



A Bridge to Health:

Ensuring Seamless Transitions from Health Insurance Exchanges and Medicaid to Medicare

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Abstract

As states and the federal government implement the Affordable Care Act of 2010 (ACA), including expanding the Medicaid program and offering new qualified health plans through exchanges, they must develop a thoughtful and comprehensive plan to ensure that newly insured individuals have seamless health coverage as they transition to Medicare. Without such a plan, these consumers could face gaps in coverage, avoidable out-of-pocket health care costs, unnecessary premiums or premium penalties for late enrollment in Medicare. This could lead to interruptions in health care and strains on individual and family financial resources, especially for those with lower or middle incomes. Medicaid consumers face particular hurdles as they will need a re-determination of their Medicaid eligibility and assistance enrolling in other subsidy programs as they enroll in Medicare. Fortunately, there are steps states and the federal government can take to mitigate potential transition problems.

Overview

Many talk of the Affordable Care Act of 2010 (ACA) having created a solid three-legged stool of American health insurance, with the legs consisting of: expanded Medicaid, new qualified health plans available through the exchanges, with premium and cost-sharing subsidies for those who qualify, and existing employer-based coverage. However, this vision of a three-legged stool leaves out a critical part, or leg, of the American system – Medicare. Perhaps a four-legged chair is the better analogy.

Beginning in 2014, Americans who have health coverage as a result of the ACA and become eligible for Medicare will face transitions to Medicare that have never before occurred. As states and the federal government implement the ACA, by expanding the Medicaid program, offering new qualified health plans through exchanges and introducing simplified application, eligibility and enrollment processes, it is critical to develop a thoughtful and comprehensive plan that ensures seamless health coverage for consumers.

In order to provide seamless coverage to all Americans, we must ensure that people who experience changes in their circumstances can transition easily to Medicare. Seamlessness is especially important for those with low-incomes as the ACA will expand eligibility for the non-Medicare population for Medicaid but not for those with Medicare. Some of those losing ACA-expanded Medicaid coverage will still qualify for Medicaid through existing, more restrictive eligibility categories. Others will not, and they will need help accessing Medicare subsidy programs.

Although some transition issues affect all groups, states and the federal government should focus their attention on three specific groups of people, each presenting some unique challenges:

- Consumers enrolled in qualified health plans becoming Medicare-eligible will need to enroll in Medicare and disenroll from their plan at the appropriate time. If

the effective date of Medicare and the termination date of qualified health plan coverage are not properly timed, consumers could face gaps in coverage, Medicare late enrollment penalties or responsibility for paying both qualified health plan and Medicare premiums. Consumers who are receiving premium tax credits and other cost-sharing subsidies to purchase a qualified health plan will need to know the rules that apply to termination of subsidies, which are different from those regarding termination of the plan itself. In addition, some of these consumers may be eligible for limited assistance with Medicare costs under existing Medicare subsidy programs and will need help understanding and enrolling in them.

- Consumers with Medicaid as expanded by the ACA who are no longer eligible for Medicaid upon becoming eligible for Medicare will need to navigate the enrollment processes for both Medicare and Medicare subsidy programs. For example, they may be able to enroll in the Medicare Savings Programs (MSPs) that help people pay for some Medicare costs or in the Low-Income Subsidy (LIS) program, which helps those who are financially eligible pay for costs under the Medicare prescription drug benefit.
- A smaller population eligible for expanded Medicaid under the ACA may still qualify for full Medicaid benefits under the existing, more restrictive Medicaid eligibility rules that apply when they become Medicare-eligible. These vulnerable individuals are at particular risk of a disruption in coverage and care if they are required to navigate the existing, more complicated pre-ACA Medicaid application, determination and enrollment processes.

To prepare for 2014, state and federal agencies need to consider how eligibility rules and enrollment systems applicable to people eligible for Medicare correspond to new rules and systems developed for the non-Medicare population under the ACA. This includes ensuring that people new to Medicare are able to access all benefits to which they are entitled, including Medicaid. To avoid confusion and disruptions for those new to Medicare, the federal government, states, insurers and exchanges can build on policies included in the ACA and other programs that are meant to streamline and facilitate benefit enrollment. Policies that could help ensure more seamless transitions to Medicare include:

- aligning and simplifying financial eligibility rules, such as income limits and asset thresholds, between ACA-expanded Medicaid for those not yet eligible for Medicare, premium tax credits and cost-sharing subsidies, Medicaid programs for Medicare beneficiaries and Medicare subsidy programs;
- aligning and simplifying application and renewal rules and processes among qualified health plans, ACA-expanded Medicaid, Medicaid programs for Medicare beneficiaries and Medicare subsidy programs;

- utilizing electronic data-sharing to automatically verify eligibility and facilitate enrollment into non-ACA Medicaid and Medicare subsidy programs as an individual becomes eligible for Medicare;
- modernizing eligibility determination and enrollment systems for all Medicaid populations; and
- using education, outreach and notices to provide accurate, easily-understood and timely information about enrollment obligations, eligibility guidelines and available benefits.

By pursuing these reforms and recommendations, states and the federal government can help ensure that consumers with ACA related coverage do not experience gaps in coverage, penalties or other avoidable out-of-pocket costs upon becoming eligible for Medicare.

New Coverage Beginning in 2014

Expanded Medicaid and premium tax credits and cost-sharing subsidies to purchase qualified health plans offered through exchanges

In 2014, pursuant to the ACA, state Medicaid programs may increase their income eligibility thresholds for people under age 65 or otherwise ineligible for Medicare, providing Medicaid to those with incomes up to 138 percent of FPL.¹ States will also be required to eliminate any asset or resource test and use a modified adjusted gross income (MAGI) calculation to determine income, which is a departure from the existing complicated net income test.² All of these measures will significantly expand the number of people eligible for Medicaid and will simplify and streamline the enrollment and renewal processes in order to ensure that those who are Medicaid-eligible get and stay enrolled.³

In addition, the ACA authorizes the creation of state health insurance exchanges for people who do not have other insurance available to them.⁴ These exchanges will act as marketplaces to enroll in Medicaid or purchase coverage through a number of private insurance products known as qualified health plans. In order to make qualified health plans affordable, the ACA provides premium tax credits to eligible individuals and

¹ P.L. 111-148 § 2001, § 2002. Income limit includes a 5% automatic income disregard which effectively extends eligibility to 138% FPL; *United Federation of Independent Business v. Sebelius*, 576 U.S. ____ (2012) (Although the Federal government cannot compel states to expand their Medicaid programs at the peril of losing all Federal Medicaid funding, states may enact the Medicaid income expansion changes and must enact other changes such as the elimination of the asset test as outlined in the ACA).

² *Id.*

³ John Holahan and Irene Headen, [Medicaid Coverage and Spending in Health Reform: National and State - by - State Results for Adults at or Below 133% FPL](http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf) (Menlo Park, Calif: Kaiser Family Foundation, May 2010), <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>.

⁴ P.L. 111-148 § 1301, §1311.

families with incomes between 138 percent and 400 percent of FPL.⁵ In addition to premium credits, the ACA creates cost-sharing subsidies for eligible individuals.⁶ The same MAGI calculation used to determine income eligibility for expanded Medicaid under the ACA will be used to determine eligibility for premium tax credits and related subsidies for qualified health plans.⁷

Eligibility determination and enrollment processes for coverage available under the Affordable Care Act

For those eligible to enroll in Medicaid or to purchase qualified health plan coverage and receive premium tax credits and subsidies, the ACA provides for a streamlined and mostly automated eligibility determination and enrollment process.⁸ Specifically, the statute and regulations require that there be “no wrong door” to coverage, meaning that individuals can simultaneously apply for Medicaid and premium tax credits and related subsidies to purchase a qualified health plan using a single, simplified application.⁹ Further, individuals applying for either Medicaid or a qualified health plan and related premium tax credits and subsidies must be able to submit their applications online, in-person, by telephone and by mail.¹⁰ The regulations also require states to accept electronic signatures on applications.¹¹

⁵ P.L. 111-148 §1401 as modified by P.L. 111-152 §1001. This paper does not discuss those individuals who have lived in the U.S. for less than five years and may be eligible for subsidies between 100% and 138% FPL.

⁶ P.L. 111-148 § 1402 as modified by P.L. 111-152 §1001.

⁷ P.L. 111-148 § 1401 as modified by P.L. 111-152 § 1004.

⁸ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* 17144 (March 23, 2010) (to be codified at 42 CFR Parts 431, 435, and 457); Establishment of Exchanges 77 *Fed. Reg.* 18310 (March 27, 2012) (to be codified at 45 CFR Parts 155, 156, and 157); Beth Morrow and Julia Paradise, [*Explaining Health Reform: Eligibility and Enrollment Processes For Medicaid, CHIP and Subsidies in the Exchanges*](#) (Menlo Park, Calif: Kaiser Family Foundation, August 2010), <http://www.kff.org/healthreform/upload/8090.pdf>; MaryBeth Musumeci, Samantha Artiga and Robin Rudowitz, [*Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's August 17, 2011 Proposed Rule and Key Issues to Consider*](#) (Menlo Park, Calif: Kaiser Family Foundation, October 2011), <http://www.kff.org/medicaid/upload/8254.pdf>.

⁹ P.L. 111-148 § 1413; Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17163-17165, 17208 (to be codified at 42 CFR 435.907); Establishment of Exchanges, 77 *Fed. Reg.* at 18454 (to be codified at 45 CFR 155.310); State Health Reform Assistance Network, [*Overview of Final Medicaid Eligibility Regulation*](#) (Princeton, New Jersey: Robert Wood Johnson Foundation, April 2012), <http://www.rwjf.org/files/research/74164.5783.overviewoffinal.2012.april.pdf>; State Health Reform Assistance Network, [*Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011*](#) (Princeton, New Jersey: Robert Wood Johnson Foundation, September 2011), <http://www.rwjf.org/files/research/72795manattregulations20110902.pdf>; T. S. Jost, [*Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*](#) (New York: The Commonwealth Fund, September 2010).

¹⁰ P.L. 111-148 § 1413; Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17163-17165, 17208 (to be codified at 42 CFR 435.907) ; Establishment of Exchanges, 77 *Fed. Reg.* at 18454 (to be codified at 45 CFR 155.310); State Health Reform Assistance Network, [*Overview of Final Medicaid Eligibility Regulation*](#); State Health Reform Assistance Network, [*Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011*](#).

¹¹ *Id.*

To further ease application procedures and encourage electronic applications, the ACA and related regulations allow self-attestation of income and other information and robust data-matching to verify such eligibility information.¹² The use of electronic application processes and data-sharing is intended to allow for real-time eligibility determinations and enrollments, eliminating the need for applicants to provide paper or other additional documentation to prove the accuracy of information provided.¹³ Regulations implementing the ACA envision a “federal hub” that will share information among states, exchanges, the Social Security Administration (SSA), the Internal Revenue Service, the Department of Treasury, the Department of Homeland Security, the Department of Health and Human Services (HHS) and any other appropriate agencies.¹⁴ In order to facilitate enrollment, states are encouraged to apply for, and have been provided with, millions of dollars in federal funding to modernize the state-based information technology systems used to determine eligibility and process enrollments. This system modernization is necessary for state agencies and their contractors to accept electronic applications and increase their capacity to share data necessary for verifying applicants’ information.¹⁵ Additional documentation will only be required from applicants if the information yielded through the data verification process is not deemed “reasonably compatible.”¹⁶

In addition to these simplifications, individuals who are found to be eligible for or enrolled in Medicaid will benefit from a mostly administrative renewal process.¹⁷

¹² P.L. 111-148 § 1413; Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17171-17180, 171965, 17196, 17211, 17212 (to be codified at 42 CFR 435.940, 435.945, 435.948, 435.949, 435.952, and 435.956); Establishment of Exchanges 77 *Fed. Reg.* at 1837-18362 18436, 18455-18458 (to be codified at 45 CFR 155.315, 155.320).

¹³ P.L. 111-148 § 1411, 1413, 1561; Deborah Bachrach, Patricia Boozang and Melinda Dutton, [Medicaid’s Role in the Health Benefits Exchange: A Road Map for States](#) (Portland, Maine: National Academy for State Health Policy, March 2011); Jost, [Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues](#).

¹⁴ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at, 17172 (to be codified at 42 CFR 435.949); Establishment of Exchanges 77 *Fed. Reg.* at 18455 (to be codified at 45 CFR 155.315); State Health Reform Assistance Network, [Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011](#); State Health Reform Assistance Network, [Overview of Final Medicaid Eligibility Regulation](#).

¹⁵ Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, 76 *Fed. Reg.* 21950 (April 19, 2011)(to be codified at 42 CFR pt. 433); Centers for Medicare & Medicaid Services, [Guidance for Exchange and Medicaid Information Technology \(IT\) Systems: Version 2.0](#) (CMS, May 2011), http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf.

¹⁶ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17171,17172,17175,17179, 17211, 17212 (to be codified at 42 CFR 435.948, 435. 949, 435.952, and 435.956); Establishment of Exchanges 77 *Fed. Reg.* at 18359-18370, 18451, 18455-18458 (to be codified at 45 CFR 155.300, 155.315, and 155.320); State Health Reform Assistance Network, [Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011](#); Musumeci et. al., [Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS’s August 17, 2011 Proposed Rule and Key Issues to Consider](#); State Health Reform Assistance Network, [Overview of Final Medicaid Eligibility Regulation](#).

¹⁷ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17180-17184, 17210 (to be codified at 42 CFR 435.916); State Health Reform Assistance Network, [Overview of](#)

Existing Medicaid law requires Medicaid eligibility to be re-determined at least annually.¹⁸ Under regulations, states will be required to use existing databases and systems to determine whether there have been changes in an enrollee's circumstances.¹⁹ If existing data shows an enrollee to be still-eligible, states will send a notice informing about the determination, requiring the enrollee to contact the state only if the information on file is incorrect as a result of a change in circumstances.²⁰ If no change has occurred, the enrollee will be automatically re-enrolled without need for further action.²¹

To help individuals who are eligible for coverage under the ACA navigate their insurance options, the ACA creates two education and outreach programs. First, states will receive federal funding to establish Patient Navigator Programs. Navigators, thereafter funded and operated through exchanges, will help individuals choose and enroll in qualified health plans. Navigators will also need knowledge about Medicaid in order to appropriately counsel consumers who contact the exchange and, in certain states, they may make Medicaid eligibility determinations for those who qualify for expanded Medicaid under the ACA.²² The ACA also provides funding to establish federally and/or independently funded Consumer Assistance Programs that will work with navigators to help provide broader information and assistance regarding coverage.²³

Coverage and Subsidy Programs for Medicare Eligible Individuals Now and After 2014

Income and asset criteria for Medicaid and subsidy programs for low and middle income Medicare eligible individuals

People eligible for Medicare, regardless of whether their eligibility is the result of age or disability, are excluded from the application of the more generous income threshold, the elimination of the asset test and the simplified MAGI income calculation required by the

Final Medicaid Eligibility Regulation; State Health Reform Assistance Network, [Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011](#). Those eligible for premium tax credits and related subsidies are also subject to redeterminations. However, unlike Medicaid renewals, individuals eligible for premium tax credits and related subsidies must sign and return a renewal form.

¹⁸ 42 C.F.R. § 435.916.

¹⁹ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17180-17184, 17210 (to be codified at 42 CFR 435.916); State Health Reform Assistance Network, [Overview of Final Medicaid Eligibility Regulation](#); State Health Reform Assistance Network, [Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011](#).

²⁰ *Id.*

²¹ *Id.* The renewal process for subsidies related to qualified health plans requires individuals to take more action.

²² P.L. 111-148 § 1002, 1311; Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* 17187, 17202, 17203 (to be codified at 42 CFR Parts 431.10 and 431.11); Sara Rosenbaum, [State Health Insurance Exchange Navigators](#) (Washington, D.C.: George Washington University's Hirsh Health Law and Policy Program, February, 2011), <http://www.healthreformgps.org/resources/state-health-insurance-exchange-navigators/>.

²³ Community Catalyst, [Navigators: Guiding People through the Exchange](#) (Boston, Massachusetts: Community Catalyst, June 2011), http://www.communitycatalyst.org/doc_store/publications/Navigators_June_2011.pdf.

ACA to determine Medicaid eligibility.²⁴ In addition, under the ACA, people eligible for Medicare are not eligible for premium tax credits and other subsidies for qualified health plans (as detailed below on p. 12).²⁵ Consequently, in and after 2014, people eligible for Medicare will remain subject to current eligibility criteria for Medicaid and Medicare subsidy programs.

Generally, a Medicare beneficiary may qualify for Medicaid under state Aged, Blind and Disabled programs if he or she maintains an income at or below 75 percent of FPL and has assets at or below \$2,000 for individuals and \$3,000 for couples.²⁶ These are the same eligibility thresholds that apply to the Supplemental Security Income (SSI) program, though some states maintain eligibility criteria that are more or less generous than the SSI standard.²⁷ Medicare beneficiaries may also be eligible for Medicaid through a medically needy or spend-down pathway, which allows individuals to “spend down” by subtracting medical expenses from their income to meet the medically needy or spend-down threshold.²⁸ Other Medicare eligible individuals may qualify for Medicaid through eligibility guidelines developed for Medicaid long-term services and supports programs (home and community-based service waivers or special rules for nursing home residents.)²⁹ For states that align their Medicaid Aged, Blind and Disabled eligibility rules with the SSI eligibility rules and enter into agreements with SSA, SSA may auto-enroll SSI-eligible individuals into state Medicaid programs.³⁰

In addition to the Medicaid programs described above, there are other benefits that help Medicare beneficiaries with limited incomes afford out-of-pocket costs under Medicare. These include Medicare Savings Programs (MSPs) and the Low-Income Subsidy (LIS). States administer MSPs through Medicaid to help people with limited incomes pay for their out-of-pocket Medicare costs.³¹ There are three main programs, and each has different income eligibility limits.³² The Qualified Medicare Beneficiary (QMB) program

²⁴ P.L. 111-148 § 2001, § 2002. Other categories of individuals are also excluded from the MAGI calculation, but are not the subject of this paper.

²⁵ P.L. 111-148 §1401(c)(2)(B).

²⁶ 42 CFR 435.120; 42 CFR 435.121 Henry J. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities* (Menlo Park, Calif.: Kaiser Family Foundation, February 2010), <http://www.kff.org/medicaid/upload/8048.pdf>.

²⁷ SSA § 1902(r)(2); 42 CFR 435.120; 42 CFR 435.121; Henry J. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities*. States have the flexibility to raise income limits for this population by increasing income thresholds up to 100% FPL. States can also increase asset disregards thereby increasing or eliminating asset limits. In addition, certain states, known as 209(b) states are permitted to have income and asset requirements that are less generous than SSI. All 209(b) states must allow persons to spend-down to state’s the income threshold for Aged Blind and Disabled Medicaid.

²⁸ Henry J. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities*.

²⁹ States can set their income thresholds for nursing home Medicaid at up to 300% the SSI level. *Id.*

³⁰ 42 CFR 435.120. In states with a 1619 Agreements with SSA, an SSI application also serves as an application for Medicaid.

³¹ Henry J. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities*.

³² Kim Glaun, *Streamlining Medicare and OMB Enrollment for New Yorkers: Medicare Part A Buy-In Analysis and Policy Recommendations* (New York: Medicare Rights Center, February 2011),

is the most generous MSP, paying for the Medicare Part A premium (if an individual does not have the requisite work history for premium free Part A) and Part B premium, as well as Parts A and B deductibles and coinsurance. The Specified Low-income Medicare Beneficiary (SLMB) and Qualifying Individual (QI) MSPs pay the Medicare Part B premium only.³³ Federal law requires that states set the following eligibility guidelines: QMB to those with incomes at or below 100 percent of FPL; SLMB to those with incomes between 100 percent and 120 percent of FPL; QI to individuals with incomes between 120 percent and 135 percent of FPL; and an asset limit of \$7,080 for individuals or \$10,620 for couples.³⁴ While many states use the federal eligibility thresholds, states have the option of increasing income and asset limits or eliminating asset limits altogether, and some do so.³⁵

The full LIS program helps to pay costs associated with Medicare prescription drug coverage, such as premiums and drug co-payments or co-insurance. In order to receive full LIS, an individual must first be enrolled in either Medicare Part A or Part B (or both) and have an income at or below 135 percent of FPL with assets not exceeding \$8,580 for individuals or \$13,620 for couples.³⁶ Some individuals may also be eligible for partial LIS that offers a sliding scale of assistance with Part D plan premiums and a set rate of cost-sharing. To qualify for partial LIS in 2013, individuals must have had incomes between 136 percent and 150 percent of FPL with assets not exceeding \$11,800 or, for couples, assets not exceeding \$23,580.³⁷

<http://www.medicarerights.org/pdf/Part-A-Buy-In-Analysis.pdf>. If you do not have Part A but meet QMB eligibility guidelines, your state will have a process to allow you to enroll in Part A and QMB. Many states allow this throughout the year, but others limit when you can enroll in Part A.

³³ Medicare Interactive, [Could I be eligible for a government program other than Medicaid to help with my health care costs \(Medicare Savings Programs\)?](http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=390) (New York: Medicare Rights Center), http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=390, accessed on April 24, 2012.

³⁴ SSA POMS HI 00815.023; Medicare Interactive, [Medicare Savings Program Financial Eligibility Guidelines by State](http://www.medicareinteractive.org/uploadedDocuments/mi_extra/msp_chart_edited.html) (New York: Medicare Rights Center), http://www.medicareinteractive.org/uploadedDocuments/mi_extra/msp_chart_edited.html, accessed on April 24, 2012. There is a disregard of up to \$1500 for individuals and \$3,000 for couples for burial expenses. However, while the burial expenses are automatically disregarded for LIS, for MSPs any states will only apply the disregard if an applicant can prove they have pre-paid burial funds or designated bank account.

³⁵ Medicare Interactive, [Medicare Savings Program Financial Eligibility Guidelines by State](http://www.medicareinteractive.org/uploadedDocuments/mi_extra/msp_chart_edited.html). Generally, states increase income and asset limits by increasing income and asset disregards set by federal law. At least nine states have eliminated asset tests for MSPs.

³⁶ POMS HI 03001.020; HI 03030.025; HI 03030.020. This amount includes \$1,500 automatic disregard for burial expenses. Again, while the burial expenses are automatically disregarded for LIS, for MSPs many states will only apply the disregard if an applicant can prove she has pre-paid burial funds or designated bank account.

³⁷ SSA POMS HI 03001.005; POMS HI 03030.025; Medicare Interactive, [Will I get help paying for the Medicare drug benefit if my income is low \(Extra Help\)?](http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=454) (New York: Medicare Rights Center), http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=454, accessed on April 24, 2012. Those eligible for partial LIS receive premium assistance dependent on income, a \$66 deductible, 15% coinsurance and up to \$2.65 generic and \$6.60 brand-name drug co-pays during catastrophic coverage.

In sum, because the income and asset limits for Medicaid and other subsidy programs for people with Medicare are more restrictive than the limits required under the ACA for Medicaid coverage for those not eligible for Medicare, there will be individuals who will lose full Medicaid coverage when they qualify for Medicare. As a result, they may face new cost burdens when they become Medicare eligible, some of which may be allayed if they qualify for Medicare subsidy programs. In all cases, they will need to be re-assessed for these programs using pre-ACA Medicaid eligibility methodologies and may be relegated to pre-ACA Medicaid enrollment processes, both of which can be complicated and unwieldy, especially when compared to what is required by and being developed for ACA-expanded Medicaid.

Medicaid enrollment processes for Medicare-eligible individuals

As discussed above, individuals eligible for expanded Medicaid beginning in 2014 will have the benefit of streamlined eligibility, application and enrollment processes, but the Medicare population, in addition to being subject to more restrictive asset standards, may still face further barriers to enrollment if they are required to follow existing Medicaid application processes. The myriad of problems with the current Medicaid application and enrollment processes has been well documented.³⁸ In short, these processes, which vary widely by state, can involve long paper applications and extensive documentation requirements to verify eligibility, including income and assets.³⁹ For instance, only a limited number of states currently use administrative renewal processes that require individuals to take no action or minimal action by using data already available to the state to make renewal determinations.⁴⁰ Currently, many states still require individuals to submit some form of paper documentation to their state Medicaid office.⁴¹

The eligibility and enrollment standards and procedures required by the ACA were a direct response to these variable, arcane and onerous eligibility rules and application and

³⁸ Doug Goggin-Callahan, [*Recertification in New York State: The Revolving Door of the Medicare Savings Program*](#) (New York: Medicare Rights Center, March 2011) <http://www.medicarerights.org/pdf/Recertification-in-New-York-State.pdf>; Laura Summer, [*Increasing Participation in Benefit Programs for Low-Income Seniors*](#) (New York: Commonwealth Fund, May 2009), http://assets.aarp.org/rgcenter/health/2005_10_medicaid_msp.pdf; Laura L. Summer and Emily S. Ihara, [*Simplifying Enrollment in Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities*](#) (Washington, D.C.: Georgetown University Health Policy Institute, December 2005), http://assets.aarp.org/rgcenter/health/2005_10_medicaid_msp.pdf; Adrienne Dulio, Susan Kannel and Michael J. Perry, [*Barriers to Medicaid Enrollment for Seniors: Findings from 10 Focus Groups with Low-Income Seniors*](#) (Menlo Park, Calif: Kaiser Family Foundation, January 2002), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14110>; Christina Chang, Susan Kannel, Michael Perry and R. Burciaga Valdez, [*Medicaid and Children: Overcoming Barriers to Enrollment, Findings from a National Survey*](#) (Menlo Park, Calif: Kaiser Family Foundation, January 2000), <http://www.kff.org/medicaid/upload/Medicaid-and-Children-Overcoming-Barriers-to-Enrollment-Report.pdf>.

³⁹ *Id.*

⁴⁰ *Id.* Non-administrative renewal processes that do not take advantage of data-sharing between state and federal agencies to verify data have been shown to result in eligible beneficiaries losing coverage.

⁴¹ *Id.*

renewal procedures.⁴² Many studies have demonstrated that the more challenging the application, determination and renewal process, the more likely it is that individuals will fail to enroll or will lose coverage—not because they are ineligible, but because they were unable to appropriately complete the application or comply with renewal procedures.⁴³ Documentation requirements are a known barrier to enrollment and retention in programs, not only because individuals may not know the array of documentation required, but also because they may have difficulty obtaining and gathering it.⁴⁴ Burdensome processes also add to state administrative costs, both in terms of processing documentation and reenrolling individuals who reapply after being unnecessarily denied or disenrolled from a benefit.⁴⁵

Recently promulgated ACA regulations and guidance and existing law offer some hope that the simplified and automated eligibility determination and enrollment processes developed for ACA Medicaid will extend to other categories of Medicaid, including those applicable to people with Medicare.⁴⁶ Under existing law, those shifting from one Medicaid eligibility category to another are protected by the requirement that state Medicaid agencies do an eligibility review for other Medicaid categories based on information already available to the agency if the agency determines that an individual will no longer be eligible for benefits under her current category of Medicaid.⁴⁷ Further, regulations implementing the ACA require that the same renewal processes apply to all Medicaid populations including those eligible for Medicare.⁴⁸ Thus, people with

⁴² Alice Weiss and Laura Grossman, *Paving the Enrollment Superhighway: Bridging State Gaps Between 2014 and Today* (Portland, Maine; National Academy State Health Policy, March 2011), http://www.nashp.org/sites/default/files/bridging.state_gaps_.pdf; Beth Morrow and Julia Paradise, *Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act* (Menlo Park, Calif: Kaiser Family Foundation, October 2010), <http://www.kff.org/healthreform/upload/8108.pdf>.

⁴³ Laura Summer, *Increasing Participation in Benefit Programs for Low-Income Seniors*; Dulio, et. al., *Barriers to Medicaid Enrollment for Seniors: Findings from 10 Focus Groups with Low-Income Seniors*; Laura Summer, *Increasing Participation in Benefit Programs for Low-Income Seniors*; Summer et. al., *Simplifying Enrollment in Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities*; Chang et. al., *Medicaid and Children: Overcoming Barriers to Enrollment, Findings from a National Survey*.

⁴⁴ *Id.*

⁴⁵ Laura Summer, *Increasing Participation in Benefit Programs for Low-Income Seniors*; Summer et. al., *Simplifying Enrollment in Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities*.

⁴⁶ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17163, 17164, 17167, 17181-17186, 17192, 17195, 17208 - 17213 (to be codified at 42 CFR 435.907, 435.911, 435.916, 435.940-435.956, and 435.1200); Establishment of Exchanges 77 *Fed. Reg.* at 18313, 18351, 18352 18380, 18437, 18461 (to be codified at 45 CFR 155.345 and 155.305); State Health Reform Assistance Network, *Overview of Final Medicaid Eligibility Regulation*; State Health Reform Assistance Network, *Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011*;

⁴⁷ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17182, 17211 (to be codified at 45 CFR 435.916); Health Care Financing Administration (now Centers for Medicare & Medicaid Services), *Dear State Medicaid Director Letter* (Baltimore, Maryland: HCFA, April, 2000), <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd040700.pdf>.

⁴⁸ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17181-17183, 17210 (to be codified at 42 CFR 435.916); State Health Reform Assistance Network, *Overview of*

Medicare who lose ACA Medicaid eligibility should have such a review to access or retain Medicaid coverage or access Medicare subsidy programs.

In addition, the ACA envisions the development of a single electronic Medicaid enrollment system compatible with federal, state and exchange databases, which would be able to share accurate information in real time. However, as states build new systems or improve upon legacy systems, it is unclear how other Medicaid populations will be part of these state-developed systems. In recent regulations, the federal government indicated that it would not provide funding for two separate enrollment systems and did not envision states maintaining two systems.⁴⁹ This implies that states will need to integrate all Medicaid populations into new systems as they develop them.

However, the reality on the ground in many states may not foster seamless transition from one Medicaid category to another or Medicare subsidy programs. For example, states may still require that individuals submit supplementary materials (such as documentation) if states do not have the needed information on file to make a determination.⁵⁰ For Medicaid eligibility determinations for people with Medicare, states may use either the application used for ACA Medicaid eligibility determinations with supplemental forms or an alternative application specifically created for other Medicaid categories.⁵¹ Though the regulations state that these supplemental forms or other applications should be accepted electronically to the extent practical, the regulations do not require states to do so.⁵² With regard to renewals or re-determinations, ACA regulations require states to send pre-populated forms to people eligible for ACA related Medicaid if they are no longer found eligible as part of the administrative renewal process, but are not required to use these forms for people with Medicare.⁵³

Consequently, if simplified and automated determination and renewal processes instituted under the ACA are not applied to people with Medicare applying for Medicaid and the Medicare subsidy programs, Medicare beneficiaries will be subject to the existing cumbersome processes. For example, this could mean that Medicaid recipients becoming eligible for Medicare may be required to submit what amounts to a new application, with

[Final Medicaid Eligibility Regulation](#); State Health Reform Assistance Network, [Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011](#).

⁴⁹ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17150, 17151.

⁵⁰ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17163, 17164, 17167, 17181-17186, 17192, 17195, 17208 - 17213 (to be codified at 42 CFR 435.907, 435.911, 435.916, 435.940-435.956, and 435.1200); Establishment of Exchanges 77 *Fed. Reg.* at 18313, 18351, 18352 18380, 18437, 18461 (to be codified at 45 CFR 155.345 and 155.305); State Health Reform Assistance Network, [Overview of Final Medicaid Eligibility Regulation](#); State Health Reform Assistance Network, [Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011](#).

⁵¹ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17163, 17164, 17208 (to be codified at 42 CFR 435.907); State Health Reform Assistance Network, [Overview of Final Medicaid Eligibility Regulation](#); State Health Reform Assistance Network, [Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011](#).

⁵² *Id.*

⁵³ *Id.*

a significant amount of additional documentation, as they transition from one category of Medicaid to another. If data exchanges are limited and do not include information, for example, on assets, this could mean that Medicare individuals may still face enrollment barriers similar to those they face today. Unfortunately, that could also mean that they suffer a break in their Medicaid coverage or fail to access Medicare subsidy programs.

Medicare Transitions

Transitions to Medicare from qualified health plans, premium tax credits and cost-sharing subsidies

Upon becoming eligible for Medicare, an individual with a qualified health plan purchased through an exchange will enroll in Medicare and need to terminate her qualified health plan coverage. If she has income below 400 percent of FPL and is receiving premium tax credits and cost-sharing subsidies, these will be terminated as well. Consequently, those with coverage through qualified health plans will not only need to understand rules and obligations concerning Medicare enrollment, but also rules about disenrollment from qualified health plan coverage and the termination of premium tax credits and cost-sharing subsidies.⁵⁴

Generally, people in qualified health plans will have to enroll in Medicare Part B during their initial enrollment period, because Medicare will become their primary health coverage and they do not have a Special Enrollment Period.⁵⁵ The initial enrollment period is the seven month period that includes the three months before an individual's 65th birthday month, the month an individual turns 65 and the three months after an individual's 65th birthday.⁵⁶ People transitioning from qualified health plans should also enroll in the Medicare prescription drug benefit during their initial enrollment period.

⁵⁴ Though not the main focus of this paper, individuals will need to coordinate enrollment into Part D and Medigap supplementary coverage, in addition to Medicare Parts A and B.

⁵⁵ 42 CFR 411.172; 42 CFR 411.204; Medicare as Secondary Payer Manual, Chapter 1, Chapter 2. There are further complications as well if individuals do not understand how Medicare interacts with other insurance. Upon Medicare eligibility, individuals sometimes assume that if they have another type of health coverage, they can keep it and forgo Medicare Part B. However, unless an individual has insurance through a current employer (and even then there are exceptions for small group health plans), an individual's current insurance, presumably including a qualified health plan, will always pay secondary to Medicare. If an individual does not enroll in Part B though they are eligible to do so, even if they have other insurance coverage, if that insurance is secondary to Medicare, it will not provide coverage unless Medicare pays first. Therefore, it is important that those with qualified health plans understand that they are obligated to take Medicare when they first become eligible. If they don't take Medicare Part B and keep their qualified health plan coverage, which presumably will act as secondary coverage, operationally, it is as though they have no coverage at all.

⁵⁶ 42 CFR 407.14, 42 CFR 407.17, 407.18. The majority of individuals eligible for Medicare are auto-enrolled into Medicare Parts A and B unless they affirmatively decline Part B, including many individuals who receive SSI, those who choose to take Social Security benefits before age 65 and disabled individuals after they have received Social Security Disability Insurance benefits for two years. Individuals may also enroll in Medicare based on disability without waiting 24 months if they have been diagnosed with Amyotrophic Lateral Sclerosis (ALS) and meet certain other parameters. Persons can also enroll in Medicare if they have End Stage Renal Disease (ESRD).

Individuals are well advised to enroll during the first three months of their initial enrollment period so that coverage begins on the first day of the month that they turn 65.⁵⁷ If an individual enrolls after the first three months of her initial enrollment period, the start of coverage may be delayed as much as one to six months from the date of initial Medicare eligibility.

The consequences for not enrolling in Medicare during the initial enrollment period are serious. If an individual with coverage through a qualified health plan does not enroll in Medicare Part B during her initial enrollment period, she will need to enroll in Medicare during the general enrollment period. The general enrollment period lasts from January through March of each year, with coverage beginning on July 1.⁵⁸ Those with qualified health plans who enroll during the general enrollment period may be subject to the late enrollment premium penalty: a 10 percent increase in the Part B premium for each year of delayed enrollment past initial eligibility for Medicare, for the duration of Medicare coverage.⁵⁹ Moreover, if a person does not enroll in Part D when she is first eligible and does not maintain creditable coverage (drug coverage that is as least as good as Medicare's) for 63 days or more, she may have a Part D premium penalty as well. It is not clear if prescription drug coverage provided by qualified health plans will be considered creditable for this purpose.

In addition to understanding Medicare enrollment rules, individuals with qualified health plans will need information about and assistance with the termination of qualified health plan coverage, premium tax credits and cost-sharing subsidies. Different rules apply to the termination of premium tax credits, cost-sharing subsidies and qualified health plans. Under the law, premium tax credits and related subsidies are terminated automatically upon Medicare eligibility.⁶⁰ However, qualified health plans do not terminate automatically and current regulations require those who are Medicare-eligible to notify their qualified health plans to effectuate termination of their coverage.⁶¹ Neither the plan nor the exchange has the authority to automatically terminate qualified health plan coverage upon Medicare eligibility.⁶² An individual must give the plan “reasonable

⁵⁷ SSA § 1837(c), (e); 42 CFR § 407.14; 42 C.F.R. § 423.38. Those covered by a QHP, except in certain limited circumstances, would not qualify for a Special Enrollment Period, which allow individuals to enroll in Medicare outside the Initial Enrollment Period. This paper does not discuss transitions to Medicare from insurance coverage provided by plans in the Small Business Health Options Program (SHOP) Exchange, which requires analysis of the how Medicare coordination of benefit rules and enrollment periods interact with SHOP coverage.

⁵⁸ SSA § 1837(e); 42 CFR §407.15. Those who wish to enroll in Part D but miss their initial enrollment period must wait to enroll during the Fall Open Enrollment Period, which runs from October 15 to December 7 of each year, with coverage beginning on January 1 of the following year or, if they are enrolling in Part B during the GEP, from April 1 to June 30, with coverage beginning July 1 of that same year.

⁵⁹ SSA § 1839(b), (c).

⁶⁰ P.L. 111-148 §1401 as modified by P.L. 111-152 §1001; Establishment of Exchanges, 77 *Fed. Reg.* at 18371-18374, 18394, 18395, 18463 (to be codified at 45 CFR 155.330 and 155.430); Health Insurance Premium Tax Credit, 76 *Fed. Reg.* at 50933, 50934, 50941 (August 17, 2011).

⁶¹ P.L. 111-148 §1401 as modified by P.L. 111-152 §1001; Establishment of Exchanges, 77 *Fed. Reg.* at 18394, 18395, 18463 (to be codified at 45 CFR 155.430).

⁶² Establishment of Exchanges, 77 *Fed. Reg.* at 18395, 18463 (to be codified at 45 CFR 155.430).

notice” about the need to terminate coverage. Reasonable notice is 14 days or more, and an individual has the ability to request a specific termination date if reasonable notice is provided.⁶³

Though exchanges and/or qualified health plans must provide notification of the termination of premium tax credits and cost-sharing as well as coverage once requested, there are currently no requirements that the exchange or a qualified health plan notify individuals of approaching Medicare eligibility.⁶⁴ Also, exchanges and plans are not required to notify individuals of potential penalties for enrolling after the Medicare initial enrollment period, nor are they required to provide information or assistance in making transitions, such as information about timeframes and methods to appropriately terminate coverage from a qualified health plan. If an individual does not terminate a qualified health plan at the right time, there may be adverse consequences. For example, if an individual terminates coverage before Medicare coverage starts, the individual will face a gap in coverage. If qualified health plan coverage does not terminate until after Medicare coverage already begins, an individual could end up paying unnecessary premiums for both qualified health plan and Medicare coverage. Furthermore, as previously described, if an individual misses her initial Medicare enrollment period, she must wait until the general enrollment period to enroll in Medicare and may have a rather lengthy gap in coverage.

Additionally, individuals transitioning from qualified health plans to Medicare will need assistance in choosing the way they receive their Medicare benefits. The majority of Medicare beneficiaries currently choose to be covered by Original Medicare and obtain coverage that supplements Medicare, such as a Medigap plan and a stand-alone Medicare prescription drug plan.⁶⁵ But a growing minority is choosing to receive Medicare through private Medicare Advantage plans (usually a Medicare HMO) that also provide prescription drug benefits.⁶⁶ Today, many individuals receive counseling about these choices through national State Health Insurance and Assistance Programs (SHIPs), which are federally funded and administered by states. However, this program, which provides objective, individual advice, has been traditionally under-funded and unable to meet even current demand.⁶⁷

⁶³ Establishment of Exchanges, 77 *Fed. Reg.* at 18394, 18395, 18463 (to be codified at 45 CFR 155.430).

⁶⁴ Establishment of Exchanges, 77 *Fed. Reg.* at 18371-18374, 18394, 18395, 18463 (to be codified at 45 CFR 155.330 and 155.430).

⁶⁵ Medicare Interactive, [What are my Medicare coverage options?](#) (New York: Medicare Rights Center), accessed on April 24, 2012, http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=255.

⁶⁶ Kaiser Family Foundation, [Medicare Advantage Fact Sheet](#), (Menlo Park, Calif: Kaiser Family Foundation, November 2011), <http://www.kff.org/medicare/upload/2052-15.pdf>.

⁶⁷ Carol V. O’Shaughnessy, [The State Health Insurance Assistance Program \(SHIP\)](#) (Washington, D.C.: National Health Policy Institute, March 2010), http://www.nhpf.org/library/the-basics/Basics_SHIP_03-29-10.pdf; Health Assistance Partnership, [State of the SHIPs, A Summary of Results from the 2009 SHIPs Needs Survey](#) (Washington, D.C.: HAP, January 2010), <http://www.hapnetwork.org/assets/pdfs/state-of-the-ships-report/2010.pdf>.

Adding further complexity to the situation, in some cases individuals will be eligible for subsidies that help pay for out-of-pocket costs associated with Medicare and require assistance to enroll in these programs. The mechanics of eligibility determination and enrollment in Medicare programs for people with limited incomes are described more fully in the context of the next group of transitioning individuals as many more in that group will be subject to this transition.

In sum, without proper notice of Medicare enrollment rules, qualified health plan disenrollment rules, information about Medicare insurance options and Medicare subsidy programs, those in qualified health plans who become Medicare eligible could miss their Medicare initial enrollment period, make a coverage choice that does not fit their needs or fail to access Medicare subsidies. As a result, affected individuals could face gaps in coverage, late enrollment premium penalties, unwittingly pay premiums for both Medicare and their qualified health plan or find their Medicare coverage unaffordable.

Transitions to Medicare from expanded Medicaid under the Affordable Care Act

As previously noted, the ACA's expansion and simplification of Medicaid financial eligibility rules, including the increase in Medicaid income limits to 138 percent of FPL and the elimination of asset tests, do not apply to the Medicare population. This means that upon becoming Medicare eligible, those who receive coverage under expanded Medicaid with incomes between the upper state limit for Medicaid for the Aged, Blind and Disabled population (between 75 percent and 100 percent of FPL in most states) and 138 percent of FPL, or who have assets above threshold limits, will, in many cases, no longer be eligible for any category of full Medicaid assistance. As a result, this population will likely face new financial and health risks upon becoming Medicare eligible because out-of-pocket costs under Medicare may be greater than under expanded Medicaid.⁶⁸ Fortunately, some of these individuals will be eligible to enroll in Medicare subsidy programs like MSPs and the LIS (see eligibility guidelines on pages 7-9 above) that help limited-income Medicare beneficiaries offset higher costs they may face under the Medicare program.

Enrollment in LIS is fairly simple and can be done electronically by beneficiaries or their advocates. Those with SSI, Medicaid or an MSP are automatically deemed eligible for LIS, even if a state's MSP eligibility rules are more generous than those used for LIS determinations.⁶⁹ For example, an individual with an MSP who lives in a state with no MSP asset test and who has assets that exceed LIS asset limits will be automatically

⁶⁸ "Near-poor and middle-income Medicare households (those between 100% and 399% the poverty level) faced a greater health care spending burden in 2009 than the poorest Medicare households, those with incomes below the poverty level (\$10,830/individual or \$14,570/couple in 2009). This is because beneficiaries in these households generally are not eligible for Medicaid because their income and/or assets exceed eligibility limits." Cubanski et. al., [*Health Care on a Budget; the Financial Burden if Health Spending by Medicare Households. An Updated Analysis of Health Care Spending as a Share of Total Household Spending.*](#)

⁶⁹ SSA POMS HI 03035.005 – 03035.10, 03035.012, 03035.020, 03035.030, 03035.050

enrolled in LIS although she would not be eligible or enrolled had she applied for LIS directly.⁷⁰

Case Study:

In 2014, Mr. R, is 64 years old. He has an income at 134 percent of FPL and \$10,000 of assets and, consequently, qualifies for Medicaid as expanded by the ACA. The following year, Mr. R becomes eligible for Medicare. As a result of Medicare eligibility, he is no longer eligible for expanded Medicaid. Also, Mr. R is not eligible for any other full Medicaid category because the upper income level for Aged, Blind and Disabled Medicaid in his state is 85 percent of FPL and because he has assets. Mr. R struggles to pay for needed health care because he faces new, more significant cost-sharing under Medicare. Because there is an asset test for LIS, he qualifies only for partial LIS. However, Mr. R lives in a state that has eliminated the asset test for MSPs. As a result, he is eligible for QI, an MSP, and thus is deemed eligible for full LIS. However, if appropriate renewal processes are not developed and outreach resources are not made available, Mr. R may go without benefits for which he qualifies. If Mr. R lived in a state with an MSP asset test he would be ineligible for all MSPs and have the limited subsidy provided from partial LIS.

Generally, participation rates in MSPs and LIS are low for a number of reasons, including ignorance about the existence of the programs and the difficulty in navigating the application and enrollment procedures.⁷¹ However, there is no doubt about the combined usefulness of the MSP and LIS programs – in 2011, they were estimated to provide over \$5000 in benefits annually for each low-income individual enrolled.⁷²

The LIS application process is a relatively paperless one. Specifically, in the initial stages of the LIS determination process, SSA does not require individuals to provide documentation to prove information provided on the application.⁷³ Instead, SSA exchanges information with the Internal Revenue Service and other agencies to certify application information, including assets.⁷⁴

Unfortunately, unlike the LIS eligibility determination and enrollment processes, the MSP eligibility determination and enrollment process frequently follows the bulky current Medicaid process described above. However, as noted in the previous section, it

⁷⁰ Id.

⁷¹ Summer, *Increasing Participation in Benefit Programs for Low-Income Seniors*; The Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy Chapter 5, Increasing Participation in the Medicare Savings Programs and the Low-income Drug Subsidy*, (Washington, D.C.: MedPAC, March 2008), http://www.medpac.gov/chapters/Mar08_Ch05.pdf.

⁷² Social Security Administration, *Understanding The Extra Help With Your Medicare Prescription Drug Plan* (Baltimore, Maryland: SSA, January 2011), <http://ssa.gov/pubs/10508.pdf>. Amount calculated by combining 12 months of 2011 Part B premium and the value of the full LIS benefits.

⁷³ SSA POMS HI 03035.005 – 03035.10, 03035.012, 03035.020, 03035.030, 03035.050

⁷⁴ Id.

is unclear to what extent improvements under the ACA will mitigate problems with the current Medicaid application process for those eligible for MSPs and whether MSP applications and renewals will be fully automated.

There is also the added problem of timing applications, eligibility determinations and effective dates among Medicare (administered by SSA and Centers for Medicare and Medicaid Services(CMS)), MSPs (administered by each state) and LIS (administered by SSA).⁷⁵ For even knowledgeable individuals, understanding the various moving parts of enrollment can be insurmountable. Individuals must understand the order in which they must apply for benefits, which state and federal offices to contact and the ways in which various benefits interact. The result of this complicated maze is that people with low-incomes may not be able to access programs for which they are eligible to help protect them from financial burdens associated with Medicare coverage.⁷⁶

Even before the ACA, some states already contemplated a more automated process for enrolling individuals into MSPs. For example, as a result of the Medicare Improvements for Patients and Providers Act, SSA is required to send the LIS application data to an applicant's home state for screening for an MSP.⁷⁷ While some states are on a path to automatically accept and process LIS data to enroll individuals in MSPs without any further action by the applicant, other states are using the LIS data only as "leads data" to conduct outreach to potentially eligible individuals, requiring those individuals to provide further documentation to prove their income and assets.⁷⁸ The protected filing date of application for those found eligible for SLMB and QI through the automatic data exchange process will be the date of their application for LIS. However, QMB benefits can only begin the first of the month after an eligibility determination for QMB itself.

⁷⁵ While SSA processes Medicare enrollment, CMS administers the Medicare benefit. SSA § 1905(a); Doug Goggin-Callahan, [Warning Signs: Preliminary Report Highlights Problems with State Implementation of MIPPA Low-Income Reforms](#) (New York: Medicare Rights Center, February 2010), <http://www.medicarerights.org/pdf/Warning-Signs-MIPPA.pdf>; Glaun, [Streamlining Medicare and OMB Enrollment for New Yorkers: Medicare Part A Buy-In Analysis and Policy Recommendations](#); Center for Medicare Advocacy, [Pennsylvania Lawsuit Increases Access to Medicare for Low-Income Medicare Beneficiaries](#) (Willimantic, Connecticut: CMA, April 2010), http://www.medicareadvocacy.org/Print/2010/MSP_10_04.29.GarciaSettlement.htm.

⁷⁶ SSA § 1905(a); Patricia Nemore, [Can You Be a "Qualified Medicare Beneficiary" If you Don't Have Medicare Part A?](#) (Willimantic, Connecticut: CMA, October 2009), http://www.medicareadvocacy.org/Projects/AdvocatesAlliance/IssueBriefs/09_10.19.QMBsWithoutPartA.pdf. For example, regardless of the state enrollment process, in most cases if an individual is not automatically enrolled in Medicare Part A, she must affirmatively enroll in Part A by contacting SSA before enrolling in an MSP at her local Medicaid office. If the individual does not yet have Medicare Part B and is found eligible for an MSP, the state will share information with SSA and CMS to enroll the individual in Part B. In these cases, the effective date of Part B is the same as the effective date of the MSP for which the individual qualifies. While SLMB and QI are effective up to three months retroactive to the date of the initial application, QMB benefits start the month after an eligibility determination is made, meaning that it may be difficult for people who qualify for QMB to have the QMB start-date coincide with the date of Medicare eligibility.

⁷⁷ SSA § 1144; SSA POMS HI 00815.024; Goggin-Callahan, [Warning Signs: Preliminary Report Highlights Problems with State Implementation of MIPPA Low-Income Reforms](#). Under MIPPA, individuals have the right to opt out of the MSP application process when they apply for LIS.

⁷⁸ Goggin-Callahan, [Warning Signs: Preliminary Report Highlights Problems with State Implementation of MIPPA Low-Income Reforms](#).

This means that LIS and QMB cannot start on the same date if someone uses LIS to apply for QMB.⁷⁹ Consequently, even if every step of this particular enrollment path goes well, beneficiaries experience a break in coverage.

In general, those with Medicaid as expanded by the ACA who are not eligible for full Medicaid upon becoming eligible for Medicare are in the most precarious position with respect to maintaining access to affordable and comprehensive health coverage. While some may qualify for Medicare subsidy programs, others will not because of more restrictive financial eligibility requirements for these programs compared to those required under the ACA for expanded Medicaid. For those who do qualify for Medicare subsidies, if transitions to these benefits do not occur seamlessly because of documentation requirements or the lack of coordination among agencies responsible for administering the programs, individuals could still face increased costs and gaps in coverage. Such costs and coverage gaps are especially problematic for a population with fixed incomes and high health care needs.⁸⁰

Transitions to Medicare and Medicaid from expanded Medicaid under the Affordable Care Act

In 2014, expanded Medicaid coverage will terminate for individuals once they become Medicare eligible, but a subset of this population will continue to be eligible for full Medicaid through other criteria.⁸¹ This population, eligible for both Medicare and Medicaid, are frequently referred to as “dual-eligibles.” Dual-eligibles are the focus of a number of reform efforts because of their low-incomes, poorer health status and higher use of care relative to the entire Medicare or Medicaid populations.⁸² These characteristics mean dual-eligibles are in special need of coverage and financial assistance.

As already discussed, most Medicaid categories have more restrictive income and asset limits than expanded Medicaid under the ACA, and states may request additional income and asset documentation in order to determine eligibility for non-ACA related Medicaid coverage.⁸³ Some individuals eligible for SSI may be automatically enrolled in Medicaid,

⁷⁹ Centers for Medicare & Medicaid Services, [Dear State Medicaid Director Letter](#) (Baltimore, Maryland: CMS, February, 2010), <http://www.medicareadvocacy.org/InfoByTopic/MedicareSavingsPrograms/MIPPASMDLetter1-19-10.final.pdf>.

⁸⁰ Harriet Komisar, Juliette Cubanski, Lindsey Dawson, and Tricia Neuman, [Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors](#) (Menlo Park, Calif: Kaiser Family Foundation, March 2012), <http://www.kff.org/medicare/upload/8289.pdf>.

⁸¹ P.L. 111-148 § 2001, § 2002; Henry J. Kaiser Commission on Medicaid and the Uninsured, [Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities](#).

⁸² Gretchen Jacobson, Tricia Neuman, and Anthony Damico, [Medicare's Role for Dual-Eligible Beneficiaries](#) (Menlo Park, Calif: Kaiser Family Foundation, April 2012), <http://www.kff.org/medicare/upload/8138-02.pdf>.

⁸³ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17181-17183, 17210 (to be codified at 42 CFR 435.916); State Health Reform Assistance Network, [Overview of Final Medicaid Eligibility Regulation](#); State Health Reform Assistance Network, [Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011](#). The most at risk

thus avoiding the Medicaid application process; others may need to apply for Medicaid anew if they are not enrolled in SSI or otherwise not subject to an automatic Medicaid enrollment process.⁸⁴ Even individuals who are eligible for SSI and could enroll in Medicaid by virtue of their SSI enrollment would need to know that the SSI program exists in the first place. Given the vulnerability of those who still qualify for full Medicaid after losing ACA coverage, in advance of 2014 states should examine their relevant Medicaid application, eligibility and enrollment processes and simplify them wherever possible.

Case Study:

Ms. J is 64 years old and is enrolled in Medicaid as expanded by the ACA. In 2016, Ms. J turns 65 and qualifies for Medicare. Her income is 84 percent of FPL and she does not have any assets. Although she no longer qualifies for Medicaid under the ACA, her state maintains an income limit of 100 percent of FPL for the Aged, Blind and Disabled Medicaid program. This means she continues to qualify for full Medicaid. But Ms. J has difficulty collecting the necessary documentation to complete her renewal application. If the state is unable to make a new Medicaid eligibility determination at the termination of Ms. J's current ACA related Medicaid coverage due to the lack of information and documentation on file, she will have a gap in Medicaid coverage despite continued eligibility, jeopardizing her access to affordable health care.

Furthermore, because Ms. J is not eligible for SSI, she will not be automatically enrolled into Medicare programs that help pay for Medicare costs. If the Medicaid agency does not help facilitate enrollment into Medicare related subsidies, Ms. J may delay enrollment into Medicare because of the premiums and cost-sharing associated with the program.

Furthermore, as previously discussed, enrollment systems can also be a barrier to coverage.⁸⁵ The infrequency of data-exchanges between states and the federal government and lack of compatibility among existing data systems acts as a barrier to electronic submission of applications, verification of application information and timely eligibility determinations.⁸⁶ For example, in some cases, data match errors between systems can cause individuals to become trapped in a data-sharing loop if a field in the federal government's database does not match the state's information.⁸⁷ If individuals

individuals are those who are turning 65 and are not disabled and who have not previously qualified for SSI, since they cannot avail themselves of automatic deeming for Medicaid through SSI in states where such deeming occurs. Even in states where deeming does occur as a result of SSI eligibility, such deeming would require eligible individuals to appropriately enroll in SSI.

⁸⁴ HI 00815.006

⁸⁵ See page 10.

⁸⁶ Glaun, [Streamlining Medicare and QMB Enrollment for New Yorkers: Medicare Part A Buy-In Analysis and Policy Recommendations](#); CMA, [Pennsylvania Lawsuit Increases Access to Medicare for Low-Income Medicare Beneficiaries](#).

⁸⁷ *Id.*

with Medicare who are eligible for Medicaid and other Medicare subsidy programs are not incorporated into new data systems appropriately, and data is not exchanged on as frequent a basis as it is for ACA covered populations, they stand to face the same barriers to coverage they face today.

Additionally, individuals may have to apply for new benefits, including Medicare and other Medicare subsidy programs, through different agencies and using several different applications (as described in the previous section). While some individuals may be auto-enrolled or have an application for certain benefits triggered when they apply for others, given that different benefits are effective at different times, it would be difficult for a person's benefits to all begin on the same date (specifically, the day after their former coverage ends) if application and enrollment are not appropriately timed.

Once again, all of these issues could mean that individuals newly eligible for Medicare do not receive the benefits for which they are eligible, resulting in gaps in coverage and/or unnecessary out-of-pocket costs.

Recommendations for Ensuring Seamless Health Insurance Coverage

The complexity of eligibility determination and enrollment processes for Medicare, Medicaid and related subsidy programs, both now and after implementation of the ACA, is daunting. However, solutions that will provide more seamless coverage and ease transitions exist, and some solutions simply require extending and improving existing policies.

The most obvious solution is to eliminate all Medicaid asset tests and further align Medicaid and Medicare subsidy programs' eligibility income limits with Medicaid as expanded by the ACA. But absent that level of change, there is still much that state and federal agencies and exchanges can do to align eligibility determination and enrollment processes and mitigate bureaucratic barriers to ensure seamless coverage transitions for people who become Medicare eligible. Specifically, to help ease transitions to Medicare, the federal government and states should:

- align and simplify financial eligibility rules, such as income limits and asset thresholds, between ACA-expanded Medicaid for those not yet eligible for Medicare, premium tax credits and cost-sharing subsidies, Medicaid programs for Medicare beneficiaries and Medicare subsidy programs;
- align and simplify application and renewal rules and processes among qualified health plans and premium tax credits and cost-sharing subsidies, ACA-expanded Medicaid, Medicaid programs for Medicare beneficiaries and Medicare subsidy programs;
- utilize electronic data-sharing to automatically verify eligibility and facilitate enrollment into non-ACA Medicaid and Medicare subsidy programs as an individual becomes eligible for Medicare;

- modernize eligibility determination and enrollment systems for all Medicaid populations; and
- use education, outreach and notices to provide accurate, easily-understood and timely information about enrollment obligations, eligibility guidelines and available benefits.

Align and simplify financial eligibility rules, such as income limits and asset thresholds, between ACA-expanded Medicaid for those not yet eligible for Medicare, premium tax credits and cost-sharing subsidies, Medicaid programs for Medicare beneficiaries and Medicare subsidy programs.

To help individuals seamlessly transition to Medicare and avoid gaps in coverage and unnecessary out-of-pocket costs, states and the federal government can better align income and asset thresholds between Medicaid as expanded by the ACA, other Medicaid categories and Medicare subsidy programs. Better alignment among requirements for these programs would help both federal and state governments to screen people for multiple benefits simultaneously, and would maximize enrollment in subsidy programs that assist vulnerable populations.

Absent a direct match of income and asset thresholds between expanded Medicaid and other Medicaid categories, or including people with Medicare in the Medicaid expansion, the federal government and states could ensure that more low-income individuals are able to transition from expanded Medicaid to Medicare with an MSP and LIS that will at least partially offset the increased costs these people may face. Specifically, by increasing the income threshold for MSPs to at least 138 percent of FPL while eliminating the asset test (as discussed in greater detail below), Congress could help ensure that every person covered in states with ACA-expanded Medicaid transitioning to Medicare after January 1, 2014 would have some subsidy for Medicare costs.⁸⁸ States could also affect the same change by increasing income disregards for MSPs.⁸⁹ For example, through the use of additional income disregards, Maine currently allows its citizens to qualify for QMB at 150 percent of FPL, SLMB at 170 percent of FPL and QI at 185 percent of FPL⁹⁰.

⁸⁸ In most states the income limit for QI is 135% FPL. The income limit for MAGI Medicaid will be 138% FPL (133% with a 5% automatic disregard). QI is a federal block grant that must be reauthorized each year. Thus, increasing the income limit for QI alone may be insufficient to assure individuals will have protections if QI is not reauthorized in the future. For this reason, Congress should consider making the program permanent or increasing the income limit for SLMB to 138% FPL.

⁸⁹ Scott Dershowitz, *Local Promise: Maximizing Enrollment in Low-Income Medicare Programs Through State Based Consumer Advocacy* (New York: Medicare Rights Center, July 2010), <http://www.medicarerights.org/pdf/Local-Promise.pdf>; MedPAC, *Report to the Congress: Medicare Payment Policy Chapter 5, Increasing Participation in the Medicare Savings Programs and the Low-income Drug Subsidy*.

⁹⁰ As of January 2013, Maine received Federal approval to decrease the income limits for MSPs, however, even under the new eligibility guidelines Maine's MSP income limits would continue to exceed the federal floor.

In addition, the elimination of the asset test, which has been found to be a barrier to enrollment in Medicaid and other Medicare subsidy programs, would ease application and enrollment processes and ensure that more individuals are able to access benefits.⁹¹ Congress should eliminate or otherwise create a more generous asset limit for Medicare subsidy programs. Absent Congressional action, states should eliminate the asset test themselves. At least nine states had eliminated asset tests for all MSPs.⁹²

While there is some precedent for federal and state cooperation on standardizing and aligning eligibility thresholds, practical experience has been unsatisfactory. For example, the Medicare Improvements for Patients and Providers Act required alignment of asset limits for MSPs and LIS but certain disregards are applied or calculated differently under these programs.⁹³ For example, while the value of life insurance is excluded from the LIS asset limit, such a disregard is not required for MSPs.⁹⁴ Also, SSA, which makes LIS determinations, automatically disregards \$1,500 of burial expenses from asset calculations.⁹⁵ However, many states have stricter requirements so that they are unable to automatically accept LIS asset data for MSP determinations. As a result, states must recollect asset information and documentation to verify assets from applicants, leading to delays or the complete failure of enrollment.⁹⁶ Aligning and applying a standardized automatic disregard for burial expenses across MSPs and LIS, if asset tests remain intact, would help states to more efficiently accept and process LIS data for MSP applications, helping to ensure that more individuals who are eligible are enrolled.⁹⁷

Align and simplify application and renewal rules and processes among qualified health plans and premium tax credits and cost-sharing subsidies, ACA-expanded Medicaid, Medicaid programs for Medicare beneficiaries and Medicare subsidy programs.

States and the federal government should also align application rules between ACA related coverage and non-ACA Medicaid and Medicare subsidy programs to help ease application hurdles for beneficiaries and allow for a completely electronic application process. States can do this by eliminating requirements to provide documentation proving income and assets and by increasing the use of electronic data exchanges, in line with principles of the ACA and the Medicare Improvements for Patients and Providers Act. In

⁹¹ Summer et. al., [How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits](#).

⁹² Kaiser State Health Facts, [Income Requirements for Qualified Medicare Beneficiaries \(OMBs\) receiving Medicaid Assistance including Income Limits, Asset Limits and Disregards, 2010](#) (Menlo Park, Calif: Kaiser Family Foundation), <http://statehealthfacts.org/comparereport.jsp?rep=61&cat=6&sub=186>, accessed on April 24, 2012; Medicare Interactive, [Medicare Savings Program Financial Eligibility Guidelines by State](#). States increase income and asset limits by increasing income and asset disregards set by federal law.

⁹³ SSA § 1860D-14(a)(3); SSA § 1905(p)(1)(C); SSA POMS HI 00815.024

⁹⁴ SSA § 1860D-14(a)(3)

⁹⁵ SSA POM HI 03001.005.

⁹⁶ CMS, [Dear State Medicaid Director Letter](#) (February, 2010); Goggin-Callahan, [Warning Signs: Preliminary Report Highlights Problems with State Implementation of MIPPA Low-Income Reforms](#). Many states will only apply the disregard if an applicant can prove they have pre-paid burial funds or designated bank account.

⁹⁷ Goggin-Callahan, [Warning Signs: Preliminary Report Highlights Problems with State Implementation of MIPPA Low-Income Reforms](#).

addition, as in the ACA, states should accept all applications electronically for all categories of Medicaid, as regulations encourage.

Furthermore, states should re-examine their current Medicaid renewal processes and more aggressively pursue outreach and enrollment to individuals who lose Medicaid under one category though they appear eligible under another category.⁹⁸ To this end, the advent of data-sharing between states and the federal government under the ACA and the Medicare Improvements for Patients and Providers Act, and the expansion of such data-sharing (as discussed in greater detail under the next recommendation), should help facilitate a more automatic transition between different types of coverage.

Lastly, the federal government and states should implement regulations that require an administrative renewal process for all categories of Medicaid including MSPs using available data. Specifically, even if current data may not be available through data exchanges for administrative renewals for certain categories of non-ACA related Medicaid, other information on file should be used to trigger the administrative renewal process. Medicare beneficiaries' incomes and assets do not tend to change dramatically from year to year so documentation provided in initial applications is often representative of an individual's financial situation in following years. States could use this information to trigger an administrative renewal notice and unless an individual notifies the agency of a change in income or assets, the state agency could renew her benefits.⁹⁹

Utilize electronic data-sharing to automatically verify eligibility and facilitate enrollment into non-ACA Medicaid and Medicare subsidy programs as an individual becomes eligible for Medicare.

Transitions to Medicare for people with ACA related coverage present opportunities for increased efficiency in identification, application and enrollment of eligible individuals into multiple benefits, including Medicare, Medicaid and Medicare subsidy programs. Again, the ACA envisions coordination among various federal and state entities and uses data-sharing to streamline application, eligibility determination and enrollment processes. The federal government and states should implement regulations, as required, to assure that these data exchanges are appropriately applied to the Medicare population eligible for Medicaid and build on these policies to ensure that people seamlessly move from ACA related coverage to Medicare.

One way to ensure a more seamless transition from ACA related coverage to Medicare and programs for low- and middle- income Medicare beneficiaries is to expand data-sharing between state, federal and non-governmental entities to allow for facilitated enrollment in all benefits upon Medicare eligibility. By sharing information between

⁹⁸ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 *Fed. Reg.* at 17182, 17211 (to be codified at 45 CFR 435.916). While states are currently required to examine individuals for all possible Medicaid categories for which they are eligible before termination, recent regulations codified language that more clearly sets out this requirement.

⁹⁹ Goggin-Callahan, [Recertification in New York State: The Revolving Door of the Medicare Savings Program](#); Summer, [Increasing Participation in Benefit Programs for Low-Income Seniors](#).

agencies to confirm the authenticity of people’s applications, agencies would also have an opportunity to screen individuals for all the programs it administers. As a result, an individual applying for any health program would automatically be screened for eligibility for others. For example data shares could be used to:

- identify individuals who are about to become Medicare eligible;
- enroll these individuals in Medicare if they are not subject to auto-enrollment;
- screen these individuals for Medicare subsidy programs; and/or
- verify applicant information and process enrollments for all Medicaid and Medicare subsidy programs.

It is important to note that even in cases where information is not available through data-sharing among federal and state agencies for the Medicare population, or if such data-sharing is implausible, there may also be data-sharing opportunities for states to engage in independent of the federal government. Some states already engage in data exchanges among state agencies to verify applicant information and process enrollments in multiple programs. For example, as part of an effort to increase enrollments, eligibility information acquired by the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and other programs can be used to trigger an application and/or enroll eligible children into the Children's Health Insurance Program (CHIP).¹⁰⁰ This kind of enrollment model, also known as “express lane eligibility,” could be applied to the Medicare population as well.¹⁰¹

In addition, states already engage in data transfers through Income and Eligibility Verification Systems (IEVS).¹⁰² This data-sharing could be expanded and used to verify applicant information for real-time eligibility determination purposes.

Modernize eligibility determination and enrollment systems for all Medicaid populations.

In building new systems for 2014, states should ensure that all populations are appropriately incorporated into one modernized enrollment system. The Department of Health and Human Services has made funding available to states, via an increased Federal Medical Assistance Percentage (FMAP) match available through 2015, to assist them in creating modern and compatible systems that can facilitate enrollment into

¹⁰⁰ Jennifer Sullivan and Laura Parisi, [Express Lane Eligibility: Early State Experiences and Lessons for Health Reform](http://www.familiesusa.org/assets/pdfs/chipra/Express-Lane-Eligibility-State-Experiences.pdf) (Washington, D.C.: Families USA, January 2011), <http://www.familiesusa.org/assets/pdfs/chipra/Express-Lane-Eligibility-State-Experiences.pdf>; Laura Summer, [Express Lane Eligibility, New Strategies for Increasing Enrollment](http://www.centerforbenefits.org/NCBOE_ELE_Issue_Brief_FINAL.pdf) (Washington, D.C.: National Council On Aging, June 2009), http://www.centerforbenefits.org/NCBOE_ELE_Issue_Brief_FINAL.pdf.

¹⁰¹ Summer, [Express Lane Eligibility, New Strategies for Increasing Enrollment](http://www.centerforbenefits.org/NCBOE_ELE_Issue_Brief_FINAL.pdf).

¹⁰² Summer et. al., [Simplifying Enrollment in Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities](#).

programs.¹⁰³ Even if states do not initially include all populations eligible for Medicaid or state-based subsidy programs in these systems, new enrollment systems should be built to easily incorporate such populations in the future and to accommodate screening for multiple programs that may have different eligibility criteria. States should also engage in daily data exchanges to ensure that any issues regarding incompatibility can be identified and fixed in a timely fashion.

For example, the Medicaid Redesign Team in New York recently approved recommendations that would require the state to build and use a single eligibility determination and enrollment system for Medicaid, including those individuals eligible for all ACA related coverage and all forms of Medicaid.¹⁰⁴ The MRT also recommended that, while MSP determinations and enrollments should be integrated into the single system by 2014, other Medicaid populations could and should be integrated by the time the enhanced FMAP for systems development expires in order to maximize the funding available for systems modernization.¹⁰⁵ In addition, New York already exchanges data almost daily for MSP applicants with the federal government.

Use education, outreach and notices to inform individuals about enrollment obligations and available benefits.

Given the complicated rules governing ACA related coverage termination and Medicare enrollment, it is necessary for states, the federal government, exchanges and qualified health plans to engage in education and outreach efforts to alert people to the existence of Medicare and related benefits, eligibility requirements and enrollment periods. Such education and outreach is necessary to prevent gaps in coverage or the creation of unnecessary and unaffordable financial burdens for those who are newly Medicare eligible. Specifically, resources must be available to allow for individualized and one-on-one counseling.¹⁰⁶

The development and funding of patient navigators and Consumer Assistance Programs shows the need to provide assistance to individuals in the exchanges as they make decisions about their health insurance coverage. As funding has been made available to these programs, so too should additional funding be made available to SHIPs and other community-based organizations that specialize in Medicare to ensure that there are appropriate educational resources available to help individuals facing transitions from ACA related coverage to Medicare.

In addition, while navigators will not specialize in Medicare, they must be knowledgeable about Medicare basics and how Medicare interacts with ACA related coverage so they

¹⁰³ Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, 76 *Fed. Reg.* 21950; CMS, [Guidance for Exchange and Medicaid Information Technology \(IT\) Systems: Version 2.0](#).

¹⁰⁴ New York State Department of Health, [Medicaid Redesign Team \(MRT\), Program Streamlining and State/Local, Responsibilities Work Group, Final Recommendations](#) (NYSDOH, October 2011), http://www.health.ny.gov/health_care/medicaid/redesign/docs/program_streamlining_report.pdf.

¹⁰⁵ *Id.*

¹⁰⁶ Summer, [Increasing Participation in Benefit Programs for Low-Income Seniors](#).

can appropriately identify people who may face this transition and connect those individuals to the appropriate resources. SHIPs and other Medicare-focused assistance resources must similarly be trained in these transitions and insurance interactions. Also, as states build their Consumer Assistance Programs' networks, states should include organizations that specialize in Medicare, which will be able to provide accurate and specific advice concerning Medicare enrollment.¹⁰⁷

Building and funding appropriate independent consumer resources to help individuals with ACA related coverage transition to Medicare will help assure that these individuals receive objective advice about the spectrum of Medicare options. For instance, the availability of such objective information from an independent source might be especially important for an individual insured by a Medicaid managed care plan or qualified health plan that also markets a private Medicare Advantage plan. While the private Medicare plan might ultimately be the right choice for this individual, she should also know about the availability of Original Medicare, Medigap plans offered by a different sponsor and other coverage options including subsidy programs.

Beyond general educational resources, state Medicaid agencies, the exchanges and qualified health plans should, at a minimum, proactively identify and provide notice to enrollees about the termination of their current coverage as well as Medicare eligibility and enrollment obligations. All notices should:

- include information about Medicare, Medicare enrollment and the potential repercussions of not enrolling in Medicare in a timely fashion;
- contain information about Medicare subsidy programs that help people with limited incomes, such as MSPs and LIS, with instructions on who to contact for more information and application assistance;
- direct people to appropriate resources specializing in Medicare and related benefits;
- be provided far enough in advance of Medicare eligibility to allow individuals adequate time to
 - educate themselves about their options,
 - take appropriate steps to terminate their current coverage, and
 - enroll in Medicare and related programs at the right time to avoid any unnecessary coverage gaps and penalties; and

¹⁰⁷ For example, New York State's CAPs network includes the Medicare Rights Center to help individuals with questions that relate to interactions in their current coverage and Medicare and Medicare related questions.

- be appropriately coordinated when multiple entities administer benefits. For example, regardless of whether an exchange or a qualified health plan provides notice, the language should be consistent to help beneficiaries avoid confusion caused by incompatible notices.

Conclusion

Beginning in 2014, people who have health coverage through the ACA will face a number of transition issues upon becoming eligible for Medicare. To ensure a smooth transition to Medicare, federal and state policymakers must examine the potential pitfalls, complications and disruptions involved in that transition and must implement the solutions recommended above or propose other solutions that will help these individuals, especially those with limited incomes, maintain seamless, comprehensive and affordable coverage. While the current landscape is uneven and tangled, the policies, procedures and technology mandated by the ACA (and to a lesser degree by the Medicare Improvements for Patients and Providers Act), deployed directly or easily expanded upon, indicate a path federal and state governments can follow to make sure that those who become eligible for Medicare are protected from gaps in coverage and unnecessary out-of-pocket costs that could put their health and financial security at risk.