Health Advocate

E-Newsletter of the National Health Law Program

Volume 25 June 2014

Understanding the Medicare Coverage "Cliff"

Prepared by: Leonardo Cuello

The Affordable Care Act (ACA) includes numerous provisions that will improve the health security of older adults. For example, the ACA eliminates the coverage gap in Medicare Part D prescription drug coverage (sometimes referred to as "the doughnut hole") and expands access to free preventive and wellness visits for seniors. Older adults are undoubtedly better off with the ACA. However, the ACA's improvement of coverage for people under age 65 makes some of the long-standing limitations of current Medicare coverage more obvious.

The ACA authorizes states to expand their Medicaid programs and creates Marketplaces through which individuals may purchase subsidized health plans that cover a comprehensive package of benefits. Both of these options provide new, high-quality coverage choices for adults under age 65. In some cases, the benefits and cost-sharing protections in this coverage will be better than what is available in Medicare. For example, Medicare may offer less coverage of some services such as rehabilitative care or durable medical equipment. Most notable, Medicare will have higher cost-sharing, such as 20% cost-sharing for many medical visits. This means that as adults transition into Medicare at age 65, Medicare will actually be a step down in coverage for some. This is not because Medicare is any worse than it has ever been (in fact, it's better!); it is because these seniors will now have better coverage *before age 65*. Below, we discuss what the transition will be like for four senior populations.

1. Older adults below 138% FPL in states that expand Medicaid

Older adults with incomes below 138% of the federal poverty level (FPL) in states that expand Medicaid will have reliable coverage available before age 65. This Medicaid coverage will include a Medicaid benefits package and cost-sharing limits. Once they turn age 65, those with income below 135% and *low assets* will continue to be eligible for Medicaid, and become "dual eligibles,"enrolled in both Medicaid and Medicare. However, after turning age 65 their Medicaid coverage will vary from a full Medicaid benefits package with cost-sharing limits to only Medicaid payment of their Medicare Part B premium, depending on their income. In other words, some of these older adults will lose the Medicaid benefits package and many cost-sharing protections when they gain Medicare. The Medicaid benefits package may include key benefits that Medicare lacks, and Medicaid cost-sharing is significantly lower than Medicare cost-sharing. This drop-off in coverage is sometimes referred to as the "**Medicare Cliff**."

Key Resources

To learn the basics about the benefits available in the Medicaid expansion and the Marketplace, see NHeLP's Health Advocate: Understanding the Difference Between Medicaid and EHB Benchmarks, available here.

For in-depth information about Medicaid expansion benefits, see NHeLP's Medicaid Alternative Benefits Webinar Presentation, available here.

For in-depth information about Medicaid cost-sharing rules, see NHeLP's Medicaid Cost-Sharing Webinar, available here.

For advocacy tips in analyzing Medicaid expansion benefits, see NHeLP's Overview of HHS' Proposed Rule on Benefits for the Medicaid Expansion Population: A Step Guide for Advocates, available here.

Coming in July's Health Advocate:

ACA Litigation

Individuals with *higher assets* face an even larger cliff: They will lose all Medicaid coverage upon turning age 65 (unless they qualify in a special category, such as one for older adults needing home attendant care), meaning they will not have any of the Medicaid benefits or any of the important Medicaid cost-sharing protections.

A subset of individuals who will often see an especially steep cliff are individuals who do not qualify for Medicaid based on disability but are "medically frail" – for example, individuals with serious and complex medical conditions or functional limitations. Because of their medical frailty, these individuals will qualify for the richest Medicaid benefits package, regardless of their assets, until age 65, and then they will transition to Medicare coverage and generally lose that rich Medicaid benefits package unless they have very low income and assets.

The addition of high quality Medicaid expansion coverage before age 65 means that when older adults transition to Medicare, some of them may end up with Medicare coverage that is significantly worse. Of course, their Medicare coverage is not any worse than Medicare has always been (remember, it's better) – it's just that they now also have access to high quality coverage *before* qualifying for Medicare, so when they qualify for Medicare it will be a significant step down.

2. Older adults below 100% FPL in states that do <u>not</u> expand Medicaid

Most adults under age 65 with incomes below the poverty line in states that don't expand Medicaid will have no affordable source of coverage. They will not be eligible for Medicaid expansion coverage because their states did not expand Medicaid (unless they are eligible through some other special Medicaid category). Also, they will not be eligible for subsidies to purchase plans through the Marketplace. This group will have higher rates of uninsurance and heavier medical debt due to their states' decisions to not expand Medicaid, and likely will arrive at age 65 poorer and in worse health.

For these adults, life after the ACA is essentially the status quo – waiting for age 65 in order to become eligible for Medicare. As has always been the case, when they turn age 65, if they have low assets they will become eligible for Medicaid, and be "dual eligibles,"enrolled in both Medicaid and Medicare. This Medicaid coverage will vary from a full Medicaid benefits package with cost-sharing limit to only Medicaid coverage of their Medicare Part B premium.

For these older adults the transition to age 65 will be, just as it has always been, dramatic. They will go from no coverage before age 65, to coverage from Medicare and possibly Medicaid after age 65. Since they have no coverage prior to Medicare they have no "cliff."

3. Older adults between 100-135% FPL in states that do <u>not</u> expand Medicaid

Adults in this group are eligible for subsidies to purchase insurance in the Marketplace until they become eligible for Medicare. Therefore, before turning age 65, these adults will have access to high quality, affordable health care coverage. Upon turning age 65, they will generally transition from Marketplace coverage to Medicare. As with the first group, those with low assets will become eligible for Medicaid, and be "dual eligibles," enrolled in both Medicaid and Medicare. Because their incomes exceed 100% of FPL, however, this Medicaid coverage will be limited to only Medicaid coverage of their Medicare Part B premium.

The transition from Marketplace coverage to Medicare (and possibly Medicaid) will mean a change to the benefits package and cost-sharing rules in their coverage. While Marketplace and Medicare coverage may be similar for many older adults, it may be a very difficult transition for those who rely heavily on a specific benefit the Marketplace covered and Medicare does not. The transition from Marketplace premiums and cost-sharing rules to Medicare

premiums and cost-sharing rules will also be a step down for many individuals. Ultimately, the potential for steps-down in benefits and cost-sharing may be a moderate, but noticeable "cliff" for this population.

4. Older adults above 138% FPL in all states

Adults with incomes above 138% FPL are not financially eligible for the Medicaid expansion, and in all states will be eligible for Marketplace coverage until they become eligible for Medicare, with subsidies available up to 400% FPL. Therefore, before turning age 65, these adults will have access to high quality, affordable health care coverage. Upon turning age 65, they will transition from Marketplace coverage to Medicare, with no Medicaid coverage unless they qualify in a special category.

As with the third group, the likely decrease in the scope of benefits and cost-sharing protections may be a moderate, but noticeable "cliff" for this population.

Conclusion

Some older adults may end up with worse coverage when they turn age 65 and qualify for Medicare, and may conclude that the ACA worsened Medicare. The reality is the contrary.

The ACA significantly benefits older adults. It helps them after age 65 by improving Medicare benefits – for example, by closing the donut hole in prescription drug coverage and expanding coverage of preventive services. It also helps them because, *before* they are age 65, many will have increased access to high quality, affordable health coverage. This means they will be more likely to be in good health and have less medical debt on the day they turn age 65.

However, the fact that some older adults will be worse off when they turn age 65 is an important signal. In fact, their Medicare coverage will be no worse (last reminder: it's actually better!). But they may be relatively worse off because the new coverage programs created in the ACA, which they will be enrolled in before transitioning to Medicare, may have some benefits and cost advantages over Medicare. The injustice is not in the creation of coverage for these individuals before age 65; it's in the fact that Medicare does not provide all of the benefits and cost protections seniors need after they turn 65. This means that more advocacy is needed to improve coverage – meaning more benefits with less cost – for seniors so that it fully meets their needs.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

Author

The following NHeLP attorney contributed to this month's *Health Advocate*:

Leonardo Cuello
Director,
Health Reform
D.C. Office

Offices

Washington, DC
1444 I Street NW, Suite 1105
Washington, DC 20005
(202) 289-7661
nhelpdc@healthlaw.org

Los Angeles
3701 Wilshire Blvd, Suite 750
Los Angeles, CA 90010
(310) 204-6010
nhelp@healthlaw.org

North Carolina
101 East Weaver Street, Suite G-7
Carrboro, NC 27510
(919) 968-6308
nhelpnc@healthlaw.org

Support

NHeLP's work is supported by individual donations, which are tax deductible. To learn more, please visit www.healthlaw.org