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Standing Back from the Medicare Cliff:

Research and Policy Options to Help Low-Income Older Adults

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Table of Contents

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Executive Summary

With the passage of the Affordable Care Act (ACA), many states expanded access to Medicaid for low-income adults ages 19 to 64 with incomes up to 138% of the Federal poverty level (FPL). As these individuals relying on expanded Medicaid become eligible for Medicare, they may lose their Medicaid coverage, with its cost-sharing protections, and be unable to afford the higher Medicare premiums, deductibles, and co-payments. This disruption in coverage is known as the "Medicare Cliff" and the resulting financial shock can be particularly difficult for those with the lowest incomes who tend to be single women, persons of color, and people with complex medical conditions or functional limitations.

With support from Arnold Ventures, the National Council on Aging (NCOA) and the Leading Age LTSS Center @UMASS Boston conducted research to analyze what happens to persons facing the Medicare Cliff. The study team utilized a mixed methodology approach that included a literature review, analysis of longitudinal data using the Health and Retirement Study (HRS), qualitative interviews with individuals with lived experience encountering the Medicare Cliff, and in-depth interviews with key informants to discuss possible policy reforms and financial offsets.

The Medicare Cliff population is more likely to be female, retired, and facing difficult affordability and health coverage challenges. The research found that this population faces several vulnerabilities:

- They have significantly higher out-of-pocket medical costs compared to individuals dually eligible for Medicare and Medicaid, and those with Medicare only.
- The Medicare Cliff population also experienced greater financial resource decline over time, with a diminishing median net worth.
- In the two years after hitting the Medicare Cliff, these individuals experienced a substantial worsening of their health.

Interviews with those who faced the Medicare Cliff revealed that they encountered confusing (and sometimes conflicting) communication about the transition between Medicaid and Medicare; could have benefitted from additional counseling assistance, such as that provided by State Health Insurance Assistance Programs (SHIPs); and often were forced to cut expenses in other areas to make ends meet.

Executive Summary

This research was intended to identify policy reforms to ensure that older adults who are new to Medicare do not lose the help they were receiving via Medicaid, so that they can continue to afford the care they need. Specifically, we sought to identify policy changes and remedies to provide vulnerable and poor older adults with better health care options, and to examine the budget offsets needed to make the policy solutions possible. While the primary focus was on the Medicare Cliff population, we also explored options to improve access to Medicare Savings Programs (MSPs) for financially and medically vulnerable older adults who are eligible for but, for a variety of reasons, not accessing MSPs.

Three major areas for policy reform emerged from this research:

1. Allowing the Medicare Cliff population to maintain Medicaid eligibility as they enter Medicare
2. Improving the education and enrollment process for MSPs without changing eligibility criteria
3. Changing eligibility criteria for MSPs to remove or raise the asset limit, and/or synchronize the income eligibility threshold with other benefits

The ideal combination would be policy reforms that offer high impact with moderate to low costs (implementation and programmatic), which further analysis identified as improved education and outreach for MSPs. While removing the asset test would have a large impact, this option would also have high cost, which is not ideal. This approach, however, may still be worthwhile given that there are potential ways to offset costs.

Yet policy reforms come at a cost. Identifying feasible budget "offsets" – i.e., how to fairly and on a bipartisan basis pay for these policy reforms – is a question of critical importance. A vital next step is to identify the costs associated with the various policy reform(s) to be pursued to identify and evaluate the possibilities for an offset.

The team identified the following as possible next steps to complement the research and explore further the implications of proposed policy reforms:

- Convene states with "best practices" regarding consumer outreach and education with those states that are struggling and enabling a transfer of knowledge
- Grant funding to test and develop improved SHIP training, communication pieces, website material, and to identify other best practices that can further enable SHIPs to better counsel this population
- Host a working policy forum, with experts from states, think tanks, advocacy organizations, consumers, and academia to help identify and prioritize policy objectives and policy reforms
- Invest in analysis and modeling to drill down on the policy recommendations coming out of this report, identify the cost implications (both savings to the system and additional costs from increased enrollment), and the sources of revenue to support these policy reforms

Project Overview

As low-income older adults relying on Medicaid become eligible for Medicare, they may lose their Medicaid coverage, with its cost-sharing protections, and be unable to afford Medicare premiums, deductibles, and co-payments. We call this disruption in their health care coverage experiencing the "Medicare Cliff". The Medicare Cliff occurs because of the discontinuity in eligibility criteria for people on Medicaid before age 65 compared to after age 65, where more stringent criteria apply.

With support from Arnold Ventures, the National Council on Aging (NCOA) and the Leading Age LTSS Center @UMASS Boston conducted a multi-phase research project to analyze the transition from Medicaid eligibility to Medicare among low-income older adults. The Medicare Cliff population faces difficult affordability and health coverage challenges. Compared to both dually eligible and Medicare-only enrollees, they have significantly higher out-of-pocket costs and experience greater financial resource decline, along with a worsening of their health in the two years after hitting the Medicare Cliff.

This research was intended to identify policy reforms to ensure that older adults who are new to Medicare do not lose the help they were receiving via Medicaid, so that they can continue to afford the care they need. Specifically, we sought to identify policy changes and remedies to provide vulnerable and poor older adults with better health care options, and to examine the budget offsets needed to make the policy solutions possible. While the primary focus was on the Medicare Cliff population — low-income adults who are no longer eligible for Medicaid and Marketplace assistance subsidies that enable them to afford the care they need as they become eligible for Medicare —we also explored options to improve access to Medicare Savings Programs (MSPs) for financially and medically vulnerable older adults who are eligible for but, for a variety of reasons, not accessing MSPs.

MSPs are designed to assist low-income older adults transitioning on to Medicare as they turn age 65 with the "financial shocks" many of them encounter because of that change. There are a wide variety of challenges to making people aware of and getting them enrolled in an MSP. Low take-up rates among those who are eligible for MSPs and the Medicare Part D Low-Income Subsidy (LIS) suggest problems with education, outreach, and enrollment. Little is known about consumers who lose Medicaid coverage or Marketplace subsidies, or are not dual eligibles, as they transition to Medicare.

Project Methodology

A unique feature of the project was to address these research issues using a mixed-methodology approach. The various methods included:

- **Literature review:** The study team conducted a comprehensive review of both peer-reviewed publications and materials from the general literature.
- **Data analysis:** We conducted analysis of longitudinal data using the Health and Retirement Study (HRS) to better understand characteristics of those who fall off the Medicare Cliff as compared with the dual eligible and Medicare-only populations.
- **Qualitative interviews:** By talking with individuals who have lived experience encountering the Medicare Cliff, we are able to better tell the story of the difficulties they encounter. These interviews were facilitated via the Benefits Enrollment Center (BEC) network (working with NCOA's Center for Benefits Access).
- **Key informant interviews and policy reform options and offsets:** NCOA conducted semi-structured, key informant interviews with experts in the field. Interviewees included public sector experts, academics, policy experts with think tanks, research institutes, state agencies, and non-profits. Among the considerations for this phase of the work was examining policy solutions and the budget offsets that may be considered to make potential solutions a reality.

Each of these methodologies and their key findings are described in brief below. Detailed reports/ briefs for each study component are provided in the appendices to this report.

Key Findings

Literature Review

The literature review examined the issues surrounding the Medicare Cliff and identified program and policy solutions that may be considered to keep people from "falling off the Medicare Cliff" by shielding them from large out-of-pocket payments when eligibility criteria change as they reach Medicare status. The analysis was based on a review of 43 articles from both peer-reviewed and grey literature. The focus was on obtaining information on the nature and magnitude of the problem and insights regarding how states have handled the issue, with an attempt to highlight "best practice" states, the modeling of policy solutions, and an inventory of policy interventions that have been put forward to address these problems.

The literature review included a focus on the Medicare Savings Programs (MSPs), which are funded through a combination of state and Federal dollars to help low-income Medicare beneficiaries afford the cost-sharing components of Medicare. While MSPs are administered by the states and follow broad Federal eligibility guidelines, they vary significantly across states in both their program design and administration.

Some articles looked at the impact on health and well-being for low-income individuals who are unable to get the financial relief available to them from enrollment in an MSP. Having to spend beyond one's means on health care may force someone to delay or even avoid receiving needed health care. Economic insecurity affects access to needed care. An AARP report of the health care spending by Medicare enrollees found that 10% of Medicare recipients reported delaying health care due to cost and having problems paying medical bills. At lower income levels, these figures rose; 17% of people with incomes 200% of the Federal Poverty Level (FPL) or below reported delaying health care for financial reasons and 18% indicated that they encountered difficulty paying routine bills.[1]

[1] Noel-Miller, C. (2020). Medicare Beneficiaries' Out-of-Pocket Spending for Health Care. AARP Public Policy Institute. https://doi.org/10.26419/ppi.00105.001

Key Findings

The literature review concludes with a discussion of policy solutions to address these issues. These fall into a few broad categories:

- Policy reforms that would address the issue of under-enrollment and state variations in enrollment so that low-income Medicare beneficiaries in different states have equitable access to MSPs
- Changes to financial eligibility criteria to expand access to MSPs to a broader population of low-income individuals and reduce the financial burden they face

These options are briefly discussed in Appendix A (Literature Review) but are explored in depth in Appendix E, the Policy Options and Financial Offsets Report.

Data Analysis

This research team analyzed longitudinal data from the Health and Retirement Study (HRS)[2] (2012 to 2018) to profile individuals affected by the Medicare Cliff in order to identify differences across three distinct populations: (1) older adults facing the Medicare Cliff, (2) individuals who are either partially or fully dually eligible for Medicare and Medicaid (dual eligibles) when they reach age 65; and (3) individuals who are enrolled only in Medicare. The analysis focused on population characteristics when these individuals are eligible for Medicare and tracked key health and financial measures over time.

The Medicare Cliff population can be characterized as follows:

- Median age 67 years old
- More likely to be female (58%)
- Just over half non-Hispanic White (52%), with the other half comprised of 27% non-Hispanic Black, 17% Hispanic, and 4% non-Hispanic other individuals
- Nearly two-thirds were married
- Over half (54%) were retired, meaning they reported no income from earnings
- 31% reported fair or poor health with an average of 2.6 chronic conditions and $2,900 in median out-of-pocket medical costs
- A median household income of $35,900 and median financial assets of $4,800, with a total median net worth of $130,100

When comparing the Medicare Cliff population with the both Medicare-only and dually eligible populations, interesting differences emerged, revealing vulnerability of the Medicare Cliff population in several domains:

- **Out-of-pocket medical costs:** The Medicare Cliff sample had significantly higher out-of-pocket medical costs across the studied period compared to the dually eligible and Medicare-only enrollees. Their out-of-pocket medical costs rose significantly within two years of experiencing the Cliff (from $2,600 to $3,100).
- **Net worth:** The Medicare Cliff sample also experienced greater financial resource decline over time. In 2012, Medicare Cliff individuals had a median net worth of $125,000 which declined over time to $114,900 in 2018.

[2] The HRS is a nationally representative, panel study of middle-aged and older adults (50 years of age and older) in the U.S. The HRS contains longitudinal data (started in 1992 with ongoing interviews conducted every 2 years) with detailed information gathered on a variety of sociodemographic, health, economic, and lifestyle factors. The HRS has an oversample of African Americans and Hispanics and is representative of community-dwelling individuals.

Key Findings

- **Health status:** The Medicare Cliff sample experienced a substantial worsening of their health in the two years after hitting the cliff. In 2012, 34% of the Medicare Cliff sample reported their health as fair or poor. By 2018 the percentage had increased to 48%. In 2012, 5% of the Medicare Cliff sample reported that their health had become worse, and just two years later, that increased to 20%. At the same time, dually eligible individuals were most likely to rate their health as fair or poor (58%) and least likely to indicate that they would survive to 75+ (82%) or 80+ (45%).

The analysis also looked at the transition into the Medicare Cliff over time. For each HRS wave from 2012 to 2018, the percentage of individuals who experienced the Medicare Cliff among those newly eligible for Medicare (65 and older) changed very little over time — with an estimated 14% of individuals hitting the Medicare Cliff each wave year. This suggests that programmatic changes over time have done little to prevent individuals from hitting the Medicare Cliff; the data show that they continue to be a vulnerable group.

Appendix B provides an in-depth analysis of the HRS data and comparison of the population groups.

Storytelling

Hearing about the Medicaid to Medicare transition experience from individuals who have been through it provides useful insight and context to the other research components. These "real stories" illustrate the challenges people encounter and, often, identify complexities that policymakers and program administrators may not be aware of.

NCOA interviewed seven older adults[3] representing a mix of genders, states, ages, health conditions, and ethnicities. Key themes that emerged from these interviews (many of which were echoed in the literature review and key informant interviews) included:

- **Confusing communications:** Respondents said the notices they received in the mail were confusing and provoked anxiety about upcoming changes in their health coverage. They did not feel they had adequate time to understand and find alternative plans.

"It was confusing sometimes because they would send one notification out that said one thing and then another one that said another."

- **Need for help navigating options:** Respondents were overwhelmed by the options and unable to navigate the choices on their own. They appreciated the help they received, when they were able to get it, and expressed great anxiety when they had to manage the process on their own. In some cases, the State Health Insurance Program (SHIP) program was not helpful, while in others, it was.
- **Financial impact of the transition to Medicare:** The loss of Medicaid support, coupled with the higher premiums and out-of-pocket costs for Medicare, is a burden that has required recipients to cut back on expenses in other areas to make ends meet.

[3] One respondent's information was captured through their health care navigator. All interviewees provided their consent to participate in the study.

Key Findings

The individuals we interviewed wanted policymakers to better understand the financial impacts of changing healthcare costs. Small changes in the cost of medical care that low-income individuals face have a big impact on their ability to cover daily living costs; this also adds stress and can adversely impact their mental and physical health. They also wanted policymakers to simplify the program choices and make it easier for people to know where to go for help navigating their choices.

"...We make a lot of sacrifices just to live, just to get by. And then, when they make decisions like this, to drop me from Medicaid, it really impacts my life. I just wish they would have more empathy and put themselves in the place of a fixed-income individual."

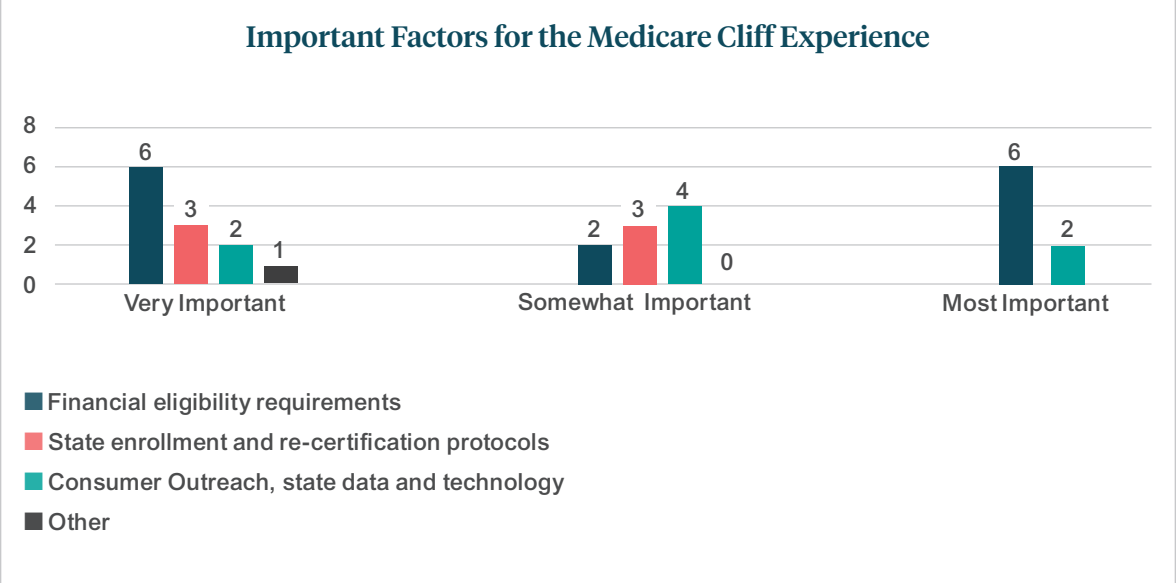
Appendix C contains additional quotes from those with lived experience who encountered the Medicare Cliff.

Key Informant Interviews

The project team identified individuals who would provide valuable and varied perspectives on the key policy issues facing the Medicare Cliff population. Names were gathered from the literature review, professional experience, and suggestions from others working on these and related topics. In total, 20 individuals were identified and the team completed eight (8) interviews.

The first, structured question asked respondents to identify how important various factors were in explaining why people encounter the Medicare Cliff and what was the MOST important of those factors. As shown in Figure 1, financial eligibility requirements emerge as more and most important over other factors.

Figure 1: Important factors explaining why people encounter the Medicare Cliff



Key Findings

Many of the comments of the key informant interviews focused on ways to leverage and increase enrollment into the MSPs as a means of alleviating the Medicare Cliff. Specifically, they recommended:

- **Removing or raising MSP asset limits.** Key informants were split between those who wanted to see states remove the asset limit completely and those who felt that the resource limits need to be increased but not eliminated. Arguments in favor of removing the asset limit included: program simplification and administrative savings; the favorable experience in states that have already done so (in terms of cost savings and enrollment improvements); the belief that program fraud is limited and more effectively identified in other ways; and analyses that indicate that low-income older adults overwhelmingly do not have sizable assets. Raising asset limits represents a middle ground solution that even the key informants who would personally like to see it eliminated understand would have broader bipartisan support and achieve similar objectives.
- **Aligning income limits with other programs.** Several interviewees felt the MSP income limits should be raised to 138% of FPL, putting it on par with the Affordable Care Act (ACA) Medicaid expansion threshold. Some felt that state variations regarding income limits make sense because there are different financial circumstances among older adults across states.
- **Improving consumer outreach and education.** There was strong support for improving how consumers are made aware of the MSPs and the Part D Low-Income Subsidy (LIS) program to assist with prescription medications, supporting the decision-making process, and simplifying enrollment. Many of the issues raised in the Storytelling section were echoed by the key informants we interviewed. Some mentioned the need for expertise in adult learning and usability testing to improve the material in the *Medicare & You* handbook to better tailor content to different target populations. Finally, the key informants talked about data and technology problems that complicate the process of information and outreach to recipients with clarity and in enough time for them to make appropriate choices.

Appendix D includes a list of key informants, comments on each of the questions posed to them, and more information about their recommendations regarding policy reforms and offsets.

POLICY OPTIONS AND FINANCIAL OFFSETS

The study team gathered perspectives from both the literature review and interviews with policy experts regarding policy options to help low-income adults who are no longer eligible for Medicaid and Marketplace assistance subsidies to afford the care they need as they become eligible for Medicare. Additionally, we explored options to improve access to MSPs for financially and medically vulnerable older adults who are eligible for MSPs but, for a variety of reasons, are not accessing them.

Key Findings

The three major categories for policy reform that emerged from discussions with policy experts were:

1. **Allowing the Medicare Cliff population to maintain Medicaid eligibility** as they enter Medicare.
2. **Improving the education and enrollment process for MSPs without changing eligibility criteria.** Participation rates vary by the type of MSP program, by state, and by demographics, with enrollment of eligible individuals in Georgia at roughly 25% and in Maine at 78%.[4] Providing equal opportunity access to MSPs based on existing eligibility rules is based on issues of equity; it may cost more in administrative expenses to enable two comparable people in different circumstances to have an equal opportunity to access the MSP for which they are eligible, but it is fair and equitable to enable them to do so. There may also be Medicaid savings that accrue to the states from precluding or delaying individuals from becoming dually eligible.
3. **Changing eligibility criteria for MSPs.** Several policy proposals seek to broaden access to MSPs to a larger group of financially disadvantaged Medicare beneficiaries whose income and assets exceed the current state eligibility limits, but who are either already facing financial hardship because of uncovered medical expenses or are at great risk of becoming "high-cost burden" individuals. Some of the rule changes would also simplify and streamline the eligibility determination process, thereby reducing administrative costs. Many are also intended to improve participation rates among those already eligible, rather than expand eligibility to additional low-income older adults. This underscores the importance of impact modeling.

Figure 2 shows the most frequently cited policy interventions to achieve these reforms. The assessment of the "impact" and "cost" associated with each intervention was derived from interviews with policy experts, based on a consensus of opinions. (See Appendix E-2)

Figure 2: Policy Reform Impacts and Costs

INTERVENTION	IMPACT*			PROGRAM & ADMINISTRATIVE COSTS		
	LOW	MED	HIGH	LOW	MED	HIGH
Improve education & outreach			X		X	
Strengthen SHIP programs		X		X		
Self-declaration and/or Less Frequent or No Re-certifications		X			X	
Address all administrative burdens mentioned above			X		X	
Auto-enroll LIS eligibles into MSP & align criteria			X			X
Remove asset limit			X			X
Raise asset limit		X				X
Income eligibility at 138% FPL			X			X

*Impact considers improvements in participation rates over current levels, reductions in administrative burdens and complexity both for program operation and applicants, and improvements in access to MSPs for those most financially and functionally in need. Program and administrative costs reflect both the cost from expanded participation and upward or downward changes to administrative costs.

The impact of a policy reform considers a variety of factors: improved participation rates, reduced program complexity and administrative burden, and easier access to MSPs for those most financially in need. Implementation cost includes changes in costs to operate the program under the new policy parameters and costs associated with additional participation.

[4] Caswell, K. J., & Waidmann, T. A. (2017). Medicare Savings Program Enrollees and Eligible Non-Enrollees. 22.

Key Findings

The ideal action set would be policy reforms that offer high impact with low or moderate implementation costs. The item categorized as such is improved **MSP education and outreach**. While **removing the asset test** would have high cost, which is not optimal, this policy option may still be worthwhile given the identified potential ways to pay for it which can help offset the costs. The assignment of "moderate cost" to education/outreach improvements is based in part on many of the suggestions included in this report. The least desirable combinations may be **raising the asset limit** – which may have "low" impact but "high" costs – and **increasing the income limit to 138% of FPL** which may have both "high impact" and "high costs." The other options fall in between with a variety of medium to high impacts on participation rates, and low or medium implementation costs.

These policy reforms, especially those designed to expand the population having access to public programs and benefits, come at a cost. Identifying feasible budget "offsets" – i.e., how to fairly and on a bipartisan basis pay for these policy reforms, is a question of critical importance. One must identify the costs associated with the various policy reform(s) to be pursued before one can identify and evaluate the possibilities for an offset. Additionally, the impacts and costs will differ by state, as will the socio-demographic impacts of various policy choices.

What are the offsets? The key informant interviewees identified various sources within Medicare where offsets may be found: provider payments, Medicare Advantage plans, savings from administrative simplification (e.g., removing the asset test), and by more fully funding SHIPs through the Older Americans Act. Others felt that offsets could not be identified "bit by bit" and that the entire consideration was a critical and major undertaking that should be part of a budget reform package. Additionally, some felt that it was an activity beyond the scope of this piece of work, or at least not an appropriate exercise within the key informant interviews.

Also for consideration is the fact that participation in MSPs for the population it is designed to reach essentially frees up some income (in the form of premiums and/or co-payments not incurred). For some, this could well lessen the burden on other state subsidy programs such as housing, food, and more. Many of the policy reforms would lower administrative costs associated with the operation of the MSPs.

Additional options for reducing costs would be to phase in changes over time and to consider other revenue options like cigarette and alcohol taxes, savings on prescription drugs, value-added taxes on luxury goods, and the like. There are also opportunities to attain budget neutrality using non-health care related offsets, many of which are identified in two Congressional Budget Office (CBO) reports.[5]

The entire consideration of offsets is a critical and major undertaking that should be part of a budget reform package. It is also important to engage in discussions that can help obtain consensus on the policy objectives and goals serving as guiding principles for reform, and how these should be prioritized. These might include improving health care access to those traditionally disadvantaged in that regard, reduced medical expenses as a percent of income for low-income individuals, reduced Medicaid costs, reduced state administrative costs and burdens.

[5] Congressional Budget Office (2022). Options for Reducing the Deficit, 2023-2032. Volume I: Larger Reductions and Volume II: Smaller Reductions. December 2022; and Congressional Research Service. (2023) State Health Insurance Assistance Programs (SHIP). InFocus. October 23, 2023.

Conclusion and Next Steps

Appendix D (Key Informant Interviews) and E (Identifying Policy Options and Financial Offsets) provide a deeper dive into policy reform proposals.

This research has raised several issues about both the policy objectives and reform options, along with possible revenue sources, for addressing the Medicare Cliff and improving Medicare Savings Program participation. In collaboration with policy experts interviewed as part of this research, a matrix of options with a variety of impacts regarding reaching the "in need" population and of costs of doing so has been created. The options where stakeholders' interviews reached the most consensus are shown in Figure 3.[6] The ideal combination would be policy reforms that offer moderate to high impact with low to moderate implementation costs, i.e., improved MSP education and outreach and strengthening the SHIP counseling program. Again, removing the asset test would have high cost, but might still be an attractive option given there are ways to pay for it, thus offsetting costs.

INTERVENTION	IMPACT*			PROGRAM & ADMINISTRATIVE COSTS		
	LOW	MED	HIGH	LOW	MED	HIGH
Improve MSP education & outreach			X		X	
Strengthen SHIP counseling		X		X		
Remove MSP asset limit			X			X

*Impact considers improvements in participation rates over current levels, reductions in administrative burdens and complexity both for program operation and applicants, and improvements in access to MSPs for those most financially and functionally in need. Program and administrative costs reflect both the cost from expanded participation and upward or downward changes to administrative costs.

Figure 3. Policy Reform Impacts and Relative Comparative Implementation Costs

The importance of improving education and outreach and strengthening the SHIP educational and counseling resources cannot be overstated. This recommendation emerged in every component of the research.

"The SHIPs are chronically under-resourced. So, when we talk about levers and additional funding that could well be used in support of this, I'd say the SHIPs are an incredible existing vehicle that should be amplified."

—POLICYMAKER

"People need to know where to go for help. It's hard for people to figure out what kind of help they need and where to go to find [it]."

—MEDICARE RECIPIENT

[6] One option, not raised during the interviews with experts, would be to "grandfather in" those on Medicaid as they transition onto Medicare. It would have impact and high implementation costs.

Conclusion and Next Steps

Not doing so is a waste of money already being spent. Mailings and websites exist, presumably informing older adults about the transition into Medicare and the availability of MSPs. But all the research indicates that they have limited efficacy at best and generate confusion and anxiety at worst. We recommend convening states with "best practices" regarding consumer outreach and education with those who are struggling and enabling a transfer of knowledge. Alternatively, Federal investment in dissemination of information on best practices and even support for creating and sharing best practice models with states that are unable to develop them on their own could also be very helpful. Grant funding to test and develop improved SHIP training, communication pieces, website material, and to identify other best practices could also help address these issues in a more cost-effective way than having each state do so on their own. State-specific considerations and involvement, however, would still be needed. We recommend that a best practice resource center evolve into or be developed by the new Office for Medicare Savings Programs within the Centers for Medicare & Medicaid Services (CMS).

Policy reforms, especially those designed to expand the population having access to public programs and benefits, come at a cost. Identifying feasible budget "offsets" – i.e., how to fairly and on a bipartisan basis pay for these policy reforms – is a question of critical importance. A vital next step is to identify the costs associated with the various policy reform(s) to be pursued to identify and evaluate the possibilities for an offset. Additionally, the impacts and costs will differ by state, as well as by the socio-demographic impacts of various policy choices.

It is worth highlighting some of the comments made on this topic from our research with policy experts:

"…. before finding the offsets, we need to figure out how much is this going to cost."

"The states and CMS can only go so far to solve the administrative issue, but eventually Congress is going to have to come back. And I think will happen. We know that and again, in my estimation, it's going to have to be done on a bipartisan basis."

While there have been data simulations and modeling of outcomes and costs of various policy pathways, each has taken a different approach, some are out of date, and none have been conducted in a collaborative and broadly participatory approach. Specifically, while there have been some state-by-state studies, there has not been a national analysis of these issues.

A productive next step would be to convene a working policy forum, bringing together a variety of experts from states, think tanks, advocacy organizations, consumers, and academia. A facilitated workshop could help identify and prioritize policy objectives and policy reforms. Following that, a new modeling analysis, drawing on the insights and oversight of the policy forum, could be commissioned. These types of next steps would shed much needed light and provide critical data points needed to identify the best pathways forward.

We close with a recommendation that next steps include an investment in analysis and modeling to drill down on the policy recommendations coming out of this report, identify the cost implications (both savings to the system and additional costs from increased enrollment), and the sources of revenue to support these policy reforms. This should be done in the context of a national conversation with experts from states, Federal government, advocacy groups, think tanks, academic researchers, and others with expertise in these areas.

Bibliography

Bibliography

Aruru, M, BPharm, J and Salmon, W. (2013) Development of a Medicare Beneficiary Comprehension Test: Assessing Medicare Part D Beneficiaries' Comprehension of their Benefits. Am Health Drug Benefits. 2013:6(8); 453-461.

Burke, G. and Prindiville, K (2011). Improving the Qualified Medicare Benefit Program for Dual Eligibles. Justice in Aging. Issue Brief. November 2011.

Burns, A. (2023). What Does the Medicaid Eligibility Rule Mean for Low-Income Medicare Beneficiaries and Medicare Savings Programs (MSPs). Kaiser Family Foundation.

California Department of Health and Community Services (2020). MediCall Asset Limits Supplemental Report.

Carter, J. (2017). Toward Seamless Coverage: Identifying Enrollment Gaps and Opportunities in Medicare Transitions for People with Expansion Medicaid. National Council on Aging (NCOA) and Medicare Rights Center. http://www.advancingstates.org/node/69853

Caswell, K. J., & Waidmann, T. A. (2017). Medicare Savings Program Enrollees and Eligible Non-Enrollees. 22.

Center for American Progress. (2022) How to Address the Administrative Burdens of Accessing the Safety Net. May 5, 2022.

Chen Y and Zhao H (2023) Long-term care insurance, mental health of the elderly and its spillovers. Front. Public Health 11:982656. https://doi.org/10.3389/fpubh.2023.982656

Chernew, M., Gibson, T. B., Yu-Isenberg, K., Sokol, M. C., Rosen, A. B., & Fendrick, A. M. (2008). Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care. Journal of General Internal Medicine, 23(8), 1131–1136. https://doi.org/10.1007/s11606-008-0614-0

Christ, A., Kwok, V., Bogart, V and Vining, A. (2022) Expanding Health Care Affordability for Older Adults and People with Disabilities. Justice in Aging. May 2022.

Christ, A., Burke, G., and Kwok, V. (2022). Expanding Health Care Affordability for Older Adults and People with Disabilities: A Guide for State Medicaid Advocates. Justice in Aging. Issue Brief. March 2022.

Cohen, MA and Tafvares, J. (2023) How Medicaid Financial Eligibility Rules Exclude Financially and Medically Vulnerable Adults. Journal of Aging & Social Policy, DOI: 10.108/08959420.2195784.

Congressional Budget Office (2022). Options for Reducing the Deficit, 2023-2032. Volume I: Larger Reductions and Volume II: Smaller Reductions. December 2022.

Congressional Research Service. (2023) State Health Insurance Assistance Programs (SHIP). InFocus. October 23, 2023.

Cubanski, J. and Neuman, T. (2023). What to Know about Medicare Spending and Financing. Kaiser Family Foundation Issue Brief.

Cutler, A and Rich, A. (2013) Medicaid Expansion in California: Opportunities and Challenges for Older Adults and People with Disabilities. National Senior Citizens Law Center. Issue Brief. November 2013.

Bibliography

Department of Health and Human Services, C. (2017). Strategies to Streamline Transitions for Medicaid-eligible Beneficiaries Who Newly Qualify for Medicare. https://www.medicaid.gov/Federal-policy-guidance/downloads/cib060717.pdf

Dorn, S., & Shang, B. (2012). Spurring Enrollment in Medicare Savings Programs Through a Substitute for The Asset Test Focused on Investment Income. Health Affairs, 31(2), 367–375. https://doi.org/10.1377/hlthaff.2011.0443

Federman, A. D., Vladeck, B. C., & Siu, A. L. (2005). Avoidance Of Health Care Services Because Of Cost: Impact of The Medicare Savings Program. Health Affairs, 24(1), 263–270. https://doi.org/10.1377/hlthaff.24.1.263

Feng, Z., Vadnais, A., Vreeland, E. V., Segelman, M., Ferrell, A., Wiener, J. M., & Baker, B. (2019). Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors, and Implications (p. 32). https://aspe.hhs.gov/sites/default/files/private/pdf/261716/DualLoss.pdf

Florez, G, Ayeh, D. and Shyken-Rothbart, B. (2023). Increasing Access to Medicare Savings Programs. Lessons Learned and Policy Recommendations from New York. Medicare Rights Center.

Florez, G, Shyken-Rothbart, B, and Ayeh, D. Medicare Savings Programs in New York State: Policy Recommendations from the Medicare Rights Center. Medicare Rights Center. 2021.

Freed, M., Neuman, T., & Jacobson, G. (2019). Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries. https://www.kff.org/medicare/issue-brief/drilling-down-on-dental-coverage-and-costs-for-medicare-beneficiaries/

Fullen, M, Lawson, G and Sharma, J. (2020). Analyzing the Impact of the Medicare Coverage Gap on Counseling Professionals: Results of a National Study. Journal of Counseling & Development. Volume 98. April 2020.

General Accounting Office. (2012). Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment (p. 34). https://www.gao.gov/assets/gao-12-871.pdf

Health and Retirement Study, Longitudinal File, public use dataset. Produced and distributed by the University of Michigan with funding from the National Institute on Aging (grant number NIA U01AG009740). Ann Arbor, MI, Years 2012-2018.

Stephen K. Holland, Sharrilyn R. Evered, and Bruce A. Center. Long-Term Care Benefits May Reduce End-of-Life Medical Care Costs. Population Health Management. Dec 2014.332-339. http://doi.org/10.1089/pop. 2013.0116

Issue Brief. Many Low-Income Medicare Beneficiaries Pay Significantly Higher Premiums than ACA Beneficiaries

Jacobson, G, Griffin, S, Neuman, T and Smith, K. (2017). Income and Assets of Medicare Beneficiaries, 2016-2035. The Kaiser Family Foundation. Issue Brief April 2017.

MACPAC. (2020). Improving Participation in the Medicare Savings Programs. Chapter 3, 20.

Medicare Rights Center. (2023) Medicare Savings Program Financial eligibility guidelines. 2023.

Bibliography

Mutchler, J. (2022). Elder Economic Security—Center for Social and Demographic Research on Aging—UMass Boston. Elder Index. https://www.umb.edu/demographyofaging/economic_security/elder_economic_security

National Council on Aging. (2022) Part D Extra Help: How It Helps Seniors Pay for Prescriptions. @NCOAging. https://www.ncoa.org/article/part-d-low-income-subsidy-extra-help-eligibility-and-coverage-chart

National Council on Aging. (2022). Medicare Savings Program Eligibility and Coverage. https://www.ncoa.org/article/medicare-savings-programs-eligibility-coverage

Nekui, F., Galbraith, A. A., Briesacher, B. A., Zhang, F., Soumerai, S. B., Ross-Degnan, D., Gurwitz, J. H., & Madden, J. M. (2021). Cost-Related Medication Nonadherence and its Risk Factors among Medicare Beneficiaries. Medical Care, 59(1), 13–21. https://doi.org/10.1097/MLR.0000000000001458

Noel-Miller, C. (2020). Medicare Beneficiaries' Out-of-Pocket Spending for Health Care. AARP Public Policy Institute. https://doi.org/10.26419/ppi.00105.001

Northwest Health Law Advocates. (2021). The Medicare Cliff: How Washington State is Failing Seniors and People with Disabilities. https://nohla.org/index.php/reports/medcliff/

Northwestern Law Advocates. (2021). Addressing the "Medicare Cliff": Extending Health Equity Lifelines to Older Adults and People with Disabilities. https://nohla.org/wordpress/img/pdf/medCliffREPORT7-2021/MedCliffReportAV6-15-2021.pdf

Northwestern Law Advocates. (2022). Fixing the Medicare Cliff: Affordable Health Care for Seniors and Persons with Disabilities. https://nohla.org/wordpress/img/pdf/medCliffREPORT7-2021/MedCliffFactSheet.pdf

Physicians For a National Health Program. Our Payments - Their Profits. Quantifying Overpayments in the Medicare Advantage Program. (2022)

Popham, L., Bedlin, H., Fried, L., & Hoadley, J. A. (2020). Take-Up Rates in Medicare Savings Programs and the Part D Low-Income Subsidy Among Community-Dwelling Medicare Beneficiaries Age 65 and Older. Issue Brief. June 2020. http://www.advancingstates.org/hcbs/article/take-rates-medicare-savings-programs-and-part-d-low-income-subsidy-among-community

Popham, L., Bedlin, H., Fried, L., Silberman, S., Hoadley, J. A., & Slanchev, V. (2020). Take-Up Rates in Medicare Savings Programs and Extra Help. https://www.ncoa.org/article/take-up-rates-in-medicare-savings-programs-and-the-part-d-low-income-subsidy

Roberts, E. T., Glynn, A., Cornelio, N., Donohue, J. M., Gellad, W. F., McWilliams, J. M., & Sabik, L. M. (2021). Medicaid Coverage 'Cliff' Increases Expenses and Decreases Care for Near-Poor Medicare Beneficiaries. Health Affairs, 40(4), 552–561. https://doi.org/10.1377/hlthaff.2020.02272

Roberts, E., James, E and Sabik, L. (2021). Modernizing Medicaid Coverage for Medicare Beneficiaries with Low Income. JAMA Health Forum. 2021:2(6). June 2021.

Schoen, C., Davis, K., Willink, A. and Buttorff, C. (2018) A Policy Option to Enhance Access and Affordability for Medicare Low-Income Beneficiaries. Issue Brief September 2018. The Commonwealth Fund.

Bibliography

Schoen, C., Buttorff, C., Andersen, M., & Davis, K. (2015). Policy Options to Expand Medicare's Low-Income Provisions to Improve Access and Affordability. Health Affairs, 34(12), 2086–2094. https://doi.org/10.1377/hlthaff.2015.0355

Schoen, C. S., Davis, K., & Willink, A. (2017). Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status. Commonwealth Fund. https://doi.org/10.15868/socialsector.27426

Schweitzer, J. (2022). How to Address the Administrative Burdens of Accessing the Safety Net. Center for American Progress. 2022.

Seniors & Medicare and Medicaid Enrollees | Medicaid. (2022). https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html

Smithwick, C. (2013). Dental Benefits: A Guide to Managed Plans (Vol. 1). International Foundation of Employee Benefit Plans. https://www.goodreads.com/work/editions/25016044-dental-benefits-a-guide-to-managed-plans

Sullivan, K. (2023). Medicare Advantage is a money grab by big insurers. Minnesotareformer.org

Sumner, L, Hoadley, J and Hargrave, E. (2010). The Medicare Part D Low-Income Subsidy Program. Kaiser Family Foundation. Publication #8094. September 2010

Tavares, J., Basel, R., Cohen, M. A., & Silverman, S. (2022). Low Income Adults and the Medicare Cliff: A Descriptive Analysis (p. 15).

Tiedemann, A. M., & Fox, K. (2005). Promising Strategies for Medicare Savings Program Enrollment: 12.

Wells, T. S., Wu, L., Bhattarai, G. R., Nickels, L. D., Rush, S. R., & Yeh, C. S. (2019). Self-Reported Hearing Loss in Older Adults Is Associated with Higher Emergency Department Visits and Medical Costs. INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 56, 0046958019896907. https://doi.org/10.1177/0046958019896907

Willink, A., Schoen, C., & Davis, K. (2018). How Medicare Could Provide Dental, Vision, and Hearing Care for Beneficiaries. 12.

Zuckerman, S., Shang, B., & Waidmann, T. (2009). Medicare savings programs: Analyzing options for expanding eligibility. Inquiry: A Journal of Medical Care Organization, Provision and Financing, 46(4), 391–404. https://doi.org/10.5034/inquiryjrnl_46.4.391

Appendices

Appendix A:
Literature Review

The Medicare Cliff:
A Literature Review and Discussion of Policy Options

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Appendix A

INTRODUCTION

The Medicare Cliff refers to the transition that takes place for a large proportion of low-income adults when they turn age 65 and transition to Medicare from Medicaid coverage. If they do not continue to meet the traditional criteria for Medicaid, they will face significantly more coverage gaps and out-of-pocket expenses in the form of premiums and co-payments for care under Medicare, compared to what they had prior to age 65, when Medicaid covered their care. This financial "shock" can be particularly difficult for those with the lowest incomes who tend to be single women, persons of color, and people with complex medical conditions or functional limitations.

With the passage of the Affordable Care Act (ACA), many states expanded access to Medicaid for low-income adults ages 19 to 64 with incomes up to 138% of the Federal poverty level (FPL), through what is called "Adult Group Medicaid." However, when those individuals reach age 65, their Medicaid eligibility ends, unless their income and assets are low enough to qualify for traditional Medicaid, which has different eligibility thresholds at age 65. When this happens, some of these individuals may find some relief from the increases in premiums and copayments they suddenly encounter under Medicare if they are eligible for one of a complex array of Medicare Savings Programs (MSPs). These programs are intended to help address affordability issues for low-income older adults on Medicare. Broad guidelines for MSPs are outlined by Medicare, but states have the authority to adopt variations that are more generous in certain ways. While the premium costs and co-payments under Medicare are set nationally, out-of-pocket expenses for care that are not covered will also vary across states based on the costs of health care. This means that low-income Medicare beneficiaries may encounter high uncovered costs in conjunction with a less generous set of MSPs in one state and/or a very different set of options in another state.

Additionally, surveys of state MSPs have revealed complex administrative and enrollment protocols which are likely to contribute to the relatively low enrollment rates observed. That means that fewer people who are eligible for the MSPs are actually participating in them. This has real implications for health services utilization among the population that could, but does not, participate in such plans. For example, evidence from the research literature suggests that individuals are likely to delay care, underutilize needed prescriptions, or not fill them entirely, when their out-of-pocket health care costs are high relative to income (e.g., 20% of income). Going without needed care has negative implications on society's costs of care, along with ethical and moral implications for the individuals faced with difficult decisions regarding whether to spend limited resources on food, housing or health care.

The purpose of this literature review is to examine the issues surrounding the Medicare Cliff and to identify program and policy solutions that may be considered to keep people from "falling off the Medicare Cliff" by shielding them from large out-of-pocket payments when eligibility criteria change as they reach Medicare status. The analysis is based on a review of 43 articles from both the peer review and grey literature. Our focus is on obtaining information on the nature and magnitude of the problem, insights regarding how states have handled the issue with an attempt to highlight "best practice" states, the modeling of policy solutions, and an inventory of a number of policy interventions that have been put forward to address the problem.

Appendix A

WHAT IS THE MEDICARE CLIFF?

As mentioned, the Medicare Cliff refers to the increase in out-of-pocket costs for people turning age 65 that are associated with Medicare coverage that were not present when low-income individuals were enrolled in adult group Medicaid prior to turning age 65. The chart below shows the type and amount of out-of-pocket costs associated with Medicare, 2023-4.

Table 1: Copayment and Deductible Levels for Medicare Coverage, 2024

Category	Costs
Part A (hospital)	$1,632 annual deductible $408/day co-pay after deductible (days 61-90) increasing to $816/day > 90 days in hospital $204/day >21 in skilled nursing facility
Part B (medical)	$174.70/month premium (or higher, based on income) $240 annual deductible 20% copay after deductible
Part D (prescriptions)	Additional premium cost (depends on plan chosen and income) Additional co-payments (depends on plan and income)
Uncovered services	Routine dental, hearing, vision care and others Personal care services
Other	Late enrollment penalty

Source: Medicare & You, 2024

Seventeen percent of the US population relies on Medicare. Many are unaware of the premiums, deductible and co-payments, along with the health care costs that are not covered such as dental, vision, hearing, and long-term care. Moreover, unlike private insurance or Medicaid coverage, Medicare does not impose a limit on out-of-pocket costs for covered services, deductibles, and co-payments. As a result, Medicare beneficiaries can spend a significant share of their income paying for Medicare coverage and for the costs of services that are not covered (C. S. Schoen et al., 2017). For the newly-eligible low-income adults, Medicare has more coverage gaps, higher copayments, and more out-of-pocket expenses than what low-income individuals can access when they obtain health insurance under the ACA exchange (Noel-Miller, 2020a).

How was the Medicare Cliff problem created? In part, it emerged because the income and asset eligibility requirements for adults to qualify for the new Medicaid expansion programs differed from requirements in place prior to the ACA expansion, with more generous income and asset limits. Because the ACA expansion maintains the same criteria for Medicaid's existing programs for aged, blind and disabled, individuals "aging out" of the new Adult Group Medicaid at age 65, automatically are disqualified from continuing on Medicaid once they have Medicare.

Appendix A

KEY CHARACTERISTICS OF THE MEDICARE CLIFF POPULATION

How does the Medicare Cliff population compare to other groups on Medicare? A recent analysis of data from the Health & Retirement Survey (HRS) compares the characteristics of the Medicare Cliff population with both the dual-eligible population and a population on Medicare who are not part of the Medicare Cliff group during the period of 2014 to 2018 (Tavares et al., 2022). Table 2 compares demographic, socio-economic and health status variables for these three sample populations: exclusively Medicare beneficiaries, dual-eligibles, and newly-eligible Medicare beneficiaries who lost Medicaid status upon enrollment (i.e., the Medicare Cliff population.) While the dual-eligible population faces more financial and health/functional status challenges than the Medicare population, the Medicare Cliff population is also significantly more represented by persons of color, individuals with limited financial means, those with health status limitations, and individuals who experience higher out-of-pocket expenses for health care.

Compared to the overall Medicare population, the Medicare Cliff population differs in the following significant ways from the general Medicare population:

- Their mean age is younger (since by definition they are new enrollees)
- They are more likely to be a person of color
- They are less likely to be married, more likely to be living alone, and less likely to be retired
- They are financially less well-off by all the financial measures shown below, including having higher out-of-pocket costs for care
- They are more likely to be in fair/poor health and have more chronic health conditions
- They have a lower probability of survival to the oldest ages

Table 2: Sample Characteristics at Medicare Eligibility by Type of Beneficiary (2014 to 2018)

Sample Characteristics at Medicare Eligibility (2014 to 2018) (N=4,165)	Medicare Cliff (N=804)	Dually Eligible (N=416)	Medicare (N=2,945)
Age (Mean)	65.0	65.1	65.3
Gender			
Female	57.5%	59.2%*	57.4%
Male	42.5%	40.8%*	42.6%
Race/Ethnicity			
Non-Hispanic White	52.3%*	21.8%*	62.9%*
Non-Hispanic Black	26.8%*	40.2%*	19.9%*
Non-Hispanic Other	3.7%*	5.4%*	3.3%*
Hispanic	17.2%*	32.6%*	13.9%*
Education Years (Mean)	13.8	11.0*	13.7
Married	63.8%*	43.0%*	67.3%*
Live Alone	21.6%*	31.6%*	19.4%*
Rural Residence	23.1%*	18.7%*	25.5%*
Retired	52.2%*	58.2%*	55.0%*
Financial Measures			
Household Income (Mean)	$58,765*	$26,100*	$84,235*
Median	*$42,220**	*$14,514**	*$52,673**
Total Financial Assets (Mean)	$239,620*	$4,295*	$385,305*
Median	*$5,239**	*$0**	*$20,000**
Net Value Primary Residence (Mean)	$154,955*	$37,350*	$164,412*
Median	*$77,000**	*$0**	*$100,000**
Net Wealth (Mean)	$520,506*	$61,501*	$613,622*
Median	*$131,700**	*$1,600**	*$205,500**
Below Federal Poverty Level	16.5%*	46.5%*	8.2%*
Out-of-Pocket Medical Costs	$3,853*	$1,247*	$2,475*
Median	*$2,880**	*$0**	*$1,082**
Health Measures			
Fair/Poor Health	33.5%*	57.0%*	24.6%*
Chronic Conditions (Mean)	2.6*	3.0*	2.2*
ADLs (Mean)	0.3	0.8*	0.2
IADLs (Mean)	0.7*	1.7*	0.4*
Cognitive Impairment	1.0%	1.9%	0.8%
Survival Probability 75+ (Mean)	81.8%*	78.1%*	91.6%*
Survival Probability 80+ (Mean)	51.1%*	46.8%*	63.5%*

*significant t-test difference $p < 0.05$.

Notes: All dollar values adjusted to 2021 US dollar values and ADLs are Activities of Daily Living Limitations, and IADLs are Instrumental Activities of Daily Living Limitations.

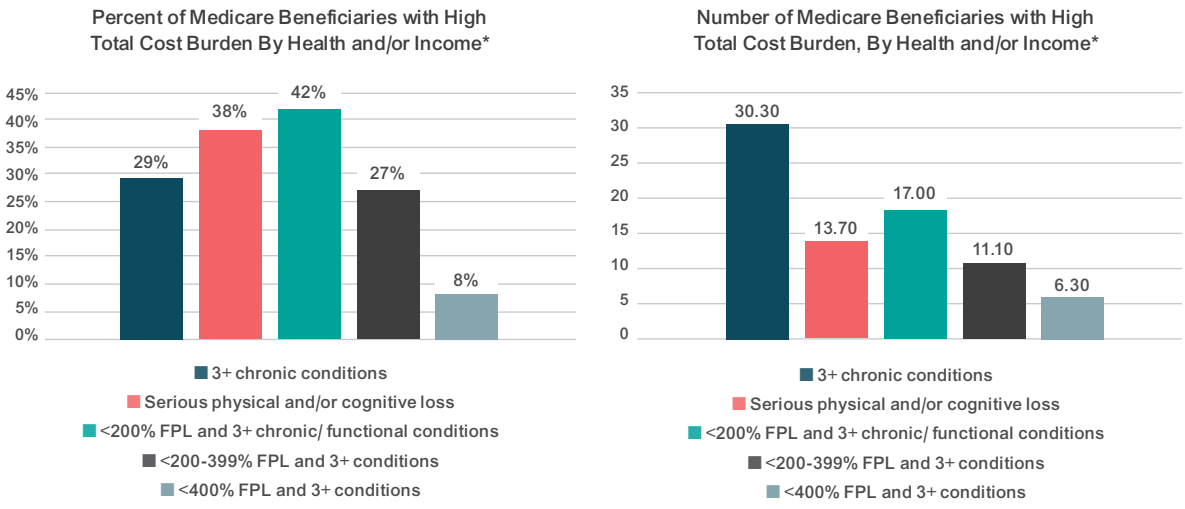
Appendix A

Earlier studies support these recent findings. For example, Schoen, et.al (2017) found that the average amount Medicare beneficiaries paid on their own, in 2017, was just over $3,000, but that more than 25% of Medicare beneficiaries spent 20% or more of their incomes on premiums and care costs. Individuals with functional limitations or multiple chronic conditions and those below 200% of the FPL were at greater financial risk. Specifically, 29% of those with significant health conditions and 38% of those with incomes below the FPL spent 20% or more of their income paying for care and/or premiums. Because low-income individuals will often have multiple health conditions, this puts them even further at financial risk. The 42% of beneficiaries with both poor health and low incomes were found to be spending close to 40% of their income on out-of-pocket care costs alone, not even considering premiums.

A more recent resource cites that among the Medicare beneficiaries with incomes 200% below FPL, half of them spent 27% or more of their income on health care costs (Northwestern Law Advocates, 2021). Another study estimated that Medicare enrollees affected by the cliff incurred an additional $2,288 in out-of-pocket spending over the course of two years, and were 33 percentage points more likely to incur catastrophic spending (Roberts et al., 2021). The authors also found that 40% of near-poor Medicare beneficiaries spend at least one-fifth of their income on health care.

As shown in Figures 1 and 2, Schoen, et al (2017) identified the number and percent of Medicare beneficiaries with a high-cost burden which they defined as anyone spending 20% or more of their income on premiums and out-of-pocket care costs. They also defined those who spent 10% or more of income as “underinsured.” The largest high-cost burden group are those who have both low income (<200% of FPL) and in poor health (three or more chronic or functional limitations); specifically, 42% of them face a high-cost burden. Even without compromised health conditions, low-income on its own can put an individual in a “high-cost burden” situation. Shown on the page that follows, roughly 40% of those with incomes at 100 to 149% and 150 to 199% of FPL spent 20% or more of their income on premiums and out-of-pocket care expenses, representing a high total cost burden.

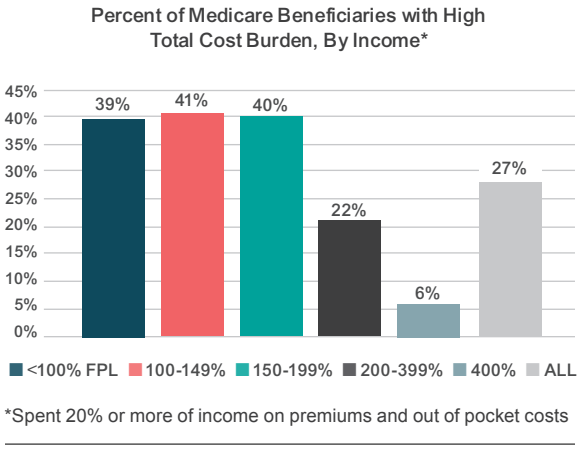
Figures 1: Percent and Number of Medicare Beneficiaries with High Total Cost Burden by Health and/or Income



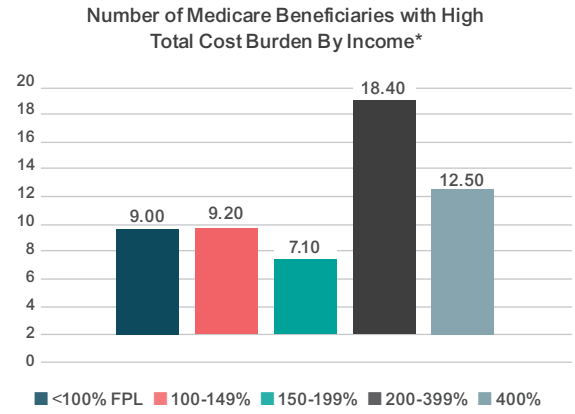
*Spent 20% or more of income on premiums and out of pocket costs

Appendix A

Figures 2: Percent and Number of Medicare Beneficiaries with High Total Cost Burden by Income



*Spent 20% or more of income on premiums and out of pocket costs



These point-in-time data clearly indicate that individuals experiencing the Medicare Cliff are both medically and financially vulnerable. Therefore, it is important to examine what happens to these individuals over time. The analysis of the HRS data previously mentioned (Tavares et al., 2022) observed characteristics of the three sample groups longitudinally to understand how they changed over time and whether the patterns of change differ among the beneficiary groups (i.e. Medicare Cliff, Dual-Eligible and Regular Medicare). Specifically, they looked at a baseline time period of 2010 to 2012 to identify three types of beneficiaries and then followed each group for every HRS wave year through 2018. The Medicare Cliff sample has significantly higher out-of-pockets medical costs across time compared to both the dually eligible and the exclusively Medicare samples. Of those who experienced the Medicare Cliff from 2010 to 2012, approximately 21% became dual eligible beneficiaries by 2018, compared to only 9% in the regular Medicare sample. Of the 21% of the Medicare Cliff sample who eventually become dual eligible beneficiaries, nearly 53% do so within about two years of experiencing the Medicare Cliff; growing to 70% within about four years. This rapid transition from initial enrollment in Medicare, entering the Medicare Cliff and becoming a dual-eligible beneficiary is a critical component in understanding and analyzing the policy options for addressing the Medicare Cliff. The costs of various proposals must be discussed in light of expanding the population of dually-eligible individuals and the societal and person-level impacts associated with that.

MEDICARE SAVINGS PROGRAMS (MSPs)

What are they?

There are several programs, funded through a combination of state and Federal dollars, designed to help low-income Medicare beneficiaries afford the cost-sharing components of Medicare. These programs, called Medicare Savings Programs (MSPs), are administered by the states, follow broad Federal guidelines, but vary significantly across states in both their program design and how they are administered.

Table 3 summarizes the 2024 Federal guidelines for financial eligibility and the benefits covered under each type of Medicare Savings Programs. Because costs of care are significantly higher in Alaska and Hawaii than in the mainland states, Federal eligibility guidelines specifically accommodate these two states individually.

Appendix A

Table 3: Medicare Savings Programs by Type, 2024 MSP Eligibility Standards

Type of Medicare Savings Plan	Benefits Covered	Financial Eligibility Requirements
Qualified Medicare Beneficiary (QMB)	**PART A:** Monthly Premium: $505 if required Hospital Deductibles: $1,632 Hospital Copays: $408 SNF Copay: $204 **PART B:** Monthly Premium: $174.70 Annual deductible: $240 Co-insurance: 20% Qualify for LIS drug coverage	**MONTHLY INCOME*:** At or below <100% FPL $1,275/single $1,724/married Alaska: $1,588/single Alaska: $2,148/married Hawaii: $1,463/single Hawaii: $1,978/married **RESOURCES:** $9,430/single $13,630/married
Specified Low-Income Medicare Beneficiary (SLIMB)	**PART B:** Monthly Premium: $174.70 Qualify for LIS drug coverage	**MONTHLY INCOME*:** Between 100% - 120% FPL $1,526/single $2,064/married Alaska: $1,901/single Alaska: $2,574/married Hawaii: $1,751/single Hawaii: $2,370/married **RESOURCES:** $9,430/single $13,630/married
Qualifying Individual (QI)	**PART B:** Monthly Premium ($174.70) Qualify for LIS drug coverage	**MONTHLY INCOME*:** Between 121% - 135% FPL $1,714/single $2,320/married Alaska: $2,136/single Alaska: $2,893/married Hawaii: $1,967/single Hawaii: $2,664/married **RESOURCES:** $9,430/single $13,630/married
Qualifying Disabled Working Individual (QDWI)	**PART A:** Monthly Premium up to $505/month For people with Medicare who are under age 65, disabled and no longer qualify for free Medicare Part A or Medicaid because they returned to work, and have income that exceed the Medicaid limit.	**MONTHLY INCOME*:** $5,105/single $6,899/married Alaska: $6,355/single Alaska: $8,598/married Hawaii: $5,855/single Hawaii: $7,918/married **RESOURCES:** $4,000/single $6,000/married

*Includes $20 income disregard per household; rounded to nearest dollar. QDWI has an $85 income disregard.

Sources: NCOA (2024). What Are Medicare Savings Programs (MSPs)? Medicare and Older Adults.

Appendix A

State Variations

Since 2001, under new Federal authority, states have been allowed to adopt one or more changes to these Federal guidelines that would liberalize eligibility for their state's MSPs. Specifically, states can increase or eliminate the resource limits for the Medicare Savings Programs, making the MSP more readily available to a larger number of low-income individuals. They can also raise the income limits that individuals must satisfy in order to qualify for a MSPs. These changes are all ways that states can expand eligibility for one or more of the programs, thereby enhancing affordability and access to health care for individuals who would otherwise encounter the Medicare Cliff.

As of 2023, only seven states and the District of Columbia have monthly income guidelines that vary meaningfully from the Federal levels cited above. States also have different naming conventions for these programs and may choose not to offer all of them (e.g., in Washington D.C., QMB is the sole program and Maine groups SLMB and QI together.) The state variations in income requirements are shown in Table 4.

Table 4: States with More Generous Monthly Income Requirements for Medicare Savings Plans, 2023

STATE	Monthly Income (single/married)
Connecticut	QMB: $2,564/$3,467 SLMB: $2,807/$3,795 QI: $2,989/$4,042
District of Columbia	QMB: $3,665/$4,950
Indiana	QMB: $1,843/$2,485 SLMB: $2,086/$2,813 QI: $2,268/$3,060
Maine	QMB: $1,699/$2,289 SLMB: $1,925/$2,594 QI: $2,268/$3,060
Maine	QMB: $1,843/$2,465 SLMB: $2,066/$2,793 QI: $2,248/$3,040
Massachusetts	QMB: $2,329/$3,142 SLMB: $2,572/$3,470 QI: $2,754/$3,718
New York	QMB: $1,697/$2,288 QI: $2,280/$3,076

Source: Medicare Rights Center. Medicare Savings Program financial eligibility guidelines. 2023.

Appendix A

A larger number of states – 13 – deviate from the resource/asset limits set by the Federal government for MSP qualification. Twelve states and the District of Columbia eliminated any asset requirement (Alabama, Arizona, Connecticut, Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Mexico, New York, Oregon, Vermont, and Washington). This is an increase of four states since 2022. California increased the asset disregard to $130,000 for a single individual and $195,000 for a married couple; this was eliminated completely in 2024. Illinois temporarily suspended the asset requirement during the COVID public health emergency, Maine increased the limits to $50,000/$70,000, Massachusetts uses $18,180/$27,260, and Minnesota uses $10,000/$18,000[1].

Prescription Drug Costs

Another source of financial assistance for low-income individuals within Medicare is the Low-Income Subsidy (LIS) program (also called "Extra Help") which is specific to lowering the out-of-pocket costs for prescription drugs under Medicare Part D coverage. All the costs for the LIS program, however, are paid by the Federal government (Medicare), not by states. There are different income and asset criteria to qualify for the "Extra Help" program, and a different schedule of benefits, depending upon whether someone has both Medicare and a Medicare Savings Program (or is a dual-eligible) or has only Medicare. Table 5 shows these requirements for the 48 continental states and Washington DC (National Council on Aging, 2022a). (Note: Beginning in 2024, all Extra Help recipients will receive the full subsidy.)

1 Medicare Rights Center (2023). Medicare Savings Program: financial eligibility guidelines. 2023.

Appendix A

Table 5: Low-Income Subsidy/Extra Help for Medicare Part D

Low-Income Subsidy (LIS)/Extra Help (2024) - 48 STATES+ DC							
Beneficiary Group	**Annual Income Eligibility requirement**	**Monthly Income Eligibility requirement**	**Asset Eligibility requirement**	**Need to apply for LIS?**	**Monthly Premium**	**Annual Deductible**	**Copy/ Coinsurance Plan's Formulary Drugs**
Full-Benefits Duals: Institutionalized or receiving Home and Community-based Services	Meet State Medicaid financial eligibility	Meet State medicaid financial eligibility	Meet State medicaid financial eligibility	No, receive it automatically	No	No	None
Full-Benefit Duals: income ≤100% FPL	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	No, receive it automatically	No	No	Copy: $1.55 generic / $4.60 brand Catastrophic Copay: 0
Full-Benefits Duals: income >100% FPL	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	No, receive it automatically	No	No	Copy: $4.50 generic / $11.20 brand Catastrophic Copay: 0
Non-duals: income ≤135% FPL	Single: $20,331/$20,571* Couple: $27,594/$27,834*	Single: $1,6941/$1,714* Couple: $2,300/$2,320*	Single: $15,720/$17,220** Couple: $31,360/$34,360**	No, if receiving SSI; otherwise yes	No	No	Copy: $4.50 generic / $11.20 brand Catastrophic Copay: 0
Non-duals with income between 135-150% FPL	Single: $22,590/$22,830* Couple: $30,660/$30,900*	Single: $1,883/$1,903* Couple: $2,555/$2,575*	Single: $15,720/$17,220** Couple: $31,360/$34,360**	Yes	No	No	Coinsurance: 0%; Catastrophic Copay: $4.50 generic / $11.20 brand Catastrophic

*Income amounts reflect threshold without/with the $20 monthly income disregard (annually = $240); income is rounded to the nearest whole dollar.
**Asset limits include amount without/with $1,500/person burial allowance.
Income Levels Source: https://aspe.hhs.gov/poverty-guidelines
Asset/Resource Levels: https://www.cms.gov/files/document/lis-memo.pdf
Part D Cost-Sharing Source: https://www.cms.gov/files/document/2024-announcement-pdf.pdf

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Enrollment Protocols and Underutilization

State protocols and procedures for identifying, notifying and certifying eligibility for MSPs differ greatly, and have been cited as an important factor in overall low enrollment rates in these critically important programs. The average is cited across the literature below is at roughly 50%. In this section, we discuss the research into reasons behind the low and varying enrollment rates.

States are not typically aware of individuals who become newly eligible for Medicare, because they are not involved in that process. They may, however, have methods for identifying individuals who are no longer eligible for Medicaid because of changes in income and assets and/or program eligibility requirements. States differ, however, in how individuals who were enrolled in Adult Group Medicaid and then transition into the Medicare Cliff at age 65, are notified about the various MSPs and the eligibility requirements and enrollment protocols for those programs.

Appendix A

Several studies have identified participation rates in the MSPs that are well below the percent of the population estimated to be eligible for them (Caswell & Waidmann, 2017) (Popham, Bedlin, Fried, Silberman, et al., 2020) (Feng et al., 2019). Participation rates vary by program, state, and demographics. Of all the MSPs, QMBs have the greatest participation rate estimated at 53%, SLMB is estimated at 32% and only 15% of those eligible for QI are estimated to be enrolled (Caswell & Waidmann, 2017). Similarly, take-up rates within the LIS program intended to assist with Part D prescription drug costs are also low. One estimate from 2014 is that fewer than 33% of those eligible were enrolled (Popham, Bedlin, Fried, Silberman, et al., 2020).

Enrollment in other government programs was the greatest predictor of MSP participation (e.g., SSI and SNAP). Variation by state was significant. Georgia had a lowest regression-adjusted participation (25.4%) and Maine has the highest (78.1% (Caswell & Waidmann, 2017). Further, the authors observe that differences across states in terms of financial eligibility criteria do not explain these differences in enrollment rates; rather they believe, as found in other research, that administrative complexity and challenges in outreach to the consumer are more likely explanatory variables driving differences in enrollment take-up. This sentiment was underscored in interviews with subject matter experts who pointed out that the administrative burden and complexity the recipients face, along with the lack of knowledge about the protocols are critical factors for newly eligible individuals [regarding] the inability to obtain coverage for which they may be eligible (Feng et al., 2019).

The Medicaid and Chip Access and Payment Program (MACPAC) identified variations in enrollment rates by each of the MSPs, examining data from 2009 and 2010, validating the finding that participation in MSPs falls well below what it could be. The MACPAC policy recommendation to address this will be discussed in the section on Policy Solutions

Table 6: Medicare Savings Programs Participation Rates

Program	Participation Rate Ages 65+
QMB or SLMB	46%
QMB	48%
SLMB	28%
QI	15%

Source: MACPAC, 2020

State Protocols

States administer their MSPs and each has different protocols for raising education and awareness of these programs, identifying and notifying individuals who might be eligible, certifying eligibility, conducting program enrollment and maintaining enrollment. In 2017, state subject matter experts were interviewed to identify both the underlying challenges inherent within state systems as well as some of the best practices some states have adopted (Carter, 2017).

Appendix A

Some of the challenges pertain to technology and information systems that are limited in their ability to share data and communicate across platforms. States also struggle to maintain adequately trained staff. The researchers also identified problems with beneficiary communications. Some states may fail to notify individuals at all or in a timely manner. Even states that do so may provide notices that lack complete or needed information, have errors or are generally unclear. Recipient communications are also hindered by the fact that not all state Medicaid websites offer a link to Medicare/CMS, providing information for Medicaid recipients who may be approaching age 65 and reaching Medicare eligibility so that they can understand the changes that they may be facing.

CMS offers assistance to states who want to identify in advance Medicaid recipients who will be approaching Medicare eligibility, by providing a data sharing arrangement once states enter into an interagency agreement with CMS. Using this information, along with proactive outreach and clear communications, would be an important step in raising awareness of the Medicare Cliff and ways to mitigate the costs associated with it for those who are at risk.

As described above, states vary in terms of how actively they invest in education, outreach and notification to individuals who may be reaching the Medicare Cliff. Some states are proactive; for example, New York sends Adult Group Medicaid recipients a CMS publication that offers advice about the transitions to Medicare at roughly nine months before they turn 65 (Department of Health and Human Services, 2017). Along with this, they include a letter that explains how to enroll in Medicare and instructions for how to qualify for an MSP. As follow-up, individuals are contacted when their Medicaid terminates and reminded again of their possible eligibility for an MSP. The state is then able to request the information it will need to determine eligibility at this time, rather than relying on the individual to volunteer the information. Additionally, some states do a preliminary analysis of eligibility for various MSPs before the individual terminates from Adult Group Medicaid and informs them both of the upcoming termination and, at that time, provides them with information on which MSP they are likely to qualify for.

Other best practices for how states can improve enrollment rates in these important MSPs have been identified from studying the protocols in other states. While these administrative changes are not “cost-free,” they represent the low-hanging fruit in terms of policy changes that can reduce the number of individuals falling into the Medicare Cliff without any change in expanded eligibility criteria (Carter, 2017). These include:

- Use the CMS data to identify and reach out to prospective Medicare enrollees
- Provide advance notice of the approaching Medicare transition
- Disseminate clear, jargon-free information and repeat the messaging in order to be more effective
- Support education and outreach with a toll-free number with well-trained staff
- Provide a dedicated website for information about the specific Medicare enrollment rules, FAQs about the MSPs and a “chat live” function that reaches a trained staff person
- Request advocate and consumer feedback and review prior to using any notices or consumer communication materials
- Always include information specific to “next steps” in consumer communications
- Automate as much of the eligibility and redetermination process as possible
- Provide both online forms and paper applications.

Appendix A

IMPACT ON HEALTH OUTCOMES AND ACCESS DISPARITIES

Concern with the out-of-pocket costs not addressed for low-income individuals with Medicare, and especially for those eligible for but not enrolled in a MSP, derives from the view that the high-cost burden will negatively impact access to care, compliance with prescription regimens and eventually health outcomes. Some research has focused specifically on this topic including Neuki et al, 2021 who used the 2016 Medicare Current Beneficiary Survey to evaluate whether there was evidence of individuals not filling prescriptions, switching to generics or reducing or skipping doses as a way of coping with unaffordable prescription costs. The researchers found that 14% of the age 65 and older beneficiaries did not take their medications as prescribed. Five percent of them went without other essentials so that they could pay for their drug costs. Those with lower incomes were 50% more likely to adopt some type of non-adherence in response to the costs of prescription drugs. But recipients who were eligible for the Part D LIS/Extra Help program did not exhibit higher rates of non-adherence. The researchers also found that older adults whose health and functional status were already limited were also at greater risk of being non-compliant in one or more ways with regard to prescriptions. Those most in need of their medications were more likely to not take them as prescribed (Nekui et al., 2021). The fact that the LIS population did not have non-adherence shows the importance of subsidies and the need to expand them.

Chernew (2008) also explored the relationship of medication adherence for individuals with chronic disease and how low-income and price sensitivity are factors in non-adherence. Looking at certain chronic conditions, the researchers found that patients in low-income areas were less likely to follow prescription recommendations as compared to patients in higher-income areas. Additionally, prescription compliance further erodes for those in low-income areas when out-of-pocket costs for prescriptions increase. Their findings implied that increases in patient out-of-pocket expenditures for prescription drugs, a widespread cost containment mechanism, are likely to exacerbate health disparities (Chernew et al., 2008).

The Elder Economic Security Index was created to estimate how much income an individual requires in order to live in economic security (Mutchler, 2022). This index varies by geography, household composition, housing type and health status. It takes into account a variety of factors such as transportation, food and more in order to estimate how much is needed for an adequate monthly income. In a report out of Washington State, the index was used to assess whether the income levels required for the MSPs were reasonable (Northwest Health Law Advocates, 2021). For example, if an individual needs “X” income in order to live and meet basic living expenses, then requiring them to have an income of less than “X” to qualify for an MSP clearly puts them at financial risk.

Having to spend beyond one’s means on health care may force someone to delay or even avoid receiving needed health care. Economic insecurity affects access to needed care. An AARP report of the health care spending by Medicare enrollees found that 10% of Medicare recipients reporting delaying health care due to cost and having problems paying medical bills. At lower income levels, these figures rose; 17% of people with incomes 200% of FPL or below reporting delaying health care for financial reasons and 18% indicated that they encountered difficulty paying routine bills (Noel-Miller, 2020b).

Appendix A

Another study found that older adults were more likely to report cost-related medication underuse as the severity of their food insecurity increased. This problem was increased for women compared to men, and for people with a chronic health condition compared to those without a chronic condition (Northwestern Law Advocates, 2021). Finally, other reports have also found that, lacking Medicare coverage of certain important services such as dental, vision and hearing care, and medical transportation impacts beneficiaries' access to and use of those services (Freed et al., 2019) (Wells et al., 2019) (Willink et al., 2018). Dental health is well-known to impact cardiovascular health and other systemic health care issues (Smithwick, 2013).

Federman (2005) examined the extent to which MSP might mitigate under-use of needed health care services. Exploring use of health care among QMB enrollees compared with comparable non-enrollees in eight study states (CA, CO, IL, MI, NY, OH, PA and TX), they found that the beneficiaries enrolled in the MSP were half as likely to report avoiding a physician visit due to costs (Federman et al., 2005). In this study, the low participation rates (roughly 30%) provided the comparison sample. The findings also suggest that improving enrollment rates would improve access to the health care services that people need. The MSP was created to reduce out-of-pocket Medicare Part B costs for low-income Medicare beneficiaries. The researchers found that the assistance appeared to improve access to care but that Medicare beneficiaries with QMB coverage were less likely than non-QMBs to avoid outpatient physician visits because of the costs of care.

POLICY SOLUTIONS AND OPPORTUNITIES FOR CHANGE

Policy solutions to address these issues of the Medicare Cliff fall into a few broad categories. One obvious area for improvement is to address the issue of under-enrollment and state variations in enrollment so that low-income Medicare beneficiaries in different states have equitable access to MSPs. Another important area for policy change is to expand access to MSPs to a broader population of low-income individuals and reduce the financial burden they face. In this section, we will discuss both of these approaches and also identify some of the current barriers to and opportunities for policy change.

Increase Enrollment for Those Currently Meeting Eligibility Criteria

As discussed above, there are nearly as many low-income individuals eligible for MSPs but not enrolled in them as there are participating enrollees. The high-cost burden faced by these non-participating low-income older adults, and the limitations on access to health care that may result could be avoided if states undertake one or more of a variety of policy options or protocols to increase enrollment.

As previously mentioned, much can be learned by reviewing the practices in high enrollment states as compared with low enrollment states, where both have comparable eligibility thresholds. Understanding differences in outreach, education, paperwork and the complexity of the enrollment and recertification process can identify and help eliminate the particular "pain points" along the way. Comparison of state practices and focus group research suggests that there is room for improvement in the outreach, education, and enrollment process for the MSP. In a study for 2002, 79% of the individuals eligible for QMB and SLMB programs were not aware of the programs, and 68% did not understand how to apply for enrollment (Popham, Bedlin, Fried, Silberman, et al., 2020). Medicare enrollment counselors report that eligible individuals do not enroll in "Extra Help" for Part D coverage (LIS) largely because "they do not have needed information, were not aware

that assistance was available, did not know how to apply or thought they were ineligible" (Popham, Bedlin, Fried, & Hoadley, 2020). Improving outreach through affinity groups, SHIP counseling, local agencies serving low-income populations, and jargon-free expanded and clear information through the Medicare and You handbook and other information sources could be helpful.

Federal law requires that states re-certify beneficiary eligibility annually, although states do have flexibility in how they undertake this redetermination process. This presents another opportunity for individuals to potentially be dropped from their MSP, even if temporarily. MACPAC reports that "individuals have been dropped from the program for failure to produce paperwork that simply verifies that their situation hasn't changed" (MACPAC, 2020). Most states do not have automatic renewal policies. Some use prepopulated forms to facilitate renewal.

A GAO report (2012) noted that differences in how financial eligibility is determined for the Part D Low-Income Subsidy which makes it harder for some states to work off of applications and data they can easily receive from the Social Security Administration. Better alignment of how resources are counted under LIS and the MSPs could make it easier for states to process the applications they get from the SSA. Nonetheless, GAO points out that states have the flexibility under Federal law to do this but not all states have done so (General Accounting Office, 2012).

Consistent with this, the 2020 MACPAC report recommended that:

> **"Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis" (MACPAC, 2020).**

The Commission felt that, while this change would help to increase enrollment in the MSPs, it would also increase state Medicaid costs. Yet they felt that, overall, the states would realize cost savings and reduced administrative burden from a simplified eligibility determination and redetermination processes. Additionally, state payments for Medicare cost-sharing would increase as enrollment increases.

Another state best practice mentioned earlier is to proactively reach out and pre-screen individuals who are enrolled in Adult Group Medicaid prior to their eligibility for Medicare. "Automatic screening...should reduce gaps in assistance for these individuals and would probably increase the number of people who enroll" (Popham, Bedlin, Fried, Silberman, et al., 2020).

Appendix A

Another suggested policy reform that is anticipated to streamline the enrollment process, and thus increase participation rates, is for more states to disregard the asset or resource limit test for MSP eligibility. An important advantage of this approach is that it will simplify and reduce costs for determining eligibility. In one analysis, Oklahoma officials reported estimated annual savings of $1.2 million after eliminating the asset test for families. Some policy advocates feel that imposing an asset requirement on low-income families, who have worked hard to set aside savings for other needs is punitive. Another rationale for removing the asset requirement is that it does not impact all Medicare beneficiaries equitably. For example, while 29% of Medicare beneficiaries were widowed, 46% of those failing the asset test were widowed and nearly all of them were women. Another suggested variation on adjusting the asset requirement is to only impose it on Medicare beneficiaries who report investment income; this would provide administrative simplification and "excuse" a significant portion of Medicare beneficiaries from the asset requirements since estimates show that at least 75% of those eligible for the MSP have no investment income (Dorn & Shang, 2012).

Approaches for simplifying the financial eligibility documentation process have also been identified as a way of increasing enrollment and reducing administrative costs. States are encouraged to use one of a number of growing data systems to obtain and verify eligibility, rather than requiring beneficiaries to provide the information. Among the states mentioned as having moved to "self-declaration" (in whole or in part) are Arizona, Arkansas, Connecticut, Hawaii, Minnesota, Mississippi, Nor Dakota, Rhode Island, Texas, Vermont, and Washington (Tiedemann & Fox, 2005).

Expand the Population Able to Access Medicare Savings Programs

Along with increasing participation rates so that all low-income older adults who are currently eligible for MSPs have an equal opportunity to enroll in the programs available to them, there are policy proposals to broaden access to MSPs to a broader group of low-income Medicare beneficiaries – more specifically, those whose income and assets exceed the current Federal and state limits, but who are either already facing financial hardship as a result of uncovered medical expenses or are at great risk of becoming one of the "high cost burden" individuals. The policy rationale for expanding access to financial protection for these additional "financially at-risk" groups is to avoid the personal and systemic impacts that may emerge as their access to care and health outcomes are compromised.

Ideally, proposed policy change would be made in the context of an analysis or modeling of the likely outcomes. Schoen, et. al. (2015) used data from the 2010 Medicare Current Beneficiary Survey, adjusted to reflect 2014 Medicare enrollment and spending levels as a way to model the impact of various policy changes. They were interested in modeling the impact on beneficiary out-of-pocket spending of providing subsidies similar to those provided under the ACA to low-income beneficiaries (those with incomes < 200% of FPL) and removing the asset test in order to qualify for an MSP. Essentially, this would provide a subsidy to the Medicare Part B premium, on a sliding-fee scale basis. The target population of Medicare beneficiaries with incomes below 200% is estimated at 20 million.

Specifically, the subsidies proposed are shown in Table 7 and are based on having no asset tests and out-of-pocket maximums for both Part A and Part B.

Appendix A

Table 7: Policy Change Options

Income Eligibility Category	Policy Change
Less than 100% FPL	46%a Full Part B Subsidy. Medicaid pays Medicare cost-sharing and Medicare Part B premium. No deductible
100-134% FPL	Full Part B premium subsidy. $250 Part A/B Deductible. Small co-pays for outpatient care. Out-of-pocket maximum $2,000
135-149% FPL	Part B premium subsidy of 2-4% on sliding fee scale (ACA). Same deductible, copays and OOP maximum as above.
150-200% FPL	Part B premium subsidy of 4-6% on sliding scale. Same deductible, copays and OOP maximum as above.

Source: (C. Schoen et al., 2015)

The researchers found that the percent of beneficiaries with a high cost burden (20% of income) would be reduced from 40% to 25% using these guidelines (C. Schoen et al., 2015). Because services not covered by Medicare (dental, vision, hearing) account for roughly half of the out-of-pocket spending incurred by low-income beneficiaries, these policy changes would have no impact on that. (Others have proposed fixing some of these gaps by adding dental or other coverage.)

They also projected that net Federal spending for the new premium subsidies and out-of-pocket cost caps would be roughly $14.6 billion, assuming full enrollment. This would be offset by an estimated $19-20 billion is savings to beneficiaries with low incomes. Other options for reducing the impact on Federal spending would be a phase-in of these changes or limiting the changes to individuals with incomes of less than 150% of FPL.

Other policy options, many of which have been proposed by Zuckerman, et. al, 2009 to address the Medicare Cliff affordability issues include the following:

- Raise QMB income limit to 300% of FPL.
- Raise SLMB income limit to 400% of FPL.
- Provide cost-sharing relief, limits on out-of-pocket expenses.
- Combine the SLMB and QI with full LIS eligibility groups into one category that uses the same income standards used for Part D LIS. This provides simplicity both in administration and program communication to potential beneficiaries.
- As an option to removing the asset limit (which seems to have broad support among those advocating for policy change), another suggestion is to count the value of assets as “annuitized income” – i.e., estimating the potential income stream as part of the application process, add this to current income, and determine eligibility based solely on this combined income level. While this approach may have some appeal to those opposed to removing the asset threshold, it does not seem to pass the objective of being relatively simple to administer, as discussed previously.

Appendix A

Using data from the 2006 Health and Retirement Study (HRS), Zuckerman, et al (2009) modeled the impact of some of these changes. Annuitizing resources and counting it along with income had only a modest impact on reducing the percent of beneficiaries not eligible for the MSP (roughly 2% decline). Removing the asset limit completely is estimated to expand eligibility to 10% more beneficiaries, although as mentioned earlier, it may have its greatest impact on raising participation and enrollment rates among those who were already eligible based on resources (Zuckerman et al., 2009).

The researchers also looked at how the population becoming eligible for an MSP changes with various policy changes around eligibility. They concluded that expanding eligibility to 200% of FPL would bring in older beneficiaries who are more likely to be in fair or poor health, to have diabetes or lung disease, or to be in a facial or ethnic minority, than an expansion achieved by removing resource requirements. This underscores the importance of modeling not only the size of the impact of policy changes, but also the cost implications and the specific socio-demographic characteristics of the Medicare population that would be impacted by the proposed change. The policy change can be most cost-effective if it can be implemented with less administrative cost, can result in good participation rates, and can reach the population most at risk of a high-cost burden and/or most vulnerable to problems with care access.

CLOSING REMARKS

The issue of the Medicare Cliff has been well studied and the literature identifies several policy and program interventions to address the problems presented by the Medicare Cliff. At least two of these – removing the asset test to qualify for an MSP and simplifying the enrollment procedures – are currently available for implementation by any state interested in doing so. And several states are acting on those reforms. Unfortunately, to date there is limited data on the impacts associated with these reforms. Through stakeholder interviews, we know which methodologies seem to be effective in increasing participation rates overall by comparison with states that have not made these changes. And there have been some reports highlighting net cost savings in terms of reduced administrative costs compared with additional benefit expenditures. But the analysis is incomplete because not all of the additional costs accounted for reside with the state.

Additionally, states that have undertaken reform have tended to adopt both reforms together – enrollment simplification and relaxation of the asset test, making it more difficult to determine which has the greatest independent positive effect on improvements in enrollment. There also has not been much analysis of how these reforms have changed the configuration of the population able to access the MSPs, although some modeling has been done that suggests both these reforms would benefit persons of color, women, and those in frailer health.

Because they are currently available to states to act upon, these two reforms – enrollment simplification and removing the asset threshold – seem to provide the most important first steps in addressing the Medicare Cliff. States that have not yet adopted one or both policies can readily learn “how to” from other states. Additionally, both these changes are important to ensuring that the existing MSP is equitable by enabling everyone currently eligible for it the opportunity to enroll; it should not be that only those somehow able to navigate the system have access to the benefit, while those with a comparable financial profile do not.

Appendix A

Even as these avenues of reform are promising, states as well as the Federal government should also consider other policy forms outlined in this review. These additional approaches will likely be viewed through the lens of the costs and benefits associated with additional expenditures for this issue considering multiple and competing policy priorities. Added to the challenges are the complexities of navigating the layers of both state and Federal politics needed to effect these changes. And when it comes to the social safety net, where there is often a lack of consensus about how best to address challenges faced by the most vulnerable and least politically advantaged in our society, change has proven to be slow going. Additional research that illustrates the overall savings from better health access and outcomes which can help build the case for expanded benefits for this group within the Medicare program may help provide additional political impetus for reform.

References

Carter, J. (2017). Toward Seamless Coverage: Identifying Enrollment Gaps and Opportunities in Medicare Transitions for People with Expansion Medicaid | advancingstates.org. http://www.advancingstates.org/node/69853

Caswell, K. J., & Waidmann, T. A. (2017). Medicare Savings Program Enrollees and Eligible Non-Enrollees. 22.

Chernew, M., Gibson, T. B., Yu-Isenberg, K., Sokol, M. C., Rosen, A. B., & Fendrick, A. M. (2008). Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care. Journal of General Internal Medicine, 23(8), 1131–1136. https://doi.org/10.1007/s11606-008-0614-0

Department of Health and Human Services, C. (2017). Strategies to Streamline Transitions for Medicaid-eligible Beneficiaries Who Newly Qualify for Medicare. https://www.medicaid.gov/Federal-policy-guidance/downloads/cib060717.pdf

Dorn, S., & Shang, B. (2012). Spurring Enrollment In Medicare Savings Programs Through A Substitute For The Asset Test Focused On Investment Income. Health Affairs, 31(2), 367–375. https://doi.org/10.1377/hlthaff.2011.0443

Federman, A. D., Vladeck, B. C., & Siu, A. L. (2005). Avoidance Of Health Care Services Because Of Cost: Impact Of The Medicare Savings Program. Health Affairs, 24(1), 263–270. https://doi.org/10.1377/hlthaff.24.1.263

Feng, Z., Vadnais, A., Vreeland, E. V., Segelman, M., Ferrell, A., Wiener, J. M., & Baker, B. (2019). Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors and Implications (p. 32). https://aspe.hhs.gov/sites/default/files/private/pdf/261716/DualLoss.pdf

Freed, M., Neuman, T., & Jacobson, G. (2019). Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries. https://www.kff.org/medicare/issue-brief/drilling-down-on-dental-coverage-and-costs-for-medicare-beneficiaries/

General Accounting Office. (2012). Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment (p. 34). https://www.gao.gov/assets/gao-12-871.pdf

Medicare Rights Center (2023). Medicare Savings Program. Financial Eligibility Guidelines. 2023.

Appendix A

MACPAC. (2020). Improving Participation in the Medicare Savings Programs. Chapter 3, 20.

Mutchler, J. (2022). Elder Economic Security—Center for Social and Demographic Research on Aging—UMass Boston. Elder Index. https://www.umb.edu/demographyofaging/economic_security/elder_economic_security

National Council on Aging (2024). What Are Medicare Savings Programs (MSPs)? Medicare and Older Adults.

National Council on Aging. (2022a, January 20). Part D Extra Help: How It Helps Seniors Pay for Prescriptions. @NCOAging. https://www.ncoa.org/article/part-d-low-income-subsidy-extra-help-eligibility-and-coverage-chart

National Council on Aging. (2022b, February). Medicare Savings Program Eligibility and Coverage. https://www.ncoa.org/article/medicare-savings-programs-eligibility-coverage

Nekui, F., Galbraith, A. A., Briesacher, B. A., Zhang, F., Soumerai, S. B., Ross-Degnan, D., Gurwitz, J. H., & Madden, J. M. (2021). Cost-Related Medication Nonadherence and its Risk Factors among Medicare Beneficiaries. Medical Care, 59(1), 13–21. https://doi.org/10.1097/MLR.0000000000001458

Noel-Miller, C. (2020a). Medicare Beneficiaries' Out-of-Pocket Spending for Health Care. AARP Public Policy Institute. https://doi.org/10.26419/ppi.00105.001

Noel-Miller, C. (2020b). Medicare Beneficiaries' Out-of-Pocket Spending for Health Care. AARP

Public Policy Institute. https://doi.org/10.26419/ppi.00105.001

Northwest Health Law Advocates. (2021). The Medicare Cliff: How Washington State is Failing Seniors and People with Disabilities. https://nohla.org/index.php/reports/medcliff/

Northwestern Law Advocates. (2021). Addressing the "Medicare Cliff": Extending Health Equity Lifelines to Older Adults and People with Disabilities. https://nohla.org/wordpress/img/pdf/medCliffREPORT7-2021/MedCliffReportAV6-15-2021.pdf

Northwestern Law Advocates. (2022). Fixing the Medicare Cliff: Affordable Health Care for Seniors and Persons with Disabilities. https://nohla.org/wordpress/img/pdf/medCliffREPORT7-2021/MedCliffFactSheet.pdf

Popham, L., Bedlin, H., Fried, L., & Hoadley, J. A. (2020, June). Take-Up Rates in Medicare Savings Programs and the Part D Low-Income Subsidy Among Community-Dwelling Medicare Beneficiaries Age 65 and Older | advancingstates.org. http://www.advancingstates.org/hcbs/article/take-rates-medicare-savings-programs-and-part-d-low-income-subsidy-among-community

Popham, L., Bedlin, H., Fried, L., Silberman, S., Hoadley, J. A., & Slanchev, V. (2020, June). Take-Up Rates in Medicare Savings Programs and Extra Help. https://www.ncoa.org/article/take-up-rates-in-medicare-savings-programs-and-the-part-d-low-income-subsidy

Roberts, E. T., Glynn, A., Cornelio, N., Donohue, J. M., Gellad, W. F., McWilliams, J. M., & Sabik, L. M. (2021). Medicaid Coverage 'Cliff' Increases Expenses And Decreases Care For Near-Poor Medicare Beneficiaries. Health Affairs, 40(4), 552–561. https://doi.org/10.1377/hlthaff.2020.02272

Appendix A

Schoen, C., Buttorff, C., Andersen, M., & Davis, K. (2015). Policy Options To Expand Medicare's Low-Income Provisions To Improve Access And Affordability. Health Affairs, 34(12), 2086–2094. https://doi.org/10.1377/hlthaff.2015.0355

Schoen, C. S., Davis, K., & Willink, A. (2017). Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status. Commonwealth Fund. https://doi.org/10.15868/socialsector.27426

Seniors & Medicare and Medicaid Enrollees | Medicaid. (2022). https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html

Smithwick, C. (2013). Dental Benefits: A Guide to Managed Plans (Vol. 1). International Foundation of Employee Benefit Plans. https://www.goodreads.com/work/editions/25016044-dental-benefits-a-guide-to-managed-plans

Tavares, J., Basel, R., Cohen, M. A., & Silverman, S. (2022). Low Income Adults and the Medicare Cliff: A Descriptive Analysis (p. 15).

Tiedemann, A. M., & Fox, K. (2005). Promising Strategies for Medicare Savings Program Enrollment: 12.

Wells, T. S., Wu, L., Bhattarai, G. R., Nickels, L. D., Rush, S. R., & Yeh, C. S. (2019). Self-Reported Hearing Loss in Older Adults Is Associated With Higher Emergency Department Visits and Medical Costs. INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 56, 0046958019896907. https://doi.org/10.1177/0046958019896907

Willink, A., Schoen, C., & Davis, K. (2018). How Medicare Could Provide Dental, Vision, and Hearing Care for Beneficiaries. 12.

Zuckerman, S., Shang, B., & Waidmann, T. (2009). Medicare savings programs: Analyzing options for expanding eligibility. Inquiry: A Journal of Medical Care Organization, Provision and Financing, 46(4), 391–404. https://doi.org/10.5034/inquiryjrnl_46.4.391

Appendix B:
Low-Income Older Adults and the Medicare Cliff: Data Analysis

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Avoiding the Medicare Cliff

A Profile of Low-Income Older Adults

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Low-Income Older Adults and the Medicare Cliff

The COVID-19 pandemic starkly demonstrated inequities in the American health care system. For older adults, in particular, the pandemic had a severe impact; this is especially true for people of color and those with lower incomes. Equitable access to benefits is one way to address social determinants of health and aging. With this in mind, the National Council on Aging (NCOA) and its research partner, the Leading Age LTSS Center @UMASS Boston, set out to understand the transition from Medicaid to Medicare among low-income older adults.

As low-income older adults become eligible for Medicare due to age or disability, many face difficult choices regarding their health coverage. They may lose their Medicaid coverage, with its cost-sharing protections, and be unable to afford Medicare premiums and cost-sharing. Not all low-income older adults who are on Medicaid will be dually eligible for both Medicaid and Medicare. This research seeks to fill in gaps in knowledge about the transition from Medicaid to Medicare for low-income older adults. The analysis also sheds light on people who experience high out-of-pocket costs when they begin the Medicare program and transition from non-Medicaid insurance arrangements.

Background

Medicaid and Medicare are two fundamental health insurance programs. In 1965 **Medicaid** became a federal law as part of Title XIX of the Social Security Act, with coverage beginning in 1966. As a joint program between the federal and state governments, it provides health insurance for low-income Americans. In 2019, over 87 million Americans were **enrolled in Medicaid** with nearly 15 million of those people between the ages of 45-64, and approximately 8.5 million adults over the age of 65. In 1965, **Medicare** became a federal law, with coverage also beginning in 1966. It provides health insurance for adults over age 65, and younger adults with permanent disabilities, end-stage renal disease, or amyotrophic lateral sclerosis. In 2019, approximately 60 million adults were **enrolled in Medicare**.

In most states (39 Medicaid expansion states), older adults with incomes below 138% of the federal poverty line have **medical insurance** through Medicaid. Once these adults turn 65, if their income is below 135% of the federal poverty level, and they have low assets, they become dually eligible for both Medicare and Medicaid. For some older adults with higher assets (individual assets over $8,400; couple's assets over $12,000), once they turn 65 and become eligible for Medicare, they lose all their Medicaid benefits. These still low-income older adults often cannot afford additional coverage under Medicare. As they transition to Medicare, the coverage and benefits they had under Medicaid change, and they lose **Marketplace subsidies**. In these instances, they face what has been called the "Medicare Cliff."

Purpose

In this data brief, we present information to describe the individuals affected by the Medicare Cliff. Our purpose is to explore the differences between three distinct populations: **(1) older adults facing the Medicare Cliff**, **(2) individuals who are either partially or fully dually eligible for Medicare and Medicaid (Dual Eligibles) when they reach age 65**, and **(3) individuals who are enrolled only in Medicare**. We focus on their characteristics when they are eligible for the program and also track key health and financial measures over time to see how their status changes during retirement.

Method

We analyzed longitudinal data from the **Health and Retirement Study (HRS)** from 2012 to 2018 to assess individuals hitting the Medicare Cliff compared to those with dual eligibility and people enrolled exclusively in Medicare. The HRS is a nationally representative, panel study of middle-aged and older adults (50 years of age and older) in the U.S. The HRS contains longitudinal data (started in 1992 with ongoing interviews conducted every 2 years) with detailed information gathered on a variety of sociodemographic, health, economic, and lifestyle factors. The HRS has an oversample of Black and Hispanic individuals and is representative of community-dwelling individuals. (Although the data does include those who have moved into institutional settings during the course of the study, estimates related to these individuals are likely underrepresented.)

To be classified as an older adult facing the Medicare Cliff, an individual needed to meet one of two criteria: (1) they lost Medicaid eligibility when they became eligible for Medicare; or (2) their out-of-pocket medical cost (not including any insurance premiums) increased by at least $100 after starting Medicare. The most recent sample characteristics (2018) were compared across three mutually exclusive groups of individuals who turned age 65 and became eligible for Medicare during 2014 to 2018: 804 individuals who had experienced the Medicare Cliff; 744 individuals who became dually eligible for Medicare and Medicaid; and 4,319 individuals who enrolled in Medicare.

For the longitudinal portion of the study, out of the total individuals who comprised the Medicare Cliff sample (N=804), we focused on individuals who hit the Medicare Cliff in 2012 when they turned 65 (N=353), and then revisited these same people in 2014, 2016, and 2018 to understand how their circumstances changed over the years. For comparison purposes, we also followed the dual eligible beneficiaries (N=320) and Medicare beneficiaries (N=1,875) during the same time period of 2012 to 2018 (mutually exclusive groups). Finally, we analyzed a sample of individuals who experienced the Medicare Cliff in 2012, when they turned 65, and then eventually became dually eligible for Medicare and Medicaid from 2014 to 2018 (N=73). By examining participants who hit the Medicare Cliff 10 years ago, we have been able to study how their health and economics have changed over the past 10 years.

Findings

2018 profile of beneficiaries who hit the Medicare Cliff between 2014 and 2018

Sample characteristics (2018) revealed that the average Medicare Cliff individual was about 68 years old and more likely to be female (58%) (see Figure 1). Just over half of Medicare Cliff individuals were non-Hispanic White (52%), with the other half comprised of 27% non-Hispanic Black, 17% Hispanic, and 4% non-Hispanic other individuals. Nearly two-thirds were married and a little over half (54%) were retired, meaning they were reporting no income from earnings. In terms of health, 31% of Medicare Cliff individuals reported fair or poor health with an average of 2.6 chronic conditions and $2,900 in median out-of-pocket medical costs. Financial characteristics showed that this group had a median household income of $35,900 and median financial assets of $4,800, with a total median net worth of over $130,100.

2018 profile of beneficiaries who became dually eligible for Medicare and Medicaid between 2014 and 2018

Sample characteristics (2018) revealed that the average dual eligible individual was 69 years old and more likely to be female (64%) (See Figure 1). Over a third of dual eligible individuals were non-Hispanic Black (25%) with the other two-thirds comprised of 32% non-Hispanic White, 28% Hispanic, and 6% non-Hispanic other individuals. Almost two out of five were married (38%) and almost three-quarters (72%) were retired. In terms of health, 58% of dual eligible individuals reported fair or poor health with an average of 3.4 chronic conditions, and median out-of-pocket medical costs of $0. Financial characteristics showed that this group had a median household income of $14,320 and median financial assets of $0 with a total median net worth of $1,900.

2018 profile of beneficiaries who enrolled in Medicare between 2014 and 2018

Sample characteristics (2018) revealed that the average Medicare-only individual was 70 years old and more likely to be female (58%) (See Figure 1). Almost three-quarters of Medicare individuals were non-Hispanic White (71%) with the other quarter comprised of 17% non-Hispanic Black, 9% Hispanic, and 3% non-Hispanic other individuals. Over half were married (57%) and over three quarters (78%) were retired. In terms of health, 36% of Medicare individuals reported fair or poor health with an average of 2.8 chronic conditions and $1,200 median out-of-pocket medical costs. Financial characteristics showed that this group had a median household income of $48,850 and median financial assets of $29,000 with a total median net worth of $264,500. Note that median net worth includes the value of financial assets and home equity minus all debt.

Selected differences in the 2018 beneficiary profiles (Appendix A)

There are a few interesting differences between these three groups. The Medicare Cliff sample is less diverse, healthier, and in a better financial position than the dually eligible sample. However, the Medicare Cliff sample is more diverse, in poorer health, and has fewer financial resources compared to the exclusively Medicare sample. The least likely group to be married are the dually eligible, with only 38% being married, compared to 65% of the Medicare Cliff individuals and 57% of the Medicare enrollees. Dually eligible are also most likely to live alone (39%) compared to 29% of Medicare enrollees and 21% of Medicare Cliff individuals. Interestingly, the Medicare Cliff sample is significantly less likely to be retired than both the dual eligible and the regular Medicare sample. This may reflect the fact that their increased out-of-pocket medical costs necessitated their staying in the labor force longer to afford these increased expenses. Dually eligible were most likely to rate their health as fair or poor (58%) and least likely to indicate that they would survive to 75+ (82%) or 80+ (45%). Finally, the Medicare Cliff sample has significantly higher out-of-pocket medical costs compared to dual eligible and Medicare enrollees. Overall, the Medicare Cliff sample most often fell between the Medicare and dual eligible samples on many demographic characteristic measurements.

Findings

Longitudinal analysis of the three beneficiary groups (Appendix C)

For each HRS wave from 2012 to 2018, we determined the percentage of individuals who experienced the Medicare Cliff among those newly eligible for Medicare (65 and older). We observed very little change over time with an estimated 14% of individuals hitting the Medicare Cliff each wave year (13.9% in 2012, 13.7% in 2014, 14.0% in 2016, and 13.5% in 2018). This indicates that programmatic changes over time have done little to prevent individuals from hitting the Medicare Cliff, and this continues to be a vulnerable group. In fact, based on Medicare enrollment data showing approximately 2 million new Medicare enrollees in 2019 (65 and older), we estimate that 280,000 individuals experience the Medicare Cliff annually.

Next, we analyzed sample characteristics longitudinally to understand how these characteristics change over time and whether the patterns of change differ among the three beneficiary groups. Our first data point represents what people looked like when they became eligible for their group in 2012. Specifically, we looked at a baseline time period of 2010 to 2012 to identify the three types of beneficiaries and then followed each of these mutually exclusive groups for every HRS wave year through 2018.

Out-of-pocket medical costs: The Medicare Cliff sample has significantly higher out-of-pocket medical costs across the studied time period compared to the dually eligible and Medicare enrollees (see Figure 2). Medicare Cliff individuals saw their out-of-pocket medical costs rise significantly within two years of experiencing the cliff (from $2,600 to $3,100) and then slightly decrease over the subsequent four-year period to a median of $2,800. This eventual decrease for Medicare individuals is due in part to the fact that about 20% of the Medicare Cliff sample became dual eligible over the studied time period. The dually eligible saw their comparatively low out-of-pocket expenses steadily fall from 2012 to 2018 (from a median of $250 to $0. Medicare enrollees also experienced a general decrease in out-of-pocket expenses from 2012 to 2018 (from $1,568 to $1,333).

Retirement: Retirement status varies across all three sample populations and our focus here is on individuals who report no earnings and full disengagement from the labor force. Thus, by definition, people who are partially working are not considered retired. The Medicare Cliff sample is significantly less likely to be retired than the dually eligible and regular Medicare samples. Notably, the Medicare Cliff sample is also the only beneficiary group that shows a pattern of retirement over time where individuals actually return to the workforce, as compared to the other two samples with a typical trajectory of having a greater number of retirees over time (see Figure 3). In 2012, 55% of Medicare Cliff individuals retired. In 2014, 57% were retired, and in 2016, the number decreased to 55% who were retired. In 2018, the number continued to decrease to 54%. In comparison, the dually eligible started with 61% retired in 2012, and this percentage steadily increased to 72% by 2018. Similarly, Medicare enrollees started with 59% retired in 2012, and this percentage steadily increased to 74% retired by 2018.

Findings

Net worth: The Medicare Cliff sample also experienced greater financial resource decline over time than the dual eligible and regular Medicare samples (see Figure 4). In 2012, Medicare Cliff individuals had a median net worth of $125,000 which continually declined over time to $114,900 in 2018. Although the dual eligible sample had an overall lower median net worth, they saw staggered growth from 2012 ($1,000) to 2018 ($2,000). The Medicare enrollees had the highest median net worth (i.e., financial assets and home value minus all debt), and saw it consistently grow from 2012 ($182,000) to 2018 ($249,999). Most of this growth reflects increasing home values rather than liquid financial assets.

Health status: The Medicare Cliff sample reports a substantial worsening of their health in the two years after hitting the cliff. In 2012, 34% of the Medicare Cliff sample reported their health as fair or poor. By 2018, the percentage had increased to 48% (see Figure 5). This experience differs from the dual eligible sample, who saw only a slight increase during those same years. The Medicare sample, although in better health, followed a similar trend as the Dual Eligible samples, seeing a slight worsening in reported health status.

In 2012, 5% of the Medicare Cliff sample reported that their health had become worse, and just two years later, that increased to 20% (see Figure 6). The dual eligible sample had more individuals who said their health had become worse (35% in 2012), but that number stayed relatively stable, dropping only slightly. Again, the Medicare enrollees had a similar experience as the dual eligible sample, staying relatively steady from 2012 to 2018.

There were also differences in the number of doctors' visits for each group. The Medicare Cliff sample had an average of 6 doctors visits in 2012. In two years, it spiked to 7.5 visits, and then decreased to 6.5 doctor visits (see Figure 7). The dual eligible sample started at 7 doctors visits a year in 2012, and that number fell to 6 visits per year by 2018. The Medicare enrollees had 5 doctor visits per year in 2012 and then increased to 6 visits per year by 2018.

There are a number of possible explanations for these trends and differences experienced by the Medicare Cliff sample. This group might experience high levels of stress when they lose Medicaid coverage. This could negatively impact their health. As their health insurance changes, they may also need to find new doctors. This would explain the initial increase in doctor visits. The change in insurance may also impact what medications are covered. To save money, Medicare Cliff individuals may stop taking medications. What is clear is that the data points to a relatively abrupt change in parameters in the immediate period after hitting the cliff, and that this is likely related to the additional financial pressure and related stress brought about by the change in insurance status.

Findings

Medicare Cliff beneficiaries who become dual eligible (Appendix D)

Our findings showed that from 2010 to 2012, one out of every five Medicare Cliff individuals eventually became dual eligible beneficiaries by 2018. That is, they again become eligible for Medicaid over the period, after having lost Medicaid benefits when they first became eligible for Medicare. We further analyzed this group to look at changes in their characteristics on their way to becoming dually eligible. Of the Medicare Cliff sample who eventually become dual eligible beneficiaries, nearly 53% do so within two years of experiencing the Medicare Cliff and 70% within four years. Average out-of-pocket medical costs are very high at the time of experiencing the cliff for the Medicare Cliff sample who eventually becomes dually eligible—nearly double that of the Medicare Cliff sample who did not transition to dual eligibility, which was already significantly higher than the other beneficiary groups.

Their median out-of-pocket medical expenses started at $3,094 in 2012, but significantly decrease from 2014 ($2,404) to 2018 ($480) (see Figure 8). This sharp decline in out-of-pocket medical expenses two years after experiencing the cliff for the Medicare Cliff sample who eventually become dually eligible is likely due to the fact that 52% of these individuals have already transitioned to becoming dually eligible at that point. This is in contrast to the out-of-pocket medical expenses for the Medicare Cliff sample (see Figure 9).

Another interesting finding is that longitudinal retirement patterns for the Medicare Cliff sample who eventually become dual eligible follow the retirement patterns of Medicare enrollees. The Medicare Cliff sample not transitioning to dual eligibility status does not follow a similar retirement pattern. In 2012, 43% are retired, and this percentage steadily increases to 70% by 2018 (see Figures 10 & 11).

Conclusions

The results of our analysis spotlight a number of key facts about those who experience the Medicare Cliff that call attention to the vulnerability of this group. Although individuals who hit the Medicare Cliff are healthier and in a better financial position than dually eligible individuals, they are demographically more similar to this group and substantially worse off than Medicare-only enrollees. Most notably, Medicare Cliff individuals have the highest out-of-pocket medical costs compared to the other beneficiary groups, while being in poorer health and having lower financial resources than Medicare-only enrollees. Despite being more physically and economically vulnerable than Medicare-only enrollees, Medicare Cliff individuals are less likely to retire and more likely to re-enter the workforce, a unique pattern when comparing the three beneficiary groups. This is in line with the longitudinal findings, which showed that Medicare Cliff individuals experienced a steeper decline in their financial situation between 2012 and 2018 compared to the other beneficiary groups.

Longitudinal observations not only showed a steady annual increase of those experiencing the Medicare Cliff over the last decade, but also showed that nearly a quarter of these individuals eventually become dually eligible (half of whom do so within two years of hitting the cliff). This may be related to the fact that like many individuals over age 65, they come to require some level of long-term services and supports as they age. For many, this necessitates spending down income and assets until Medicaid eligibility thresholds are reached. In fact, changes over time in the characteristics of the Medicare Cliff individuals who eventually become dually eligible more closely follow those who became dual eligible right away than those who remain eligible for Medicare-only, or typical Medicare beneficiaries. The overall findings indicate that Medicare Cliff individuals could significantly benefit by receiving assistance through the social safety net of Medicaid.

When these individuals do not get this assistance, they may be forced back into the labor force to make ends meet. It also leads to greater rates of dual eligibility because they are unable to afford care. This may also lead them to forego care, contributing to their reporting worsening health outcomes. Ultimately, these outcomes become expensive for society. Thus, when making proposed changes to Medicare and Medicaid, advocates and policymakers need to keep in mind how these changes will impact not just the dual eligible individuals and typical Medicare beneficiaries, but also on Medicare Cliff individuals.

ncoa national council on aging

About NCOA

The National Council on Aging (NCOA) is the national voice for every person's right to age well. We believe that how we age should not be determined by gender, color, sexuality, income, or zip code. Working with thousands of national and local partners, we provide resources, tools, best practices, and advocacy to ensure every person can age with health and financial security. Founded in 1950, we are the oldest national organization focused on older adults. Learn more at **www.ncoa.org** and **@NCOAging**.

LeadingAge LTSS CENTER @UMass Boston

Research bridging policy and practice

About the LeadingAge LTSS Center @ UMass Boston

The LeadingAge LTSS Center @UMass Boston conducts research to help our nation address the challenges and seize the opportunities associated with a growing older population. Established in 2017, the LTSS Center is the first organization of its kind to combine the resources of a major research university with the expertise and experience of applied researchers working with providers of long-term services and supports (LTSS). Learn more at **www.ltsscenter.org**.

Appendix A: Sample Characteristics by Type of Beneficiary (2018)

Sample Characteristics (2018)	Medicare Cliff (N=804)	Dually Eligible (N=416)	Medicare (N=2,945)
Age (Mean)	67.8	68.8	70.4
Gender			
Female	57.5%	64.1%	58.4%
Male	42.5%	35.9%	41.6%
Race/Ethnicity			
Non-Hispanic White	52.3%*	31.9%	71.1%
Non-Hispanic Black	26.8%*	34.7%*	16.8%*
Non-Hispanic Other	3.7%*	5.8%*	2.7%*
Hispanic	17.2%*	27.6%*	9.4%*
Education Years (Mean)	13.8*	11.0*	13.3*
Married	65.0%	37.6%*	56.7%
Live Alone	20.5%*	38.6%*	29.3%*
Rural Residence	23.1%*	22.1%*	26.7%
Retired	53.7%	72.1%	77.5%*
Financial Measures			
Household Income (Mean)	$59,752	$23,774	$69,706
Median	*$34,900**	*$14,320**	*$48,850**
Total Financial Assets (Mean)	$271,649*	$19,586*	$328,774*
Median	*$4,800**	*$0**	*$29,000**
Net Value Primary Residence (Mean)	$166,265*	$46,237*	$194,086*
Median	*$71,000**	*$0**	*$110,000**
Net Wealth (Mean)	$558,218*	$87,801*	$679,417*
Median	*$130,100**	*$1,900**	*$264,500**
Below Federal Poverty Level	14.8%*	42.6%*	8.1%*
Out-of-Pocket Medical Costs	$3,852*	$1,970*	$3,142*
Median	*$2,900**	*$0**	*$1,200**
Health Measures			
Fair/Poor Health	30.6%	57.8%	35.7%
Chronic Conditions (Mean)	2.6*	3.4*	2.8*
ADLs (Mean)	0.3	1.2*	0.5
IADLs (Mean)	0.7	2.1*	0.9
Cognitive Impairment	1.2%	4.2%*	1.6%
Survival Probability 75+ (Mean)	82.8%	81.9%*	93.6%
Survival Probability 80+ (Mean)	51.3%*	44.5%*	60.5%*

*significant t-test difference $p < 0.05$
All dollar values adjusted to 2021 U.S. dollar values
Abbreviations: ADLs (Activities of Daily Living Limitations), IADLs (Instrumental Activities of Daily Living Limitations)

Appendix B: Sample Characteristics at Medicare Eligibility by Type of Beneficiary (2014 to 2018)

Sample Characteristics at Medicare Eligibility (2014 to 2018) (N=4,165)	Medicare Cliff (N=804)	Dually Eligible (N=744)	Medicare (N=4,319)
Age (Mean)	65.0	65.1	65.3
Gender			
Female	57.5%	59.2%*	57.4%
Male	42.5%	40.8%*	42.6%
Race/Ethnicity			
Non-Hispanic White	52.3%*	21.8%*	62.9%*
Non-Hispanic Black	26.8%*	40.2%*	19.9%*
Non-Hispanic Other	3.7%*	5.4%*	3.3%*
Hispanic	17.2%*	32.6%*	13.9%*
Education Years (Mean)	13.8	11.0*	13.7
Married	63.8%*	43.0%*	67.3%*
Live Alone	21.6%*	31.6%*	19.4%*
Rural Residence	23.1%*	18.7%*	25.5%*
Retired	52.2%*	58.2%*	55.0%*
Financial Measures			
Household Income (Mean)	$58,765*	$26,100*	$84,235*
Median	*$42,220**	*$14,514**	*$52,673**
Total Financial Assets (Mean)	$239,620*	$4,295*	$385,305*
Median	*$5,239**	*$0**	*$20,000**
Net Value Primary Residence (Mean)	$154,955*	$37,350*	$164,412*
Median	*$77,000**	*$0**	*$100,000**
Net Wealth (Mean)	$520,506*	$61,501*	$613,622*
Median	*$131,700**	*$1,600**	*$205,500**
Below Federal Poverty Level	16.5%*	46.5%*	8.2%*
Out-of-Pocket Medical Costs	$3,853*	$1,247*	$2,475*
Median	*$2,880**	*$0**	*$1,082**
Health Measures			
Fair/Poor Health	33.5%*	57.0%*	24.6%*
Chronic Conditions (Mean)	2.6*	3.0*	2.2*
ADLs (Mean)	0.3	0.8*	0.2
IADLs (Mean)	0.7*	1.7*	0.4*
Cognitive Impairment	1.0%	1.9%	0.8%
Survival Probability 75+ (Mean)	81.8%*	78.1%*	91.6%*
Survival Probability 80+ (Mean)	51.1%*	46.8%*	63.5%*

*significant t-test difference $p < 0.05$
All dollar values adjusted to 2021 U.S. dollar values
Abbreviations: ADLs (Activities of Daily Living Limitations), IADLs (Instrumental Activities of Daily Living Limitations)

Appendix C: Longitudinal Sample Characteristics by Type of Beneficiary from 2012 to 2018: Medicare Cliff, Dually Eligible, and Regular Medicare

	Experienced Medicare Cliff 2010 to 2012 (N=353)				Became Dually Eligible 2010 to 2012 (N=320)				Began Medicare 2010 to 2012			
Sample Characteristics	**Baseline 2012**	**2014**	**2016**	**2018**	**Baseline 2012**	**2014**	**2016**	**2018**	**Baseline 2012**	**2014**	**2016**	**2018**
% Dual Eligible	0.0%*	15.1%*	17.0%*	20.7%*	100%	100%	99.7%	99.4%	0.0%	6.5%	7.8%	8.9%
Age (Mean)	65.1*	67.0*	69.1*	71.0*	65.8*	67.7*	69.8*	71.7*	65.4*	67.5*	69.5*	71.4*
Female	54.4%	---	---	---	65.4%	---	---	---	55.4%	---	---	---
Male	45.6%	---	---	---	34.6%	---	---	---	44.6%	---	---	---
Non-Hispanic White	59.2%	---	---	---	34.5%	---	---	---	69.8%	---	---	---
Non-Hispanic Black	26.9%	---	---	---	34.1%	---	---	---	20.2%	---	---	---
Non-Hispanic Other	2.5%	---	---	---	3.9%	---	---	---	2.5%	---	---	---
Hispanic	11.4%	---	---	---	27.5%	---	---	---	7.5%	---	---	---
Education Years (Mean)	13.2	13.2	13.2	13.2	10.9	10.9	11.0	11.0	13.4	13.6	13.6	13.6
Married	64.9%*	63.5%	60.6%*	57.2%*	37.5%*	38.6%	36.4%	34.9%*	70.9%*	68.2%*	66.9%*	67.2%*
Live Alone	17.8%*	18.3%	19.5%*	22.6%*	32.3%*	31.5%	33.7%*	36.7%*	16.2%*	18.4%*	20.3%*	21.2%*
Rural Residence	22.1%	22.7%	21.0%	20.4%	22.7%*	20.9%	19.5%*	19.1%	26.2%	26.1%	25.8%	25.0%
Retired	54.5%*	56.9%*	55.1%*	53.8%*	60.8%*	62.2%*	68.8%*	71.6%*	58.5%*	63.0%*	68.2%*	73.6%*
Household Income (Mean)	$63,452*	$62,566	$60,465*	$57,962*	$18,446	$20,197	$20,078	$19,713	$70,016*	$76,789	$76,339	$76,101
Median	*$42,000**	*$37,380**	*$36,120**	*$34,362**	*$12,600*	*$12,200*	*$12,100*	*$12,000*	*$50,400*	*$49,248*	*$48,660*	*$48,392*
Total Financial Assets (Mean)	$140,505*	$116,227*	$113,046*	$106,330*	$5,745	$5,034	$4,850	$4,534	$235,242*	$265,749	$262,552	$259,734
Median	*$15,000**	*$11,000**	*$5,000**	*$4,200*	*$0*	*$0*	*$0*	*$0*	*$25,000**	*$38,000*	*$37,100*	*$35,000*
Net Value Primary Residence (Mean)	$121,182*	$120,841	$118,181*	$117,282*	$27,781*	$36,972	$35,607	$39,851*	$128,078*	$137,895	$158,041	$176,723*
Median	*$70,000**	*$70,000*	*$60,500**	*$60,000**	*$0*	*$0*	*$0*	*$0*	*$85,000**	*$100,000*	*$100,000*	*$110,000**
Net Wealth (Mean)	$384,747*	$361,416*	$310,300*	$306,995*	$43,783*	$47,021	$46,291	$49,653*	$496,526*	$545,565	$556,394	$598,834*
Median	*$125,000**	*$119,000**	*$116,000**	*$114,900**	*$1,000**	*$1,700*	*$1,500*	*$2,000**	*$182,000**	*$222,000*	*$230,000*	*$249,999**
Below Federal Poverty Level	13.0%*	14.3%	15.0%	16.2%*	47.8%*	47.1%	48.9%	52.3%*	6.8%*	7.2%	7.4%	7.3%*
Out-of-Pocket Medical Costs	$3,891*	$4,149*	$3,833*	$3,668*	$2,441	$2,346	$2,086	$1,996	$2,733	$2,604	$2,723	$2,653
Median	*$2,600**	*$3,100**	*$2,900**	*$2,800**	*$250*	*$72*	*$0*	*$0*	*$1,568*	*$1,410*	*$1,500*	*$1,333*
Fair/Poor Self-Reported Health	34.4%*	34.9%	40.6%*	47.7%*	58.9%*	59.4%	62.3%*	63.1%*	26.3%	26.8%	27.7%	27.9%
Chronic Conditions (Mean)	2.4*	2.6	2.8	3.1*	3.0*	3.1	3.3	3.5*	2.0*	2.2	2.5*	2.7*
ADLs (Mean)	0.3*	0.3	0.4	0.5*	1.2*	1.2	1.4	1.5*	0.3	0.3	0.4	0.4
IADLs (Mean)	0.6*	0.6	0.8	0.9*	2.3*	2.4	2.7	3.0*	0.5*	0.6	0.7	0.9*
Cognitive Impairment	2.8%*	3.4%	3.5%	3.7%*	4.8%*	5.4%	5.8%*	6.0%*	1.1%	1.1%	1.3%	1.5%
Survival Probability 75+ (Mean)	82.5%	82.3%	83.1%	83.7%	76.8%*	79.4%	81.1%*	83.8%*	85.6%*	87.6%	89.8%*	90.1%*
Survival Probability 80+ (Mean)	57.8%*	57.1%	56.3%	52.8%*	42.5%	41.3%	41.1%	41.0%	61.5%*	61.3%	59.7%	57.3%*

*significant t-test difference $p < 0.05$
All dollar values adjusted to 2021 U.S. dollar values
Abbreviations: ADLs (Activities of Daily Living Limitations), IADLs (Instrumental Activities of Daily Living Limitations)

Appendix D: Sample Characteristics for Individuals who Experienced Medicare Cliff (2010 to 2012) and Became Dually Eligible (2014 to 2018)

	At Medicare Cliff			
Sample Characteristics (N=73)	**2012**	**2014**	**2016**	**2018**
% Dual Eligible	**0.0%***	**52.8%***	**70.3%***	**100.0%***
Age (Mean)	**65.2***	**67.2***	**69.3***	**71.3***
Gender				
Female	**64.9%**	-	-	-
Male	**35.1%**	-	-	-
Race/Ethnicity				
Non-Hispanic White	**13.5%**	-	-	-
Non-Hispanic Black	**51.4%**	-	-	-
Non-Hispanic Other	**2.7%**	-	-	-
Hispanic	**32.4%**	-	-	-
Education Years (Mean)	**11.1**	**11.1**	**11.1**	**11.1**
Married	**51.4%***	**48.6%***	**40.5%***	**38.5%***
Live Alone	**24.3%***	**25.0%***	**32.4%***	**35.1%***
Rural Residence	**24.3%**	**21.6%**	**21.6%**	**20.4%**
Retired	**43.2%***	**58.2%***	**65.1%***	**69.6%***
Financial Measures				
Household Income (Mean)	**$20,584***	**$19,645***	**$17,613***	**$18,469***
Median	***$16,370****	***$14,928****	***$14,480****	***$15,000****
Total Financial Assets (Mean)	**$4,666**	**$3,638***	**$3,666***	**$4,112**
Median	***$0***	***$0***	***$0***	***$0***
Net Value Primary Residence (Mean)	**$51,486***	**$54,833***	**$47,648***	**$67,636***
Median	***$0***	***$0***	***$0***	***$0***
Net Wealth (Mean)	**$71,822***	**$64,175***	**$61,787**	**$80,673***
Median	**$5,000***	**$4,600***	**$4,000**	**$10,700***
Below Federal Poverty Level	**37.8%***	**45.9%***	**48.6%***	**44.4%***
Out-of-Pocket Medical Costs	**$6,750***	**$3,817***	**$3,133***	**$2,058***
Median	***$3,094****	***$2,404****	***$1,900****	***$480****
Health Measures				
Fair/Poor Health	**41.8%***	**48.7%***	**54.1%***	**46.9%***
Chronic Conditions (Mean)	**3.0***	**3.3**	**3.5***	**3.7***
ADLs (Mean)	**0.4***	**0.5**	**0.7***	**0.7***
IADLs (Mean)	**0.7***	**0.8**	**1.3***	**1.4***
Cognitive Impairment	**2.7%***	**3.4%**	**3.8%***	**4.3%***
Survival Probability 75+ (Mean)	**75.1%***	**80.5%***	**81.4%***	**86.6%***
Survival Probability 80+ (Mean)	**43.4%***	**43.2%**	**42.1%**	**45.5%***

*significant t-test difference $p < 0.05$
All dollar values adjusted to 2021 U.S. dollar values
Abbreviations: ADLs (Activities of Daily Living Limitations), IADLs (Instrumental Activities of Daily Living Limitations)

Appendix C-1:
Storytelling

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Appendix C-1

Sample

Three respondents had lost Medicaid within the past few months. Three thought they might lose Medicaid but still had it at least through the end of this year. One respondent was a health care navigator who described her clients' experiences.

- **Cindy** – female, 67, on Medicaid for 3-4 years after getting sick and losing her job, on both since 2020, now only Medicare only
- **John** – on Medicaid since 2021 due to disability/illness that prevented him from working; he appealed to get SSDI benefits. Once he got those, he lost Medicaid and moved to Medicare. Now on the same HMO plan that he had on Medicaid, so little changed. 55 years old
- **Valerie** – has a disability (autoimmune disorder and bipolar), on Medicaid and Medicare for 6 years – lost Medicaid a few months ago, on Medicare only
- **Ventura** – CA – 64, retired at 62 due to medical condition, on disability, MediCal (aid), and Medicare, Spanish-speaking
- **Janet** – on Medicare and Medicaid until at least the end of December, on Medicaid and Medicare for 20 years due to colon cancer
- **Mr. S.** – caregiver to wife with Alzheimer's; wife was on MediCal and became eligible for Medicare in April – now has both
- **Peggy** – health care navigator in KS

Themes

1. ***All respondents reported receiving confusing and anxiety-producing notices in the mail about impending changes in their insurance. All felt their coverage was terminated abruptly, leaving them little time to find alternative plans.***

- **Cindy**
  - So, I didn't really do anything, and I didn't really understand what was happening.
  - I got so upset I had to end the call because I just don't have that [money]. So, I was just going to have to be uninsured or not eat or something.
  - I had a really horrible time. I've panicked. I've cried. I was so upset at losing Medicare or Medicaid, and I just didn't understand why. I have a low income. I'm on Social Security only. I have a mortgage. I have the utilities to pay. I buy groceries, and I buy gas for my car. All these things. The money just was not there.
  - Medicaid is so important to senior citizens…I'm on a fixed income, and it's not very much.
- **John**
  - The process was anxiety-producing. It wasn't healthy.
- **Valerie**
  - It was confusing sometimes because they would send one notification out that said one thing and then another one that said another.
- **Ventura**
  - Recently got Medicare and still has MediCal but is concerned about losing it due to an error in her disability benefit check.

Appendix C-1

- **Janet**
  - I don't really know. I received a letter stating that I'm back on Medicaid now. So, I don't know, it's really tricky.
- **Mr. S.**
  - However, as a caregiver, it was very difficult with severe stress, anxiety, and financial stress. Because of the switch to Medicare for Mrs. S, it was so confusing. It made Mr. S's anxiety worse.
- **Peggy**
  - Then you get all these letters in the mail threatening you. "You're being dropped, you're being dropped, you only have 14 days to give us what we need." Or you have 30 days. It takes 10 to 12 days to get an envelope from Topeka out to Northwest Kansas. And it's so frustrating, and it's so nerve-wracking for the clients that I work with.

2. Trying to understand the options and navigate the insurance system was overwhelming. Respondents reported needing help.

- **Cindy**
  - The letter from United Healthcare had her [health care navigator's] number; I called that number, and she has been an angel. I can't tell you enough how nice she was, how understanding, how she helped me. She just helped me through this whole process. She kept me calm and sane. She's just been amazing.
- **John**
  - We had to make a rushed decision. We were doing it right up until…the very last day of the month, August 31st, I was up in the middle of the night trying to figure it out.
- **Valerie**
  - Didn't have to change plans – on the Medicare Advantage plan.
- **Ventura**
  - I have been lucky to have my children assist me with the thousands of notices I have received. I do not understand how it works or if there is a standard process to follow. I rely on others to help me with this.
- **Janet**
  - I didn't know what was going on. I really didn't. So, I just sat back and cried and had other people try and help me. I didn't know what to do.
  - I had a really close friend who helped me a lot, and then my son also helped. I was told to contact the SHIP program through an insurance agency I was talking to. So, I got ahold of that and of Deborah, and she started investigating for me.
- **Mr. S.**
  - Mr. S reached out to HICAP and other organizations but isn't getting clear assistance or answers.
  - The Kaiser Medicare representative only knew about Medicare, while the Kaiser MediCal representative only knew about MediCal.

Appendix C-1

- **Peggy**
  - They are in a fragile emotional state because they're being told they're going to lose their insurance again: "What do I do? What do I do? What do I do?"

3. All respondents ultimately either found a new plan that met their needs or had Medicaid benefits extended through at least the end of the year.

- **Cindy**
  - And I think that this plan will cover what I need. I think this will meet my needs very well.
- **John**
  - We ended up going with the same HMO plan that we had our Medicaid through. That seems to be working out pretty well because we basically kept with the same providers we had under Medicaid.
- **Valerie**
  - So, I've got medication coverage, I've got pharmacy coverage. And then I've got all the other coverage that you would have with regular insurance.
  - I was getting some infusions for my autoimmune condition, but I had to stop doing them because I can't afford it now….. I called my Medicare provider to ask them how much it's going to cost to do it. I haven't heard back from them yet.
- **Ventura**
  - No changes in providers or health.
  - I would not be able to afford to pay high premiums or purchase supplemental insurance because my RSDI benefits are not sufficient to cover my rent and food expenses. I would be required to ask my family for help.
- **Janet**
  - Several weeks later, she [health care navigator] called back and said I should have never received those letters. I don't know exactly what she did, but she got me cleared so I still qualify for Medicaid.
  - My other friend who was helping me with it said it's only good till the end of the year, and then I have to reapply for something else. And I'm not sure what that something else is either. So, it's been very, very confusing.
- **Mr. S.**
  - Did not have to change any providers.
  - We were able to get him onto Medicare because we were still within the [enrollment] window.

4. The loss of additional Medicaid support (i.e., a monthly stipend for incidentals), coupled with higher premiums and out-of-pocket costs for Medicare, has been a burden and required cutting back expenses in other areas to make ends meet.

- **Cindy**
  - Another advantage I had was a $130 card every month to buy toothpaste and supplements and over-the-counter things like that, plus food. I could use it however I wanted…I've lost that, and that's going to hurt.

Appendix C-1

- **John**
  - I will probably have at least a hundred bucks a month copay on that medication, which is a lot more than what I had before. But I do have to pay a sizable amount if I go to the hospital.
  - One big thing prior to this was that we qualified for food stamps, and they stripped that away from us immediately, which was really hard on us…I think we'll be okay, but I'm not taking any big vacations or anything.
- **Valerie**
  - With Medicaid, the plan that I had gave you $150 a month towards groceries or whatever [you needed]. That was a huge help. So now, that's another $150 gone. So yeah, it's going to hit hard.
- **Ventura**
  - I really wish Medicare provided dental and vision plans. This would take away the worry of having to pay for it out of pocket. I cannot afford to pay for a supplemental plan.
- **Janet**
  - No changes in care or costs for now.
- **Mr. S.**
  - Although his wife has Medicaid and Medicare, he was told the medication she has been taking now costs $500. It is still unclear what is covered and what he must pay for. Mr. S cut other expenses because he was told he has a co-pay, so he wasn't buying as much food and was trying to save more.
- **Peggy**
  - I was trying to help him find a plan that he could afford. When he got a raise with his Social Security Disability, it kicked him out of the Medicaid bracket for income. So that raise didn't help him. It screwed him in the long run.

5. Respondents want policymakers to understand how hard it is to live on a fixed income. Small changes in the cost of medical care can have a big impact on the ability to cover daily living expenses. The added stress can adversely affect mental health.

- **Cindy**
  - My mental well-being was desperately affected. Whoever makes the decision has to realize that Social Security doesn't go very far…So, we make a lot of sacrifices just to live, just to get by. And then, when they make decisions like this to drop me from Medicaid, it really impacts my life. And I just wish they would have more empathy and put themselves in the place of a fixed-income individual.
- **John**
  - For somebody who is going through the process, it is just amazing how dramatically different the plans are…It is unfair how they're giving me enough money that I'm over the poverty gap—just barely. And that's going to take everything away from me.

Appendix C-1

- **Valerie**
  - I don't make a ton of money...$21,000 a year is not a lot of money. And so, having that [Medicaid] go away and all of the things that went with it is just going to make things so tight that I'm not going to be able to do fun things or…do extra things like buy my grandson something…So yeah, it impacts everything, really. I am going to have to squeeze my budget for groceries.
- **Ventura**
  - Medicare is very complicated. Lawmakers should ease the process because this process is very complex, especially when you speak a different language.
  - Medicare providers should be required to provide the same level of care as if I had private insurance.
- **Janet**
  - I just wish these programs were a little simpler to understand.
  - One thing I do know is that when I got a raise in Social Security, I don't think that should put me over the limit to qualify for Medicaid. It did so something needs to be done there. I was only over a hundred and some odd dollars.
  - And I've heard from other people who got booted off too because of that very thing. Social Security put them over the limit, so that doesn't really seem very fair for a hundred dollars you get booted off this program.
- **Mr. S.**
  - There is no guidebook in different languages to explain this switch. He doesn't feel other professionals can provide an explanation. There is a Medicare specialist and MediCal specialist, but there is no specialist for both, causing him a lot of stress and confusion.
- **Peggy**
  - People need to know where to go for help: If I didn't know anything about it, what would I do? What would be my first step? Where would I go? And I think that's hard. It's hard for people to figure out what kind of help they need and where to go to find that kind of help.

Appendix C-2:
Story Collection Protocol/Consent Form

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Appendix C-2

Storytelling Interview Protocol

- **I'm interested to learn a little more about you. Let's talk first about your health care coverage and health before you became eligible for Medicare.**
  a. What health insurance did you have prior to beginning Medicare?
  i. Prompts: How long had you been receiving Medicaid?
  b. While you were on Medicaid, how happy were you with the medical care you were receiving?
  i. Prompts: Did you get the care you needed when you needed it? Were you easily able to get to your medical providers (e.g., Were there any problems with transportation)? Did you delay care for any conditions? If so, why? Were your providers responsive and respectful?
  c. How was your health before you enrolled in Medicare?
  i. Prompt: Were you being treated for any chronic conditions? How would you say your health affected your daily life? Did health issues make it hard for you to work? Socialize? Travel? Are there things you wanted to do but couldn't?
- **What health insurance do you have now?**
  a. Prompts: Do you have insurance that covers hospital stays? Prescriptions? Doctor visits? Outpatient care? Home health care? Medical equipment? Do you have Medicare Part B? If not, why not? Is it because the premiums or co-pays are too high? Do you have or did you consider Medigap or Medicare Advantage?
- **Thinking about your health care now, how has it changed since you became eligible for Medicare?**
  a. Prompts: Did your out-of-pockets costs change (e.g., higher deductibles)? Did you have to change providers? Did you lose coverage for the treatment of any conditions you have? Did you lose coverage for any preventative care you used to get (e.g., eye exams, routine dental care)? Did you lose any assistance programs that helped with costs?
- **How has the quality of the care you receive been affected by the change in your health insurance?**
  a. Prompts: Did you have to change doctors? How do the doctors you see now compare to those you saw before you switched to Medicare? Have you had to skip or delay medical appointments because you couldn't afford them? Have you stopped taking medications or reduced how often you take them because you couldn't afford them?

1. **How is your health now compared to before you enrolled in Medicare?**

a. Do you feel better or worse off with Medicare? Or do you feel about the same? How would you say your health affects your daily life now? Do health issues make it hard for you to work? Socialize? Travel?

2. **Has the switch to Medicare affected other aspects of your life? If so, how?**

a. Prompts: Have you had to go back to work to afford health care? Cut other expenses? Changed how you pay your bills? Changed how you shop for groceries and eat? Changed how you pay for housing and or utilities? Are you behind on some payments?

Appendix C-2

3. **What do you want elected officials to know about how the switch to Medicare has impacted your life? Your health? Your sense of well-being?**

Consent Form for Storytelling

Thank you for participating in this project. We appreciate your willingness to answer questions about and share your own experience. The purpose of this study is to gather stories about people who move from Medicaid/MediCal to Medicare. Your participation is voluntary. You may decline to answer any or all questions and you may terminate your involvement at any time, if you choose. Information will be aggregated and de-identified to protect your privacy. There will be no direct benefit to you for your participation in this study. However, we hope that the information obtained from this study may help shed light on the challenges for people who move from Medicaid/MediCal to Medicare. Also, there is no harm associated with your participation.

Do you consent to speak with me and share your story?

- Yes (circle “YES” or check the box to indicate respondent said yes) ☐
- No (end) ☐

Appendix D-1:
Key Informant Interviews

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Appendix D-1

PROJECT OVERVIEW

With support of Arnold Ventures, the National Council on Aging (NCOA) and its research partner, the Leading Age LTSS Center @UMASS Boston, are conducting a multi-phase research project to analyze the transition from Medicaid eligibility, particularly in expansions states, to Medicare among low-income older adults. The purpose is to identify policy options for improvements. As these beneficiaries age into Medicare, many lose various low-income protections they had been eligible for.

Additionally, as low-income older adults become eligible for Medicare due to age, many face difficult health coverage challenges. They may not qualify as dual eligibles, but still face financial challenges affording the premiums, co-payments and out-of-pocket costs encountered under Medicare. Those that had Medicaid coverage prior to age 65 may lose their Medicaid coverage or benefits, with its protections from both premiums and cost-sharing, and be unable to afford Medicare out-of-pocket costs. Protection for low-income individuals – regarding both eligibility and coverage – is often less generous for those who turn age 65 compared to those available for these same individuals living in Medicaid expansion states when they were under age 65. Low take-up rates among those who are eligible for the confusing array of Medicare Savings Programs (MSPs) and Medicare Part D Low-Income Subsidy (LIS) available to help, also suggest problems with education, outreach, and enrollment. Little is known about consumers who lose Medicaid coverage or Marketplace subsidies, or are not dual eligibles, as they transition to Medicare.

This project aims to fill in these knowledge gaps. What can we learn from individuals who hit what is called this “Medicare Cliff” when they turn 65? What program and policy solutions are available to address their needs? With this information, we can consider remedies to address shortfalls and identify the types of state and Federal policies that can be expanded or revised to provide vulnerable and poor Americans with better health care options. Importantly, we intend to examine the budget offsets that may be available to make the needed policy solutions possible.

The project’s aim is to research these issues using the following different methodologies:

- A comprehensive literature review including both peer-reviewed publications and materials from the general literature;
- A quantitative description of the characteristics of those who fall off the “Medicare Cliff[1]”(Research & Evaluation);
- Storytelling via the Benefits Enrollment Center (BEC) network, putting faces on individual experiences (Center for Benefits Access); and
- Key Informant Interviews. NCOA conducted semi-structured, key informant interviews with experts in the field; interviewees included public sector experts, academics, policy experts with think tanks, research institutes, and non-profits. Among the considerations for this phase of the work was examining policy solutions and the budget offsets that may be considered to make potential solutions a reality.

A final report will pull together the analyses, stories, and recommendations for policy options with related offset ideas. NCOA will consider how to best move forward, setting priorities from the policy options and offsets identified, and determining a division of labor for each partner to educate on and advocate for specific changes.

Appendix D-1

METHODOLOGY FOR THE KEY INFORMANT INTERVIEWS

The project team individually identified and discussed potential individuals that would provide valuable and varied perspectives on these issues. Names were gathered from the literature review, professional experience, and suggestions from others working on these and related topics. In total, a list of 20 individuals were identified. The team individually assigned priorities to satisfy the objective of completing the five to six interviews intended. Individuals assigned the highest priority, and where there was the most agreement, were included in the outreach process. Anyone who was unable to participate was replaced with another individual from the list.

An invitation e-mail was sent to each of the potential key informants, along with a project summary to help them understand how the interviews would be integrated into the other components of the project research.

A discussion guide was created in collaboration with the NCOA project team. It included mostly open-ended questions exploring interviewees' opinions about a variety of policy solutions raised in the literature. At the outset, however, all respondents were asked to "rate the importance" of three (3) broad categories of policy solutions, or to identify any other category that they felt was of greater important. With participants' consent, interviews were recorded on Zoom and transcripts provided. All information gathered would remain without attribution to any individual interviewed.

Key informant interviews were completed with the following individuals and organizations. In some cases, individuals contacted requested that a colleague be included in the interview or suggested that an alternative colleague would be a better fit for the interview:

- **Brandy Bauer** | Director, Health Coverage and Benefits, NCOA;
- **Amber Christ** | Managing Director of Health Advocacy, Justice in Aging;
- **Trisha Dugan** | Senior Vice President of The Kaiser Family Foundation and Executive Director of The Program on Medicare Policy at KFF and **Alice Burns**, Associate Director with The KFF Program on Medicaid and The Uninsured;
- **Zhanlian Feng** | Senior Research Analyst, RTI;
- **Jack Hoadley** | Research Professor Emeritus, Georgetown University, McCourt School of Public Policy;
- **Kate McEvoy** | Executive Director of the National Association of Medicaid Directors;
- **Allison Rizer** | Principal with ATI Advisory and Group Lead, overseeing Medicaid, LTSS, and Integrated Programs; and
- **Dennis G. Smith** | Medicaid Strategies 360. (Now an independent consultant, Dennis has a depth of experience with Medicaid programs at both the Federal – CMS/HHS – and State level – AR, CA, VA, WI).

Policy options and offset interviews were completed with the following individuals:

- **Derek Ayeh** | Coordinator of Education & Policy, Medicare Rights Center;
- **Amber Christ** | Managing Director of Health Advocacy, Justice in Aging;
- **Kate McEvoy** | Executive Director, National Association of Medicaid Directors;
- **Gretchen Jacobson** | Vice President of Medicare, The Commonwealth Fund;
- **Lynn Hearn** | Florida Health Justice;
- **Tricia Neuman** | Senior Vice President, KFF; and
- **Beth Shyken-Rothbart** | Attorney, Medicare Rights Center.

Appendix D-1

FINDINGS

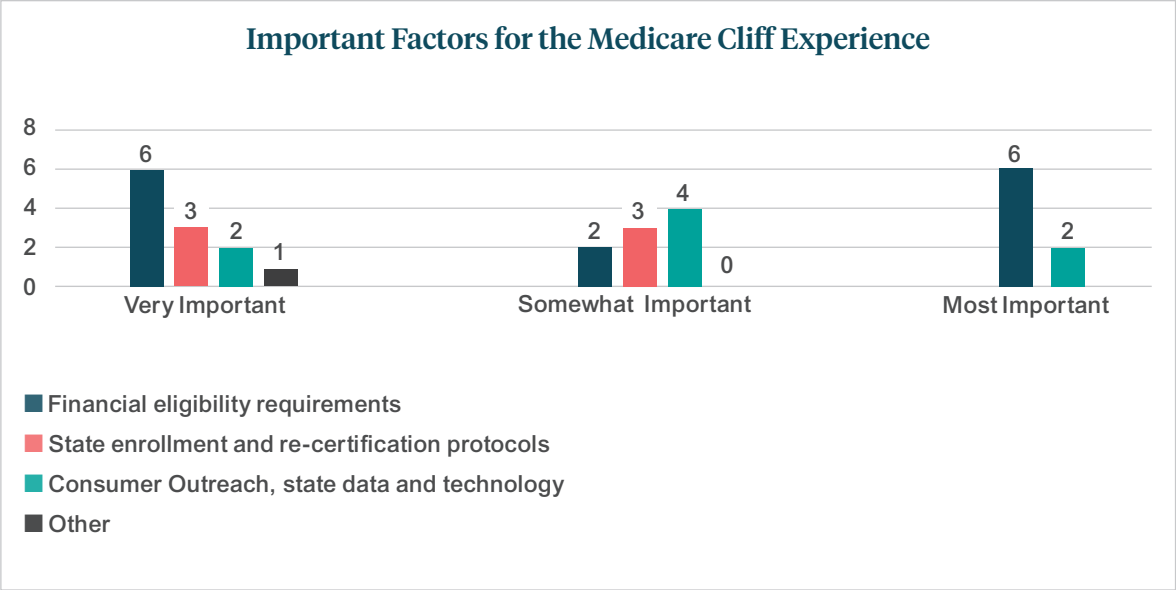
As mentioned, following general introductory remarks, each interview began with a set of structured questions asked of most of the interviewees (See Appendix A for full interview protocol.). Specifically, they were asked:

> **"How important do you feel each of the following issues are as factors driving low-income adults encountering the Medicare Cliff – i.e., not accessing one or more of the Medicare Savings Plans designed to assist them, yet not qualifying as dual eligibles?"**

The response options were: "Very important; Somewhat important; Not very important; or Not at all important."

The results of this first question are shown in Figure 1 below.

FIGURE 1: IMPORTANT FACTORS EXPLAINING WHY PEOPLE ENCOUNTER THE MEDICARE CLIFF.



Respondents did not classify any factor as "not important." They did differentiate factors they felt were "very" vs. "somewhat" important. Respondents were first asked to evaluate each factor individually and thus were free to identify one or more of the factors as "very important." For the most part, financial eligibility requirements were most often cited as "very important." However, state enrollment/re-certification protocols and the efficacy of consumer education and outreach efforts were also cited as "very important." Also seen as "very important" were state protocols for enrollment and re-certification and, to a lesser extent, the technology, and data to support those procedures, along with the process for outreach and education to consumers. One person mentioned "having the right plan choices" as a choice for an "other" option that was also very important.

Appendix D-1

When forced to choose the single most important, most interviewees chose financial eligibility requirements. But two of those interviewed felt that consumer education and outreach were the single most important factor.

Some comments on these options and why they were ranked as shown above are illustrated in the verbatim quotes shown here:

> **"I think the financial requirements are the biggest one. The rest all relate to that or [are] subsidiary to that in some sense."**
>
> **"...increasing the consumer literacy is absolutely foundational to this."**
>
> **"I think awareness, literacy, more essentially available, situationally available, means of understanding the financial parameters. I feel like those are ridiculously difficult to access."**
>
> **[Regarding the importance of consumer education and outreach.] "I would have said 'very,' but I don't think it's as great an issue as the financial barriers. But, it's still an issue. People tell us they don't know about it or they don't think they would qualify."**

Financial Eligibility Requirements

The next topic for discussion focused on policy changes regarding the financial eligibility requirements, including criteria and procedures. The Medicare Savings Programs (MSPs) are administered by the states, follow broad Federal guidelines, but vary significantly across states in both their program design and how they are administered.

Table 1 summarizes the Federal guidelines for financial eligibility and the benefits covered under each of the types of Medicare Savings Plans, as of 2022. (Because costs of care are significantly higher in Alaska and Hawaii than in the mainland states, Federal eligibility guidelines specifically accommodate these two states individually.)

Appendix D-1

TABLE 1: FINANCIAL ELIGIBILITY REQUIREMENTS FOR MSPs BY TYPE, 2023

Type of Medicare Savings Plan	Benefits Covered	Financial Eligibility Requirements
Qualified Medicare Beneficiary (QMB)	**PART A:** Monthly Premium (up to $506) Hospital Deductibles: $1,600 per benefit period Hospital Copays: $400/day for days 61-90; $800/day for days 91-150. SNF Copay: $200 days 21-100 **PART B:** Monthly Premium ($164.90) Annual deductible ($236) Co-insurance (20%) amount varies	**MONTHLY INCOME*:** At or below <100% FPL disregard $1,215/$1,235/single $1,643/$2073married Alaska: $1,518/$1538/single Alaska: $2,053/$2,073/married Hawaii: $1,378/$1,418/single Hawaii: $1,890/1,910/married **RESOURCES:** $9,090/single $13,630/married
Specified Low-Income Medicare Beneficiary (SLIMB)	**PART B:** Monthly Premium ($164.90)	**MONTHLY INCOME*:** Between 121% - 135% FPL $1,640/$1,660/single $2,219/$2,239/married Alaska: $2,049/$2,069/single Alaska: $2,772/$2,792/married Hawaii: $1,887/$1,907/7single Hawaii: $2,552/$2,572/married **RESOURCES:** $9.090/single $13,630/married
Qualifying Individual (QI)	**PART B:** Monthly Premium ($164.90)	**MONTHLY INCOME*:** Between 121% - 135% FPL $1,640/$1,660/single $2,219/$2,239/married Alaska: $2,049/$2,069/single Alaska: $2,772/$2,792/married Hawaii: $1,887/$1,907/7single Hawaii: $2,552/$2,572/married **RESOURCES:** $9.090/single $13,630/married
Qualifying Disabled Working Individual (QDWI)	**PART A:** Monthly Premium up to $503/month *For people with Medicare who are under age 65, disabled and no longer qualify for free Medicare Part A or Medicaid because they returned to work, and have income that exceed the Medicaid limit.*	**MONTHLY INCOME*:** $4,945/single $6,659/married Alaska: $6,155/single Alaska: $8,299/married Hawaii: $5,675/single Hawaii: $7,645/married **RESOURCES:** $4,000/single $6,000/married

*Includes $20 income disregard per household. Source: www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html.
As cited by National Council on Aging. Updated February 2023

Appendix D-1

Since 2001, under new Federal authority, states have been allowed to adopt one or more changes to these Federal guidelines that would liberalize eligibility for their state's MSPs. These include increasing or eliminating the resource limits, making the MSP more readily available to a larger number of low-income individuals and/or raising the income limits that individuals must satisfy to qualify for a MSPs. Table 2 illustrates states with increased income eligibility thresholds.

TABLE 2. STATES WITH HIGHER INCOME ELIGIBILITY LIMITS FOR MSPs, 2023

STATE	Monthly Income (single/married)
Connecticut	QMB: $2,564/$3,467 SLMB: $2,807/$3,795 QI: $2,989/$4,042
District of Columbia	QMB: $3,665/$4,950
Indiana	QMB: $1,843/$2,485 SLMB: $2,086/$2,813 QI: $2,268/$3,060
Maine	QMB: $1,823/$2,465 SLMB: $2,066/$2,793 QI: $2,248/$3,040
Massachusetts	QMB: $2,329/$3,142 SLMB: $2,572/$3,470 QI: $2,754/$3,718
Nebraska	QMB program replaced with full Medicaid
New York	QMB: $1,679/$2,288 QI: $,280/$3,076
South Carolina	QMB program provi2des full Medicaid

Source: NCOA, February 2023

Appendix D-1

Asset Requirements. In terms of the asset requirements, 11 states and the District of Columbia eliminated any asset requirement. Illinois suspended it during the public health emergency. And four (4) other states have raised it significantly. Key informants were split between those who wanted to see states remove the asset limit completely and those who felt that the resource limits need to be increased but should not be eliminated. Arguments in favor of removing the asset limit included: program simplification and administrative savings; the favorable experience in states that have already done so (in terms of cost savings and enrollment improvements); the belief that program fraud is limited and more effectively identified in other ways; and analyses that indicate that low-income elderly overwhelmingly do not have sizable assets. Those that may have some assets are using them to pay Part B premiums, co-pays and out-of-pocket health care costs, along with daily living costs in retirement. Tapping into assets to cover these costs is needed as many older adults are living on fixed incomes. Others mentioned program alignment as another rationale for eliminating the asset test since the Affordable Care Act's (ACA) premium subsidies (premium tax credits) and the expansion of Medicaid under the ACA do not have an asset test. In both cases, eligibility is simply based on income.

Another concern mentioned was the complex and lengthy process of determining eligibility when the asset test is included. Delays can impact other decisions the beneficiary needs to make about plan selection and may cause them to not optimize their choices.

> **"I think in my preferred world...there is no asset test for the Medicare subsidies because it is ridiculous to penalize people who have been successful at saving....and they'll use that for the things they need to come out of their pocket for."**

> **"The asset requirement is the biggest slowdown in the approval process. Income is, for many people, just their social security checks, so it's very straightforward. It's the assets that are a lot more complicated and intimidating."**

> **"The asset test can be challenging, paperwork-wise. So even if they meet the financial criteria, it's hard to prove it."**

> **"The reason for elimination [of the asset limit] is that...having to prove your poor year after year is an issue. It cuts people off from coverage."**

> **"It adds paperwork and delays that impact peoples' health."**

> **"It becomes this notion that this person with low-income somehow has $100,000 in the bank. And it seems that can be resolved by the fact that most of those assets are also income-producing. So, if you really do have $100,000 in the bank, that's going to kick you off on the income limit."**

Appendix D-1

Raising asset limits represents a middle ground solution that even the key informants who would personally like to see it eliminated understand that raising the limits would have broader bipartisan support and achieve some similar objectives. Another advantage one person cited was that, based at least on the first year of experience in California, the increase in the number of people gaining eligibility has been modest. Of course, it is difficult to isolate other factors such as education, outreach, and enrollment complexity as factors mitigating the impact on program growth. And maintaining a limit does not "free up" administrative costs. Probably the strongest argument for raising, rather than eliminating the asset limits, lies in the political feasibility of doing so.

To summarize, the reasons cited for preferring to raise asset limits, rather than eliminating them had to do with: the impact on program costs due to increased enrollment; fraud and abuse; and political feasibility.

> **"I would favor updating the asset test, but would not favor eliminating an asset test."**
>
> **"There's the financial cost of having more people on the rolls for those first few years until the system kind of works itself out."**
>
> **"You're going to significantly increase the number of people who are eligible; you still have a lot of middle-class Americans who in retirement now are only going to get a Social Security check. So, on the income side, they're going to qualify, but they're sitting on substantial assets...."**
>
> **"Should my neighbor have to now subsidize me instead of me paying for something on my own?"**
>
> **"A lot of states would not support that. [It] would be a hard way to go politically."**
>
> **"There's still an orientation that is a legacy, despite the evidence that shows that there's not a lot of individual fraud going on or asset transfers or gaming. There's a widely held view among a lot of policymakers that is ubiquitous."**
>
> **"So far, [in California] with the increase up to $130,000, I think it is less than 7,000 people who have gained eligibility."**
>
> **"I think the number of people that are affected by changing the asset test just isn't that large."**
>
> **"Whether you lift the asset test or eliminate [it] is a political question."**

Income Limits. Seven states have more generous income limits for their MSPs than are prescribed by the Federal levels shown in Table 1. As a start, several interviewees felt that income limits should be raised to 138% of FPL, putting it on par with the ACA expansion, or increasing it further to be on par with subsidy eligibility levels within the ACA for the under age 65 population. Some felt that state variations regarding income limits make sense because there are different financial circumstances among the elderly across states. There was some support for raising the income limits for QMB to 300% of FPL and for SLMB to 400% of FPL.

Appendix D-1

> **"Any kind of consistency for systems…and just that orientation that there's a broad target population…that's something that would be workable for states."**

> **"Income limits should be raised…I'm not certain …where to raise it to. 300% of poverty in the South is a substantial percentage of the state population…300% in New York…is a totally different situation."**

> **"Raising the income limit up to 138% is one of our systemic policy solutions…When you turn 65 or obtain Medicare, it's not like your financial situation is changed; and if it has, it's usually less favorable and then stagnant."**

> **"[Some] states use the special income rule…three times the SSI rate or 260% of FPL. Do [those people] have enormous amounts of resources? My guess is no."**

> **"The ACA goes up to 400% of FPL and still gives financial assistance. And yet people with Medicare eligibility are getting assistance up to 150% of FPL."**

Another topic that emerged when talking about income limits was the notion of having the Part B premium subsidy on a sliding-scale basis for people above the FPL. However, it was also noted that this would certainly add complexity (and cost) to an already confusing program.

> **"[Consider] all the reconfiguration or processes that states would need to do, which is unbelievably expensive and time-consuming."**

While there was agreement across key informants that income levels needed to be raised, there was no consensus on how much or even a framework for doing so, other than the 138% of FPL used in the ACA expansion and the need for flexibility across states.

Out-of-Pocket Limits. Some of the key informants suggested limits on out-of-pocket expenses as a better approach to helping low-income individuals that would also better meet the needs of those with high-cost health care conditions.

> **"Maybe a better way to think about it is that we need a program out-of-pocket limit."**

> **"I think I would explore trying to do a lot through the out-of-pocket limit, which I think is something that politically would have the benefit of helping everybody in Medicare…That helps you build a constituency for change.**

Appendix D-1

Consumer Education and Outreach

As cited in the literature review, several studies identify participation rates in the MSPs that are well below the percent of the population estimated to be eligible for them.[2] Participation rates vary by program, state, and demographics. Of all the MSPs, QMBs have the greatest participation rate estimated at 53%, SLMB is estimated at 32% and only 15% of those eligible for QI are estimated to be enrolled.[3] Similarly, take-up rates within the LIS program, intended to assist with Part D prescription drug costs, are also low. One source estimates that fewer than 33% of those eligible were enrolled.[4] Enrollment in other government programs was the greatest predictor of MSP participation (e.g., SSI and SNAP). Variation by state was significant. Georgia had a lowest "regression-adjusted participation (25%) and Maine has the highest (78%)."[5] Finally, the literature cites that different financial eligibility criteria across states do not explain enrollment rate differences; rather, as found in other research, administrative complexity, and challenges in outreach to the consumer are more likely explanatory variables driving differences in enrollment rates.

State Health Insurance Counseling Programs. All the key informants felt that improving outreach and education to consumers was either very or somewhat important to realizing gains in the number of individuals eligible for MSPs being enrolled in them. Some even cited consumer education as the single most important factor. Others noted that, in addition to being important, it is likely to be a relatively, bipartisan, and cost-effective intervention, given that a state health insurance counseling programs for seniors infrastructure, supported by technical assistance at both the state and Federal levels, already exist. (These programs go by a variety of names in different states: Health Insurance Information, Counseling and Assistance Program (HICAP); State Health Insurance Assistance Program (SHIP), and Serving the Health Insurance Needs of Everyone (SHINE); they may be based either in the State Department of Aging or Insurance.) There was agreement that these are valuable resources that are chronically under-resourced and that more could be invested in the counseling infrastructure at both the state and Federal level to raise awareness and guide people to an understanding of and speedier eligibility process into the MSPs appropriate to their needs and circumstances. Massachusetts, New York, and Iowa were identified in one interview as examples of "best practice" states regarding SHIP counseling on this topic.

> **"[We need to] allocate more resources to under-performing states. This is about the Social Security offices or SHIPs that are under-resourced. That could at least supplement what states are or are not doing."**

> **"The SHIPs are pretty knowledgeable about Medicare subsidies…the challenge is that there are too few counselors for the volume of people."**

[2] Popham, L, Bedlin, H. Fried, L., Silberman, S, Hoadley, J, and Slanchev, V. Take-Up Rates in Medicare Savings Programs and the Part D Low-Income Subsidy Among Community-Dwelling Medicare Beneficiaries Age 65 and Older. NCOA Issue Brief, June 2020. Zhanlian Feng, PhD, Alison Vadnais, MHS, Emily Vreeland, MSPH, Micah Segelman, PhD, Abigail Ferrell, BA, Joshua M. Wiener, PhD, Bob Baker, BA, RTI International. Prepared for the Office of the Assistant Secretary for Planning and Evaluation, Loss Of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors And Implications: Policy Brief. May 2019.

[3] Caswell, KJ and Waidmann, TA. Medicare Savings Program Enrollees and Eligible Non-Enrollees. June 2017 Report for Medicaid and CHIP Payment and Access Commission (MACPAC)

[4] Popham, L, et. al, op. cit.

[5] Caswell, et al, op. cit.

Appendix D-1

> **"There isn't a public service announcement about SHIPs. Most people...don't even know that they exist for communities to take advantage of."**

> **"The SHIPs are chronically under-resourced. So, when we talk about levers and additional funding that could well be used in support of this, I'd say the SHIPS are an incredible existing vehicle that should be amplified."**

> **"They meet people where they live and work...They are very fact-based."**

> **"They are a gem of a program that just doesn't have enough money to really step up to the order of magnitude that it should."**

Other Educational Resources. Key informants also identified an expanded educational role for Medicare, ranging from a public service awareness campaign to a significant overhaul of the Medicare & You handbook to do a better job of calling out and directing people to the information on low-income support programs that are available. A comparison was made to the very aggressive job that Medicare Advantage sales entities do with nearly continuous TV broadcasting, often directed at older and more price-sensitive consumers, while Medicare has little or no visibility on the airwaves letting people know about the "extra help" programs that are available without regard to which plan you select, and the free and objective personalized counseling that is available.

Some mentioned the need for expertise in adult learning and usability testing to improve the material in Medicare & You to better tailor content to the different populations it needs to reach. Greater transparency is also needed. It was felt that too much detail is provided on what is and is not covered, and not enough attention is paid to premium costs, additional premium surcharges for those with higher incomes, and, germane to this issue, the MSPs available to those with lower incomes and financial resources. Sometimes people pay more attention to "call-out boxes" or personal stories. Perhaps using a real-life example of someone who has enrolled in an MSP (and a profile of their personal and financial situation) would be an easier way for people to understand the concept.

> **"Increasing the consumer literacy is absolutely foundational to this. And doing it in a manner that routinizes it in the same way we do with other aspects of preparing to become part of Medicare."**

> **"Maybe it's really pulling out those pieces that are going to have significant financial implications...bill-boarding or call-out boxes."**

> **"Bringing into the fold [people that know about translating material, adult learning and the like]."**

Appendix D-1

State Data and Technology – Certification Protocols

Key informants named a series of points in the process of identifying, certifying eligibility, and enrolling individuals in MSPs where problems exist. All felt that one or more of these factors contribute to lower enrollment rates than reflect the number of individuals who would otherwise be eligible. Some of the examples provided include:

- Did Medicaid notify individuals that they are about to transition off Medicaid onto Medicare? Did they do so effectively and by "any and all" means available?
- How up-to-date are available address files and what is done to maintain and update them?
- Are the materials sent in way that encourages people to "notice" and "open" them?
- Are the materials sensitive to the literacy and language diversity of the populations they are hoping to reach?
- As mentioned above, how widely publicized are the insurance counseling programs? Do populations have easy access and transportation options to access them? Is telephone-based and language-appropriate counseling available?
- How often are materials updated?
- Are materials available in multiple distribution channels (e.g., internet, through trusted community partners, direct mail, and more)?

> **"You're taking a population that generally needs more one-on-one assistance for a variety of reasons, but you're not giving them any sort of 'leg-up' information."**
>
> **"[Someone] could be sitting out there lost without any knowledge of what's available."**
>
> **"I think having good outreach and listening, websites that really spell out what the requirements are.... these issues of what counts and what doesn't count is very confusing to people."**
>
> **"They can't figure out the right paperwork, or they don't understand that they need to send in certain things."**
>
> **"We push information at people in ways that resonate with us. But how do you educate in an effective way so that they know that they could be eligible for these programs?"**

Other topics that emerged in discussion with key informants under the general heading of "State Data, Technology and Outreach" included the following:

Making People Aware of the Transition from Medicaid to Medicare

> **"There's no uniformity in terms of what the Medicaid office is supposed to do...Some states do a really good job...a very few states take the burden off the consumer and help to...usher them through the application screening process. And that would be an ideal world."**
>
> **"I think what happens in most states is that they send a letter and it may or may not even mention that there are subsidies."**

Appendix D-1

Letting People Know about Medicare Savings Programs and the "How to" or Enrolling

> "People may or may not get a notice in the mail or they may not pay attention or it may not come to the correct address."

> "People don't even pay attention to the "snail mail" they get...they're inundated."

> "I think what happens is most states is that they send the letter and the letter may or may not even mention that there are these subsidies."

> "In an ideal world...the state would identify people to evaluate their eligibility for the different forms of subsidies and they would get contacted with this information."

Enrollment Simplification. Aligning the Low-Income Subsidy (LIS) in Part D with one of the other programs – perhaps QMB – was mentioned as an enrollment simplification that would enable an individual to automatically enroll in two programs at once, using the same 150% of FPL criteria for both.

Self-Declaration and/or Less Frequent or No Re-Certifications. There were more diverse opinions about whether simplifying state protocols by allowing self-attestation regarding financial eligibility (with periodic fraud checks based on known patterns) or reducing or eliminating the frequency of re-certifications would result in greater enrollment among qualified individuals and lower administrative costs.

> "I think that makes a lot of sense. We have enough access to tax returns. We can do back-up checks, whether it's on everybody or spot-checking."

> "Give people a chance to get things established. That's what's important."

> "The data is clear that people with income limits that we're talking about aren't acquiring large amounts of assets. Options around [eliminating re-certification] would minimize the administrative burden it puts on extremely marginalized populations."

> "I think it is something that is overbroad and too much concerned about accountability and fraud than is warranted by the stability of the income and other circumstances of the population that typically receives these benefits."

> "I'm a huge proponent of that...I feel like there's so much administrative expense."

On the other hand, one interviewee was not comfortable with removing re-certification or allowing self-declaration.

> "We saw how much fraud would happen with COVID. How many billions of people were able to find cracks in the system because it was self-attestation. So, no, you cannot do that."

Appendix D-1

Offsets

Policy reform, especially those designed to expand the population having access to public programs and benefits, comes at a cost. Identifying feasible budget "offsets" – i.e., how to fairly and on a bipartisan basis pay for these policy reforms, is a question of critical importance. But key informants identified many challenges before one can even begin to answer these questions.

Here are some of the comments and suggestions regarding the expected costs and impacts of various policy reforms and where and how those costs could be offset.

> **[That]….is always a challenge."**

> **"When you say offsets, are you asking about how you'd pay for it?"**

To begin with, interviewees felt that it is important to identify the costs associated with the policy reform(s) to be pursued before they could identify and evaluate the possibilities for an offset.

> **"And again, we don't know how much money we're trying to raise here. That makes this exercise super hard."**

> **"I don't know what the numbers are."**

> **"…. before finding the offsets, we need to figure out how much is this going to cost."**

> **"My last estimate was that a third or so of the MSP spending was in states that had eliminated asset tests. So, there'd be no cost to eliminating the asset test in those states."**

> **"I think there's two places that are also relevant in figuring out how much costs do we need to even offset? One of them is….to [what] extent we can streamline the asset and application process with LIS? There's going to be administrative savings. The other piece of this is the Medicaid proposed eligibility rule that strongly encourages states to adopt the LIS asset limits and definitions. It also would treat the LIS application as an MSP application. All of that is going to increase spending on MSP, which means any other changes that are being proposed need to be compared against a world with that rule in place. Which would mean lower costs. Between those two things, you have a smaller number of states where you're going to see a huge change which overall reduces the amount of costs we need to find offsets for."**

Thinking about Medicare as a whole, one respondent felt that there were opportunities for offsets regarding provider payments. Additionally, more than one respondent identified savings from Medicare Advantage that such be captured.

> **"I think I would start looking at the Medicare Advantage program. I think there's been substantial overpayment to MA plans over the years. MA plans certainly enroll a lot of low-income seniors. So, I think that's even got a logical connection. We don't want to…. we shouldn't be overpaying them."**

> **"I'm sure everybody in the universe has mentioned to you Medicare Advantage overpayments. "**

> **"But there are certainly savings from Medicare Advantage program we ought to be achieving."**

Appendix D-1

> **"There's overpayment in Medicare Advantage...I wholeheartedly subscribe to that. There are resources that could be redirected there."**

A different take on leveraging offsets from Medicare Advantage was to impose greater educational requirements on MA plans regarding MSPs as part of their enrollment process.

Other sources for offsetting the costs of policy reforms to address the Medicare Cliff that were mentioned in the key informant interviews were tied to Medicare Part D.

> **"There's continued revenue to be picked up in addressing drug pricing. We've started that process with the Inflation Reduction Act. Some of that was used to pay for some of the sweetening of the Part D benefit, the elimination of the out-of-pocket, higher out-of-pocket costs. But we can probably find ways to save more money on drug pricing. So those would probably be the first two areas I'd look at."**

For other respondents, the need for offsets and the vehicles to consider would depend upon the policy reform under consideration, since they anticipate that some changes would have a larger impact on increasing participation than others; or that some policy reforms would reduce program costs.

> **"The asset test change is not so huge in magnitude. So, I'm not concerned about finding offsets."**

> **"I think the number of people that are affected by changing the asset test just isn't that large."**

> **"[But]...moving the eligibility up from 130% or 150% up to 200% or something like that...you could pull a lot more people in that and that would be a bigger offset issue."**

> **"If our goal is to get everyone who deserves to be enrolled, then you are talking about a big increase in the number of people on these programs."**

A few interviewees felt that some savings could be obtained because of the administrative simplification that would come from some of the proposed changes such as improving enrollment efficacy, removing the asset test, allowing self-declaration, and improving the counseling and automation process. Others mentioned that the cost impact of removing the asset test would be mitigated by the fact that a good number of states have already done so.

> **"My last estimate was that a third or so of the MSP spending was in states that had eliminated asset tests. And so, there'd be no cost to eliminating the asset test in those states."**

For those who supported greater investment in SHIP counseling to improvement education and enrollment in MSPs, they felt that the additional costs to better leverage the program would be small, relative to other changes.

> **"The Older Americans Act funding is just so insignificant in the sphere of the Federal budget. I just don't feel it requires a big offset to argue for more funding for that."**

Others felt that offsets could not be identified "bit by bit" and that the entire consideration was a critical and major undertaking that should be part of a budget reform package. Additionally, some felt that it was an activity beyond the scope of this piece of work or at least not an appropriate exercise within the key informant interviews.

Appendix D-1

> **"To me, this feels beyond the scope of the questions you're asking because when Congress starts to look at offsets, they have lots of things to pick and choose from. That don't seem to be narrowly limited to the scope of the Medicare Savings Programs or Medicaid."**

> **"Well, my answer is that it all must be part of an overall reform package. You can't do it a piece at a time; there are too many moving parts and the fiscal impact is enormous. So, again, I do not think we should do this piece meal one at a time. You've got to do it as a total package. "**

> **"This is how to pay for it. You could do taxes. Right. There's a whole slew of taxes. You could go on the table. You could look at the Medicare, the CBO budget book, and look at the savings options."**

There was some discussion of whether "savings" or offsets could be derived from the improved health of program participants because of better preventive care, and/or having a "usual source of care" which the literature does show to be associated with better health, and the like. Key informants mentioned that, traditionally, CBO does not acknowledge "medical offsets" but there may be some flexibility there.

> **"CBO for a long time wouldn't count...medical offsets. But in Part D, they eventually did agree that if people are more compliant taking their drugs, that there's a savings to be created."**

> **"...various kinds of screening and prevention things could potentially have scores hat offset."**

In closing, some felt that ultimately the changes needed to streamline the program and make the types of reforms that are needed would have to come at the Federal level with Congressional reform. They mentioned, in part, the challenges states face in dealing with these issues.

"The challenge down the state path is that a Medicaid director is maybe in the seat for two years and they must balance their budget every year. So, if an investment isn't going to pay off for 10 or more years, that is hard to sell and convince their budget offices that it's something that they should be doing."

"For both Social Security and Medicare, there's got to be some coming together on a bipartisan basis and to deal with issues like this and this should be one of those issues."

"The States and CMS can only go only so far to solve the administrative issue, but eventually Congress is going to have to come back. And I think will happen. We know that and again, in my estimation, it's going to have to be done on a bipartisan basis."

CONCLUSION

We are grateful to the individuals who shared their time and expertise with us and agreed to participate in these interviews. They all seemed genuinely engaged in the conversation and had a wide variety of perspectives to offer. Most seemed eager to continue to be involved, should the need arise, for follow-up or clarification on any of the ideas they raised.

Appendix D-2:
Key Informant Interview Invitation

AUTHOR:

Eileen J. Tell, MPH,
LeadingAge LTSS Center @UMASS Boston

Appendix D-2

I am contacting you as part of a project sponsored by Arnold Ventures and conducted by the National Council on Aging (NCOA) in collaboration with the Leading Age LTSS Center @ UMass Boston. Specifically, the project focuses on analyzing the transition from Medicaid to Medicare among low-income older adults and identifying policy options addressing the problems that these individuals encounter.

I am reaching out to you on behalf of Susan Silberman, Ph.D., the NCOA Research Team Leader for this project. A one-page summary of the project scope and activities is attached to provide additional context for my inquiry. As noted, a component of this research is to conduct interviews with a small number of key informant experts involved in this field.

Potential interviewees include Federal and state government officials, academics, and policy experts. Importantly, we also want to speak with experts on the ground, in communities who are knowledgeable about dual eligible populations and state Medicaid eligibility protocols, and enrollment criteria and processes for Medicare Savings Programs. One objective for these interviews is to identify state best practices and Federal policy options to address shortfalls and disparities in current Medicare and Medicaid policy. Paramount is identifying possible policy solutions and the offsets that are possible to make these potential solutions a reality

We plan to conduct Zoom-based interviews with key leaders and stakeholders like yourself. To that end, we would like to schedule a time at your convenience to speak with you. We will provide you with additional information about the topic areas we would like to discuss with you once we have the interview time set up. We want to be respectful of your time and appreciate in advance your willingness to help us learn from your valuable experience.

Please let me know if you can participate, or would like to talk further about the project before deciding. Please let me know if any of the times and dates proposed below might work for you. *[Options inserted here]*

I look forward to hearing from you.

Appendix D-2

KEY INFORMANT INTERVIEWS PHASE II: POLICY RECOMMENDATIONS AND OFFSETS OUTREACH

We would like your help with input for an impact analysis, as part of a project sponsored by Arnold Ventures and conducted by the National Council on Aging (NCOA) in collaboration with the Leading Age LTSS Center @UMass Boston. Specifically, the project focuses on analyzing the transition from Medicaid, particularly in expansion states, to Medicare eligibility and its less generous protections for low-income older adults. In this context, and more broadly, we are hoping to identify and evaluate policy options to increase access to Medicare Savings Programs for these and other low-income populations.

I am reaching out to you on behalf of Susan Silberman, Ph.D., the NCOA Research Team Leader for this project. A project summary is attached. As noted, there are four components to this research, including a series of key informant interviews which we have just concluded.

Now that we have gathered a wide range of suggested policy interventions, we are hoping to develop a broad sense of the relative costs and outcomes of various policy recommendations, and the ease or difficulty of implementation. We would also like to pair this with a list of potential revenue offsets that could be brought to bear to support the cost of policy changes. We are looking to construct a very general matrix with qualitative measures (e.g., high, medium, low) as a starting point for a broader discussion or listening session with policy experts like yourself at a future date.

That is where we would like your input. Your name was suggested to us as someone who could speak more specifically about these issues at the state implementation level – based on part on “lessons learned” from recent policy changes in New York, California, and Washington, and explorations in other states.

Can you let me know if you are available to speak with me on any of the following dates and times:

Name of Interviewee: _____

Position/Title:_____

Date: _____

Appendix D-3:
Key Informant Interview Protocols

AUTHOR:

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Appendix D-3

Logistics *[N.B.: these points can be made in confirmation e-mail or at outset of interview]:*

- All comments will be confidential. While we will list the names of individuals we have interviewed in the final report, no comments will be attributed to any individual.
- I may be asking a common set of questions across all interviews, in addition to some specific questions just for you. Please bear with me if some of these questions seem less relevant to your involvement in this issue.
- While the interview is mostly conversational and can flow wherever it feels natural to go, there are a small number of "closed-category" survey type questions that we would also like all respondents to answer.
- The interview is being recorded and transcribed so that we can accurately capture the nuances of the conversation when it comes time to do our analysis. This also helps us stay totally focused on being present for the conversation and not having to worry about "taking notes." [Describe the confidentiality of the transcript after the fact.]

INTRO

Review Project Summary. This is one of four components of a study of "what we can learn from low-income individuals who lose eligibility for low-income protections under Medicaid or Marketplace subsidies when they turn age 65 (and hit the "Medicare Cliff)." We want to know what program and policy solutions are available to address their needs and how to identify politically and economically feasible policy solutions.

Other components are: lit review; quantitative analysis; and storytelling.

BACKGROUND:

For the purposes of the transcript, can you please state your name, title, and affiliation?

Please tell me what your role (your organizations' role) has been regarding this issue?

DISCUSSION ISSUES:

> **"I'm going to start with a structured question and then the rest of the interview will be qualitative. We do this because we want to have one question that is consistent across all interviews."**

We define the Medicare Cliff as the point in which people who have received full/expansion Medicaid/Marketplace assistance lose that coverage upon becoming eligible for Medicare and do not receive assistance through the Medicare subsidies--i.e., the Medicare Savings Programs (MSPs) and Part D Low-Income Subsidy/Extra Help (LIS) —that can help them afford premiums and cost-sharing.

How important do you feel each of the following issues are as factors driving low-income adults toward encountering the Medicare Cliff? **Please tell me if you think it is Very, Somewhat, Not Very or Not at all Important.**

Appendix D-3

- Financial eligibility requirements for MSPs and LIS? – Income? Assets?
- Other related eligibility barriers?
- Administrative burden: state enrollment and re-certification protocols
- State technology, data
- Consumer education and awareness
- Outreach and enrollment assistance
- Other (please specify)

Which of these is most important?

POLICY SOLUTIONS*:

Let's discuss some of the policy solutions that have been mentioned in the literature. For each, please tell me what priority you would assign to that option, what you feel would be its efficacy in terms of addressing the Medicare Cliff problem and whether it would be cost-justified?

- **Reduce Administrative Burden re. Eligibility:** Have states use the same definitions of income and assets for MSP eligibility as is used for LIs. Allow SSA to transfer eligibility program data to states annually.
- **Increase Enrollment in Existing Programs:** Follow best practices used in high-enrollment states re. early notification, aggressive outreach, counselor training, improve communications materials and methods, etc.
- **Disregard/remove/raise asset/resource limit for MSP and LIS eligibility.** Only count "investment income"? Exclude retirement plan savings from asset eligibility test. Exclude disbursements from plan savings from income eligibility test.
- Allow states to use **"self-declaration"** regarding financial eligibility
- **Broaden eligibility for MSP** to "high-cost burden" low-income older adults who otherwise exceed the financial criteria
- Part B and D premium subsidy on **sliding scale basis** for individuals, like ACA, up to 400% FPL
- Raise QMB income limit to 150% or 200% of FPL. Align QMB eligibility criteria with LIS, eliminating the SLMB and QI programs Provide cost sharing relief/limits on OOP expenses
- Combine SLMB and QI with full LIS eligibility groups into one category – using same income standards for Part D LIS. Administrative simplicity
- Count assets as annuitized income, rather than eliminating asset requirement
- Some form of auto-enrollment, deeming
- Possible savings proposals to offset the cost of new spending for improved low-income protections.
- Anything else?

Appendix D-3

IF YOU WERE IN CHARGE…. What would you identify as the most important policy change? Why? What obstacles would need to be overcome to make that a reality? How would you address that?

OTHER IDEAS? CONCLUDING THOUGHTS?

*There was flexibility in the interview process for the respondent to make opening statements, address high priority issues prior to responding to these prompts, etc. Many respondents jumped in with their own thoughts on policy reforms without needing these prompts, however, we did ask all respondents about each of these ideas as raised in the literature.

January 22, 2024

Appendix E-1:

Low-Income Older Adults and the Medicare Cliff: Identifying Policy Options and Financial Offsets

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Appendix E-1

INTRODUCTION

This issue brief highlights the relative impact of various policy reform proposals specifically intended to address the Medicare Cliff. As low-income older adults relying on Medicaid become eligible for Medicare they may lose their Medicaid coverage, with its cost sharing protections, and be unable to afford Medicare premiums, deductibles, and co-payments. The Medicare Cliff occurs because of the discontinuity in eligibility criteria for people on Medicaid before age 65 compared to after age 65, where more stringent criteria apply.

As reported in the companion study, Low-Income Older Adults and the Medicare Cliff: A Data Analysis, it is important to identify policy reforms to address the needs of this population, given their vulnerability on several domains. Compared to both dually eligible and Medicare-only enrollees, they have significantly higher out-of-pocket costs, experienced greater financial resource decline, along with a worsening of their health in the two years after hitting the cliff.

In this issue brief, we report on perspectives from both the literature and interviews with policy experts regarding policy options to help low-income adults who are no longer eligible for Medicaid and Marketplace assistance subsidies, to afford the care they need as they become eligible for Medicare. Additionally, we explored options to improve access to Medicare Savings Programs (MSPs) for financially and medically vulnerable older adults who are eligible for MSPs but, for a variety of reasons, are not accessing them.

The approach we took was to use the research and interviews to identify and rate policy options in terms of whether they would likely have low, moderate or high impact and costs (i.e. programmatic and administrative). These classifications represent rough “best estimates” because precise estimates can only be provided on a state-by-state basis, as population demographics, administrative infrastructure, eligibility criteria, enrollment protocols and program costs vary across states. Our classifications are also informed by information obtained during key informant interviews with policymakers along with reviews of existing state-specific and national modeling. A more expanded and robust qualitative and/or quantitative, multi-state analysis would be an important next step to better inform these issues.

There are three major strategies for policy reform:

For the Medicare Cliff population, simply allow them to maintain Medicaid eligibility as they enter Medicare.

Improve the enrollment process for existing MSPs without changing eligibility criteria. Several studies have identified participation rates for MSPs that are well below the percent of the population estimated to be eligible for them.6 Participation rates vary both by the type of MSP program, state, and demographics. Variation by state is significant, with Georgia citing roughly 25% of eligible enrollees participating with a comparable number of 78% for Maine.[7]

[6] Popham, 2020; Feng, 2019; and Caswell, KJ and Waidmann, TA 2018.

[7] Caswell and Waidmann, 2018.

Appendix E-1

Providing equal opportunity access to MSPs based on existing eligibility rules is based on issues of equity; it may cost more in administrative expenses to enable two comparable people to have an equal opportunity to access the MSP for which they are eligible, but it is fair and equitable to enable them to do so. There may also be Medicaid savings that accrue to the states from precluding or delaying individuals from becoming dually eligible.

Changing financial eligibility criteria for Medicare Savings Programs. Several policy proposals seek to broaden access to MSPs to a larger group of financially disadvantaged Medicare beneficiaries whose income and assets exceed the current state eligibility limits but who are either already facing financial hardship because of uncovered medical expenses, or are at great risk of becoming one of the "high-cost burden" individuals (defined as those spending 20% or more of income on health care).[8] Some of the rule changes regarding eligibility would also have the effect of simplifying and streamlining the eligibility determination process, thereby reducing administrative costs. Indeed, these expansions would likely have implementation, administrative and/or program expansion costs associated with them. However, these costs may be mitigated, so some degree, by lowered administrative burdens. Additionally, there is a potential that getting people affordable access to coverage may reduce health care costs in the long-run by getting people access to the services they need sooner, thereby preventing avoidable utilization of more costly care setting such as emergency room or nursing home care. One study found that providing expanded access to home and community-based care and care coordination for individuals in "end of life" care (through having fully-funded long-term care coverage) was associated with "significantly lower health care costs at end of life, including 14% lower total medical costs, 13% lower pharmacy costs, 35% lower inpatient admission costs, and 16% lower outpatient visit costs. They also experienced 8% fewer inpatient admissions and 10% fewer inpatient days" compared to those without access to paid LTSS care (Holland, SK, et. al, 2014). A more recent study found improved memory, cognitive function, and satisfaction with life in older adults with disabilities that had fully-funded access to LTSS (Chen, 2023)

The policy rationale for expanding access to financial protection for existing and additional "financially at-risk" individuals is to avoid the personal and systemic impacts that may emerge as their access to care and health outcomes are compromised due to their inability to afford cost-sharing and care costs so that in the words of one of our key informants, "…their costs become our costs."

Some of the broader proposals with regard to changing eligibility criteria could also address the Medicare Cliff population as they would move toward aligning MSP eligibility with Medicaid eligibility.

[8] Schoen, C, et al. 2018.

Appendix E-1

IMPROVING THE ENROLMENT PROCESS

Reducing administrative burdens that cause errors, delays or disrupt the process is an important strategy for improving the enrollment process and ultimately improving program participation. Administrative burden refers broadly to "any challenge…that makes it significantly more difficult to access or maintain a benefit for which [a person] would otherwise be eligible."[9]

Some[10] of the suggestions include:

- **Outreach and Communications:**
  - Improve education, outreach, and marketing so that individuals are aware of the MSPs and how to enroll. Do this as early as possible, in advance of age 65;
  - Improve training and support available through state health insurance counseling programs/ state health insurance programs (HICAP/SHIP) and broadly publicize the free services they provide;
  - Conduct "usability" testing of consumer education and outreach materials with the target market to ensure that they are easy to understand and delivered in the variety of mechanisms consumers prefer (e.g., direct mail, public service announcements, on-line, radio talk shows, social media, SMS, and more);
  - Meet people where they are – identify trusted sources and affinity groups that can do better outreach to the most difficult to reach populations. Provide materials at community centers, faith-based organizations, public libraries, bus shelters, and more;
  - Offer a single-entry point (no wrong door), dedicated toll-free number that is adequately staffed and trained to support callers through the education and enrollment process. This should not be 1-800-Medicare which is already over-taxed and not equipped to provide anything other than general information (if that);
  - Require standardized education and communication on MSPs within Medicare Advantage (MA) Plans; and
  - Revise "Medicare & You" to address MSPs more clearly and thoroughly and direct folks to the dedicated toll-free number and/or fully dedicated MSP website where they can learn more.
- **Application Process and Data Systems:**
  - Reduce the onerous interview and paperwork application process;
  - Enhance funding and expand staffing for the agencies required to support eligibility verification, outreach, and education;
  - Improve the legacy systems, data and technology agencies rely on to identify and reach out to people about to become eligible for Medicare; and
  - Auto-enroll anyone eligible for (Low-Income Subsidy) LIS into an MSP. CMS has just adopted this proposed rule and states may follow. (It is important to note that this also incorporates a change in eligibility criteria, not just a procedural simplification, since, in the Federal eligibility allowance for LIS (150% of poverty) is less rigorous than the current income requirements for enrollment into an MSP.)[11]

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[9] Center for American Progress. How to Address the Administrative Burdens of Accessing the Safety Net. May 5, 2022.

[10] Carter, J. Medicare Rights Center. (2017). Toward Seamless Coverage. Identifying Enrollment Gaps and Opportunities in Medicare Transitions for People with Expansion Medicaid. National Council on Aging (NCOA) and Medicare Rights Center.

11 Roughly 174% of FPL in 2023. Eligibility for LIS is roughly 150% of FPL.

Appendix E-1

Improving Education and Enrollment. There are several suggested strategies for improving enrollment among eligible individuals by addressing critical problems with the way in which education and support is provided to potential enrollees. This section discusses some of the strategies identified by policy experts interviewed and suggestions from the literature.

- **Create and Share Best Practice Models for Education and Enrollment.** There is great variation across **states** in education and enrollment strategies and resource investment as well as in other obstacles to enrollment. Federal investment in dissemination of information on best practices and support for creating and sharing best practice models with states that are unable to develop them on their own could also be very helpful. As well, grant-funding to test and develop improved **Health Insurance Counseling and Assistance Program (HICAP) and State Health Insurance Assistance program (SHIP)** training, communication pieces and website material that focused on enrollment and administrative best practices would be important. State-specific considerations and involvement, however, would still be needed. We recommend that a best practice resource center evolve into or be developed by the new Office for Medicare Savings Plans within CMS.
- **Enhanced funding and support for the Health Insurance Counseling and Assistance Program (HICAP) and State Health Insurance Assistance program (SHIP)** – the primary resource for counseling Medicare beneficiaries about their plan choices – including MSP options – is required as the program is underfunded. For example, HICAP/SHIPs receive $70M in Federal funding to serve 65 million people, compared to over $90 million in financing to educators for the ACA exchange that enrolls just over 18 million individuals; in effect, HICAP/SHIPs get 25% less funding, yet they are meant to serve 3.5 times more people in a program that is far more complex.[12] While we know how many individuals enroll in the ACA (just over 18 million), and we know the disparity in funding between HICAP/SHIPs (that are mandated to counsel on much more than just Medicare, MSPs, and Supplemental or MA plans), we do not know the number of individuals utilizing either resource. That said, the policy experts with whom we spoke felt strongly that HICAP/SHIPs are understaffed and inadequately trained.
- Another suggestion is to **establish an Office** for Medicare Savings Plans within Medicare/CMS and to include an Ombudsman specifically to address consumer issues and problems with MSPs. Beneficiaries or applicants encountering difficulties and exhausting available resources (or unable to find them) at the state level, do not have anywhere to turn for access to high level support and information. One example provided was an applicant for QMB being deemed ineligible at the state level because the state's definition of "family and household" differed from recently released CMS guidelines for how those definitions should be made for the purpose of determining "household income." In this instance, the woman's adult children were living with her (but not providing any income), but their presence in the household was counted against her income-eligibility. Another beneficiary was being billed a co-pay for services from her MA plan providers, even though her QMB program excludes her from a copayment. The provider went so far as to send the matter to "collections" for the prior co-pays she was billed, but that her state-level CMS advocates told her she was not responsible for. State level advocates report they have difficulty finding this type of support on behalf of the individuals they counsel.

[12] Congressional Research Service. State Health Insurance Assistance Program (SHIP). In Focus. October 23, 2023.

Appendix E-1

Other policy reforms (discussed below) that might expand MSP eligibility such as changing or removing the asset limit, having more selective criteria for or longer durations between eligibility redetermination periods, or self-attestation approaches, would also likely increase participation rates as well as reduce administrative burden costs associated with eligibility determination. The extent to which they could be expected to expand enrollment is discussed in the section that follows.

CHANGING FINANCIAL ELIGIBILITY CRITERIA FOR MEDICARE SAVINGS PLANS.

A wide variety of proposals fall into this category, most notably including:

- Raising the asset limit;
- Removing the asset limit;
- Aligning eligibility standards and procedures across the various MSPs to promote efficiency across states and reduce program costs, and;
- Raising the income limit(s).

Some states have exercised their authority to make these types of changes (See Appendix I for a summary table of state-specific income and asset limits that differ from Federal standards.):

- States without an asset limit include: Alabama, Arizona, Connecticut, Delaware, District of Columbia, Louisiana, Mississippi, New Mexico, New York, Vermont, and Washington.
- States with higher asset limits include: California, Maine, Massachusetts, and Minnesota.
- States that use higher income limits for one or more of the MSPs include: Connecticut, District of Columbia, Indiana, Maine, Massachusetts, and New York.[13]

EVIDENCE OF POLICY REFORM IMPACTS AND COSTS

This section summarizes findings from a variety of sources that have either modelled or implemented MSP policy changes and thus shed some light on the costs and resulting changes to program enrollment and/or administrative savings. The relative ratings of impact and cost shown in Figure 1 were based, in part, on these analyses, along with input from the stakeholder interviews and insights from the additional interviews conducted specifically for this report. First, we discuss Figure 1 and then we provide a review of the literature supporting it. (It is important to note that some of the literature focuses only on implementation costs, while some analyses address changes in program costs from potentially expanded eligibility. Therefore, the cost impacts shown in Figure 1 are informed "guesstimates" both from the literature and from the ratings assigned from the policy experts interviewed for this report.)

As noted above, the impact of a policy reform considers a variety of factors: improved participation rates, reduced program complexity and administrative burden, and easier access to MSPs for those most financially in need. The implementation cost is simply the change in costs to operate the program under the new policy parameters compared to the old.

[13] Medicare Rights Center. (2023). Medicare Savings Program financial eligibility guidelines.

Appendix E-1

The ideal combination would be policy reforms that offer high impact with low costs. Improved **education and outreach**, for example, has high impact but only modest costs. **Removal of the asset test**, which is assessed as having high impact, also has high costs, thus making it a more challenging policy option. Nevertheless, such an approach may still be worthwhile given the identified potential ways to pay for it which can help offset high costs. The assignment of "low cost" to education/outreach improvements is based in part on many of the suggestions provided by insights from the literature review, key stakeholders, and policy experts. The least desirable combinations may be **raising the asset limit** – which may have "low" impact in terms of enrollment participation rates but "high" costs – and increasing the **income limit to 138% of FPL** which may have both "high impact" and "high costs." The other options fall in between with a variety of medium to high impacts on participation rates, and low or medium costs.

Along with input from our interviews with policy experts and key informants, we have also drawn on the literature to create Table 1. These findings are summarized below.

TABLE 1: Policy Reform Impacts and Costs

INTERVENTION	IMPACT*			PROGRAM & ADMINISTRATIVE COSTS		
	LOW	MED	HIGH	LOW	MED	HIGH
Improve Education & Outreach			X		X	
Strengthen HICAP/SHIP Programs		X		X		
Self-declaration and/or Less Frequent or No Re-certifications		X			X	
Address all Administrative Burdens Mentioned Above			X		X	
Auto-enroll LIS eligibles into MSP & align criteria			X			X
Remove Asset Limit			X			X
Raise Asset Limit		X				X
Income eligibility at 138% FPL			X			X

*Impact considers improvements in participation rates over current levels, reductions in administrative burdens and complexity both for program operation and applicants, and improvements in access to MSPs for those most financially and functionally in need. Program and administrative costs reflect both the cost from expanded participation and upward or downward changes to administrative costs.

In one analysis, Oklahoma officials reported estimated annual savings of $1.2 million in administrative costs after **eliminating the asset test** for families.[14] "Eliminating the asset test simplifies the application process by easing documentation requirements and reducing the need for program staff to verify information."[15] Many of the stakeholders we interviewed felt that removing the asset limit would not have a significant impact on expanding program costs from additional enrollment. As discussed below, Cohen, et al. (2023) modeled a 2% enrollment increase from removing the asset limit – the smallest impact of the various options they modelled.

Zuckerman, et. al also modeled **removing the asset limit** completely. They found it was estimated to expand eligibility to 10% more beneficiaries, although it may have its greatest impact on raising participation and enrollment rates among those who were already eligible based on resources from simplifying the enrollment and certification process.[16]

[14] As cited in Popham, L, et al. (2020). Take-Up Rates in Medicare Savings Programs and the Part D Low-Income Subsidy Among Community-Dwelling Medicare Beneficiaries Age 65 and Older. Issue Brief.

[15] Ibid.

[16] Zuckerman, S., Shang, B., & Waidmann, T. (2009). Medicare savings programs: Analyzing options for expanding eligibility. Inquiry: A Journal of Medical Care Organization, Provision and Financing, 46(4), 391–404. https://doi.org/10.5034/inquiryjrnl_46.4.391

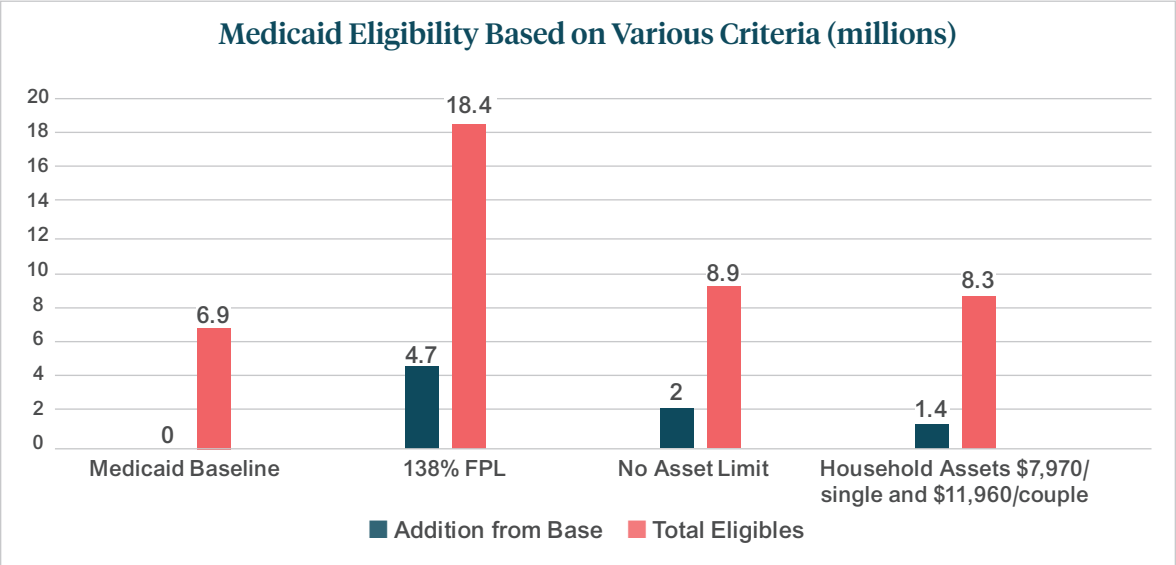
Appendix E-1

Schoen, et. al. (2015) used data from the 2010 Medicare Current Beneficiary Survey (MCBS), adjusted to reflect 2014 Medicare enrollment and spending levels, to model the impact of various policy changes. They were interested in modeling the impact on beneficiary out-of-pocket spending of providing subsidies like those provided under the ACA to low-income beneficiaries (those with incomes < 200% of FPL) and **removing the asset test** to qualify for an MSP. Essentially, this would provide a **subsidy to the Medicare Part B premium**, on a sliding-fee scale basis. The target population of Medicare beneficiaries with incomes below 200% is estimated at 20 million older adults.

Specifically, Schoen, et. al. projected that net Federal spending for the new premium subsidies and out-of-pocket cost caps would be roughly $14.6 billion, assuming full enrollment. This would be offset by an estimated $19-20 billion in savings to beneficiaries with low-incomes. Other options for reducing the impact on Federal spending would be a phase-in of these changes, or limiting the changes to individuals with incomes of less than 150% of FPL.

Zuckerman, et.al also looked at how the population eligible for an MSP would change with various policy changes around eligibility. They concluded that expanding eligibility to **200% of FPL** would bring in elderly beneficiaries who are more likely to be in fair or poor health, to have diabetes or lung disease, or to be in a racial or ethnic minority, as compared to than an expansion achieved by **removing resource requirements**. This underscores the importance of modeling not only the size of the impact of policy changes, but also the cost implications and the specific socio-demographic characteristics of the Medicare population that would be impacted by the proposed change. The policy change can be most cost-effective if it can be implemented with less administrative cost, can result in good participation rates, and can reach the population most at risk of a high-cost burden and/or most vulnerable to problems with care access.

Cohen and Tavares[17] also evaluated changes in financial eligibility rules (for Medicaid), focusing both on the number and the associated socio-demographic characteristics that change under alternative financial eligibility thresholds.



[17] Cohen, MA and Tavares, J. (2023). How Medicaid Financial Eligibility Rules Exclude Financially and Medically Vulnerable Adults. Journal of Aging & Social Policy, DOI: 10.108/08959420.2195784.

Appendix E-1

Shown above, the largest impact on enrollment – an increase of 4.7 million individuals – comes from **increasing eligibility based on income to 138% of FPL**. Changes in the **asset limit (either removing it or raising it)** have a much lower impact. Additionally, removing the asset limit entirely has the advantage of reducing program administrative and re-certification costs. Comparing health and economic characteristics of the populations under the alternative eligibility criteria with the current Medicaid population, Cohen and Tavares find that the reduced asset and expanded income eligibility criteria extend the reach of Medicaid to a greater share of those with cognitive impairment, but who are otherwise comparable on other health measures.

COST OFFSETS

All the strategies designed to expand access to MSP benefits come with a cost. Identifying feasible budget "offsets" to pay for such reforms is often required to obtain bipartisan support for proceeding with the change. In this section, we summarize information from the literature and include learnings from key informants to begin to lay out possible cost offsets to some of the policy proposals designed to expand access to the program.

Given that the enhancements we propose would be to Medicare and Medicaid, we focused on those programs for potential savings. Within Medicare, one opportunity mentioned was reducing provider payments. Additionally, other options include reducing provider taxes, addressing supplemental payments, and intergovernmental transfers. Other sources for offsets citing the costs of policy reforms that were mentioned in the key informant interviews were tied to Medicare Part D.

The literature references significant overpayments that are made to Medicare Advantage plans that could be re-allocated to other purposes. One mentioned shifting those payments to enable traditional Medicare to cover dental and vision care.[18] A study by the Physicians for a National Health Program estimated 2022 overpayments to MA plans of between 22 and 35%, translating to "between $88 billion and $140 billion more than it would have been if those beneficiaries remained in traditional Medicare."[19]

Also, in our interviews, several key informants identified savings from Medicare Advantage that should be captured

"I think I would start looking at the Medicare Advantage program. I think there's been substantial overpayment to MA plans over the years. MA plans certainly enroll a lot of low- income seniors. So, I think that's even got a logical connection. We shouldn't be over paying them."

"There's overpayment in Medicare Advantage...I wholeheartedly subscribe to that. There are resources that could be redirected there."

Another strategy for leveraging offsets from Medicare Advantage is to impose greater educational requirements on MA plans regarding MSPs as part of their enrollment process.

[18] Sullivan, K. Medicare Advantage is a money grab by Big Insurers. Minnesota Reformer.com. November 2023.

[19] Physicians for a National Health Program. Their Profits: Our Payments. Quantifying Overpayments in the Medicare Advantage Program. October 2023. (The report identifies five causes of the MA overpayments.)

Appendix E-1

Along these same lines, the Kaiser Family Foundation reports that a large and growing portion of Medicare payments are made to Medicare Advantage plans – presently at $361 billion which represents an increase from 26% of Part A and B spending in 2011 to 47% in 2021. By 2031, payments to Medicare Advantage plans are expected to represent 60% of Medicare spending - $943 billion; Medicare pays more for beneficiaries in MA plans than for those in traditional Medicare[20] This is not only because enrollment in MA plans over traditional Medicare is growing. "Medicare pays more to private Medicare Advantage plans for enrollees than their costs would be in traditional Medicare…and these higher payments have contributed to growth in spending on Medicare Advantage."[21] Payments are currently estimated to be 104% of what traditional Medicare would have spent on the same beneficiaries. Furthermore, MA plans may be associated with more efficient health care utilization patterns and are reported to have 17% higher administration costs than traditional Medicare. This translates to a lower percent of Medicare dollars going to consumers in benefits, in which case, neither the Medicare program nor consumers benefit. (That said, it is important to determine whether the care coordination and care management that MA plans may provide is accounted for in the administrative vs. the medical portion of the loss ratio.)

Another source for funding to support enhanced education and enrollment is to reallocate Federal funding for health insurance counseling and education away from the ACA/exchange education enrollers to the HICAP/SHIP program. The idea is to provide specific support of MSP education and enrollment. We cannot know for certain whether this means we are over-spending on the ACA side for consumer education, but based on feedback from the stakeholder and key informant interviews, there is insufficient support for HICAP/SHIP program education for the Medicaid and Medicare choices consumers face.

It should not be forgotten that participation in MSPs leads to greater discretionary income for enrollees who no longer must pay premiums and/or co-payments for medical care. Having additional income may well lessen the burden on other state subsidy programs such as housing, food, and more. California expanded income eligibility for the MSPs, including raising the income limit from 135% to 186% of the FPL for Qualifying Individuals (QI) and to 138% of the FPL for Qualified Medicare Beneficiaries (QMB) to assure alignment between Medicaid and QMB eligibility. The state had already eliminated the asset limit for MSP; based on modeling completed in 2018, up to 500 individuals became newly eligible for MSP, and the estimated savings to enrollees were at least $3,700 annually per person.[22] Administrative savings from eliminating the asset test were estimated at just under $4 million.[23] This study did not report on savings to the state or Federal government; the purpose was to demonstrate that policy changes can impact out-of-pocket costs for beneficiaries which in turn can trickle down to savings for other state support programs such as food stamps, subsidized housing, and other social support programs.

[20] Cubanski, J and Neuman, T. (2023). What to Know about Medicare Spending and Financing. KFF. https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/

[21] ibid

[22] Florez, G, Ayeh, D. and Shyken-Rothbart, B. Increasing Access to Medicare Savings Programs. Lessons Learned and Policy Recommendations from New York. Medicare Rights Center. 2023.

[23] Department of Health and Community Services. MediCal Asset Limits Supplemental Report. March 2020.

Appendix E-1

Additionally, Arizona eliminated the asset test in its Health Care Cost Containment System[24] and found that even as the number of eligible participants in the program increased, administrative and programmatic savings also accrued to the program. These derived from reduced postage and forms costs; reduced application processing time; improved customer service/satisfaction; and improved quality control leading to reduced error rates because of the simplified eligibility process.[25]

Many of the policy reforms put forward would lower administrative costs. Key informants pointed out that savings would result from the administrative simplification associated with enrollment efficiencies, removal of the asset test, allowing self- declaration, and improving the counseling and automation process. Others mentioned that the aggregate cost impact of removing the asset test would be mitigated by the fact that a good number of states have already done so. Until more detailed modeling is done, however, it is not clear to what extent these cost savings offset in whole or in part the additional costs associated with improved participation rates.

In a 2018 issue brief from the Commonwealth Fund, the authors estimated costs and savings associated with the following policy reform: set the **out-of-pocket limit at $2,000** and provide Part B premium subsidies for those with **incomes up to 150% of FPL**. These options were chosen to specifically address concerns with low-income beneficiaries who spend 20% or more of their income on health care. They estimate that these changes would lead to an additional 8 million beneficiaries who would experience close to $12 billion in savings from reduced premiums and care costs. The estimated annual Federal costs to support these policy changes was $8.4 billion, with the premium subsidy representing the largest component.[26] Additional options for reducing costs would be to phase the program in overtime and to consider other revenue options like cigarette and alcohol taxes, savings on prescription drugs, value-added taxes on luxury goods, and the like.[27]

There are also opportunities to attain budget neutrality using non-health care related offsets, many of which are identified in the Congressional Budget Office (CBO) report: Options for Reducing the Deficit, 2023 to 2032. Volume I: Larger Reductions and Volume II: Smaller Reductions. December 2022. Some examples include areas previously referenced, such as reducing Medicare Advantage benchmarks (projected to release $392 billion), limit charitable giving tax deductions ($257-$272 billion), increase alcohol tax ($92-$114 billion), and excise tax on tobacco products ($42 billion).

The prevailing perspective of policy experts and key informants was that offsets cannot be identified “bit by bit.” Ultimately, the changes needed for program improvement would have to come at the Federal level with Congressional reform and for such an effort to be successful, consensus on the policy objectives and goals need to be prioritized -- the most prevalent among them being improving health care access to those traditionally disadvantaged, reduced medical expenses as a percent of income for low-income individuals, reduce Medicaid costs, reduce state administrative costs and reducing health care cost burdens.

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[24] Arizona does not have a Medicaid program, but instead has the Arizona Health Care Cost Containment System

[25] Department of Health and Community Services. MediCal Asset Limits Supplemental Report. March 2020.

[26] Schoen, C, Davis, K, Willink, A and Buttorff, C. A Policy Option to Enhance Access and Affordability for Medicare’s Low-Income Beneficiaries. Issue Brief September 2018. The Commonwealth Fund.

[27] Ibid.

Appendix E-1

NEXT STEPS

This issue brief has raised several issues about both the policy objectives and reform options, along with possible revenue sources, for addressing the Medicare Cliff and improving Medicare Savings Plans (MSPs). While there have been several data simulations and modeling of the outcomes and costs of various policy pathways, each has taken a different approach, some are out of date, and none have been conducted in a collaborative and broadly participatory approach. Specifically, while there have been some state-by-state studies, there has not been a national analysis of these issues.

A productive next step could be to convene a working policy forum, bringing together a variety of experts from states, think tanks, advocacy organizations, consumers, and academia. A facilitated workshop could help identify and prioritize policy objectives and policy reforms. Following that, a new modeling analysis, drawing on the insights and oversight of the policy forum, could be commissioned.

Additionally, a parallel effort to identify, develop and disseminate best practices regarding education, enrollment and SHIP training and support is needed. Development of a Technical Assistance resource center, drawing on the success of best practice states and including the experience and input of beneficiaries, would offer valuable assistance to states that do not yet have the resources or protocols needed to improve outreach and education.

Appendix E-2:
Discussion Guide for Policy Options and Financial Offsets

Appendix E-2

A. INTERVIEW GUIDE: POLICY REFORM AND OFFSETS

[This was sent out to participants in advance of the call]

Here are some of the questions we would like to address:

1. What evidence do we have from existing states that have implemented policy reforms regarding the cost savings (administrative costs), cost impacts (in terms of expanded enrollment) and the socio-demographics of the additionally enrolled population?
2. How have these states "paid for" these changes – find the budget to support additional participation in MSP?
3. Are there other policy reforms not listed on this chart that should be?
4. How would you rank these reforms in terms of "impact" and "cost?" Also, while not shown on the table, what impact would these have if no program administrative costs?
5. At the state level, what other "offsets" or "pay for" should be considered to make these policy changes?
6. At the Federal level, where should or can the money come from to support expanding and improving outreach, education, SHIP counselor training, a Federal/grant-supported "best practice" effort and more?
7. What are good next steps for expanding this conversation, generating cost estimates and viable policy recommendations for how to pay for change?

This is the matrix we would like to discuss and get your input on.

INTERVENTION	IMPACT*			COST		
	LOW	MED	HIGH	LOW	MED	HIGH
Improve Education & Outreach						
Strengthen SHIP Program						
Self-declaration and/or Less Frequent or No Re-certifications						
Address all Administrative Burdens Mentioned Above						
Auto-enroll LIS eligibles into MSP & align criteria						
Remove Asset Limit						
Raise Asset Limit						
Income at 138 percent FPL						

*Impact considers improvements in participation rates over current levels, reductions in administrative burdens and complexity both for program operation and applicants, and improvements in access to MSPs for those most financially and functionally in need.

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