MEDICARE RIGHTS CENTER

Getting Medicare right

Marketplace to Medicare

HIICAP Training
September 2019

Medicare Rights Center

The Medicare Rights Center is a national not-for-profit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through

Counseling and advocacy

Educational programs

Public policy initiatives

Medicare Rights Center

The Medicare Rights Center has a helpline available for HIICAP counselors:

800-480-2060

hiicap@medicarerights.org

Learning objectives

- Understand Marketplace coverage options
  - Qualified Health Plans (QHPs)
  - Expansion Medicaid
- Explain Medicaid and Medicare basics
  - Medicare Savings Programs
- Help clients transition between different types of coverage
  - QHP to Medicare
  - Expansion Medicaid to Medicare

Marketplace basics

The New York State of Health (NYSoH)

- Forum (sometimes referred to as Marketplace or Exchange) where individuals can shop for health coverage – established by Affordable Care Act (ACA)
- Types of insurance include:
  - **Qualified Health Plans**
  - **Essential Plan**
  - **Expansion Medicaid**
- Allows for comparison of available plan options based on price, benefits, services, quality

Qualified Health Plans

- Health insurance policies that meet protections and requirements set by the ACA
  - Follow federally established cost-sharing limits
  - Provide essential health benefits

Essential Plan

- Marketplace plan in New York State for people with low incomes who do not qualify for Medicaid
- Offers low or no premium and no deductible for coverage*
- To be eligible, a beneficiary must be both:
  - Age 19-64
  - Ineligible for other insurance, including employer insurance

Household size	2019 Income limits
1	$24,280
2	$32,920
3	$41,560
4	$50,200

Expansion Medicaid

- Medicaid insurance with higher income limits than ABD Medicaid
  - Eligibility calculated from modified adjusted gross income (MAGI) – will be addressed in slides
- Expands Medicaid to populations not previously eligible for the program
- Resources and assets not counted
  - Eligibility based only on individual's taxable income
- After approval, individual can receive expansion Medicaid for up to how many months during their continuous coverage period?
  - 12 months

MAGI budgeting

- MAGI = **Modified Adjusted Gross Income**
- Expansion Medicaid eligibility calculated based on an individual's modified adjusted gross income from their tax return and their household size
  - If a person does not file taxes, eligibility rules match those for tax filers to the maximum extent. Spouses, parents, stepparents, and children living together are included in same household.
- Certain income disregarded (not counted), including:
  - Veterans benefits
  - Workers compensation
  - Child support
- Medicaid (expansion and ABD) regulated at state and federal level

Expansion Medicaid eligibility

- Beneficiary must have income below 138% of the FPL and fall into one of these categories, sometimes called expansion populations:
  - Childless adults ages 19-64
    - » “Childless” refers to individuals who currently do not have a dependent child living with them.
  - Individuals who are pregnant
    - » Income limits are higher if you are pregnant
  - Parent and caretaker relatives*
- Remember, expansion Medicaid eligibility does not take into account an individual’s resources/assets

Medicaid Managed Care

- Individuals may be able to receive Medicaid (ABD and expansion) through private managed care plans
  - May offer greater care coordination
  - Individuals with Expanded Medicaid generally receive their Medicaid through a managed care plan.
- Beneficiaries with managed care plans usually must:
  - Use a certain group of doctors (doctors who are in network) to pay the least for health care
  - See a primary care provider before seeing a specialist
  - Receive permission from their plan before getting expensive care

Medicaid and Medicare basics

What is ABD Medicaid?

- State and federal program offering health insurance to those with limited incomes/assets
  - » Each state has its own Medicaid rules
  - » People of different ages and groups may have different financial qualification limits
    - One group is for folks who are Aged, Blind, or Disabled

2019 New York Medicaid qualification limits if a beneficiary is aged, blind, or disabled		
Family Size	**Monthly Income Limit**	**Asset Limit**
Single	$879	$15,450
Married	$1,287	$22,800

ABD Medicaid eligibility

- Populations typically eligible for ABD Medicaid include:
  - Individuals 65+
  - Individuals with disabilities
    - » Individuals who receive SSDI for 24+ months
  - Blind individuals
  - Individuals in need of long-term supports and services (LTSS)
    - » Require LTSS that is not covered by mainstream Medicaid plans
  - Individuals who fall into a “medically needy” category
  - Former foster care youth

People with Medicare and Medicaid

- Known as **dually eligible, dual-eligible,** or duals
- Medicare pays first, Medicaid may pay after
  - Medicaid covers some services that Medicare doesn't, such as dental, hearing, podiatric, and vision care
  - Beneficiaries pay the least by using doctors who accept both Medicare and Medicaid
- Required to enroll in a Medicare Part D plan (prescription drug coverage)

Medicare Savings Programs

- What are some benefits of the MSP?
  - Pays for monthly Part B premium
  - Removes late enrollment penalties
  - Depending on program, MSP can also help pay:
    - » Part A and Part B deductibles
    - » Costs of health care services
  - Beneficiaries transitioning from expansion Medicaid to Medicare should be evaluated for an MSP automatically

Helping clients transition from a QHP to Medicare

The QHP-to-Medicare transition

- Most people with QHPs should enroll in Medicare once they become eligible and drop their QHP
  - It's likely not cost-effective to have both Medicare and a QHP
  - After beneficiary becomes eligible for premium-free Part A, they are no longer eligible to receive tax credits or premium assistance to help afford QHP
- Beneficiaries should enroll in Medicare Parts A, B, and D during their IEP
  - Keep track of when beneficiary first qualifies for Medicare
  - Actively enroll beneficiary if they are not auto-enrolled
  - Contact Social Security Administration to enroll: 800-772-1213

Delaying Medicare enrollment

- Delayed enrollment may result in:
  - Late enrollment penalties on Medicare premiums
  - Gaps in coverage
- Medicare-eligible individuals likely have to pay the full QHP premium
  - Remember, beneficiaries eligible for premium-free Part A lose QHP premium tax credits
  - Exception: Beneficiaries who pay a premium for Part A can continue receiving premium tax credits but should still consider the consequences of delaying Medicare enrollment
- QHP and Medicare coordination of benefits is unclear

Questions to consider

- Beneficiaries should consider these questions as their benefits and coverage change
  - What services are they receiving that Medicare does not cover, and how might gaps in coverage be filled?
  - What drug plan works best for them, now that Part D will pay for drug coverage?
    - » Make sure Part D plan covers all medications
  - Do the beneficiary's current health care providers accept Medicare?

Helping clients transition from expansion Medicaid to Medicare

Medicare and expansion Medicaid coverage

- Beneficiaries should be advised to enroll in Medicare after becoming Medicare-eligible
  - Potential consequences for delaying enrollment include gaps in coverage and Medicare late enrollment penalties
  - Medicare is primary insurance for eligible individuals with Medicaid, and Medicaid may not provide coverage unless Medicare pays first
- Beneficiaries may also be eligible for the Medicare Savings Program (MSP)
  - Expanded Medicaid income limit is 138% FPL
  - The MSP income limit is 135% of FPL

Delaying Medicare enrollment

- Delayed enrollment may result in:
  - Late enrollment penalties on Medicare premiums
  - Gaps in coverage
    - » Both may be avoided if the beneficiary qualifies for the MSP
- Beneficiaries will not have primary insurance
  - Medicaid is secondary to Medicare, meaning it may pay very little or nothing

Part D enrollment

- Part D is responsible for a beneficiary's drugs after they become eligible for Medicare
  - Medicaid is no longer the primary payer
- Beneficiaries should automatically be enrolled in Part D and the federal Extra Help program
  - Beneficiaries should check that all of their medications are on the Part D plan formulary
  - Extra Help provides a monthly Special Enrollment Period (SEP). Beneficiaries can switch their Part D plan if it does not suit their needs
  - Extra Help lowers prescription drug costs

The expansion Medicaid-to-Medicare transition

- An individual with expansion Medicaid should be evaluated for aged, blind, and disabled (ABD) Medicaid
  - ABD Medicaid is also known as traditional Medicaid and has stricter eligibility requirements than expansion Medicaid
- Timing depends on how the individual became Medicare-eligible
  - Eligible due to age: evaluation occurs when the individual becomes Medicare-eligible
  - Eligible due to disability: evaluation occurs at the individual's MAGI Medicaid renewal date
- When a person's expansion Medicaid ends, their case will be closed on the NYSoH and will be transferred to their Local Department of Social Services (LDSS). Their LDSS will then manage the evaluation

Medicaid renewal forms

- Individual's case will be transitioned from NYSoH to the Local Department of Social Services (LDSS)
- Before the individual is evaluated for ABD Medicaid, they should receive notices from the NYSoH and their LDSS about the process
  - Notices may look like Medicaid renewal notices
  - If a person does not receive paperwork, they can call their LDSS to ask for more information
- All paperwork should be completed by the individual, caregiver, or professional to ensure that the individual is evaluated for ABD Medicaid
- All paperwork should be completed and returned timely to ensure a smooth evaluation process

Part B premium reimbursements

- New York State Department of Health (DOH) should notify the beneficiary about Part B premium reimbursements, meaning getting reimbursed for Part B premium payments while they have expanded Medicaid and Medicare
- The person should receive reimbursement checks in the mail for their Part B premium. Their Part B premium should still be deducted from their Social Security, or they will receive a bill if their premiums are not deducted from Social Security.
  - They should continue to receive reimbursements while they are evaluated for ABD Medicaid
- If they do not receive premium reimbursements, they should call NYSoH for assistance.

ABD Medicaid and MSP evaluation

- Individuals should be evaluated for traditional Medicaid **and a Medicare Savings Program (MSP)**
  - Expansion Medicaid benefits will continue temporarily while their case is being evaluated
  - Notices now include clear MSP-related language
- Individuals will receive information from their LDSS about whether they are eligible for ABD Medicaid and/or an MSP after they submit the required paperwork.
- If a beneficiary does not receive information about the MSP or is unsure if they were evaluated, they should contact their LDSS.

Possible transition conclusions

- There are four possible outcomes of ABD Medicaid and MSP evaluation:
  1. Transition from expansion Medicaid to Medicare with ABD Medicaid and an MSP
  2. Transition from expansion Medicaid to Medicare with an MSP and without ABD Medicaid
  3. Transition from expansion Medicaid to Medicare without ABD Medicaid or an MSP
  4. In limited circumstances (if a parent/caretaker relative), receive Medicare and remain in expansion Medicaid with a Part B reimbursement

Troubleshooting

- Use these questions to help troubleshoot if issues arise with a client's transition
  - Has the beneficiary received and filled out their renewal application? If there is any confusion, call NYSoH and ask if their case has been transferred to the LDSS. If so, call the LDSS to request materials that need to be filled out prior to evaluation
  - Has the beneficiary been disenrolled from their Medicaid managed care plan, or do they have to actively disenroll?
  - Is individual receiving reimbursement for Medicare Part B premiums? If not, contact the NYSoH
  - Does the beneficiary know which cards to use to access care? Since they now have Medicare and are disenrolled from their Managed care plan they should show 1) red, white and blue Medicare card AND 2) NYS Benefits Card. At the pharmacy show the Part D drug plan card.

Questions to consider

- Beneficiaries should consider these questions as their benefits and coverage change
  - What services are currently being received that Medicare does not cover, and how might gaps be filled?
  - What drug plan works best for the beneficiary, now that Part D instead of Medicaid will handle drug coverage?
    - » Dual-eligible and MSP-eligible individuals are generally auto-enrolled into a Part D plan
    - » Make sure Part D plan covers all medications
  - Do the beneficiary's current health care providers accept Medicare? Medicaid?

Case studies

Case study #1

- Mr. Johnson lives in New York State and has expansion Medicaid. He is single. He has a monthly income of $800, and $17,000 in his savings account. Currently he uses his Medicaid for his doctor's visits and for prescription drugs. He is turning 65 in four months and is concerned about switching to Medicare.

What are important takeaways for Mr. Johnson to remember as he transitions to Medicare?

Answer

- Mr. Johnson will receive paperwork from the NYSoH and his LDSS to complete in order to be evaluated for ABD Medicaid after becoming Medicare-eligible
  - He should receive Part B premium reimbursements through NYSoH temporarily while being evaluated for ABD Medicaid
- What benefits does he seem eligible for?
  - His assets put him over the limit for ABD Medicaid
  - He will be eligible for the MSP QMB which provides balance billing protections

Answer (continued)

- Medicare will become Mr. Johnson's primary insurance.
  - He will be automatically enrolled if he receives Social Security income.
  - He should call SSA to make sure he is enrolled, if he is not collecting Social Security.
- Part D will cover his prescription drugs
  - Mr. Johnson should be aware that his drugs may have coverage restrictions, depending on the plan
  - He should enroll in a Part D plan that has the pharmacies he needs in network, the drugs he takes on the formulary, and costs he can afford
  - He will be enrolled in the Extra Help program to help save costs

Case study #2

- Ms. Morrison is concerned about her transition to Medicare. She received a notice from NYSoH informing her that she will no longer be eligible for Medicaid. Afterwards she received a Medicaid renewal application that she did not fill out because she's no longer eligible. Ms. Morrison is also worried about the monthly premium for Medicare. She has an income of $750 a month and cannot afford the Part B premium. She has assets under the Medicaid limit.

What information would help Ms. Morrison?

Answer

- Explain to Ms. Morrison that she needs to fill out her Medicaid renewal application to be evaluated for ABD Medicaid and an MSP
  - She is eligible for both programs
  - She will not have to pay for the Part B premium
  - She will be enrolled into a benchmark Part D plan, meaning she will not pay a premium*
    - » She can change her Part D plan if it does not cover her drugs

Case study #3

- Julie is approaching her 65th birthday and plans to enroll in Medicare. She currently has a QHP through NYSoH but knows that individuals who are 65 and older typically need to enroll in Medicare. However, Julie learned that because she only has five years of work history in the U.S., she will have to pay a monthly $437 Part A premium along with her monthly Part B premium of $135.50.

Does Julie have any other options?

Answer

- Individuals who do not have the work history to qualify for premium-free Part A may wish to continue using their Marketplace plan instead of Medicare
  - Julie can opt to continue using her QHP, and will continue to be eligible for premium tax credits
- If she decides to enroll in Medicare in the future, she will likely incur late enrollment penalties and will be restricted to enroll during the General Enrollment Period
- Julie should see if she is eligible for the MSP QMB.
  - QMB will provide free Medicare, as well as balance billing protections

For assistance:

- Please call the Medicare Rights Center at 800-480-2060
  - Or contact us at hiicap@medicarerights.org
  - For questions about premium reimbursements, contact the New York State of Health at 1-855-355-5777
  - For questions about evaluation for ABD Medicaid, contact the beneficiary's Local Department of Social Services (LDSS), sometimes called the Medicaid office