider supplemental coverage to assist with Medicare cost-sharing.

If an individual is in need of Medicaid, they can also speak to their local Medicaid office to see if there is a Medicaid spend-down option in their state (note that not all states have a spend-down). This would allow them to spend down their income by either submitting medical bills or paying Medicaid directly in order to meet the Medicaid income eligibility requirements.

If an individual is found eligible for an MSP, they will not have to pay their monthly Part B premium and may receive additional help paying for Medicare cost-sharing. Individuals who are found eligible for an MSP will be automatically enrolled in Extra Help, which helps cover the cost of an individual's Part D premium, copayments, and deductible, if the plan has a deductible.

15. What happens if an individual with expansion Medicaid is found ineligible for traditional Medicaid and ineligible for the MSP?

Individuals found ineligible for traditional Medicaid will no longer have Medicaid benefits. In many cases, Medicare may be the individual's only health insurance. The individual may lose coverage of services that only Medicaid covers (depending on the state), like certain vision and dental care.

Individuals in this situation may want to consider enrollment in a Medicare Advantage Plan that covers some of the services Medicare does not cover. Beneficiaries may also wish to consider supplemental coverage to assist with Medicare cost-sharing.

If an individual needs Medicaid, they can also speak to their local Medicaid office to see if there is a Medicaid spend-down option in their state (note that not all states have a spend-down). This would allow them to spend down their income by either submitting medical bills or paying Medicaid directly in order to meet the Medicaid income eligibility requirements.

Without Medicaid or an MSP, an individual is responsible for all Medicare cost-sharing unless they choose to enroll in supplemental insurance options and/or charity care. They are also responsible for paying the monthly Part B premium. The individual may qualify for Extra Help, which helps cover the cost of an individual's Part D premium, copayments, and deductible, if the plan has a deductible. They will not be enrolled automatically, and will have to actively apply. If the individual does not qualify for Extra Help, then they will also be responsible for their Part D costs.

16. When can an individual with Medicare continue to receive expansion Medicaid? What happens in this situation?

In limited circumstances, individuals may be able to keep expansion Medicaid while having Medicare as their primary insurance. In order for this to occur, the beneficiary must be a parent/relative caretaker. In these instances, the beneficiary may be able to continue to receive expansion Medicaid through the Marketplace and will therefore most likely be reimbursed for the Part B premium through their state. An individual in this situation should contact their Marketplace or local Medicaid office to learn more.

17. Who does an individual need to contact when transitioning to Medicare?
We encourage individuals to be proactive during this process to make sure that everything is working the way it should. Individuals can ask their Marketplace, Medicaid office, or other agency clarifying questions, since some states may operate differently from others. Some questions one can ask include the following:

- When will the individual be evaluated for traditional Medicaid and an MSP?
- Does the individual have to actively request/complete any materials to be evaluated for traditional Medicaid and an MSP? What sort of materials should the individual expect to receive about the evaluation process?
- Is the individual eligible to receive reimbursement for Medicare Part B premiums through their state while transitioning from expansion Medicaid to Medicare? Do they have to actively request reimbursement?
- If the individual is currently receiving expansion Medicaid through a Medicaid managed care plan, do they have to actively disenroll from it and enroll in traditional Medicaid?
- Has the individual been or will they be auto-enrolled into Extra Help and a Part D plan?

18. Which services are covered by expansion Medicaid but not by Medicare, and how might gaps be filled?

Medicaid may provide coverage for services that Medicare does not cover, such as dental care, vision care, and/or long-term care. Individuals should ask their Marketplace about the specific services covered by expansion Medicaid that are not covered by Medicare.

The first way to fill potential coverage gaps is to be evaluated for traditional Medicaid and a Medicare Savings Program (see question 7). If ineligible for these programs, individuals may want to consider a Medicare Advantage Plan, a supplemental plan, and/or charity care.

19. Does an individual who has transitioned from expansion Medicaid to Medicare have to do anything to make sure their drug coverage is working?

As described in questions 8 and 9, it is important to find out if the individual has been or will be auto-enrolled in Extra Help and a Part D plan. Typically, dually eligible individuals are auto-enrolled in a Part D plan and will receive notices about this from Social Security. Individuals should review their Part D plan options if they are auto-enrolled, because automatic enrollment does not always pick the best option for the individual. Remember that individuals with Extra Help have a continuous Special Enrollment Period (SEP) and can change their Part D coverage on a monthly basis.

20. How will an individual’s access to care change after their transition from expansion Medicaid?

It is important to make sure that the beneficiary sees providers who accept Medicare. Once an individual has Medicare, Medicare will pay primary. This means that if they see providers who do not accept Medicare, they may have to pay out of pocket for care. If the individual is also eligible for traditional Medicaid, they should see providers who accept both Medicare and Medicaid in order to pay the least for their care. Medicare is always primary to Medicaid, but if a service is not covered by Medicare, Medicaid might pay.

21. Should an individual consider managed care?

Depending on where an individual lives, they may be able to enroll a Medicare Advantage Plan, a managed care plan that covers both Medicare and Medicaid services, or other sorts of managed care.
plans. Managed care plans are offered through private health insurance companies. These plans may offer greater care coordination. If an individual wishes to learn more about their options, they can call their State Health Insurance Assistance Program (SHIP) to find out what is available to them (https://www.shiptacenter.org/).

If an individual has Medicare and Medicaid and is in need of long-term care services, they may live in an area where managed care is required. SHIPs can also counsel on this topic.

22. Where can I find more information about transitions from expansion Medicaid to Medicare?

Learn more about this topic and/or receive additional assistance by contacting:

- Local State Health Insurance Assistance Program (SHIP)
  - www.shiptacenter.org
  - www.eldercare.gov
- Social Security Administration
  - 800-772-1213
  - www.ssa.gov
- Medicare
  - 1-800-MEDICARE (1-800-633-4227)
  - www.medicare.gov
- Medicare Rights Center
  - 800-333-4114
  - www.medicareinteractive.org
    - Web-based Medicare compendium and counseling resource developed and maintained by the Medicare Rights Center; receives more than two million visits annually
- National Council on Aging
  - www.ncoa.org
  - www.centerforbenefits.org
  - www.mymedicarematters.org
  - www.benefitscheckup.org