

Medicaid Expansion in California: Opportunities and Challenges for Older Adults and People with Disabilities

By Amber Cutler and Anna Rich

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Foreword

This issue brief is designed to highlight issues likely to arise from the transition of individuals out of the newly created Affordable Care Act programs – specifically, expansion Medi-Cal and Covered California – after turning 65 or go on Medicare. We provide both short-term and long-term recommendations for advocates and other interested policy-makers and stakeholders on how to address these issues.

Subsequent to the publication of this issue brief, California finalized policies that make the information presented in this issue brief outdated. Please contact Amber Cutler at acutler@nsclc.org for the current status of Medi-Cal expansion in California.

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Executive Summary

Expansion of California's Medi-Cal program under the Affordable Care Act is a welcome opportunity to bring health care to an estimated million or more Californians. Some individuals who qualify for expansion Medi-Cal, however, will face challenges once they turn 65 or become eligible for Medicare after reaching the end of a 24-month disability waiting period. These challenging transitions include the:

- **Income eligibility gap.** Because expansion Medi-Cal has a higher income limit, and counts income differently, some people will lose Medi-Cal when they become Medicare eligible, despite still having very low income.
- **Resource eligibility gap.** Expansion Medi-Cal has no asset test; traditional Medi-Cal has a very restrictive asset test. Even a modest financial cushion will cause some people suddenly to lose Medi-Cal when they become Medicare eligible. Others may get into trouble if they do not understand Medi-Cal's transfer

of assets rules, and try to give money away to stay on Medi-Cal.

- **Benefits gap.** California has generally done a good job of aligning the expansion and traditional Medi-Cal benefits package. But expansion Medi-Cal participants could lose out on needed long-term care benefits if they are not adequately screened for eligibility.
- **Affordability gap.** Expansion Medi-Cal, and the tax credits and subsidies that are available to people participating in the Covered California health exchange, mean that health care will be very affordable to people with low incomes who become eligible in 2014. However, Medicare by itself is not affordable for seniors and persons with disabilities who have low incomes, but not low enough for traditional Medi-Cal.
- **Enrollment gap.** Applying for traditional Medi-Cal and Medicare subsidy programs is harder than the streamlined application for expansion Medi-Cal. Some people will fall through the cracks when they lose eligibility for expansion Medi-Cal. Others will have trouble making the new decisions needed when they start Medicare.

There is a great need for both short-term strategies to educate beneficiaries and improve state policies and procedures as well as long-term advocacy to address the underlying structural problems and inequities.

In the short term, we recommend:

- High quality notices so that those becoming eligible for Medicare understand their options and rights.
- Rigorous, proactive redeterminations for Medi-Cal, Medicare Savings Programs, and the Part D Low-Income Subsidy.
- Effective screening for medical frailty exemptions from mandatory enrollment in expansion Medi-Cal's Alternative Benefits

Package.

- More resources and training for independent enrollment counselors and navigators (e.g., HICAPs) to help those becoming eligible for Medicare.

In the longer term, we recommend:

- Modernization of eligibility and enrollment systems for all Medi-Cal populations, not just expansion Medi-Cal.
- Alignment and simplification of traditional Medi-Cal eligibility, including raising income limits and asset thresholds.
- And alignment and simplification of Medicare Savings Program eligibility rules, including raising income limits and eliminating the asset test for those programs.

Introduction

On June 27, 2013, California became one of the first states in the nation to enact legislation expanding its Medicaid program pursuant to the Affordable Care Act (ACA), a.k.a. health reform or “Obamacare.” This expansion is an exciting and historic opportunity to bring health care to an estimated million or more Californians who previously could not afford insurance and did not qualify for *Medi-Cal* (the name for California’s Medicaid program), mostly adults under the age of 65 who have not been determined by the Social Security Administration to be permanently disabled.

Hallmarks of the new Medi-Cal program include a streamlined application process, simpler and more generous methods for determining income eligibility, and the absence of an asset test. This streamlining applies, however, only to the expansion Medi-Cal populations. Individuals in populations eligible for Medi-Cal under previously existing Medi-Cal categories (“traditional Medi-Cal”), including individuals who are 65 and over as well as anyone who qualifies for Medicare, will not benefit from the changes in eligibility rules or processes.

The monumental task of preparing to extend

Medi-Cal to previously uncovered individuals is well underway. But relatively little attention has been paid to individuals who qualify for expansion Medi-Cal, but later will face a reduction in coverage or access to health services – an eligibility “gap” or “cliff”--when they become eligible for Medicare or turn 65.

This issue brief is a first step in identifying those issues. We begin by summarizing eligibility requirements for both traditional Medi-Cal and expansion Medi-Cal. We then describe some of the problems likely to arise during eligibility transitions for older adults and persons with disabilities. We also make recommendations for how advocates can help beneficiaries navigate through the gap. Finally, we recommend system changes to address the structural problems creating the gaps.

Traditional Medi-Cal for Seniors and Persons with Disabilities¹

In California, several different programs provide Medi-Cal coverage for older adults and persons with disabilities. Each has its own financial eligibility requirements, but all require that the beneficiary be either age 65 or older or be determined to have a disability as defined by the Social Security Administration. These traditional Medi-Cal programs include the following:

- **SSI linked Medi-Cal.** In California, Supplemental Security Income (SSI) recipients are automatically entitled to free Medi-Cal. SSI recipients do not need to apply. Rather, they are automatically notified of their eligibility for Medi-Cal. The current monthly SSI benefit for an aged or disabled individual is \$710 or \$1066 for a couple. In California, SSI recipients also receive a State Supplementary Payment (SSP), which increases an individual’s SSI/SSP benefit to \$866.40 or \$1462.20 for a couple.²

¹ For basic information and statistics about Medi-Cal, see the California HealthCare Foundation’s recently updated “California Health Care Almanac: Medi-Cal Facts and Figures: A Program Transforms” (May 2013), available at www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFactsAndFigures2013.pdf.

² See “Supplemental Security Income (SSI) in California” available at www.ssa.gov/pubs/EN-05-11125.pdf.

To be eligible for SSI, an individual's assets must be below \$2,000 or \$3,000 for a couple. Some individuals who received SSI in the past, but no longer qualify, may also automatically qualify for Medi-Cal under the so-called "Pickle" eligibility program.³

- **Aged and Disabled Federal Poverty Level (A&D FPL)** program. This option has the highest income limits for free, no share-of-cost Medi-Cal (also known as "spenddown"). Countable income is the same as or below 100 % of the federal poverty level (FPL) plus a standard deduction for an individual (\$230) or a couple (\$310).⁴ That means that the current countable income limit for a qualifying individual is \$1188/month or \$1603/month for a couple—about 124% of the 2013 FPL. Health insurance premium payments may be used as deductions to reduce countable income, an important allowance.⁵
- **250% Working Disabled** program. Persons who originally qualified for Social Security or Medi-Cal on the basis of disability who have some earned income can also qualify for zero share-of-cost Medi-Cal even with income up to 250% of the FPL through the 250% Working Disabled Program. These individuals, however, have to pay monthly premiums on a sliding scale.⁶
- **California's Medically Needy** program. This program provides Medi-Cal coverage for those whose spending on medical expenses meets their share of cost, which is the difference between an individual's countable income and the maintenance allowance (just \$600/month

for an individual, and \$934 for a couple).⁷

Expansion Medi-Cal

The expansion of Medi-Cal is especially welcome, because it will bring coverage to some of the most needy people who were previously uninsured: individuals who are unable to work or who have very low income but have not yet obtained or cannot obtain a determination of disability based on federal rules; older adults who are nearing retirement age but have not yet turned 65; and people with disabilities who must wait 24 months for Medicare coverage and have too much income or resources to qualify under traditional Medi-Cal eligibility rules.

Eligibility

Adults with income up to 138% FPL (133% FPL plus a standard 5% disregard) will be eligible for expansion Medi-Cal—an income limit that is significantly higher than the approximately 124% FPL limit for eligibility for the A&D FPL Medi-Cal category. In accordance with ACA requirements, California will determine financial eligibility for expansion Medi-Cal based on modified adjusted gross income (MAGI).⁸ The MAGI formula does not count certain income including, for example, Veterans' benefits, child support received, and scholarships, grants, and awards used for education purposes. Expansion Medi-Cal will also allow other income deductions that are not permitted under traditional Medi-Cal income calculations, including for example, alimony paid and pre-tax contributions for expenses such as child care or retirement (although, conversely, it will *not* allow the usual A&D FPL deductions for health insurance premiums).⁹

3 For a summary of Pickle eligibility, see "A Quick and Easy Method of Screening Medicaid Eligibility under the Pickle Amendment," available at www.nsclc.org/wp-content/uploads/2011/12/2012-Pickle-chart.pdf.

4 WIC § 14005.40(1); [All County Welfare Letter No. 13-10](#). The statute requires use of FPL or the SSI/SSP rate, whichever is higher. The SSI rate has been and continues to be significantly below 100% of FPL.

5 22 CCR §§ 50555, 50555.2.

6 WIC § 14007.9.

7 There are some special rules for individuals who need an institutional level of care; California Advocates for Nursing Home Reform has a good summary of Medi-Cal for long term care available at www.canhr.org/factsheets/med-cal_fs/html/fs_medcal_overview.htm.

8 MAGI is defined by Internal Revenue Code § 36B(d)(2); see also 42 C.F.R. § 435.603 (explaining application of MAGI to Medicaid eligibility).

9 For more information on MAGI, The National Health Law Program has published an "Advocate's

Furthermore, expansion Medi-Cal will have no asset or resource test - a significant departure from traditional Medi-Cal eligibility requirements.¹⁰ Finally, expansion Medi-Cal will have no disability requirement.

Importantly, however, the ACA puts limits on who can become eligible using this expanded version of Medi-Cal. **It excludes from expansion coverage all Medicare beneficiaries as well as individuals who are 65 or older.**¹¹

In contrast, individuals under the age of 65 who have been determined to be disabled by SSA, but who are still in the mandatory 24-month waiting period for Medicare, and do not financially qualify for traditional Medi-Cal, *are* eligible for expansion Medi-Cal.

Questions remain about how people who currently have Medi-Cal with a share of cost under California's Medically Needy program will be treated. While federal regulations make it clear that these individuals will be eligible for expansion Medi-Cal provided that they are under 65 and their income is at or below 138% FPL,¹² California has not

yet provided guidance on how these individuals will be evaluated for coverage.¹³

Medi-Cal Expansion Benefits

States that decide to expand Medicaid have flexibility to develop a different benefit package for newly eligible adults, the benchmark Alternative Benefit Package (ABP).¹⁴ California has essentially chosen to offer the same benefit package to those on expansion Medi-Cal as provided to those receiving traditional Medi-Cal state plan benefits.¹⁵ This means that individuals in expansion Medi-Cal will get the full traditional Medi-Cal state plan benefit package (though access to long-term care services is more complicated; see below). California's decision to offer the same benefit package also helps beneficiaries in traditional Medi-Cal because they will enjoy the right to access the ten categories of ACA-required "essential health benefits," including expanded access to certain mental health services and substance use disorder services.¹⁶

Unfortunately, confusion still surrounds expansion Medi-Cal's coverage of long-term services and supports. The California legislature decided to include long-term services and supports in the ABP with a major caveat: "to the extent federal approval is obtained, the department shall provide coverage for long-term services and supports (LTSS) to only those individuals who meet the asset requirements imposed under the Medi-Cal program for receipt of such services."¹⁷ In other words, California will only

Guide to MAGI," available at http://healthlaw.org/images/stories/2013_10_18_AGMAGI.pdf?utm_source=MAGI+Notice&utm_campaign=NHeLP+Matters++6%2F2013&utm_medium=email.

10 19 U.S.C. §1902(e)(14)(C) ("A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan"). See page 5 for a discussion of California's attempt to impose an asset test on long term care.

11 42 USC § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.603(j) (effective Jan. 1, 2014) (MAGI eligibility methodology will not be used to determine eligibility for individuals with Medicare, individuals age 65 or over, or to assess eligibility for traditional Medi-Cal programs). [See also 77 FR 17144, 17157.](#)

12 See [77 FR 17144, 17157, 17158](#); see also CMS's response to comments to federal regulation parts 431, 435, and 457 "...as explained in the preamble to the Medicaid Eligibility proposed rule (76 FR 51151), blind and disabled individuals whose income exceeds the standard established in a 209(b) State for coverage under § 435.121 are not required to spend down to such standard to become eligible for Medicaid. However, such individuals have the choice to spend-down to establish eligibility under § 435.121 if coverage on such basis better meets their needs." CMS-2349-F available at www.medicaid.gov/Federal-Policy-Guidance/Downloads/REG-03-16-12.pdf.

13 CMS is expected to release federal guidance to states on the Medically Needy program and its interaction with Medicaid expansion, but it has not yet done so.

14 As part of the expansion of Medi-Cal under the ACA, California is required to provide benchmark or benchmark equivalent coverage as described in section 1937 of the Social Security Act, as an Alternative Benefit Package (ABP). For an overall summary of state options, see CMS State Medicaid Director Letter, www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf.

15 SBx1 1 § 28 (adding WIC § 14132.02).

16 WIC § 14132.03.

17 WIC § 14132.02(b) (emphasis added). The statute goes on to define "long-term services and supports" to "include nursing facility services, a level of care in any institution equivalent to nursing facility services, home- and community-based services furnished under the state plan

offer LTSS in the benchmark ABP to the expansion Medi-Cal population if it can also apply an asset test on those people for that service, presumably through a waiver approved by the federal government.

This attempt to impose an asset test on the expansion Medi-Cal population flies in the face of the ACA rule that, for those in MAGI-eligible Medicaid, a state should not apply an asset test.¹⁸ In light of this federal law, NSCLC expects that California will not receive federal approval to retain an asset test for this purpose, and therefore that the state will decide not to offer LTSS in the ABP. CMS has not yet issued its final decision.

Regardless of whether California's ABP includes long-term care, those services should still be available to people in expansion Medi-Cal who need them. This is because the federal regulatory framework includes broad exemptions from mandatory enrollment in the standard ABP, providing that individuals eligible for expansion Medi-Cal who fit the exemption criteria must be given the option of a plan "that includes all benefits available under the approved State plan."¹⁹ These exemptions ensure that high-risk populations can access the traditional Medi-Cal benefit package despite becoming eligible for Medi-Cal based on the new MAGI rules.²⁰ Exemptions include individuals with disabilities, residents of long-term care facilities, and the "medically frail." The "medically frail" exemption is particularly broad; it "must at least include ... individuals with disabling mental disorders..., individuals with chronic substance use disorders, individuals with serious and complex

medical conditions," and "individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living."²¹

In other words, the same condition or disability that causes a person to need a long-term care service like In-Home Supportive Services (California's personal care services program) or nursing home care should also cause that person to qualify for an exemption that will guarantee that individual the right to those benefits.

Exactly *how* the state is going to make sure that people who apply for health benefits and qualify for expanded Medi-Cal are appropriately notified and screened for long-term care needs is still unclear, however. The federal government "encourage[d]" but did not require states to implement a process for screening potentially exempt individuals, and acknowledged the importance of beneficiaries making individualized determinations about whether the ABP or the regular Medicaid state plan best meet their needs.²² California has yet to issue guidance on how the state will assess and determine if an individual meets the exemption criteria. Some of our recommendations on page 8 below address this issue.

Covered California

In addition to Medi-Cal expansion, California will operate its own health insurance exchange, called Covered California.²³ Subsidy programs will help eligible beneficiaries pay for this insurance. Tax credits will be available on a sliding scale to those between 100% and 400% of FPL, and the credits will be advanceable (paid directly to the insurer on behalf of eligible individuals) or refundable (like the Earned Income Tax Credit). Cost-sharing subsidies will be available for those with incomes up to 250% of FPL, and will effectively lower an eligible individual's deductible, co-insurance, and co-payments, again with the exact benefit depending on income level.

With only a few exceptions, anyone can purchase

or a waiver under Section 1315 or 1396n of Title 42 of the United States Code, home health services as described in Section 1396d(a)(7) of Title 42 of the United States Code, and personal care services described in Section 1396d(a)(24) of Title 42 of the United States Code." 14132.02(c).

18 See *supra* note 10.

19 42 C.F.R. § 440.315.

20 CMS has indicated that this alternative to the standard benchmark ABP includes traditional state plan benefits as well as 1915 waiver benefit, but it is not yet clear whether benefits available through a 1115 waiver (such as California's Community Based Adult Services (adult day health care program) will be an option for those who qualify for an exemption.

21 42 C.F.R. § 440.315(f); see also ACA sec. 1937(a)(2)(B). 22 78 FR 42231.

23 www.coveredca.com.

insurance on the exchange.²⁴ However, not everyone will be eligible for the financial assistance (tax credits and cost-sharing subsidies) that will make the exchange affordable to those with low incomes. In particular, individuals who are eligible for Medicare and Medi-Cal are not eligible for financial assistance on the exchange.²⁵

Immigrant Eligibility

Under the ACA, all “lawfully present” immigrants with incomes between 133% and 400% FPL and who do not have other minimum essential coverage will be allowed to purchase subsidized insurance through Covered California. However, the same five-year waiting period on immigrant eligibility that currently applies to traditional federally funded Medi-Cal will also apply to expanded Medi-Cal. Those individuals who have incomes below 133% FPL who, but for their immigration status, would be eligible for traditional or expansion Medi-Cal, will be eligible for coverage under the ACA.

Eventually, these individuals will be able to purchase health insurance through Covered California and will receive financial assistance that makes this coverage affordable. California is still ²⁴ ACA sec. 1312(f)(1) stating that citizens and lawful residents who are not incarcerated are qualified to purchase insurance on the exchanges. However, pursuant to Medicare anti-duplication provisions, it is unlawful for private insurers to sell a Medicare beneficiary a private plan that duplicates Medicare benefits, except in the case of a Medicare Supplement policy (MediGap). See 42 USC § 1395ss(d)(3)(A)(i). Accordingly, although a Medicare beneficiary is qualified to purchase insurance on the exchanges, the exchanges are prohibited from selling Medicare beneficiaries exchange policies. See “People with Medicare and the Health Insurance Marketplace FAQ,” available at www.cms.gov/Center/Special-Topic/Open-Enrollment/Downloads/Medicare-Marketplace-FAQs.pdf.

²⁵ Specifically, individuals eligible for or enrolled in premium free Part A Medicare are not eligible for financial assistance on the exchanges. Conversely, individuals who do not qualify for premium-free Part A Medicare are eligible for financial assistance to purchase policies on the exchanges. See IRS Notice 2013-41 available at <http://www.irs.gov/pub/irs-drop/n-13-41.pdf>; and CMS’s “Medicare & Health Insurance Marketplace” available at <http://marketplace.cms.gov/getofficialresources/publications-and-articles/medicare-and-the-health-insurance-marketplace.pdf>

in the process of creating this “affordability wrap” benefit for this population. In the interim, these individuals will be placed in California’s state-funded Medi-Cal program. Undocumented immigrants are ineligible for both programs.²⁶

The Gaps

California has led the nation in its expansion of Medi-Cal coverage. However, discrepancies in eligibility and benefits between expansion Medi-Cal and traditional Medi-Cal mean that some seniors and people with disabilities will face gaps, or potential disruptions, especially when they turn 65 or as they become eligible for Medicare (and thus lose eligibility for expansion Medi-Cal). These gaps include: (1) the income eligibility gap; (2) the resource eligibility gap; (3) the benefits gap; (4) the affordability gap; and (5) the enrollment gap.

Income Eligibility Gap

Expansion Medi-Cal overall has more generous income eligibility rules than most traditional Medi-Cal programs for seniors and persons with disabilities. Its 138% FPL income limit (133% plus a standard 5% disregard) is higher than the current A&D FPL program income limit. Further, those who are advantaged by differences in the MAGI calculation from current Medi-Cal income counting rules may have an easier time qualifying for expansion Medi-Cal.

The limits of the new adult category will be felt when people who became eligible for expansion Medi-Cal thanks to MAGI methodology later lose that eligibility upon turning 65 or qualifying for Medicare. Many of these individuals will be close to the border of traditional eligibility, and therefore will be highly likely to benefit from proactive and expert benefits counseling to reduce the income eligibility gap. In order to ensure seamless access to needed medical care, this group needs:

- Help identifying alternative Medi-Cal programs, including the underutilized 250% Working

²⁶ For more details about immigrants and the ACA, go to the National Immigration Law Center, www.nilc.org/immigrantshcr.html.

Disabled program.

- Help identifying appropriate deductions that would reduce countable income in order to qualify for A&D FPL.²⁷
- Review for eligibility for Medicare Savings Programs, which go up to 135% FPL (for the QI program, which pays Part B premiums).
- Review for eligibility for the Medicare Part D Low Income Subsidy, which goes up to 150% FPL.

In the longer run, discrepancies and disruptions could be eliminated by legislation applying the MAGI methodology under expansion Medi-Cal to those on Medicare and those 65 and older.

The Resource Eligibility Gap

The difference between expansion and traditional Medi-Cal resource eligibility is not so much a gap as a chasm. Expansion Medi-Cal has no asset test, while traditional Medi-Cal limits resources to a meager \$2,000 for individuals.²⁸ The result could be a significant gap in health care access for individuals who lose eligibility for expansion Medi-Cal because they turn 65 or reach the end of a 24-month waiting period for Medicare (of course, this gap could also be in addition to the income gap described above). Moreover, transfer of asset penalties can be traps for individuals who attempt to protect even modest savings from being counted by traditional Medi-Cal.

In order to ensure seamless access to needed medical care, this group needs:

- Adequate education and notice so that individuals who are nearing the end of expansion Medi-Cal eligibility due to age or date of disability determination are aware of the

27 See Disability Rights California, “Worksheets for Determining Eligibility Under the Aged & Disabled Federal Poverty Level (A& D FPL) Medi-Cal Program,” available at www.disabilityrightsca.org/pubs/545001.pdf. [Note: income limits are not current.]

28 The only exception is the 250% Working Disabled program, which does allow beneficiaries to maintain retirement accounts and certain other assets.

traditional Medi-Cal asset limits and the rules regarding transfers of assets.

- Access to low-cost counseling and legal advice to assist beneficiaries from inadvertently disqualify themselves through an improper transfer of assets.

As with the income gap, in the long run, discrepancies and disruptions can be eliminated by applying the expansion Medi-Cal standard—no asset test — to those on Medicare and those 65 and older.

Benefits Gap

The “benefits gap” describes the discrepancy between the benefits covered by expansion Medi-Cal and those covered by traditional Medi-Cal. Because California has, for the most part, decided to offer the same state plan benefit package to both traditional Medi-Cal enrollees and to those on expansion Medi-Cal, the benefits gap will be smaller and less confusing in California than it may be in other states.

The biggest likely²⁹ difference between expansion and traditional Medi-Cal coverage—long-term supports and services —will affect those who ought to qualify for an exemption to the ABP (see page 5 above). However, expansion Medi-Cal beneficiaries who are not properly screened for an exemption or are improperly denied an exemption³⁰ may be at risk. For instance, someone who enrolled in expansion Medi-Cal may, after enrollment, suffer a severe and disabling accident. That individual could be stuck with a benefit package that does not cover needed personal or nursing care.

In order to ensure seamless access to needed medical care, this group needs:

- The opportunity to make an informed choice

29 This assumes that CMS does not allow California’s proposal to impose an asset test on LTSS, and that the state as a result excludes LTSS in the APB, as the legislation indicates.

30 The state’s record of improperly denying medical exemption requests in the managed care context does not auger well for its ability to properly determine ABP exemptions. See, for example, *Saavedra v. Douglas*, No. BS 140896, Cal, Super. Ct. (filed Dec. 21, 2012).

about whether to be screened for disability-based traditional Medi-Cal (see sections below for more details).

- Rigorous screening and accurate determinations regarding exemptions.
- The option of redetermination after events that are likely to cause a need for long-term supports and services (e.g., after an acute health incident).

In the long run, alignment of benefits between expansion and traditional Medi-Cal would ensure that all people get the health services that they need. Aligning benefits would eliminate procedural hurdles for Medi-Cal beneficiaries needing LTSS and improve consistency; reduce churning between programs; reduce complexity; and save money by reducing the need for redeterminations and separate eligibility determinations.

Affordability Gap

Even with good notices, outreach, and education, not all individuals who will benefit from Medi-Cal expansion coverage will be eligible for traditional Medi-Cal. These individuals face an affordability gap, in which the costs of Medicare are too high without Medi-Cal to fill in the gaps, or their only access to Medi-Cal comes with an unaffordable share-of-cost.³¹ The problem arises when low income individuals nevertheless have income or assets that are too high for traditional Medi-Cal.

³¹ Note that CMS, in its latest rule-making, has made clear that it accepts, or at least does not plan to solve, the issue of inequity or imbalance between those on traditional Medi-Cal and those eligible for expansion Medi-Cal. See 78 FR 42193 (acknowledging commentator's observation that higher income expansion population may receive a more generous benefit than existing Medicaid population, and noting "it is true that the benefit package may be different because of the requirement that the ABPs provide EHBs"). So while it may not seem fair that, for instance, a person with an income of 135% FPL and substantial assets gets free Medi-Cal, including access to all LTSS if they meet exemption criteria, while a Medicare beneficiary with the exact same income only has access to LTSS after spending down her assets and income to levels that ensure poverty—this is indeed will be the reality.

The Affordability Gap- Mary Turns 65

Mary is 62 and single with a monthly income of \$1500. She signs up for Covered California at the "silver" plan level. She would have an estimated \$661 monthly premium, but after the estimated \$596/month refundable tax credit, her monthly premium would be just \$65/month.¹ Her co-pays for outpatient care would range from zero (for preventive care) to \$5-\$30 for other types of outpatient services, and she would have a \$2,250 maximum limit on out-of-pocket costs.² Even if she found herself with substantial medical bills for the year, the most she would have to pay would be limited to Covered California's out-of-pocket maximum.

Mary turns 65, qualifying for Medicare. She pays \$104.90³ per month for her Part B premium, and an additional \$147 per year for the Medicare deductible, and then a 20% co-payment. She also needs to enroll in a plan to get Part D coverage for prescription drugs and would be responsible for the premiums, deductibles, and co-pays associated with her plan. If her drug costs are significant, she also would enter the coverage gap or so-called "donut hole" where she would have to pay close to half of the price of her drugs.⁴ She does

¹ Online calculator available at www.coveredca.com/calculating_the_cost.html.

² https://www.coveredca.com/PDFs/English/CoveredCA_HealthPlanBenefitsSummary.pdf

³ Based on 2013 amounts. Premiums and deductibles are adjusted annually.

⁴ The donut hole will gradually decrease and is scheduled to entirely close by 2020. Health Care and Education Reconciliation Act of 2010 ("HCREA"), Pub. L. No.11-152, 124 Stat. § 1101 (2010).

The Affordability Gap- cont.

not qualify for the Low Income Subsidy, or any of the Medicare Savings Programs, because her monthly income is more than 150% FPL. While she could, after first spending down any resources to \$2,000, qualify for the medically needy Medi-Cal program, that would leave her with just \$600 in monthly income—a financially devastating situation.

In addition, some individuals receiving significant subsidies under Covered California will face an affordability gap because they lose their subsidies and their incomes will qualify them only for share-of-cost Medi-Cal. That gap translates into potential disruption to their health care following the transition to Medicare.

In order to ensure seamless access to needed medical care, this group needs:

- Counseling about the 250% Working Disabled program and HCBS/spousal impoverishment provisions, if applicable.

In the long term, expansion of both Medicare Savings Programs (including elimination of the asset test³²) and Low-Income Subsidy programs would act to minimize the affordability gap.

Enrollment Gap

One of the main lessons learned from both the introduction of Medicare Part D in 2006 and the 2011 transition of seniors and persons with disabilities into Medi-Cal managed care is that transitions in coverage lead to confusion and mistakes—which can then lead to gaps in enrollment and continuity of care. The transition from expansion Medi-Cal to traditional Medi-Cal, for all the reasons already described, is likely to be rocky. Even when Medi-Cal enrollment is ultimately restored or preserved, the transition period may include gaps.^{33 34}

³² Several states have eliminated the asset test for Medicare Savings Programs. They include Alabama, Arizona, Delaware, Maine, Mississippi and New York.

³³ This issue brief does not address many other potential disruptions faced by individuals who participate in Covered California and then become Medicare eligible, such as the choice of whether to enroll in Medicare Parts B or D, or to choose a Medicare Advantage plan, and the risks of coverage gaps and late enrollment penalties. For more details about the risks associated with the transition, see Medicare Rights Center, “A Bridge to Health: Ensuring Seamless Transitions from Health Insurance Exchanges and Medicaid to Medicare” (January 2013), available at www.medicarerights.org/pdf/A-Bridge-to-Health.pdf.

³⁴ Note that this memo does not address the important problem of actually getting access to medical providers. This is already a problem for current Medi-Cal enrollees,

Beginning in 2014, the ACA requires states to simplify Medicaid eligibility rules and enrollment. California has to create a “no wrong door” environment that is intended to make accessing coverage easy, including a single enrollment point that works for the state insurance exchange, Medi-Cal, and CHIP through Covered California.

To meet these requirements, California is developing the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) to support enrollment functions for both the Covered California and Medi-Cal. For example, if an individual contacts Covered California to obtain coverage, CalHEERS will act as a portal to screen applicants for Medi-Cal eligibility (both expansion and traditional), and then refer them to counties for actual Medi-Cal enrollment. Covered California is supposed to coordinate with the state’s Department of Health Care Services and counties to help transition Medi-Cal enrollees between coverage programs if their eligibility changes.

Individuals transitioning out of Medi-Cal expansion may find that applying for traditional Medi-Cal is much more difficult than applying for expansion Medi-Cal. The traditional Medi-Cal application is long and complicated, requiring a detailed listing of expenses ranging from child support to health insurance premiums paid, as well as descriptions of many kinds of assets.³⁵

many of whom report difficulty getting appointments with primary care physicians, and 42% report difficulty getting appointments with specialists. On average, California pays its Medi-Cal providers just 51% of the Medicare rates for the same service, a ratio far below the national average. The good news is that the ACA requires states to increase Medicaid payments for primary care physicians to reach parity with Medicare rates, at least through 2014. See “How Dual Eligibles Can Benefit From Medicaid PCP Payment Increases,” available at, <http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Medicaid-Physician-Fee-Increase-2-22.pdf>.

³⁵ Approximately 25% of individuals who will be enrolled in Medi-Cal after the expansion are already eligible under current Medi-Cal rules, but had not known to apply or had not done so successfully. See, California HealthCare Foundation’s, “California Health Care Almanac” (May 2013, slide 53), available at www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFactsAndFigures2013.pdf.

In contrast, an initial application to Covered California for both coverage under the exchange or for expansion Medi-Cal is half as long and requires much simpler information about income and insurance status.

Legal protections already in place ought to protect beneficiaries from harm during transitions. When a Medi-Cal beneficiary loses eligibility under one Medi-Cal category, both state and federal law require the state to assess eligibility for other categories of Medi-Cal before terminating eligibility.³⁶

In California, this process is referred to generally as “SB 87.”³⁷ *Before cutting off Medi-Cal*, the county is required to (1) do an ex parte review, in which county must “make every reasonable effort” to gather information relevant to Medi-Cal eligibility *prior* to contacting the beneficiary; (2) reach out by telephone to the beneficiary; and (3) if neither of those two methods works, send a form highlighting information needed to complete an eligibility determination, with a “simple, clear, consumer friendly” cover letter.³⁸ Requests for information from the beneficiary cannot ask for information that has previously been provided, is not necessary to eligibility, or is not subject to change e.g. birthday or Social Security number). If the beneficiary returns an incomplete form, the county must try to contact

36 42 C.F.R. § 435.916(c) (requiring state agency to promptly redetermine eligibility when it receives information about changes or anticipated changes in circumstances that affect eligibility); 435.930 (agency must furnish Medicaid promptly and without delay, until they are found to be ineligible); WIC § 14005.37(a) (requiring redetermination of eligibility based on information regarding change in circumstance); WIC § 14005.37(d) (“A Medi-Cal beneficiary’s eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal under any basis and due process rights guaranteed under this division have been met”). The county does not have to go through this process if it has evidence of the beneficiary’s death or move to another state.

³⁷ For a more detailed description of the SB 87 process, see the Western Center on Law and Poverty’s “SB87 Guide: Changes in the Medi-Cal Eligibility Determination Process,” (Nov. 2001), available at <http://healthconsumer.org/SB87.pdf>.

³⁸ WIC § 14005.37(e-g).

the individual by phone and in writing for more information.

In enacting Medi-Cal expansion, the California legislature explicitly extended the protection of SB 87 to the expansion population, a valuable protection. When redetermining eligibility of expansion Medi-Cal enrollees, counties cannot terminate coverage without first assessing the beneficiary's potential eligibility for traditional Medi-Cal as well, and vice versa.³⁹ What is less clear from the current legislation, however, is whether the beneficiary has an initial choice about whether to be assessed for traditional Medi-Cal eligibility during a reassessment. The statute provides:

[F]or a beneficiary who is subject to the use of MAGI-based financial methods, the determination of whether the beneficiary is eligible for Medi-Cal benefits under any basis shall include, but is not limited to, a determination of eligibility for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods only if either of the following occurs:

(A) The county assesses the beneficiary as being potentially eligible under a program that is exempt from the use of MAGI-based financial methods, including, but not limited to, on the basis of age, blindness, disability, or the need for long-term care services and supports.

(B) The beneficiary requests that the county determine whether he or she is eligible for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods.⁴⁰

It is not clear whether and how a MAGI-eligible beneficiary with a disability linkage who might also be eligible for share of cost Medi-Cal can ensure that her eligibility is assessed under the more generous MAGI rules (see also discussion of share of cost at p. 5 – above).

In order to ensure seamless access to needed medical care, this group needs:

³⁹ WIC § 14005.37(d).

⁴⁰ ABx1 1 Section 7 (adding WIC s. 14005.37(d)(A-B).

- More clarity about the activities the county will be required to do to meet its obligation to provide assistance and screening for those losing access to expansion Medi-Cal (including all of the issues raised in this memo).
- Well-trained and accessible patient navigator and consumer assistance programs that are equipped to counsel prospective Medicare beneficiaries and other people at risk for gaps, especially those with limited English proficiency.

Recommendations to Bridge the Gaps

The gaps and challenges for prospective Medicare beneficiaries facing potential loss of Medi-Cal coverage are significant. There is a great need for both shorter-term strategies to educate consumers and to improve state policies and procedures, as well as longer-term advocacy to address the underlying structural problems.

In the short term, advocates can work to:

- Urge the state to develop high quality and specific notices for those transitioning to Medicare and/or traditional Medi-Cal, and to develop procedures for individualized and timely eligibility redeterminations.
- Urge the state to set up an effective screening process to identify medically frail individuals who qualify for an exemption to the expansion Medi-Cal standard ABP.
- Provide counseling about alternative ways to qualify for Medi-Cal, such as availability of deductions that reduce countable income for purposes of traditional Medi-Cal eligibility.
- Train navigators, enrollment counselors and other helpers about Medi-Cal and Medicare eligibility for seniors and persons with disabilities.

In the long term, advocates can work to:

- Modernize eligibility and enrollment systems for all Medi-Cal populations, not just expansion Medi-Cal. Some specific steps that would move California in the right long-term direction, towards modernization of eligibility and enrollment, include:
 - Increase A&D FPL program income requirements to 138%. This would provide for continuation of Medi-Cal for the Medi-Cal expansion population who turn 65 and have incomes too high for traditional Medi-Cal. It would also ensure access to LTSS, with an asset test, for individuals with disabilities up to 138% FPL.
 - Adjust Share-of-Cost Medi-Cal income level to 138%. This is a more realistic income to meet basic needs for food and shelter than the current \$600 per month, which has not been adjusted since 1988, and was grossly inadequate even at that time. It would provide equity between individuals who have a share-of-cost for

Medi-Cal and individuals who receive zero share-of-cost Medi-Cal.

- Align and simplify traditional Medi-Cal eligibility rules, including raising income limits and asset thresholds.
- Align and simplify Medicare Savings Program eligibility rules, including raising income limits and eliminating the asset test.
- Coordinate with the Social Security Administration to assist individuals with enrollment in the low-income subsidy program.

Conclusion

This brief has outlined some short and long-term recommendations for addressing the challenges individuals will face transitioning from the new coverage options afforded under the ACA. As older adults and persons with disabilities transition out of these new coverage options, it is imperative that they have continued access to healthcare.



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