The Medicare Rights Center is a national, nonprofit 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
This toolkit for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) was made possible by grant funding from the National Council on Aging.
This training will cover

- MAGI Medicaid
- Categories of MAGI Medicaid-to-Medicare transitions
  - Review of Medicare eligibility and coverage
  - Review of Medicare cost-sharing
- Transitions from MAGI Medicaid to Medicare
  - Transitioning from MAGI Medicaid to traditional Medicaid and a Medicare Savings Program
  - Transitioning from MAGI Medicaid to a Medicare Savings Program without traditional Medicaid
  - Transitioning from MAGI Medicaid to Medicare without traditional Medicaid or a Medicare Savings Program
- Questions to ask when transitioning from MAGI Medicaid to Medicare

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MAGI Medicaid
Marketplaces: Home of MAGI Medicaid

- Marketplaces = Exchanges, and may have other names depending on state – established by Affordable Care Act (ACA)

- Forums where businesses and individuals can shop for health coverage
  - Insurance for individuals = Qualified Health Plans (QHPs)
  - Insurance for businesses = Small Business Health Options Program (SHOP) plans

- Typically provide insurance to uninsured and under-insured individuals

- As a result of ACA, many states expanded Medicaid eligibility (see next slide)

- Marketplaces enroll individuals into MAGI Medicaid
MAGI Medicaid background

- **MAGI** = Modified Adjusted Gross Income
- MAGI 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, the eligibility rules match those for tax filers to the maximum extent. Spouses, parents, stepparents, and children living together are included in the same household.
- Medicaid (MAGI and non-MAGI) regulated at the state and federal level
MAGI Medicaid eligibility

Who is eligible for MAGI Medicaid?

- Individuals with income below 138% of the Federal Poverty Level (FPL) who fall into one of these categories:
  - Childless adults ages 19-64
  - Individuals who are pregnant
    - NOTE: Income requirements are higher for individuals who are pregnant
  - Children up to age 19 (or 21 depending on the state)
  - Parent and caretaker relatives

NOTE: Individuals who are eligible for Medicare benefits (i.e. those with a disability or age 65+) generally not affected by Medicaid expansion
MAGI Medicaid eligibility

- Certain income is disregarded (not counted) when calculating for MAGI Medicaid eligibility, including:
  - Veterans benefits
  - Workers compensation
  - Child support

- Resources and assets **not counted**
  - Eligibility based only on individual’s taxable income

- Individuals approved for MAGI Medicaid may receive MAGI Medicaid for up to a 12-month continuous coverage period
MAGI Medicaid costs and delivery

- Medicaid coverage (MAGI and non-MAGI) is comprehensive and very low cost
  - States may impose nominal deductible or copayment
  - No premiums, and monthly or quarterly maximum out-of-pocket expense of 5% of income
  - Certain populations (e.g., institutionalized) do not have Medicaid cost-sharing

- Individuals may be able to receive Medicaid (MAGI and non-MAGI) through private managed care plans
  - May offer greater care coordination
  - Individuals with Medicaid Managed Care (MMC) should make sure to see providers in their plan’s network
Non-MAGI (traditional) Medicaid

- Individuals who do not fall into one of the MAGI Medicaid populations may be eligible for non-MAGI (traditional) Medicaid

- These individuals include:
  - Individuals 65+
  - Individuals with disabilities
  - Blind individuals
  - Individuals in need of long-term care (LTC)
  - Individuals who fall into a “medically needy” category
  - Former foster care youth
Non-MAGI (traditional) Medicaid

- When an individual with MAGI Medicaid becomes Medicare-eligible, they will generally be immediately or eventually evaluated for traditional Medicaid

- **Traditional Medicaid has different eligibility requirements**
  - More strict
  - Individual must generally have an income less than 100% of FPL (compared to 138% of FPL for MAGI Medicaid eligibility)
    - Budgeting depends on state rules
  - Resources and assets are counted (i.e. there is an asset test)

- Individuals receiving MAGI Medicaid may be found ineligible for traditional Medicaid (see following slides for different types of transitions)
Categories of MAGI Medicaid-to-Medicare Transitions
MAGI Medicaid-to-Medicare transitions

- Transitions from MAGI Medicaid to Medicare will often look different from transitions for those with traditional Medicaid and Medicare because
  - The Marketplace may be involved
  - The budgeting limits for MAGI Medicaid are more generous than the limits for traditional Medicaid
- Also note: Medicare is **different from Medicaid**
  - Eligibility not based on income (i.e. not means-tested)
  - Administered by federal government, not by combination of federal and state governments
MAGI Medicaid-to-Medicare transitions

When an individual with MAGI Medicaid becomes Medicare-eligible, they may:

- Transition from MAGI Medicaid to Medicare with traditional Medicaid and a Medicare Savings Program (MSP)
- Transition from MAGI Medicaid to Medicare with a Medicare Savings Program and without traditional Medicaid
- Transition from MAGI Medicaid to Medicare without traditional Medicaid or a Medicare Savings Program
- In limited circumstances, receive Medicare and remain in MAGI Medicaid
Medicare enrollment for those with Medicaid

- Key point: Medicare acts as primary insurance to Medicaid (MAGI and non-MAGI)
  - Medicaid is always payer of last resort: Medicare pays first and Medicaid pays second
- Those with MAGI Medicaid should enroll in Medicare when first eligible
- If individual with MAGI Medicaid is eligible for Medicare but not enrolled, Medicaid may pay little or nothing on health claims
Medicare Eligibility, Coverage, and Costs
Medicare eligibility: Age

Who is eligible for Medicare?

Those 65+ years who:

- Collect or qualify to collect Social Security or Railroad Retirement benefits, or
- Are a current U.S. resident, and either
  - A U.S. citizen OR
  - A permanent U.S. resident having lived in the U.S. for 5 continuous years before applying for Medicare

NOTE: The 5 years may be reduced if the individual qualifies for premium free Medicare Part A
Medicare eligibility: Disability

Who is eligible for Medicare?

- Those under 65 years who:
  - Are a U.S. citizen or have a resident visa, have lived in the U.S. for five years in a row AND
  - Have been receiving Social Security Disability Insurance (SSDI) for more than 24 months

OR

- Have been diagnosed with End-Stage Renal Disease (ESRD) AND
  - Getting dialysis treatments or have had a kidney transplant
  - Have applied for Medicare benefits
  - Been deemed eligible for SSDI, railroad retirement benefits, or are otherwise considered to be fully insured by Social Security

OR

- Have been diagnosed with Amyotrophic Lateral Sclerosis (ALS)
Parts of Medicare

- Medicare benefits are administered through three parts
  - **Part A** – Hospital/Inpatient benefits
  - **Part B** – Doctors/Outpatient benefits
  - **Part D** – Prescription drug benefit
    - Added 2006

- What happened to Part C?
  - Private health plans (e.g., HMO, PPO)
    - Way to get Parts A, B, and D through one private plan
    - Known as **Medicare Advantage**
    - Not a separate benefit
    - May cover benefits not covered by Parts A and B (i.e. Original Medicare), such as vision and dental
What Part A covers

❖ Inpatient hospital care
  ● Individual is formally admitted into the hospital by a hospital doctor

❖ Inpatient skilled nursing facility care
  ● Individual must have spent 3 nights as a hospital inpatient

❖ Home health care
  ● Individual must be considered homebound and need skilled care
  ● A doctor must approve and services must be received from a Medicare-certified home health agency

❖ Hospice care
  ● Individual must be considered terminally ill

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## Part A costs

<table>
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<tr>
<th>Premium</th>
<th>Free for those with 10 years of Social Security work history</th>
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<tbody>
<tr>
<td></td>
<td>$226/month if someone worked 7.5 to 10 years</td>
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<tr>
<td></td>
<td>$411/month if someone worked less than 7.5 years</td>
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<tr>
<td>Hospital deductible</td>
<td>$1,288 in 2016 for each benefit period</td>
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<tr>
<td>Hospital copay</td>
<td>$322 per day for days 61-90, for each benefit period</td>
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<td></td>
<td>$644 per day for days 91-150 (these are 60 non-renewable lifetime reserve days)</td>
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<tr>
<td>Skilled nursing facility (SNF) copay</td>
<td>$161 per day for days 21-100, for each benefit period</td>
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What Part B covers

- Doctor services
  - Medically necessary outpatient care
  - Preventive care, such as mammograms and colonoscopies

- Durable medical equipment (DME)
  - Wheelchairs, walkers, oxygen tanks

- Home health care

- X-rays, lab tests, ambulance services

- Therapy services (physical, occupational, speech)

- Mental health/substance abuse treatment
## Part B costs

### Medicare Part B Costs for 2016

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<tr>
<td><strong>Annual deductible</strong></td>
<td>$166</td>
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</table>
| **Monthly premium**   | $104.90 per month if you paid this amount out of your Social Security last year.  
Note: The premium is $121.80 if you are new to Medicare in 2016 or if you are not collecting Social Security.  
People with high incomes pay more for the monthly premium. |
| **Coinsurance**       | Medicare pays 80% of Medicare-approved amount for a doctor’s service; beneficiary pays 20% coinsurance. |

- Exceptions: no coinsurance or deductible for certain preventive services; outpatient hospital copays cannot exceed the Part A deductible ($1,216) for the year.
- Note: coinsurance is sometimes called cost-sharing.
What Medicare does not cover

- Most dental care
- Most vision care
- Routine hearing care
- Most foot care
- Most long-term care
- Alternative medicine
- Most care received outside the U.S.
- Personal care or custodial care if a person does not also need skilled care
- Most non-emergency transportation

**Note:** Medicare Advantage Plans and/or Medicaid may cover some of these services.
Medicare compared to Medicaid

- Remember: Medicare acts as primary insurance to Medicaid (MAGI and non-MAGI)
- Those transitioning from Medicaid to Medicare should understand coverage and cost differences between the two programs, such as
  - Depending on state, possible reduction in covered services under Medicare
  - Greater cost-sharing for those enrolled in Medicare (and without secondary coverage), such as the 20% coinsurance on most outpatient claims
    - Those without a Medicare Savings Program also responsible for monthly Medicare Part B premiums
Medicare Savings Programs
What are Medicare Savings Programs?

- Medicare Savings Programs (MSPs) = Medicaid-administered benefits that help pay Medicare costs for beneficiaries with limited incomes
- Important resource for eligible individuals transitioning from MAGI Medicaid to Medicare
- Types of MSPs:
  - Qualifying Individual (QI), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Medicare Beneficiary (QMB), and Qualified Disabled Working Individual (QDWI)
    - Each MSP has its own eligibility levels
      - This includes income and assets, though some states do not have asset tests
Medicare Savings Programs

- **QI, SLMB, and QMB**
  - Can be used to enroll in Part B for the first time
  - Cover the cost of the monthly Part B premium

- **QMB**
  - Pays for coinsurance and deductibles
    - Provides balance billing protections, prohibiting providers from balance billing beneficiaries for any Medicare-related costs
  - May help enroll a person in Medicare Part A and may cover the cost of the monthly Part A premium
    - Depends on state-specific rules
# MSP eligibility levels in 2015

<table>
<thead>
<tr>
<th></th>
<th>QMB</th>
<th>SLMB</th>
<th>QI</th>
<th>QDWI</th>
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<tbody>
<tr>
<td>Income: all states except AK &amp; HI</td>
<td>Single: $1,001&lt;br&gt;Couple: $1,348</td>
<td>Single: $1,197&lt;br&gt;Couple: $1,613</td>
<td>Single: $1,345&lt;br&gt;Couple: $1,813</td>
<td>Single: $4,009&lt;br&gt;Couple: $5,395</td>
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* Some states do not have resource/asset tests.
MAGI Medicaid-to-Medicare Transitions: The Process
MAGI Medicaid-to-Medicare: The Process

- Individuals who have MAGI Medicaid and are becoming Medicare-eligible (thus losing MAGI Medicaid) should be evaluated for traditional Medicaid
  - Timing depends on state-specific rules
    - Individual may be evaluated for traditional Medicaid at their MAGI Medicaid renewal date
    - Individual may be evaluated for traditional Medicaid as soon as they become Medicare-eligible

- Regardless of evaluation status, when individual has MAGI Medicaid and becomes Medicare-eligible, they should enroll into Medicare Parts A and B
  - Remember: Medicare is primary, Medicaid is secondary
  - The individual may automatically receive Full Extra Help, which will automatically enroll them into Medicare Part D
MAGI Medicaid-to-Medicare: The Process

- Before individual is evaluated for traditional Medicaid, they should receive notices from their Marketplace about the process
  - Notices may look like Medicaid renewal notices
  - Individual should ask their Marketplace if they need to complete additional paperwork
- All paperwork should be completed by the individual, caregiver, or professional to ensure that the individual is evaluated for traditional Medicaid
- Individual’s case will be transitioned to the local Medicaid office
- Individuals may be able to receive state reimbursement for their Part B premiums while they transition
  - State-specific rules apply; individual should confirm with their Marketplace
MAGI Medicaid-to-Medicare: The Process

- Individuals will be evaluated for traditional Medicaid and a Medicare Savings Program (MSP)
  - Individuals should ask their Marketplace if they need to complete additional paperwork or any other steps
  - Individuals should ask their Marketplace about whether their benefits will be continued (continuation of benefits) while their case is being evaluated
    - State may allow beneficiary to continue receiving MAGI Medicaid benefits while their case is being evaluated

- Individuals will receive information from their local Medicaid office about whether they are eligible for traditional Medicaid and/or and MSP
Recap: MAGI Medicaid-to-Medicare transitions

- For individual becoming Medicare-eligible (thus losing MAGI Medicaid) and being evaluated for traditional Medicaid, possible outcomes are:
  1. Transition from MAGI Medicaid to Medicare with traditional Medicaid and a Medicare Savings Program (MSP)
  2. Transition from MAGI Medicaid to Medicare with a Medicare Savings Program and without traditional Medicaid
  3. Transition from MAGI Medicaid to Medicare without traditional Medicaid or a Medicare Savings Program
  4. In limited circumstances, receive Medicare and remain in MAGI Medicaid
1. MAGI Medicaid to Medicare with traditional Medicaid and a Medicare Savings Program

- Individual evaluated for traditional Medicaid and found eligible will continue to receive Medicaid benefits, along with Medicare
  - Individual should find out their Medicaid benefits from their local Medicaid office

- Medicare will pay primary on claims, and Medicaid will pay secondary
  - Services not covered by Medicare may be covered by Medicaid
  - Individual should make sure they see providers who accept both Medicare and Medicaid

- If individual is also found eligible for an MSP, they will not have to pay their monthly Part B premium and may receive additional help paying for Medicare cost-sharing
2. MAGI Medicaid to Medicare with a Medicare Savings Program and without traditional Medicaid

- Individual evaluated for traditional Medicaid and found ineligible will no longer have Medicaid benefits
  - In many cases, Medicare will be sole insurance
  - The individual may lose coverage of services that only Medicaid covers (e.g., certain dental and vision services)
    - The individual could choose to enroll in Medicare Advantage Plan that covers some of these services
- If individual is also found eligible for an MSP, they will not have to pay their monthly Part B premium and may receive additional help paying for Medicare cost-sharing
3. MAGI Medicaid to Medicare without traditional Medicaid or a Medicare Savings Program

- Individual evaluated for traditional Medicaid and found ineligible will no longer have Medicaid benefits
  - In many cases, Medicare will be sole insurance
  - Individual may lose coverage of services that only Medicaid covers (e.g., certain dental and vision services)
    - Individual could choose to enroll in Medicare Advantage Plan that covers some of these services

- Because individual is also not eligible for an MSP, they will be responsible for all Medicare cost-sharing
  - Individual may wish to explore supplemental insurance options and/or charity care
4. Remain in MAGI Medicaid with Medicare

- In limited circumstances, individual may be able to retain MAGI Medicaid while having Medicare as primary insurance
  - Individual must be a Parent/Caretaker Relative
MAGI Medicaid-to-Medicare Transitions: Questions to Ask
Questions to ask Marketplace representative

- When will individual be evaluated for traditional Medicaid and an MSP?
- Does individual have to actively request/complete any materials to be evaluated for traditional Medicaid? What sort of materials should individual expect to receive about the evaluation process?
- If individual is currently receiving MAGI Medicaid through a Medicaid managed care plan, do they have to actively disenroll from it and enroll in traditional Medicaid?
- Is individual eligible to receive reimbursement for Medicare Part B premiums through their state? Do they have to actively request reimbursement?
Additional questions to consider

- What services is individual receiving under MAGI Medicaid that Medicare does not cover, and how might gaps be filled?
  - Traditional Medicaid (is individual eligible?)
  - Medicare Savings Program (is individual eligible?)
  - Medigap
  - Charity care

- Has individual been or will they be auto-enrolled into Extra Help and a Part D plan?
  - Dual-eligibles generally auto-enrolled
  - Make sure Part D plan covers all medications
    - Those with Extra Help can make changes any time
    - Those auto-assigned receive notice from Social Security
Addtional questions to consider

- How will individual’s access to care change after transition from MAGI Medicaid?
  - Medicare is primary, Medicaid is secondary
  - If the individual is eligible for traditional Medicaid, they will use Medicare and Medicaid card when accessing care

- Does individual’s health care providers accept Medicare? Medicaid?
  - If individual receives service not covered by Medicare, Medicaid might pay

- Is managed care a good choice for individual?
  - Offered through private plans
  - May offer greater care coordination
  - Individuals with any sort of managed care or advantage plan should make sure to see providers in their plan’s network
For more information and help

- Local State Health Insurance Assistance Program (SHIP)
  - [www.shiptacenter.org](http://www.shiptacenter.org)
  - [www.eldercare.gov](http://www.eldercare.gov)

- Social Security Administration
  - 800-772-1213
  - [www.ssa.gov](http://www.ssa.gov)

- Medicare
  - 800-Medicare (633-4227)
  - [www.medicare.gov](http://www.medicare.gov)

- Medicare Rights Center
  - 800-333-4114
  - [www.medicareinteractive.org](http://www.medicareinteractive.org)

- National Council on Aging
  - [www.ncoa.org](http://www.ncoa.org)
  - [www.centerforbenefits.org](http://www.centerforbenefits.org)
  - [www.mymedicarematters.org](http://www.mymedicarematters.org)
  - [www.benefitscheckup.org](http://www.benefitscheckup.org)
Medicare Interactive

- Medicare Interactive
  - www.medicareinteractive.org

- Web-based compendium developed by Medicare Rights for use as a look-up guide and counseling tool to help people with Medicare.
  - Easy to navigate
  - Clear, simple language
  - Answers to Medicare questions and questions about related topics, for example:
    - “How do I choose between a Medicare private health plan (HMO, PPO or PFFS) and Original Medicare?”
  - 2 million annual visits and growing
Medicare Interactive Pro (MI Pro)

- Web-based curriculum that empowers professionals to better help clients, patients, employees, retirees, and others navigate Medicare
  - Four levels with four to five courses each, organized by knowledge level
  - Quizzes and downloadable course materials
- Builds on 25 years of Medicare Rights Center counseling experience
- For details, visit [www.medicareinteractive.org/learning-center/courses](http://www.medicareinteractive.org/learning-center/courses) or contact Jay Johnson at 212-204-6234 or [jjohnson@medicarerights.org](mailto:jjohnson@medicarerights.org).
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