NoHLA
Northwest Health Law Advocates

Addressing the "Medicare Cliff":

Extending Health Equity Lifelines to Older Adults and People with Disabilities

Prepared by Northwest Health Law Advocates

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*All benefit standards cited in this report use the April 1, 2021 federal updates.

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SUMMARY

What is the Medicare Cliff? Many Americans hope to get better health coverage when they start Medicare, after turning age 65 (or earlier for some people experiencing disability). But when lower-income adults become eligible for Medicare, many *lose* more affordable, comprehensive coverage.

The result nationally is: *Half of low-income Medicare enrollees spend 27% or more of their income on out-of-pocket health care costs*.[1] The disparity is stark. It especially hurts women and people from racial and ethnic minority communities, who are more likely to have lower incomes.

What causes the Cliff? Medicare is not free and has no effective cap on expenses. Medicare also lacks coverage for important health services, such as dental, vision, and hearing services. Some healthcare assistance programs (like Medicaid) can help. But assistance programs available to people with Medicare are much more restricted compared to the Affordable Care Act (ACA) programs available to people without Medicare.

How are Washington State residents affected? Washington's Medicare Cliff is huge. As soon as Medicare starts, a person's income limit to get comprehensive, no-cost coverage from Medicaid drops from 138% of poverty (FPL) to ~75% FPL, and a very low savings limit is imposed.

People with higher incomes also have a huge cliff to get assistance for premiums or cost-sharing. People without Medicare may enroll in a Qualified Health Plan (QHP) sold on Washington's Health Benefit Exchange, where premium subsidies are now offered to people with unlimited income, and cost-sharing subsidies go to people with income up to 250% FPL. No savings limit is required.

But people with Medicare cannot get a QHP. They can get premium assistance from a Medicare Savings Program only if income is 135% FPL or below, and cost-sharing assistance if income is 100% FPL or below. All assistance programs for people with Medicare require low savings limits.

People in Washington State affected by the Cliff face unaffordable health care expenses. The Cliff affects their economic security as well as their access to the health services they need.

Can we Fix the Cliff? Yes! Federal law allows states to change eligibility requirements for the healthcare assistance programs available to people with Medicare. Federal funding shares the cost. Thirty-four states plus Washington, D.C., have taken at least one step to address the disparity. Washington State is one of 16 states that have not, keeping eligibility at the lowest level federal law allows.

[1] Noel-Miller, Claire. *Medicare Beneficiaries' Out-of-Pocket Spending for Health Care.* Washington, DC: AARP Public Policy Institute. June 2020. (Figure 1) Retrieved from: https://doi.org/10.26419/ppi.00105.001.

1. What is the "Medicare Cliff?"

Over 680,000 adults in Washington State without Medicare and with income below 138% FPL get assistance to pay health care costs through Medicaid's Affordable Care Act Expansion program.[2] Another 215,000[3] individuals and families purchased "Qualified Health Plans" (QHP) on Washington's Health Benefit Exchange ("Exchange"), where those with lower income can get subsidies for cost-sharing and/or premiums.

Medicare eligibility begins for most Americans at age 65, or earlier if the person gets Social Security benefits based on disability or blindness for two years. But when low-income adults in Washington State become eligible for Medicare, they may no longer qualify for *any* health cost assistance program. This happens even to people who have had no change in their income or resources when their Medicare starts. The reason for the loss is that the health assistance programs available to people on Medicare have much more restrictive eligibility requirements than the programs available before a person has Medicare: The income limits are lower, and resources also are limited.

This sudden loss of access to health care cost assistance when someone starts getting Medicare is known as the "Medicare Cliff." Medicare does not provide the affordable, comprehensive health coverage that Medicaid does. Medicare leaves significant health costs uncovered. **For people with low or moderate income, starting Medicare can feel like a life-threatening fall.**

Here's how the Medicare cliff works in Washington State:

Losing Medicaid: Before Medicare begins, a Washington resident can get Medicaid with income up to 138% of the Federal Poverty Level (FPL) ($1482/month in 2021[4]), and with no limit on resources (savings). This Medicaid program charges no premiums or cost sharing, and the benefits are more comprehensive than Medicare provides. After Medicare begins, however, people are excluded from this Medicaid program provided under the Affordable Care Act. Instead, a person on Medicare can apply for Washington's Medicaid program for people who are "Aged/Blind/Disabled" (also known as "SSI-related," or "Classic" Medicaid). Medicaid for this group that is eligible for Medicare requires a much lower income limit: about 75% FPL ($814/month). In addition, resources (savings) must be below $2,000 for a single person (or $3,000 per married couple).

Losing premium and cost-sharing subsidies: Before Medicare begins, qualifying Washington residents with income above 138% FPL may get subsidies for cost-sharing and/or premium expenses when they purchase insurance from a QHP on Washington's Exchange. Ordinarily, those who do not have access to other minimum essential coverage (such as through employer-based insurance) can purchase a QHP and get a premium subsidy if income is below 400% FPL, with no limit on resources. They can also qualify for

[2] January 2021 figures available from the Health Care Authority's posted "Dashboard," accessible at this link: https://www.hca.wa.gov/about-hca/client-eligibility-data-dashboard .

[3] Enrollment figures disclosed by Washington's Exchange at this link: https://www.wahbexchange.org/record-number-of-washingtonians-secured-health-insurance-coverage-through-washington-healthplanfinder-in-2020/

[4] Washington State rounds the monthly amount calculations in a way that results in $1 higher in the monthly standards for 138% FPL for households with 1, 2, and 3 people compared to standards charts developed by national sources. This Report uses the Washington State figures.

assistance to pay cost-sharing for services if income is 250% FPL or below, with no limit on resources. But a new pandemic-relief law, American Rescue Plan Act of 2021 ("ARPA"), greatly increased access to premium subsidies for people with income beyond these limits during 2021 and 2022.[5]

After Medicare starts, a person is generally disqualified from purchasing a QHP. Premium assistance and cost-sharing for Medicare enrollees is available only to people with very limited income and resources.[6] The income limit for the Medicare Savings Programs that cover only premiums, not cost-sharing, is 135% FPL. That is even lower than the income limit (138% FPL) that applies to full Medicaid benefits for adults before they get Medicare. The result is that many individuals moving from QHPs to Medicare experience significant increases in bills for premiums and cost-sharing.

People without Medicare who have QHP coverage also may struggle with health care costs. Policy makers have acknowledged that even the existing income limits for QHP subsidies are not sufficient for health coverage affordability.[7] The new pandemic relief bill also reflects affordability problems for people with higher incomes.

2. Why is there a Medicare Cliff?

Before the Affordable Care Act, Medicaid provided health care coverage only for certain "categories" of people: people with disabilities or blindness, people age 65 and older, needy families with dependent children, and pregnant women.[8] Blindness and disability are determined under Social Security Administration program guidelines. Adults who were not in one of these categories could not get Medicaid, no matter how poor or how acutely ill they were.

This changed after 2010, when Congress passed the Affordable Care Act (ACA). The ACA expanded medical coverage to low-income adults who did not qualify before, beginning in 2014. Although later litigation made this eligibility expansion for adults optional for states, Washington is among the majority of states that provide this Medicaid program.

Financial eligibility for the new "Medicaid expansion" program for adults is completely different from the financial requirements that applied to the programs for Medicaid-covered adults that preceded the ACA. The income limit is much more generous, and resources are not limited. Eligibility is easier to establish: income eligibility is based on a modified version of taxable adjusted gross income that usually can be established electronically, and applicants need not document the value of their resources.

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[5] ARPA also offers extra premium subsidies plus cost-sharing for certain people with unemployment compensation during 2021. See the section on COVID impacts, Section 4 below.

[6] These programs, the Medicare Savings Programs (MSPs) and the "Low-Income Subsidy" program for Part D prescription drugs (also known as "LIS" or "Extra Help"), are discussed in detail in Section 5 below.

[7] The Washington State Legislature directed agencies to study options to address affordability with state-funded premium and cost-sharing subsidies for a "Cascade Care" health plan. ESSB 5526, Ch. 364, Laws of 2019. The Legislature is considering implementing these subsidies this session in E2SSB 5377, in line with the actions of several other states. See also the discussion about temporary premium increases provided in the American Rescue Plan Act of 2021, in Section 4 below.

[8] 42 U.S.C. § 1396-1.

But the ACA did not change eligibility for the existing program for people who were aged, blind, or disabled to match the more liberal eligibility standards of the new program. The ACA disqualifies people from the new adult Medicaid program once they have Medicare. As a result, the federal eligibility standards for Medicaid for people who are aged, blind, or disabled and receiving Medicare continue to be based on the old eligibility standards. Those standards are based on the standards required for people to get Supplemental Security Income (SSI), the federal needs-based cash assistance program for people who are aged, blind, or disabled. This program is designed to serve people who are destitute.

The ACA also created the subsidized insurance program through QHPs, available to people not qualified for Medicaid or for other coverage, such as through an employer. The income-based subsidies for QHPs are more generous than the subsidy programs for Medicare enrollees, and no resource limits apply. The ACA did not revise existing standards for the health cost assistance programs that pre-date the ACA and are the ones available to Medicare enrollees.

Application processing for medical assistance programs is in general much slower for the programs available to people with Medicare compared to those for people without Medicare. The reason is that people with Medicare must supply income and resource verification before eligibility can be determined. The new ACA programs generally verify income through automated electronic systems, and because resources are not limited, they need not be reported or verified before eligibility is determined.

Evaluating the impact of the Medicare cliff on individuals is complex. Individuals at different income levels and savings levels are affected differently. People with different levels of health care needs are affected differently.

One way to begin to understand the impacts is to consider two illustrative examples. The first example (Case Study # 1) is someone we call “Martha,” who qualified for Medicaid adult coverage before Medicare. The second (Case Study # 2) is someone we call “Jorge,” who was enrolled in a Qualified Health Plan before getting Medicare.

Figure 1. Case Study: "Martha."

Case Study: "Martha"

	At Age 64	At Age 65
Income	$1,187/month ($14,244/year) in Social Security (~111% FPL)	
Resources	$10,000 in life savings for retirement, most in an IRA	
Health Needs	Diabetes, severe arthritis	
Health Coverage Eligibility	**Medicaid** (ACA Expansion program, for adults without Medicare)	**Medicare** • No longer eligible for Medicaid; above income/resource standards applied at age 65 • Ineligible for any premium or cost-sharing assistance except partial subsidy for Medicare Part D prescription drug costs
Health Costs	**$0 – 0% of her total income** • No premiums • No cost-sharing	**$320/month[9] - 27% of her total income** • Medicare Part B premiums: $148.50/month • Cost-sharing for appointments, diagnostics, prescription drugs, and expenses not covered by Medicare: ~$172/month
Health Benefits	Comprehensive, broad coverage	Does not cover dental care or personal care services needed to stay independent at home
Income left after Health Costs	$1,187/month available for other needs, including food, rent, utilities, transportation	$867/month left for all other needs, including food, rent, utilities, transportation

[9] Based on Medicare spending data, AARP 2020 report. (Figure 1) See footnote 1.

Figure 2. Case Study: "Jorge."

Case Study: "Jorge"

	At Age 64	At Age 65
Income	$1,675/month ($20,100/year) in Social Security (156% FPL)	
Resources	$12,000 in life savings for retirement, most in an IRA	
Health Needs	COPD, cardiovascular disease, mobility impairment, hearing loss	
Health Coverage Eligibility	**Qualified Health Plan** • Premium tax credit plus new ARPA subsidy reduces premium for silver-level plan to $7/month[10] • Cost-sharing reduced to maximum of $2,250/year or ~$187/month	**Medicare** • No longer eligible for QHP because of Medicare enrollment • Ineligible for any other medical assistance
Health Costs	**$194/month, ~12% of total income**	**$452/month,[11] 27% of total income** • Medicare Part B premiums: $148.50/month • Cost-sharing for appointments, diagnostics, prescription drugs, and expenses not covered by Medicare: ~$304/month
Health Benefits	Does not cover dental or hearing care or nonemergency transport	Does not cover dental, hearing aids, or transportation to medical appointments for his chronic conditions
Income left after Health Costs	$1,481/month to pay for all essential needs, including food, rent, utilities, and transportation	$1,223/month left for all other needs, including food, rent, utilities, and transportation

[10] The Affordable Care Act provides for premium tax credits, which would reduce premium to $77/month. The American Rescue Plan Act of 2021, the most recent pandemic relief act, further reduces premiums through 2022.
[11] Based on Medicare spending data, AARP 2020 report (Figure 1). See footnote 1.

3. How does the Medicare Cliff hurt enrollees with limited income?

As the Martha and Jorge examples illustrate, Medicare enrollees with limited income may need to pay hundreds of dollars each month to access care. These costs can jeopardize financial security, and health.

a. Out-of-pocket health costs on Medicare can be unaffordable.

Medicare is not free.[12] Most people can get Medicare Part A coverage (for inpatient hospital care, limited skilled nursing facility care, and hospice care) with no premium. But "no-premium Part A" applies only to people with sufficient work history in the U.S. to qualify for free Part A.[13] Moreover, Medicare Part B is required to get coverage for physician services, medical tests, outpatient care in general, and preventive services. Enrolling in Medicare Part B Part requires paying monthly premiums, and Part B pays only 80% of the Medicare-allowed costs. Parts A and B both have deductibles as well as cost-sharing. Neither covers prescription medications. Getting coverage for outpatient medications requires enrolling in Medicare Part D, with its own system of premiums, deductible, and cost-sharing.

People able to do so can purchase supplemental insurance to help with Medicare Part A and B costs. The most extensive coverage offered by "Medigap" Medicare Supplement Plan G potentially limits out-of-pocket costs for Medicare-covered services (other than prescription drugs) to the amount of the yearly Medigap premiums plus the Part B deductible. "Medicare Advantage" plans may effectively limit costs for services (other than prescriptions) to the cost of premiums plus the yearly out-of-pocket-maximums ("MOOP") for in-network and out-of-network services. See Appendix A for more details.

Those who cannot afford supplemental Medicare insurance plans cannot get help for Part A and B cost-sharing expenses unless their income and resources are low enough to qualify for the Aged/Blind/Disabled Medicaid program (see p. 4 above) or for the specific Medicare Savings Program called Qualified Medicare Beneficiary (QMB). In Washington State, the income limit for QMB is 100% of the Federal Poverty Level (FPL), and the resource limit is $7,970 for an individual or $11,960 for a couple.[14] Other Medicare Savings Programs pay only Part B premiums, not cost-sharing.

Even people who have purchased supplemental insurance face additional out-of-pocket costs for prescriptions. People must enroll in a Part D plan for prescription costs. Enrollees have no cap on prescription costs unless they qualify for the federal "Low Income Subsidy" program (a/k/a "Extra Help").[15] And anyone without Medicaid eligibility may spend significant amounts for services they need that are not covered by Medicare. See Section 3(b) below.

b. Medicare does not cover important health services that Medicaid covers.

People who qualify for Medicaid in addition to Medicare have coverage for important health services not covered by Medicare. People with Medicare-only may be unable to afford or access these services,

[12] See Appendix A for details.
[13] Others must pay for Part A coverage, up to $471 per month in 2021.
[14] Eligibility also allows $1500/person for burial expenses.
[15] See Appendix C. States that expand MSP programs provide automatic LIS eligibility to all MSP-eligible residents.

no matter how much they need them. See Section 3(c) below for research about access problems for these services.

Services Medicare does not cover but Washington State's Medicaid programs do cover include:

- Routine dental care
- Hearing aids and hearing services
- Routine vision exams
- Non-emergency medical transportation
- Personal care services[16]

Medicaid provides broader coverage than Medicare does for some other services:

- Behavioral health (treatment for mental health and substance use disorders)
- Home health
- Medical equipment.

c. The cost of health expenses not paid by Medicare jeopardizes financial security and health for Medicare beneficiaries.

A number of studies shed light on how uncovered health expenses affect the financial security and health of Medicare beneficiaries. Some of the Medicare research focuses on older adults, age 65 and older, although about 12% of Washington's Medicare population is younger and gets Medicare based on disability.[17] Some findings from this research and reporting are discussed below.

How much income do older adults in Washington State need for basic economic security?

A valuable tool for assessing the level of income required for basic economic security for older adults living in the community is the "Elder Economic Security Index."[18] The Elder Index is specific to: location (state and county); household size (single or couple); housing situation (renter, homeowner with mortgage, homeowner without mortgage), and a general division for health status (poor, good, or excellent).[19] The Index considers the cost of housing, health care, transportation, food, and miscellaneous essentials in determining the amount of monthly income needed for basic expenses. It

[16] For more information about personal care services, see this pamphlet on the www.washingtonlawhelp.org website: Questions and Answers on the Community First Choice Program.
[17] Source: Kaiser Family Foundation data page, 2019 data, accessed at: https://www.kff.org/statedata/ For more info about this resource, see: https://www.kff.org/about-state-health-facts/
[18] The Elder Index was developed jointly in 2012 by the Gerontology Institute at the University of Massachusetts Boston and Wider Opportunities for Women (WOW). Currently the Index is maintained and updated through a partnership between the Gerontology Institute and the National Council on Aging (NCOA).
[19] The Index addresses only adults age 65 and older, living alone or with another older adult. It does not include those who live in group quarters such as institutional settings, those who reside in households including three or more people, and those living with anyone under the age of 65.

adjusts costs by specific household sizes, state and county of residence, housing situations, and health status.[20]

In 2019 the Elder Index was used to determine the percentage of older adult households with income insufficient for economic security.[21] This "Elder Economic Insecurity Rates (EEIRs)" measure was used to identify the age-65-and-older population living with income insufficient for their essential expenses.

The EEIR showed that in Washington State in 2019, 49.3% of single older adults living in the community had income below the level required for economic security. But only 15.5% of these older adults had income below the poverty level. Thus 33.8% were living "in the gap" between the federal poverty level and having sufficient income for economic security.[22]

This economic research shows that older adults in Washington State need significantly more income for basic economic security than our state's medical assistance programs allow them to have. According to updated Elder Index figures for 2021, in Washington State, a single older adult in "good" health who rents housing needs $2360 per month ($28,320 per year) for essential expenses. That represents 220% of the Federal Poverty Level. In King County, the same single older adult in "good" health who rents needed $2831 per month ($33,972 per year) for essential expenses. That income is level is 264% FPL. People with "poor" health need significantly more income due to higher health expenses; see Figure 3.[23]

The table below summarizes data from the latest Elder Index for single older adults in Washington State. For more details, see tables in Appendix B.

Figure 3. 2021 Elder Economic Security Index – WA.

Monthly Expenses	Housing – Owner with Mortgage	Housing – Rent	Housing – Owner, no Mortgage
Housing	1652	1111	601
Food	272	272	272
Transportation	215	215	215
Miscellaneous	308	308	308
Health care (for "poor" health) *	648	648	648
Total – in WA State	3095	2554	2044
COMPARE totals:			
- in King County	3560	3049	2239
-in Snohomish County	3212	3025	2094

*Estimated monthly healthcare cost in WA for single in "good" health is $454; "excellent" health, $366.

[20] Information about how costs are determined is here: https://elderindex.org/about. Specific data is available through searches on this website: https://elderindex.org/

[21] Mutchler, Jan; Li, Yang; and Roldán, Nidya Velasco. *Living Below the Line: Economic Insecurity and Older Americans, Insecurity in the States 2019* (2019). Center for Social and Demographic Research on Aging Publications. 40. Retrieved from: https://scholarworks.umb.edu/demographyofaging/40

[22] *Id*.

[23] Appendix B to this report provides specific Index figures for Washington State and for King County.

How can out-of-pocket health expenses affect financial security, health, and mortality for Medicare enrollees?

In the most recent Medicare affordability data available, half of Medicare beneficiaries with income 200% FPL or lower reported spending 27% or more of their income on out-of-pocket costs.[24] Health care out-of-pocket costs thus may be especially unmanageable for lower-income Medicare beneficiaries. But half of all Medicare beneficiaries, regardless of income, spent 16% or more of their income on out-of-pocket costs, and the highest-spending ten percent of all beneficiaries spent 53% or more of their income. These figures are from a study published in 2020 by AARP Public Policy Institute that analyzed national data from 2017 concerning out-of-pocket spending by Medicare beneficiaries. Earlier studies of this issue by Kaiser Family Foundation also show untenable out-of-pocket spending in relation to income of Medicare beneficiaries.[25]

Economic insecurity affects access to needed health care services. The 2020 AARP report of Medicare enrollee health spending showed that 10% of all people on Medicare reported delaying health care due to cost and having problems paying medical bills. But 17% of people with income 200% of PFL or below reported delaying health care for financial reasons, and 18% had trouble paying bills.[26]

An earlier study focusing on medication underuse found that older adults had increasing likelihood of "cost-related medication underuse" as the severity of the person's food insecurity increased.[27] This problem was increased for women compared to men, and for people with a chronic health condition compared to those without a chronic condition. Significantly, *this study showed that older adults were less likely to report cost-related medication underuse when they had Medicaid or other public insurance (such as Medicare Savings Programs) in addition to Medicare, compared to older adults with Medicare alone.*

Medicare enrollees with health conditions and high health care costs are particularly vulnerable to economic insecurity that can exacerbate health concerns, such as cost-related medication underuse. A 2019 article in *Health Affairs*[28] described financial hardships of seriously ill Medicare beneficiaries

[24] AARP 2020 report (Figure 1) See note 1. Retrieved from: https://doi.org/10.26419/ppi.00105.001.
[25] Cubanski, Juliette *et al*. *Medicare Beneficiaries Out-of-Pocket Health Care Spending as a Share of Income.* Kaiser Family Foundation (Jan. 26, 2018) Retrieved from: https://www.kff.org/report-section/medicare-beneficiaries-out-of-pocket-health-care-spending-as-a-share-of-income-now-and-projections-for-the-future-report/ See also Cubanski, Juliette *et al*. *How Much Do Medicare Beneficiaries Spend Out of Pocket on Health Care?* (Nov 04, 2019) Retrieved from Kaiser Family Foundation: https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/ Both studies, like the AARP 2020 study, were based on data from the Medicare Current Beneficiary Survey (MCBS), a nationally representative survey of Medicare beneficiaries with traditional Medicare (not Medicare Advantage).
[26] AARP 2020 report (Figure 2). Retrieved from: https://doi.org/10.26419/ppi.00105.001.
[27] Afulani, Patience; Herman, Dena; Coleman-Jensen, Alisha; and Harrison, Gail G. (2015) *Food Insecurity and Health Outcomes Among Older Adults: The Role of Cost-Related Medication Underuse*, Journal of Nutrition in Gerontology and Geriatrics, 34:3, 319-342 DOI:10.1080/21551197.2015.1054575. This study analyzed 2011 and 2012 data from the National Health Interview Survey.
[28] Kyle, Michael Anne *et al. Financial Hardships Of Medicare Beneficiaries With Serious Illness.* Health Affairs (Nov. 2019). Retrieved from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00362

reported in a national survey. The financial hardships existed despite the fact that many had purchased supplemental insurance. About half reported problems paying medical bills, especially bills for prescription drugs.

And research now confirms that cutbacks to health services such as prescription medications can be a life or death matter. New economic research on Medicare cost-sharing for prescriptions indicates that *even modest cost increases can result not only in reduction of prescription use but also a significant increase in mortality*.[29] The magnitude of the mortality effect detected is of the same order of magnitude as other literature describes regarding the effect of health insurance on mortality.[30]

Other reports indicate that the absence of Medicare coverage for certain important services affects beneficiaries' access to the services. See articles on dental care (Freed, Meredith *et al. Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries*. Kaiser Family Foundation, March 13, 2019); hearing aids (Wells, Timothy S. *et al*. *Self-Reported Hearing Loss in Older Adults Is Associated with Higher Emergency Department Visits and Medical Costs.* Journal of Health Care Organization, Provision, and Financing Volume 57: 1–8, 2019); vision services (Willink, Amber *et al. How Medicare Could Provide Dental, Vision, and Hearing Care for Beneficiaries.* Commonwealth Fund, *January 18, 2018);* non-emergency medical transportation (Gleckman Howard. *Why Can't We Expand Access to Transportation for Older Adults?* Forbes.com, February 18, 2019); and long-term services and supports (Graham, Judith. *Seniors Aging in Place Turn to Devices and Helpers, But Unmet Needs Are Common.* Kaiser Health News, February 14, 2019).

Washington's Medicaid program covers these services and others, for people who qualify for Medicaid (see Section 3(b), above). Medicare Savings Programs, however, do not add any covered services to what Medicare provides.

d. Health equity concerns: Poverty, gender, race/ethnicity.

Women and people from racial and ethnic minority communities are disproportionately affected by the relative lack of assistance for Medicare low-income beneficiaries, primarily because these groups are also disproportionately low-income.[31] Although the disparity is especially stark at lower income levels, in Washington State it continues up to 400% of FPL.[32]

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[29]Chandra, Amitabh; Flack, Evan; and Obermeyer, Ziad. *The Health Costs of Cost-Sharing*. National Bureau of Economic Research Working Paper 28439 (Feb. 2021). Retrieved from: https://www.nber.org/system/files/working_papers/w28439/w28439.pdf.

[30] *Id*., pp. 23-24. This study *excluded* Medicare beneficiaries who had Medicaid or Medicare Supplement Program coverage.

[31] Women and minorities are especially likely to have income below 100% FPL and 200% FPL. Cubanski, Juliette *et al*. *How Many Seniors Live in Poverty?* Kaiser Family Foundation Issue Brief (Nov. 2018). Retrieved from: http://files.kff.org/attachment/Issue-Brief-How-Many-Seniors-Live-in-Poverty.

[32] Data analysis prepared for NoHLA by Public Health-Seattle & King County, Assessment, Policy Development & Evaluation Unit, February 2020. This analyzes demographics for Washington residents and King County residents age 65 and older with income in these categories which exceed current Washington income limits for Medicaid: 75%-139% FPL, 140% FPL-200% FPL, 201% FPL-250% FPL, 251 FPL-300% FPL, 301% FPL-400% FPL, and above 400% FPL.

Although many states other than Washington have undertaken expansions of Medicaid and Medicare Savings Programs for Medicare beneficiaries in the past two decades, relatively little published research addresses outcomes (such as improved health or decrease in mortality) from these expansions.[33] By contrast, a number of studies have evaluated outcomes from the ACA expansions of Medicaid eligibility (Medicaid for adults who are ineligible for Medicare). There is little doubt that these ACA expansions have improved health.[34] A review[35] of that literature indicates that the (ACA) Medicaid expansion is linked to increased coverage; access improvements, financial security, some measures of health status/outcomes; and economic benefits for states and providers.

Research suggests the ACA Medicaid expansion has reduced disparities in coverage by income, age, marital status, and in some cases, by race/ethnicity.[36] Recent research reviewing health access measures, for example, observed post-ACA decreases in racial/ethnic disparities for measures of delayed care and unmet need for care.[37] But the ACA Medicaid expansion didn't eliminate race/ethnicity disparities in health access across the board, even though individuals from these racial and ethnic minority communities are disproportionately represented in the population with income low enough to be eligible for the program.

This experience with the ACA suggests that reducing disparities for people from racial and ethnic minority communities requires more than just expanding eligibility for a program. The program and its implementation also should be designed to reduce barriers for members of these communities in accessing the program benefits.

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[33] Tiedemann, Amy M and Fox, Kimberley. *Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements.* Rutgers Center for State Health Policy (May 2005). Retrieved from: http://www.cshp.rutgers.edu/publications/promising-strategies-for-medicare-savings-program-enrollment-modifying-eligibility-criteria-and-documentation-requirements . In contrast, a number of studies have evaluated outcomes from the ACA expansions of Medicaid eligibility for adults in eligible for Medicare. See Guth, Madeline; Garfield, Rachel; and Rudowitz, Robin. *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review.* Kaiser Family Foundation Issue Brief (Mar 17, 2020). Retrieved from: https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/

[34] See Sommers, Benjamin D *et al. Three-Year Impacts of The Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*. Health Affairs (2017). Retrieved from: https://doi.org/10.1377/hlthaff.2017.0293

[35]Antonisse, Larisa *et al*. *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*. Kaiser Family Foundation (Aug. 15, 2019). Retrieved from: http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review

[36] Yue, Dahai; Rasmussen, Petra W; and Ponce, Ninez A. *Racial/Ethnic Differential Effects of Medicaid Expansion on Health Care Access.* HSR: Health Services Research (Oct. 2018). Retrieved from: https://doi.org/10.1111/1475-6773.12834. Lee, Hyunjung; Porell, Frank W. *The Effect of the Affordable Care Act Medicaid Expansion on Disparities in Access to Care and Health Status.* Medical Care Research and Review 2020 Oct; 77(5):461-473. doi: 10.1177/1077558718808709. (Epub 2018 Oct 26) PMID: 30362848.

[37] Lee, Hyunjung; Hodgkin, Dominic; Johnson, Michael P; and Porell, Frank W. *Medicaid Expansion and Racial and Ethnic Disparities in Access to Health Care: Applying the National Academy of Medicine Definition of Health Care Disparities.* Sage Journals (Feb. 20, 2021). Retrieved from: https://doi.org/10.1177/0046958021991293

Studies long have shown that many more people are eligible for Medicare Savings Programs than the number who enroll.[38] The complexity of the application process is a barrier believed to be a significant reason for Medicare Savings Program under-enrollment. Part of the complexity is caused by the limitation on resources a person can have for eligibility. Just having a resource limit, at any level, requires an applicant to document and verify values of resources in order to qualify, and the agency must receive and review this information before awarding benefits.

In addition, Medicare-eligible adults are now the only group required to meet a resource limit to get regular, non-institutional, Medicaid benefits. Resource limits apply to the Medicaid programs for people whose eligibility is based on being aged, blind, or disabled, including institutional Medicaid programs and medically-needy "spenddown" programs. Resource tests do not apply to Medicaid for adults who are not on Medicare, to Medicaid programs for pregnant women or children, or to Qualified Health Plan (QHP) enrollees who get subsidies for premiums and cost-sharing.

States can opt to eliminate resource limits both for Medicare Savings Programs and for Medicaid. A resource test for regular Medicaid benefits can be eliminated without affecting the resource requirements for long-term-care Medicaid programs. Those long-term-care programs include institutional Medicaid and the Home and Community Based waiver programs that provide long term services and supports outside of institutions.

Eliminating a resource test for the Medicare Savings Programs would help people with resources that are higher than the current limits. But eliminating the test also would make it easier to enroll for people who *already* are below those limits and who meet all eligibility factors. Eliminating the resource test would end the need for applicants to identify and verify values of their assets. It would also simplify and reduce the cost of program administration.

To reduce disparities, it is important to choose expansion options and adopt practices that streamline the eligibility process for members of minority communities.[39] Incorporating good communication and effective strategic outreach during implementation also are important to address potential disparities in any eligibility expansion.

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[38]Summer, Laura and Friedland, Robert. *The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs*. Georgetown University Center on an Aging Society (Oct. 2002), posted on www.cmwf.org, retrieved from: https://www.commonwealthfund.org/publications/fund-reports/2002/oct/role-asset-test-targeting-benefits-medicare-savings-programs Caswell, Kyle J. *Medicare Savings Program Enrollees and Eligible Non-Enrollees.* MACPAC and The Urban Institute (June 2017). Retrieved from: https://www.macpac.gov/publication/medicare-savings-program-enrollees-and-eligible-non-enrollees/.

[39]Carter, Julie. *Toward Seamless Coverage: Identifying Enrollment Gaps and Opportunities in Medicare Transitions for People with Expansion Medicaid.* National Council on Aging (NCOA) (2017). Retrieved from: https://www.ncoa.org/article/expansion-medicaid-to-medicare-transitions-toward-seamless-coverage

4. How has the COVID pandemic affected Medicare enrollees and the Medicare Cliff?

The COVID-19 pandemic has had a particularly severe impact on older adults and on people with certain underlying health conditions. These groups have had high rates of severe illness, hospitalization, and death, compared to the rest of the population.[40] "Older adults" and "people with health conditions" is a good short-hand description of the people likely to be eligible for Medicare. Data in Washington State also shows disproportionate rates of COVID-19-related infection, hospitalization, and death for people from certain ethnic and racial minority communities.[41] People who are older/have certain health conditions and *also* are from ethnic or racial minority communities may have even higher impacts, but data addressing those intersections is not now available.

Detailed research on how the pandemic has affected healthcare affordability for Medicare enrollees also is not yet available. However, we do know that COVID-19 pandemic-related affordability programs have not decreased the Medicare cliff disparity problem, and in some ways have increased it.

Federally funded pandemic relief programs have provided cost coverage for COVID-19 testing, treatment, and vaccines. This largely prevented these new health costs from affecting Medicare beneficiaries financially. But as of April 2021, none of the pandemic relief programs has changed premium or cost-sharing expenses for the *other* health services Medicare beneficiaries receive that are unrelated to COVID-19.

The American Rescue Plan Act of 2021 (ARPA)[42] significantly reduces premiums for adults *without* Medicare who can purchase Qualified Health Plans (QHPs).[43] The new premium subsidies are temporary (2021 and 2022), but extensive. The Act's enhanced premium subsidy caps the amount Exchange enrollees are expected to pay for premiums at 8.5% of their household income for enrollees at all income levels, including those with incomes above 400% FPL. The law also reduces premiums significantly for those who are currently eligible for subsidies. For example, Exchange enrollees with incomes under 150% FPL now have zero premium liability to enroll in a benchmark plan. Other ARPA provisions for people with unemployment status increase the income limits for access to cost-sharing subsidies for this group.

None of these ARPA provisions address health care affordability for Medicare beneficiaries. Having Medicare in itself disqualifies a person from purchasing a QHP.

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[40] The DCD maintains a webpage about the special risk for these groups. Link: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html?

[41] Washington State Department of Health (DOH) posts data, at this link: https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard

[42] Public Law 117-2, available at this link: https://www.congress.gov/bill/117th-congress/house-bill/1319/text.

[43] McDermott, Daniel; Cox, Cynthia; and Amin, Krutika**. "***Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums.* Kaiser Family Foundation Issue Brief (Mar. 15, 2021). Retrieved from: https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-will-improve-affordability-of-private-health-coverage/

Federal pandemic-related programs to date have made no eligibility changes to expand Medicaid or Medicare Savings Programs to cover more Medicare enrollees. In Washington State, getting Medicare premium subsidies still requires Medicare enrollees to have income below 135% FPL and limited resources. Getting cost-sharing subsidies for Medicare-covered expenses still requires Medicare enrollees to have income below 100% FPL and limited resources. Getting the additional services covered by Medicaid but not Medicare requires still lower income - below ~75% FPL. All these programs also impose low resource limits, which do not apply to people who get subsidies to purchase QHPs.

Earlier federal pandemic legislation, the Families First Coronavirus Response Act (FFCRA), provides a Medicaid funding incentive to states to maintain eligibility for current Medicaid enrollees during the pandemic. Because of this provision, Washington State residents who were eligible for Medicaid have continued to receive that same Medicaid program even if they became eligible for Medicare and do not meet the (much stricter) eligibility standards for the Medicaid program for people with Medicare.

The good news for these Medicare beneficiaries is that, so far, they have not fallen off the "Medicare Cliff." They currently retain the same Medicaid coverage, at no cost, that they had before the pandemic.

But there is bad news for these people as well. This reprieve is temporary. When the pandemic-caused emergency ends, the state Medicaid program terminations can begin. Anyone who does not meet the state's restrictive eligibility standards for the Medicaid program for people on Medicare will be subject to termination. Unless the state expands income and resource eligibility criteria, everyone on Medicaid who became eligible for Medicare during the pandemic and has income above 75% FPL (or resources above $2000/single or $3000/couple) will experience the "Cliff" – all together -- after the public health emergency ends. These low-income Washington seniors and people with disabilities will face serious health affordability challenges just as they are trying to regain stability from the crisis.

To add further injury, some of these people who stayed on Medicaid despite gaining Medicare during the emergency may have lost an important opportunity to enroll in a "Medigap" Medicare Supplement Plan that they may need after their Medicaid stops. Staying on Medicaid prevented them from enrolling in a Medigap plan. But the "guaranteed issue" period to enroll in a Medigap plan without meeting medical underwriting criteria expires 6 months after Medicare Part B eligibility begins.

Losing the opportunity to buy a Medigap plan without meeting medical underwriting standards is bad for people with significant health conditions and high health costs, because a Medigap plan may be significantly less costly for them compared to the alternatives. Yet these are exactly the people who will have difficulty meeting the medical underwriting standards required to purchase a Medigap plan outside of that guaranteed-issue period. Washington State at this time does not provide for any special enrollment options for these people at the time Medicaid terminates.[44]

[44] People rejected for Medigap coverage for health reasons may be able to purchase a Medicare Advantage Plan, which may have maximum out-of-pocket costs thousands of dollars higher than the yearly cost of a Medigap plan. A person without other options may qualify to purchase a "high-risk" policy through the Washington State Insurance Pool (WSHIP) program. Premiums for these WSHIP plans in general are higher than premiums for regular Medigap plans. See information about WSHIP at this link: wship.org

5. Medicare Cliff Lifelines: How can medical assistance programs help Medicare beneficiaries?[45]

Medical assistance programs help Medicare beneficiaries afford the health care costs and services that Medicare does not cover. Federal law allows states to set their own income and resource limits for Medicaid programs for this group as well as for Medicare Savings programs. Washington could do much more to support Medicare beneficiaries experiencing problems affording health care costs.

Figure 4. Medical Assistance programs for adults with Medicare.

Program	Monthly income limits for single person for assistance programs[46]	Resource limit for single person for assistance programs
ACA Medicaid* *Comparison; not for Medicare enrollees	$1,482 (138% FPL)	No limit
Medicaid for aged/blind/disabled	$814 (~75% FPL)	$2,000
Medicaid-Medically Needy	$814 (income above this is a "spenddown" liability)	$2,000
Medicare Savings Program-QMB	$1,094 (100% FPL + $20)	$7,970 (plus up to $1,500 burial funds)
Medicare Savings Programs –Other** **Pays Part B premium only	$1,469 (135% FPL + $20)	$7,970 (plus up to $1,500 burial funds)
Medicare Rx Low-Income Subsidy (LIS)	See eligibility and level of subsidy chart in Appendix C	See eligibility and level of subsidy chart in Appendix C

Washington provides some assistance to supplement Medicare coverage that is targeted to enrollees with very low incomes. However, the current financial eligibility standards are the *lowest* that federal law allows, for both Medicaid and Medicare Savings Programs. Thirty-four other states, and Washington, D.C., provide more support. See section 6 below.

The medical assistance program types and the coverage they provide are described below. For each of these programs, we describe how states may increase the income and/or resource limits in Section 6.

Medicaid for aged/blind/disabled group. The broadest assistance with health costs is available to individuals qualifying for "Categorically Needy" Medicaid as well as Medicare, as "full dual-eligible" persons. Income and resource limits for this status is in the above table in the row for "Medicaid for aged/blind/disabled." Having Medicaid in addition to Medicare adds coverage for services Medicare

[45] This report addresses programs for people with Medicare *except* the programs available only to people with disabilities who work or to those who qualify for Medicaid long-term care programs. Eligibility differs for those.
[46] All the standards in this chart except the "Adult Medicaid" group are based on income-counting methodology for the Supplemental Security Income (SSI) federal cash assistance program for people who are age 65 or older, blind, or disabled. For these programs, a $20 per household "disregard" is allowed for any income a person has other than SSI cash assistance. The chart figures accordingly include the $20 "disregard" to the standard where appropriate.

doesn't cover (dental, hearing, vision, non-emergency medical transportation, personal care services; and broader behavioral health, home health, and medical equipment coverage). Having Medicaid also addresses affordability. The "full dual eligible" person -- who has Medicaid plus Medicare -- pays no deductibles, premiums, or cost-sharing except some (reduced) cost-sharing for prescription drugs. Medicare pays 80% of the "Medicare allowed amount" for Medicare-covered inpatient and outpatient services, after deductibles. Medicaid then "wraps around" this payment, protecting the patient from paying Part B premiums or cost-sharing, except for (subsidized) copays for prescription drugs. The actual costs to the state include the Part B premiums and the services only Medicaid covers. But for services covered by Medicare, Washington State pays nothing more than Medicare pays whenever the Medicare payment is higher than 100% of the Medicaid rate, which is common.[47]

Medically Needy ("Spenddown") Medicaid. Washington has a "medically needy" Medicaid program for people whose income exceeds the usual Medicaid eligibility standard, and whose resources are still within the limits shown on Figure 4, above.[48] This program is important to soften the harshness of having a set income standard for assistance, which is in effect another kind of "cliff." The Medically Needy program, however, works best for people with only a relatively small amount of income above the standard. Otherwise the spenddown liability may be too high for the person to meet, considering their income and other living expenses. The spenddown program concept is to assign all income above the eligibility standard to a "spenddown," which is like a deductible that the person is responsible to pay. Assistance begins only after the person incurs health care out-of-pocket costs exceeding the "spenddown" amount. The program allows the applicant to choose a 3-month or 6-month period. The "spenddown" amount is three times, or six times (respectively), the monthly income that exceeds the eligibility standard. The spenddown is smaller for the shorter time frame, but eligibility ends at the end of the 3-month or 6-month period chosen. After that, the person must reapply and meet a new spenddown to get another period of assistance. Even for people with a modest amount of income, "spenddown" can exceed a month's worth of income, or more. Few people can sustain repeated or continued eligibility for the program over time unless their "excess" income is very low.

Medicare Savings Programs (MSP). These programs pay Medicare Part B premiums ($148.50/month in 2021 for most beneficiaries). One MSP program (QMB) also addresses cost-sharing expenses for services covered by Part A or Part B.[49] MSPs do not cover prescription costs, but they qualify people for the "Low Income Subsidy" (LIS) program that reduces Part D prescription costs.

- The MSP program called Qualified Medicare Beneficiary or **"QMB"** covers Part B premiums, Part A premiums when they are charged, and is the *only* MSP that *also* covers out-of-pocket costs for deductible, copays, and coinsurance for services covered by Medicare Parts A and B. QMB does not cover prescription cost-sharing, but eligibility for QMB makes the person eligible for the

[47] See WAC 182-502-0110

[48] For more information, see The Medically Needy "Spenddown" Program: Medicaid for Adults 65 and Older or Disabled Who Don't Get SSI . Retrieved from: http://washingtonlawhelp.org

[49] QMB and another MSP program, QDWI (Qualified Disabled and Working Individuals), pay Part A premiums when those apply. QDWI serves only people under age 65 with disabilities who work and is not addressed separately. See note 45.

"Low-Income Subsidy" program ("LIS," also known as "Extra Help") that reduces Medicare Part D prescription costs. Washington uses the lowest income standard allowed for the MSP-QMB program, which is 100% FPL. As of April 1, 2021, this limit is $1,094/month single person, $1,472/month couple.[50] The program also has resource limits for eligibility, as shown in Figure 4, above. Medicare remains the primary payer. The Medicaid program pays the premiums, with the cost divided between the state and federal government. Medicaid adds payment to the provider only when the amount Medicare paid is lower than 100% of the Medicaid program's rate for the service. Because Medicaid rates are significantly below Medicare rates, 100% of Medicaid's rate is usually less than 80% of Medicare's allowed rate.

- Other MSP programs are **Specified Low-Income Medicare Beneficiary** or "**SLMB"** (available to people with income up to 120% FPL), and "**ESLMB,"** also known as **Qualifying Individual "QI-1**" (for people with income up to 135% FPL). These programs also have resource limits, as shown in Figure 4, above. These programs cover *only* Part B premiums, not cost-sharing for Medicare-covered services. But being eligible for these programs provides automatic eligibility for the federal "LIS" program that reduces Part D prescription costs.

"Low-Income Subsidy" program for prescription medications (also called "LIS" or "Extra Help"). This federal program lowers prescription out-of-pocket costs for Medicare Part D prescription drug coverage. Income and asset limits and cost-sharing amounts are shown in Appendix C. In states that have expanded eligibility for Medicaid or MSP, LIS is also expanded automatically. All the cost for LIS expansion, however, is paid by the federal government, not by the state. LIS has two levels of assistance, with different levels of costs left to the Medicare beneficiary. Even people with full Medicaid plus Medicare still pay something for prescription drugs covered by Medicare, unless they receive a Medicaid institutional program (for nursing home care) or other long-term care program (in assisted living facilities, adult family homes, or in-home care).

6. How are states allowed to increase access to medical assistance for Medicare beneficiaries, and what have other states done?

Social Security Act § 1902(r)(2) gives states broad authority to change income and resource standards for Medicaid and Medicare Savings Programs. At least 26 states have done this to expand Medicaid, using this authority or authority under an older statute that allowed increases up to 100% FPL.[51]

[50]These figures are the FPL standard plus $20, which is the program's allowed $20 income "disregard." FPL standards change for Medicaid programs April 1 of each year.

[51] Musumeci, MaryBeth *et al*. *Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey.* Kaiser Family Foundation Issue Brief (June 14, 2019) (see Tables in Appendix section). Retrieved from: https://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/. Hereinafter referred to as "KFF survey 2018."

Since 2001, after the federal agency changed the interpretation of § 1902(r)(2),[52] states have been allowed to use this authority to:

- Eliminate Medicaid resource limits or set them higher than the federal standard
- Raise income limit for Medicaid
- Eliminate or increase resource limits for Medicare Savings Programs
- Raise the amount of income limits for Medicare Savings Programs

Thirty-four states and Washington, D.C., have liberalized one or more of these eligibility standards to expand eligibility for one or more of these programs.[53] Doing this enhances health care affordability and access, with modest cost to the state. Washington is one of sixteen states with no expansion.[54]

Some comparisons of Washington's standards and those applied in other states are shown below.

Figure 5. Assistance programs for Adults with Medicare: Standards.

		Washington State	Other States
MEDICAID for aged/blind/ disabled people with Medicare:	**Income Limit**	**WA:** ~75% FPL (federal minimum)	**24 states + D.C.**: raised income levels **Most use**: 100% FPL[55] **California: 138% FPL** (2020)[56]
	Resource Limit	**WA:** $2,000 individual/$3,000 couple (federal minimum)	**10 states +D.C.:** Raised limit [57] **Arizona: No resource limit** (for non-institutional Medicaid program)
QMB - Medicare Savings Program (premium + cost-sharing subsidies):	**Income Limit**	**WA:** 100% FPL (federal minimum)	**6 states + D.C.:** Above 100% FPL[58] **Washington, D.C.: 300% FPL**
	Resource Limit	**WA:** $7970 individual/ $11,960 couple (federal minimum)	**10 states + D. C.:** No resource limit **+ 4 states** increased limit[59] **Maine: $58,000/single; $87,000/couple**

[52] 42 C.F.R. 435.1007, amended in Fed. Reg. Vol. 66, No. 8 (January 11, 2001).
[53] Regarding Medicare Savings Programs, *see* National Council on Aging, *Medicare Savings Programs (MSPs): Eligibility and Coverage* (March 17, 2021) (hereinafter: "NCOA 2021 chart"). NCOA 2021 chart retrieved from: https://www.ncoa.org/article/medicare-savings-programs-eligibility-coverage. NCOA updates MSP program information yearly or more often when states make changes. Regarding Medicaid, *see* KFF Survey 2018, note 49.
[54] States without eligibility expansions are: AK, GA, IA, KS, KY, MD, MT, NV, NH, OH, SD, TN, TX, WA, WV, WY.
[55] KFF Survey 2018, note 49 (Appendix, Table 1)
[56] California's current standard was implemented in 2020 after adoption of Assembly Bill 1088 in 2019. This state is not listed in the KFF 2018 Survey, note 49 above. *See* article by Disability Rights California retrieved from: https://www.disabilityrightsca.org/publications/what-advocates-need-to-know-about-the-aged-blind-and-disabled-fpl-medi-cal-expansion
[57] KFF Survey 2018, note 49 (Appendix, Table 2)
[58] NCOA 2021 chart, note 51.
[59] KFF Survey 2018, note 49, and NCOA 2021 chart, note 51. NoHLA's list of states with higher limits includes ME, MA, MN, and CO. NCOA lists only ME, MA, and MD. The KFF survey 2018 included New Mexico., which NCOA now

7. What has Washington done to increase access to medical assistance for Medicare beneficiaries?

Washington attempted to increase access to medical assistance for Medicare beneficiaries more than ten years ago. A broad coalition of advocacy organizations in Washington State worked from 2005 to 2008 to pass legislation to increase Medicaid income standards. By that time, many states had adopted 100% FPL as the income standard, and that was the goal pursued in Washington.

Legislation passed in Washington, finally, in 2008.[60] It would have raised the Medicaid income level to 80% FPL, not the 100% FPL level originally sought, and it required a report to the Legislature afterward about costs and cost savings. However, it also required funding in the 2009 budget. By then, the Great Recession thwarted getting the funds required. Thus, the eligibility change was never implemented.

Washington State remains one of only 16 states[61] that have done nothing to expand eligibility for these assistance programs for Medicare enrollees. Costs for Medicare enrollees continue to increase. The passage of the Affordable Care Act (ACA) means we now have a significant disparity in eligibility and coverage for older adults and people with disabilities compared to younger adults without disabilities, who benefit from the ACA programs.

Federal law allows Washington to change the income and resource limits that apply to these programs for Medicare beneficiaries to any amounts the state chooses. Although doing that requires state funding, the federal government shares in the cost. The benefit to people with Medicare from increasing access to Medicaid and MSP programs would be significant, providing more economic security and, for Medicaid, access to important health care services not covered by Medicare.

Policy Options to improve health care access and affordability for aged, blind and disabled people receiving Medicare

Many of the options described above and implemented in other states could remove existing disparities and ease the burden of health care costs for Washington Medicare beneficiaries. The following strategies are offered for consideration. Where possible, we project the potential impact of these options based on available demographic data.

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shows as having no resource limit in 2021. KFF also included Colorado. NoHLA correspondence with Colorado's Medicaid agency staff in 2021 and research of Colorado's 1902(r)(2) documents confirm that Colorado has an additional $1500 exclusion plus the usual burial fund exclusion.

[60] The legislation was SSB 6583, Chapter 317, Laws of 2008. Retrieved from: https://app.leg.wa.gov/billsummary/?BillNumber=6583&Year=2007&Initiative=false

[61] These states are: Alaska, Georgia, Iowa, Kansas, Kentucky, Maryland, Montana, Nevada, New Hampshire, Ohio, South Dakota, Tennessee, Texas, Washington, West Virginia, Wyoming.

A. POLICY OPTIONS for Categorically Needy (CN) Medicaid for aged/blind/disabled group

Categorically Needy Medicaid (CN) covers cost-sharing for Medicare-covered services, and it also adds covered services not available through Medicare, like dental, hearing, vision, non-emergency medical transportation, personal care services, and broader behavioral health coverage. Two options for offering this "wraparound" coverage of Medicaid to more Medicare beneficiaries are: (1) raising the Medicaid income limit to parity with the ACA Medicaid expansion program, and (2) eliminating the resource limit for this program.

1. OPTION: Raise CN Medicaid income limit to 138% FPL

138% FPL is the Medicaid income standard for other adults without Medicare (who are younger than age 65 and not disabled). Changing the income limit for aged/blind/disabled adults with Medicare to this same 138% FPL limit would achieve parity with these younger adults without disabilities. California adopted this limit in 2020 for its Medicaid program for aged/blind/disabled people. Washington's current limit for this group is significantly lower than the income allowed for younger adults: ~75% FPL ($814/mo. single person, $1211/mo. married couple).[62] *Approximately 23,000 King County residents and 100,000 Washington residents have income between these two limits and would potentially benefit from this option.*[63]

2. OPTION: Eliminate Medicaid resource limits

The Medicaid program for adults without Medicare has no resource limit. But Medicaid resource limits do apply to adults who are aged/blind/disabled and have Medicare. This is a huge disparity. Washington's current limits for aged/blind/disabled people with Medicare are $2000/single person, $3000/married couple. These standards have not changed since 1989, despite inflation. The option to eliminate resource limits would remove the existing disparity in Washington State. Washington could follow the example of Arizona, which has no resource limit for its (non-long-term-care) Medicaid programs.[64] *Estimates are not available at this time for the number of residents who would benefit from eliminating resource limits.*

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[62] Many states use 100% FPL as their Medicaid income standard for Medicare-eligible people. Some states like CA also "disregard" additional income, making the effective income limit higher. At the time many states adopted the 100% FPL limit, the ACA adult Medicaid expansion to 138% FPL was not yet in place.

[63] Data provided by King County: King County and Washington State Population by Federal Poverty Level, Ages 65+ (2014-2018). Numbers in this section reflect over-65 population estimates for the income brackets reflected in each proposed option.

[64] If the resource limit is not eliminated, there are less robust options for change. Federal legislation has been proposed to update the SSI cash assistance program to raise the resource limit for that program to $10,000 for an individual and $20,000 for a couple, and add yearly COLA increases (SSI Restoration Act of 2019). Changing those SSI standards would automatically change the related Medicaid eligibility, or Washington could adopt those standards independently for the state's Medicaid program for people with Medicare. Some states such as California exempt retirement accounts from being counted as resources. This option recognizes that people with such accounts instead of traditional pensions rely on withdrawals to maintain income levels throughout their retirement years. Exempting retirement accounts is a Medicaid State Plan option states also can choose.

B. POLICY OPTIONS for Medically Needy (MN)) Medicaid ("Spenddown")

The Medically Needy (MN) or "Spenddown" program helps people who meet all eligibility standards for the aged/blind/disabled Medicaid program *except* that their income exceeds the limit for regular (CN) Medicaid. To get assistance, the person must first be responsible for a "spenddown," like a deductible, in the amount that the person's income "exceeds" the income limit.[65]

1. OPTION: Raise MN income and resource limits to the same (raised) levels for regular (CN) Medicaid for aged/blind/disabled group (section A above).

Currently, Washington State has maintained MN income and resource limits at the same level that applies to CN Medicaid. If CN limits are raised or eliminated, changing MN limits to match those is needed to prevent inequities that create another kind of inequitable "cliff." This would allow MN clients to have the same amount of income to live on for their non-medical costs that people on full CN Medicaid have. Keeping the limits the same for the two programs prevents people with income above the CN standard from being worse off financially compared to those with lower income.[66] *Estimates are not available at this time for the number of residents who would benefit from raising the spenddown threshold.*

C. OPTIONS for Medicare Savings Programs (MSP)

Medicare Savings Programs can greatly improve affordability for Medicare enrollees, although they do not provide full wraparound coverage. The **QMB** program covers Medicare Parts A and B premiums and cost-sharing for Medicare-covered services. It does not provide coverage for additional services that only Medicaid covers. The **SLMB** and **ESLMB** programs cover Part B premiums only, not cost-sharing.

As noted above, other states have raised income limits and eliminated resource limits for the QMB and SLMB programs. When MSP income and resource limits are expanded, people newly eligible for an MSP automatically become eligible for prescription cost-sharing subsidies under the Medicare Part D "Low-Income Subsidy" (LIS) or "Extra Help" program. This program is 100% federally funded. However, expanding MSP does not add coverage for any benefits not already covered by Medicare.

The options below, separately or in combination, could help address Medicare cliff affordability issues.

1. OPTION: Raise QMB income limit to 300% FPL

QMB subsidies would address all out-of-pocket costs for Medicare-covered services. Washington, D.C. raised their QMB income limit to 300% FPL, three times Washington State's

[65] MN is an optional program, and not all states have it. Some states that do have it have failed to maintain the income standard for MN at the same level as the regular Medicaid program. In those states, people with even a few dollars of income above the limit must "spend down" *more* than just the level that exceeds the income limit to get help, leaving them with even less than the SSI cash income level to use for all their non-medical living expenses. Washington State has retained the same income standards for both programs by using the same law that allows other eligibility liberalization (Social Security Act § 1902(r)(2)).

[66] As with CN, less robust options might also be considered for the MN program. One alternative is to use a higher resource standard for MN than for CN. If MN retains a resource limit, a person with resources above the limit is simply denied benefits. They can qualify for the MN Medicaid program later only if they deplete their resources first to below the eligibility level, and then reapply the month after doing so. They still would need to incur medical costs in the amount of the "spenddown" before getting benefits.

current level of 100% FPL ($1,094/mo. single, $1472/mo. couple in 2021). The state pays 50% of the cost of Part B premiums, but pays almost nothing for the extra coverage of cost-sharing expenses due to reimbursement policies.[67] *Approximately 70,000 King County residents and 347,000 Washington residents have income between 100-300% FPL and would potentially benefit from this option.*[68]

2. OPTION: Raise SLMB income limit to 400% FPL

Individuals with income in the 300-400% FPL range still struggle to afford out-of-pocket health care costs. A modest step to assist them would be to provide SLMB coverage for Medicare Part B premiums. This would provide some measure of equity with subsidized individuals enrolled in QHP health coverage, which people with Medicare cannot get. QHP premium subsidies ordinarily phase out with higher income and stop for people above 400% FPL income. But the pandemic-relief ARPA temporarily expands this limit premiums to 8.5 % of income, regardless of income level. Medicare Savings Programs work differently. SLMB provides full coverage of premiums for anyone under the eligibility limit. In 2021, 400% FPL is ~$4,293/month. In comparison, the statewide median income for a single person in 2021 is $4454/month.[69] Although SLMB subsidies would provide full premium relief, SLMB provides no cost-sharing subsidy and thus no limit on out-of-pocket costs. Cost-sharing expenses are likely to be considerably greater for an individual over age 65 or with disabilities compared to QHP enrollees, who are younger. *Approximately 33,000 additional King County residents and 160,000 additional Washington residents would benefit from this option.*[70]

3. OPTION: Eliminate resource limits for all Medicare Savings programs

Ten states and Washington, D.C., have already removed resource limits for MSP programs:

- Alabama
- Arizona
- Connecticut
- Delaware
- Louisiana
- Mississippi
- New Mexico
- New York
- Oregon
- Vermont
- Washington, D.C.

Washington currently uses the lowest resource limit that federal law permits: $7970/single person, $11,960/ couple, plus up to $1500 each for funds set aside for burial. This is a significant barrier for individuals who have a modest amount of savings. As seen in the examples in Figures

[67] In the Health Benefit Exchange, cost-sharing assistance is available for households with income up to 250% FPL. (in addition to a premium subsidy). QHP subsidies are partial and decline with higher income. The Exchange has identified affordability, even with subsidies, as a major concern for QHP enrollees. QHP enrollees as a group are younger than Medicare enrollees, and for that reason, Medicare enrollees may have higher health costs.
[68] See note 32.
[69] Source: Washington State Department of Social and Health Services. Retrieved from: https://www.dshs.wa.gov/esa/eligibility-z-manual-ea-z/state-median-income-chart
[70] See note 32.

1 and 2, retaining modest savings disqualifies people from getting MSP assistance that could offset medical bills by thousands of dollars each year. Depleting savings puts such a person at significant risk when unexpected expenses or financial crises arise.[71] Once gone, life savings of a retired person unable to resume work cannot be replaced later by saving earnings.

Eliminating resource limits makes it much easier for states to ensure that people losing the adult Medicaid program transition successfully to a Medicare Savings Program after they qualify for Medicare. The requirement to document the person's resource values is a barrier to getting those benefits and adds cost for the state to process benefits.[72]

Conclusion

Washington State could significantly broaden access to coverage for healthcare costs and services for lower-income Medicare beneficiaries. Medicare beneficiaries by definition are over age 65 and/or have a permanent disability. Many have low income, and people in communities of color or other minority communities are disproportionately in this situation. The state could pursue parity for this vulnerable group that currently lacks the level of access to health assistance afforded to younger adults without disabilities, who can get assistance with much higher income and no limit on resources. The state can take advantage of a variety of options to leverage federal funding to do so.

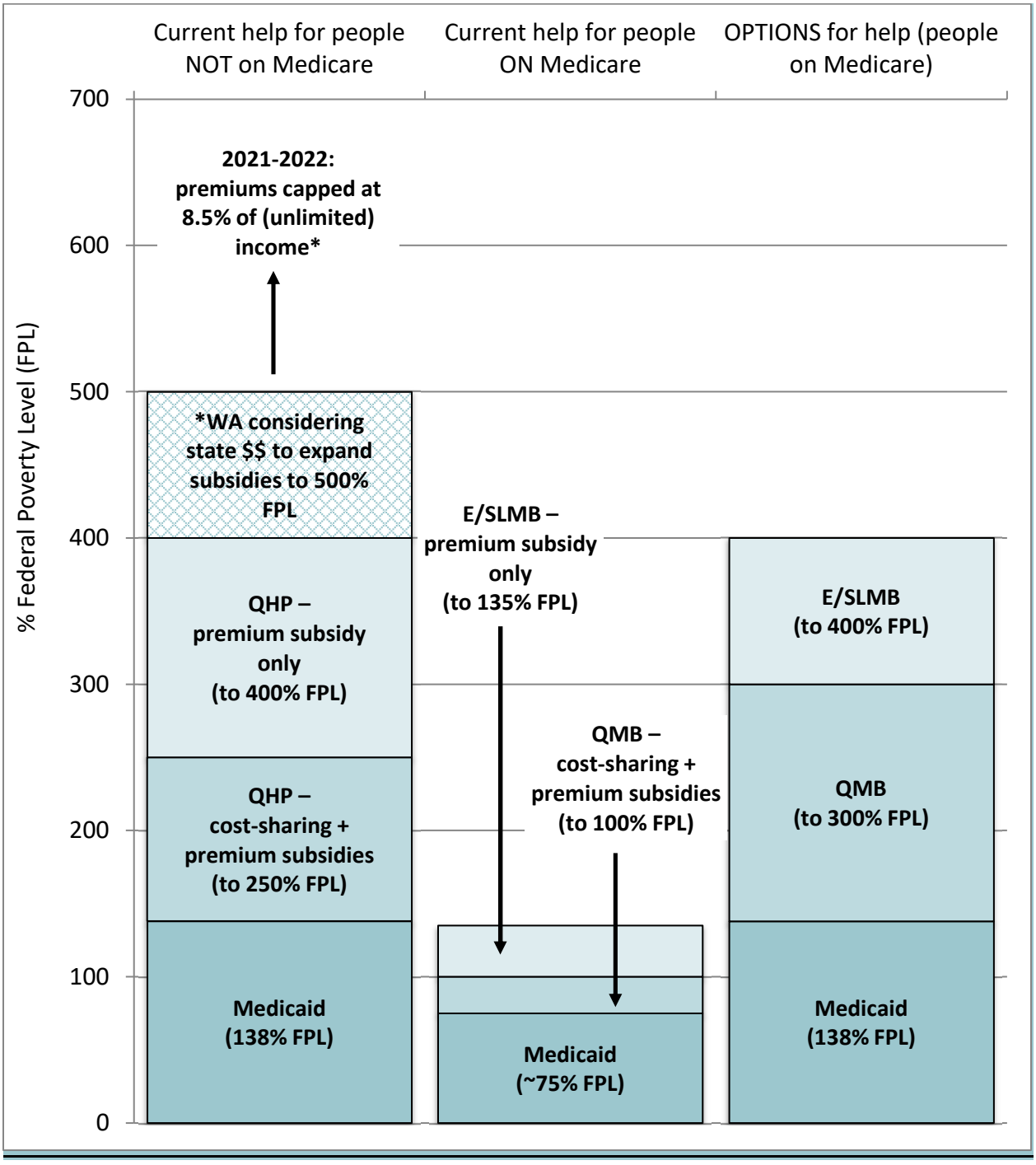
The chart in Figure 6 below shows the current health cost subsidy programs available for people before they get Medicare compared to the ones available for people after they get Medicare, and how the options identified could address the disparity.

NoHLA is grateful to the Pacific Hospital Preservation and Development Authority (PHPDA) for the grant funding that allowed us to produce this report.

[71] The Board of Governors of the Federal Reserve System, in its *Report on the Economic Well-Being of U.S. Households in 2019-May 2020,* includes a section on "Dealing with Unexpected Expenses." Retrieved from: https://www.federalreserve.gov/publications/2020-economic-well-being-of-us-households-in-2019-dealing-with-unexpected-expenses.htm This report indicates that even a small ($400) unexpected expense can result in substantial hardship. Many people reported going without needed health care due to inability to pay.

[72] Some states have raised resource limits without eliminating them, although this approach does not help ensure eligible people can enroll more easily. Maine uses a resource limit of $58,000 for an individual and $87,000 for a couple; Minnesota uses a resource limit of $10,000 for an individual and $18,000 for a couple.

Figure 6.



*Under the American Rescue Plan Act of 2021 for pandemic relief. Washington is separately considering subsidy expansion above 400% FPL income, using state funds.

** Work is in progress regarding Washington State's legislative directive to consider options to address affordability with state-funded premium and cost-sharing subsidies ("Cascade Care"). See ESSB 5526, Ch. 364, Laws of 2019.

APPENDIX A: Costs for people with "Medicare Only" (no assistance based on financial need)

- **Part A (hospital) coverage:** Free for most people (if the individual has sufficient work quarters in U.S.); annual deductible in 2021: $1484.
- **Part B (physicians etc.) coverage costs:**
    - Standard premium $148.50/month in 2021
    - Yearly deductible of $203 in 2021
    - After deductible, Part B covers 80% of the Medicare allowed costs.
- **Supplement to Part B:** Main choices[73] are a Medigap plan or a managed care "Medicare Advantage" plan.
    - **Medigap plans:** Medigap Plans usually are more cost-effective than Medicare Advantage Plans for people with high health expenses. Plan G covers 20% of Medicare allowed costs, but not the deductible. This is the highest Medigap plan coverage now available to new Medicare enrollees. Premiums for Plan G standard deductible plans in 2021 range from $169-$288/month for plans offered in one or more areas of Washington State. The plans available vary by county. The effective out-of-pocket health cost for people with Plan G is the yearly cost of Part B premiums and Supplement Plan G premiums, plus the Part D deductible, cost of medications (Part D), and the cost of services not covered by Medicare.
    - **Medicare Advantage Plans:** Premiums and cost-sharing requirements vary by the plan, and the plans available vary by county.[74] Some counties have no Medicare Advantage Plan. Some plans add coverage for dental, vision, and exercise programs (such as "Silver Sneakers"). Medicare beneficiaries with few health conditions may pay significantly less than those with significant health conditions. Medicare sets a maximum out-of-pocket limit ("MOOP") for Medicare Advantage Plans for the cost of Part A and B services (not prescriptions). In 2021 the "MOOP" is $7550 per year for in-network costs, and $11,300 for combined in-network and out-of-network

[73] For Washington residents who lack reasonable access to Medicare Advantage Plans and supplement plans, the WSHIP (Washington State Health Insurance Pool) program offers supplements. Cost is higher than for regular Medigap plans. Link for more information: http://www.wship.org/ Eligibility info retrieved from: https://www.wship.org/medicare_eligibility.asp

[74] See information from the Washington Office of the Insurance Commissioner (OIC): https://www.insurance.wa.gov/2021-medicare-advantage-and-special-needs-plans-snps

costs. Enrollees also have prescription costs under Part D, and cost of services not covered by Medicare.

- **Part D prescription coverage:** Costs depend on amount for premiums, copays, coinsurance, and covered drugs, and whether a person has "Low-Income Subsidy" (also called "Extra Help")[75] eligibility. Even people with Medicare plus Medicaid still pay cost-sharing for prescriptions, unless they qualify for the Medicaid Institutional or other long-term care programs. Without full or partial "Low-Income Subsidy" eligibility, there is NO CAP on out-of-pocket costs for medications. In 2020, the amount of out-of-pocket expenses for a person to enter the "catastrophic coverage" phase of Medicare Part D (called the TrOOP) is $6350. While in the catastrophic phase, a person pays 5% of the cost of each medication. People with full "Extra Help" eligibility have prescription costs capped at $6550 per year. Those with "partial" Extra Help eligibility continue to pay cost-sharing, at a reduced percentage, even after costs reach $6550 per year.

[75] See Appendix C for more information about the Low-Income Subsidy/Extra Help program.

APPENDIX B:[76] Elder Economic Security Index charts

Figure 7. The Elder Economic Security Standard Index for Washington State 2021.

		Elder Living Alone			2-person Elder Household		
Monthly Expenses		**Owner with Mortgage**	**Renter**	**Owner without Mortgage**	**Owner with Mortgage**	**Renter**	**Owner without Mortgage**
Housing		1652	1111	601	1652	1111	601
Food		272	272	272	498	498	498
Transportation		215	215	215	332	332	332
Miscellaneous Essentials[77]		308	308	308	468	468	468
Healthcare IF health is:	Poor- Good- Excellent-	648 454 366	648 454 366	648 454 366	1296 908 732	1296 908 732	1296 908 732
MONTHLY TOTAL COSTS IF health is:	Poor- Good- Excellent-	3095 2901 2813	2554 2360 2272	2044 1850 1768	4246 3858 3682	3705 3317 3141	3195 2807 2631
YEARLY TOTAL IF health is:	Poor- Good- Excellent-	37,140 34,812 33.756	30,648 28,320 27,264	24,528 22,200 21,149	50,952 46,296 44,184	44,460 39,804 37,692	38,340 33,684 31,572

[76] Costs shown in Figures 7 and 8 were identified using the tool found at this link: https://elderindex.org/.

[77] "**Miscellaneous"** definition: **"**The miscellaneous expense category includes all other essentials, such as clothing, household items, personal hygiene items, and telephone service. It does not allow for recreation, entertainment, gifts, or savings. Miscellaneous expenses are estimated as 20% of all other costs, based on the remaining costs for elders living in an owned home with no mortgage. This same expenditure is applied to the other housing scenarios, separately for singles and couples." Elder Index definitions are at this link: https://elderindex.org/about.

Figure 8. The Elder Economic Security Standard Index for King County WA 2021.

		Elder Living Alone			2-person Elder Household		
Monthly Expenses		**Owner with Mortgage**	**Renter**	**Owner without Mortgage**	**Owner with Mortgage**	**Renter**	**Owner without Mortgage**
Housing		2099	1588	778	2099	1588	778
Food		272	272	272	498	498	498
Transportation		205	205	205	316	316	316
Miscellaneous		337	337	337	490	490	490
Healthcare	Poor-	647	647	647	1294	1294	1294
IF health is:	Good-	429	429	429	858	858	858
	Excellent-	332	332	332	664	664	664
MONTHLY TOTAL							
IF health is:	Poor-	3560	3049	2239	4697	4186	3376
	Good-	3342	2831	2021	4261	3750	2940
	Excellent-	3245	2734	1924	4067	3556	2746
YEARLY TOTAL							
IF health is:	Poor-	42,720	36,588	26,868	56,304	50,232	40,512
	Good-	40,104	33,972	24,252	51,132	45,000	35,280
	Excellent-	38,940	32,808	23,088	48,804	42,672	32,952

APPENDIX C: "LIS" Extra Help Program (for Part D prescriptions)

Chart[78] for the "Extra Help" program, also known as the "Low-Income Subsidy" or "LIS," is reprinted with permission from Medicare Rights Center.

MEDICARE RIGHTS CENTER
Getting Medicare right

Extra Help Program
Income and Asset Limits 2021

If you have Medicare only

Income limit	Asset limit	Program	Copayments
Below $1,630 ($2,198 for couples) per month[1] • **And** your income and/or assets are above Full Extra Help limits	**Up to** $14,790 ($29,520 for couples)[2] • **And** your income and/or assets are above Full Extra Help limits	**Partial Extra Help** Premium depends on your income $92 deductible or the plan's standard deductible, whichever is cheaper	15% coinsurance or the plan copay, whichever is less After $6,550 in out-of-pocket drug costs, you pay $3.70/generic and $9.20/brand-name or 5% of the drug cost, whichever is greater
Up to $1,469 ($1,980 for couples) per month[1]	**Up to** $9,470 ($14,960 for couples)[2]	**Full Extra Help** $0 premium and deductible[3]	$3.70 generic copay $9.20 brand-name copay No copay after $6,550 in out-of-pocket drug costs

If you have Medicare and Medicaid and/or a Medicare Savings Program

Enrolled in	Income limit	Program	Copayments
Medicaid and/or a Medicare Savings Program	**Above** $1,093 ($1,472 for couples) per month[1]	**Full Extra Help** $0 premium and deductible[3]	$3.70 generic copay $9.20 brand-name copay No copay after $6,550 in out-of-pocket drug costs
Medicaid	**Up to** $1,093 ($1,472 for couples) per month[1]	**Full Extra Help** $0 premium and deductible[3]	$1.30 generic copay $4.00 brand-name copay No copay after $6,550 in out-of-pocket drug costs

Note: Income and asset limits on this chart are rounded to the nearest whole dollar. There's also a $20 income disregard (factored into the income limits above) that the Social Security Administration automatically subtracts from your monthly unearned income.

[1]Income limits are based on the Federal Poverty Level (FPL), which changes every year in February or March. Limits are higher for each additional relative living with you for whom you are responsible.

[2]Asset limits include $1,500 per person for burial expenses.

[3]You pay no premium if you have Full Extra Help and a basic Part D drug plan with a premium at or below the Extra Help premium limit for your area.

 Helpline: 800-333-4114 www.medicareinteractive.org

[78] 2021 chart retrieved from: https://www.medicarerights.org/fliers/Help-With-Drug-Costs/Extra-Help-Chart.pdf?nrd=1