Evolution of Medicaid Coverage of Medicare Cost Sharing

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State Medicaid agencies are required to assist low-income Medicare beneficiaries to pay Medicare cost sharing, defined as premiums, deductibles, and coinsurance, as follows: all cost sharing for those below the Federal poverty level (FPL) and otherwise qualifying; Part B premiums for persons with incomes 100-120 percent of FPL; all or a portion Part B premiums for persons 120-175 percent of FPL, limited by funding availability; Part A premiums for persons with disabilities who have worked their way off Social Security and whose incomes are below 200 percent of FPL. States also have the option to extend additional protections or to cover additional Medicare beneficiaries beyond what is mandated by Federal law. Obviously, Federal changes in Medicare may have profound, if not always anticipated, implications for Medicaid. Understanding how current policy on dually eligible beneficiaries came into being may help shape what it will become.

INTRODUCTION

Medicaid has subsidized Medicare cost sharing for certain low-income Medicare beneficiaries since the two programs were enacted as part of the Social Security Amendments of 1965. The complexities of the original Medicare "buy-in" have been added to as Federal policies have evolved through a series of incremental expansions. Each of these increments may be more readily understood as the result of the influence of short-term budget constraints and the need for political compromise at the time than as the product of an overarching policy design. The purpose of this article is to enhance understanding of current policy on dually eligible Medicare-Medicaid beneficiaries by allowing it to be viewed through the lens of history as it developed over the last 3 decades.

ORIGINAL BUY-IN IN 1965

Medicaid coverage of Medicare cost sharing for persons who are eligible for both programs was part of the Social Security Amendments of 1965, which created both programs. Medicare was designed as a Federal program serving individuals without regard to their income who are entitled by virtue of their past work and payments into the Social Security system. Such individuals receive inpatient hospital, skilled nursing facility, home health, and other services under Medicare Part A, while Medicare Part B covers physician and certain other outpatient services. The split resulted from political jousting between hospitals and physicians. From the outset, Medicare beneficiaries have been expected to pay Medicare cost sharing, consisting of a premium to obtain Part B (and in limited instances, for Part A), as well as front-end deductibles and coinsurance when a person uses Medicare-covered services.

By contrast, Medicaid is a joint State-Federal partnership administered by States under broad Federal guidelines and which pays for a range of mandatory and optional health services for certain categories of individuals who are poor. Medicaid coverage

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overlaps considerably with Medicare coverage, for example, both cover inpatient hospital and physician services.

In crafting the original buy-in, Congress recognized that low-income persons entitled to both Medicare and Medicaid would have no personal incentive to pay out-of-pocket for the Medicare Part B premium, since they could obtain virtually the same kind of services under Medicaid without paying a premium. It also recognized that beneficiaries might enjoy superior access to services under Medicare, with its broader provider participation, than under Medicaid, with its stigma as a welfare-related program. However, Congress was loathe to impose a mandate on State Medicaid programs to pay the Medicare Part B premium.

The result was that Congress gave State Medicaid agencies two options. States could pay for physicians and other Part B-like outpatient services directly when a dually eligible beneficiary obtained these as a Medicaid service. The costs in this case would be shared with the Federal Government according to the State's usual matching percentages. Alternatively, States could choose to pay the Medicare Part B premium for dually eligible beneficiaries. In this case, Medicare became the primary payer of covered services. This option should have been attractive to States because premium payments financed less than one-half the total costs of Part B benefits, with the remainder subsidized by Federal general tax revenues.

Special Federal Matching Provisions

While States had a choice in how to cover outpatient services for dually eligible beneficiaries, Congress provided an incentive, albeit a negative one, to induce States to buy dually entitled Medicaid beneficiaries into Medicare. That is, States were to be penalized by a loss of Federal Medicaid matching payments if a State paid directly for a Medicaid service that could have been paid by Medicare if the Medicaid eligible had been enrolled in that program.

In addition, Federal matching to States is available at the State's usual matching rate only for Part B premiums paid on behalf of "cash recipients." For the most part, these are Medicaid eligibles who receive income support from the Federal Supplemental Security Income program, (SSI). States were authorized to pay for Part B premiums for "non-cash recipients." These are typically people in nursing homes or medically needy who have too much income to qualify for SSI but who nevertheless qualify for Medicaid under a non-SSI eligibility category. However, if States chose to buy-in for non-cash recipients, the State could not claim Federal matching funds but instead financed the cost entirely with State funds.

The "cash"-"non-cash" distinction has no exact operational parallel in any other part of Medicaid. Congress' general idea was to steer States more strongly to covering the poorest of the poor—to those so poor that they qualify for publicly funded income support. However, practical problems in distinguishing cash from non-cash individuals have raised doubts about the accuracy of State claims for Federal match for non-cash recipients and of State or Federal identification of claims that should not be matched because Medicare would have paid if the person had been enrolled in Medicare.

Buy-in as an Administrative Mechanism

As used in the previous discussion, buy-in has referred to the general practice of State Medicaid agencies paying Medicare Part B premiums. The term is also used by some in a more limited sense to refer to the

option States have to enter into a buy-in contract that involves States, the Social Security Administration (SSA), and the Department of Health and Human Services (DHHS), under which dually eligible beneficiaries are automatically enrolled in Medicare and under which States pay their share of premium costs to the Federal Government. This administrative arrangement continues today, and has been expanded to qualified Medicare beneficiaries (QMBs).

The advantage for persons enrolled in Medicare under this buy-in administrative arrangement is that they can be enrolled without regard to Medicare limitations on when a person may enroll or premium surcharges that would otherwise apply in cases of late enrollment.

States may use this administrative arrangement for Part B, Part A, or both. All States have chosen to use this administrative arrangement for Part B for cash recipients and for QMB and specific low-income Medicare beneficiaries (SLMBs). About one-half use it for non-cash recipients who have too much income to qualify as an SSI recipient or as a QMB or SLMB.

Buy-in to Part A affects far fewer people than buy-in for Part B. Elderly and disabled people who receive Social Security benefits are entitled to Medicare Part A without having to pay a premium. However, a minority of elderly persons have insufficient work history and therefore do not qualify for Social Security. Such individuals can nevertheless obtain Medicare Part A by paying a premium ($309 per month in 1998). If they qualify for Medicaid, States may use buy-in to enroll them and to pay this amount on their behalf. About 37 States use the buy-in administrative arrangement to pay the Part A premium.

The remaining States use what is called the "Group Payer" method. The significance for affected beneficiaries is that, while the State is obligated to eventually pay their premium, it is up to them to get enrolled in the first place. Without the protections afforded by the buy-in administrative agreement, the individual is potentially subject to enrollment limitations and premium surcharges for late enrollment which the individual may not be able to surmount.

1986 OPTIONAL EXPANSION

The Omnibus Budget and Reconciliation Act of 1986 (OBRA 86) permitted States to provide Medicaid benefits to higher income persons if they:

- Were elderly or disabled.
- Were entitled to Medicare Part A.
- Had income not in excess of 100 percent of FPL.
- Had resources not in excess of the SSI resource level (currently $2,000 for an individual, $3,000 for a couple).

This option essentially allowed States to provide benefits to elderly and disabled persons with income in the band between SSI (about 70-80 percent of FPL) and 100 percent of FPL.

States provide either of two Medicaid benefit packages to this group: They could limit coverage to Medicare cost sharing (premiums, deductibles, coinsurance) for persons meeting the new eligibility criteria who were not otherwise entitled to Medicaid, or they could, in addition to Medicare cost sharing, provide full Medicaid benefits to the same extent as all other Medicaid eligible elderly and disabled people.

OBRA 86 also allowed States to provide Medicaid to higher income pregnant women and children with incomes below

variable percentages of FPL. States that wanted to cover poverty-related elderly and disabled were prohibited from doing so unless they also covered poverty-related pregnant women and infants.

This option continues today. As of 1993, 16 States elected this option. These States get Federal matching funds at the usual rate for spending on this group.

MANDATORY QMBS IN 1988

The Medicare Catastrophic Coverage Act (MCCA), enacted in 1998, required States to cover qualified Medicare beneficiaries or QMBs. Although most of the MCCA was subsequently repealed, Congress chose to retain the QMB mandate.

Eligibility criteria for QMBs are the same as for the poverty-related group described earlier, except that the limit on resources was increased from 100 percent to 200 percent of SSI limits on resources. The mandate was phased in. (MCCA mandated similar eligibility expansions for children and pregnant women.) Congress limited the Medicaid benefits for QMBs to Medicare cost sharing, that is, Medicare premiums for Part B (and Part A in the limited instances previously described), deductibles, and coinsurance. Medicaid spending for QMBs is matched at the usual Federal-State percentage rate for each State.

The assumption behind this provision of MCCA was that the cost of these Medicaid expansions would be offset by reductions in other Medicaid spending. For example, had MCCA not been repealed, the addition of a prescription drug benefit to Medicare would have caused a reduction in Medicaid spending on this benefit for dually eligible beneficiaries. However, with the repeal of MCCA a year after its enactment, the promised Medicaid savings disappeared while the Medicaid expansions and their costs remained.

Refinements in the Definition of QMBs

The definition of QMBs was subsequently switched by the Technical and Miscellaneous Revenue Act of 1988, from exclusive (limited to those meeting the criteria and otherwise ineligible for Medicaid) to inclusive (anyone meeting QMB requirements, even if otherwise eligible, e.g., as an SSI recipient or as medically needy). The purpose of this change was to avoid requiring people to switch eligibility categories every time their incomes changed. Switching categories could cause lapses in coverage for administrative reasons, even though the person continued to have income and assets below QMB levels. As a result, it is now possible for a person to meet the eligibility criteria for more than one eligibility category, causing considerable confusion and problems with enumeration due to inconsistent use of terminology and application of eligibility labels. For example, by definition, SSI recipients meet QMB criteria. However the manner in which such individuals are labeled for counting purposes is not consistent among all the States, and is the cause of frequent confusion about how many QMBs are being served by Medicaid.

THREE CHANGES IN OBRA 89

Medicare "Balance Billing" Changes

In OBRA 89, Congress amended Medicare to require that Medicare Part B providers treat dually eligible beneficiaries, including QMBs, on an assignment-related basis. This meant that providers were prohibited from balance billing their low-income Medicare beneficiaries. A beneficiary is balance billed if the provider sends the beneficiary a bill that exceeds the beneficiary share of the Medicare rate. For example, if the Medicare rate for a ser-

vice is $100, of which Medicare pays $80 and beneficiary coinsurance in $20, then the provider who bills the beneficiary for more than $20 has balance billed. However, this provision did not prohibit providers from continuing to bill beneficiaries for the 20 percent coinsurance, even if the beneficiary was eligible for Medicaid. Of course, providers could elect to bill Medicaid for that coinsurance, thus relieving the beneficiary of any exposure to out-of-pocket costs, but the law did not require them to do this.

Buy-in Administrative System for Part A

OBRA 89 also gave States the option of using the buy-in administrative mechanism, that had long been in place for Part B premiums, for Part A premiums. Where States use this system for Part A, beneficiaries are protected against enrollment limitations and premium surcharges provisions penalties for late enrollment in Part A just as they are for Part B.

New Benefit for QDWIs

OBRA 89 amended law on Medicare entitlement of disabled persons who return to work. Before these changes, disabled beneficiaries who returned to work risked the eventual loss of both Social Security and Medicare if their earnings from work were substantial enough to cause them to be considered no longer "disabled." This threat existed even for those who had not experienced any change in their medical condition but who nevertheless had employment potential. OBRA 89 responded to assertions that many disabled people would be able and willing to work their way to independence from Social Security if they could be assured of continued Medicare coverage. Given that the need for health care services is well above average for this population, opportunities for obtaining adequate private health insurance coverage at a reasonable cost were low. OBRA 89 provided this assurance of continuing health care coverage but at a cost. Persons with disabilities whose work activities cause them to lose Medicare and Social Security could have access to Medicare Parts A and B, but only by paying the premiums for both Parts.

Since working individuals with disabilities at low end of the income scale could arguably ill afford such an amount, Congress imposed a new mandate on States to pay for Medicare Part A premiums (but not Part B) for a new group called qualified disabled working individuals (QDWIs). To qualify as a QDWI, a person must have lost Social Security due to work, still have the disabling condition, have income below 200 percent of FPL, and resources below 200 percent of SSI limits.

OBRA 90 ELIGIBILITY EXPANSIONS

OBRA 90 incrementally expanded the mandate for Medicaid coverage of Medicare cost sharing by creating a new Medicaid eligibility group called SLMBs. In effect, SLMBs are just like QMBs except they have slightly more income and Medicaid covers less of their total Medicare cost-sharing liabilities.

SLMBs meet the same eligibility criteria as QMBs, except that Congress set the SLMB income level at 120 percent of FPL. The Medicaid benefit for persons meeting SLMB (but no other Medicaid eligibility) criteria is limited to just the Part B premium. Federal matching funds are provided to States at the usual match rate for spending on premiums for SLMBs.

In addition, OBRA 90 increased QMB/SLMB eligibility protection by requiring States to disregard annual Social Security cost-of-living adjustments (COLAs).

That is, in comparing a person's income to the relevant income eligibility threshold, a State would first subtract from the person's total income amounts equal to the current and certain former Social Security COLAs. This provision, similar to several other mandatory COLA disregards, ensures that individuals are not harmed under one public program—Medicaid—due to an improvement in their benefits under another Federal program—Social Security.

OUTREACH REQUIREMENT IN 1994

The Social Security Act Amendments of 1994 required the Secretary of DHHS to establish a method for obtaining information useful to a QMB eligibility determination and for transmitting it to States. This requirement was a response to congressional concern over reports that many individuals who are eligible for Medicaid assistance with Medicare cost sharing are not receiving the benefits.

BBA ELIGIBILITY AND PROVIDER PROVISIONS

Expansion to Qualifying Individuals

The Balanced Budget Act of 1997 (BBA) added a further incremental expansion of Medicaid coverage of Medicare cost sharing for two groups of qualifying individuals (QIs). However, in response to State concerns about unfunded Federal mandates, BBA adopted a different approach to financing the program, and it permitted States to employ restrictions on enrollment procedures that are unique to this new eligibility group.

Under this expansion, States must pay for Medicare Part B premium assistance as follows:

- QI-1s—These are individuals who would be eligible as QMBs or SLMBs except that their income is in the range of 120-135 percent of FPL. Their sole Medicaid benefit is coverage of the Medicare Part B premium.
- QI-2s—This new Medicaid eligibility group consists of Medicare beneficiaries with incomes between 135-175 percent of FPL who meet all other QMB eligibility requirements. The Medicaid benefit for this group consists only of the increase in the Part B premium that will occur due to another BBA provision that shifted the cost of Medicare home health benefits from Part A into Part B. The cost of this shift will be fully phased in to the Part B premium in 2004.

Financing Limits on QIs

Financing of the QI benefit was capped both in terms of dollars and time. The BBA authorized a total of $1.5 billion to be allocated over 5 years ($200 million in 1998, $250 million in 1999, $300 million in 2000, $350 million in 2001, $400 million in 2002). After 2002, the program will continue only if Congress reauthorizes it.

Each State's allocation is based on the Secretary's estimate of the sum of twice the number of Medicare beneficiaries with incomes of 120-135 percent of FPL, plus the number of such beneficiaries with incomes between 135-175 percent of FPL, relative to the sum for all States.

To avoid imposing an unfunded mandate on States, Congress provided for the Federal share of QI spending to be 100 percent. If a State spends more than its allocation, there is no authority for Federal matching for that excess spending. The State is fully liable for the excess spending.

Enrollment Restrictions on QIs

States must permit all who qualify as either a QI-1 or QI-2 to apply. However, because the constraints on Federal funding

for QIs are unique to Medicaid, Congress also gave States the tools to limit the number of QIs served in a given year so that the State may keep aggregate costs from exceeding the State's allocation in that year. Selection by States is on a first come-first served basis. Persons selected to receive assistance in a calendar year are entitled to receive assistance for the remainder of the year if they continue to qualify, and if there are still amounts remaining in the State's funding allocation for this program. There is no guarantee that a person who receives benefits as a QI in 1 year will continue to receive them the next, even if they continue to meet the eligibility criteria. However, in selecting persons who will receive assistance in years after 1998, States must give preference to persons who received assistance in the last month of the previous year.

Payment Rates for Cost Sharing

Prior to the BBA, the courts in a number of jurisdictions had ruled that States had to make payments for services to QMBs based on the full Medicare rate, which is often higher than the rate paid by States for Medicaid-only recipients. To illustrate, assume the Medicaid rate for a particular service was $75 and the Medicare rate for the same service was $100. Medicare would pay $80 and, according to certain courts, States in their jurisdiction were obliged to pay the beneficiary cost-sharing amount of $20. The provider in this instance would receive a total from both programs of $100 for a QMB—more than the $75 that the State would pay for a Medicaid-only eligible who was not entitled to Medicare.

The BBA clarified that States have the option to pay the full Medicare cost-sharing amount for deductibles and coinsurance or to limit their payments to amounts that, when added to the amount paid by Medicare, equal the amounts that the State pays for the same service when provided to Medicaid beneficiaries who are not entitled Medicare. In cases where the Medicaid rate is significantly lower than the Medicare rate for the same service—as in the oversimplified example previously mentioned—this new provision could result in Medicaid making no payment at all for Medicare cost sharing because the provider would already have received a Medicare payment that matched or exceeded the Medicaid rate.

The BBA provision applies explicitly to coverage of cost sharing for QMBs, and not to cost sharing for other groups of dually eligible beneficiaries. This State flexibility in setting payment rates for QMBs now matches the flexibility States have always had to use Medicaid-based payment rates for Medicare cost sharing for such non-QMB dually eligible beneficiary groups such as higher income persons in nursing homes or qualifying as medically needy.

Restrictions on Medicare Providers

The BBA completed the OBRA 89 beneficiary protection against balance billing by requiring Medicare providers to consider whatever amount they are paid by a State Medicaid program for Medicare cost sharing to be payment in full for any QMBs that they serve. Under the BBA amendment, QMBs are relieved of the liability to pay any Medicare cost sharing to any Medicare providers or Medicare managed care entities, whether those providers participate in Medicaid or not. Providers or managed care entities are subject to sanction if they charge beneficiaries for any cost sharing at all.

SSA OUTREACH DEMONSTRATION

The most recent congressional action regarding dually eligible beneficiaries responded to widely circulated reports that many who could qualify for Medicaid assistance are not enrolled. One explanation advanced by advocates is that Medicare beneficiaries who potentially qualify for one of the Medicaid eligibility groups do not come forward to apply because they lack knowledge about Medicaid or because they are unfamiliar with or reluctant to pursue an application through the State welfare structure, which typically administers Medicaid eligibility. Since SSA is more familiar to and more favorably viewed by beneficiaries than State welfare offices, advocates believe that greater involvement by SSA would increase the number of elderly and disabled people enrolled in Medicaid. To test this assumption, Congress appropriated $6 million in the Omnibus Consolidated Emergency Supplemental Appropriations for SSA to establish Federal-State partnerships and to evaluate various approaches to greater SSA involvement in outreach and the enrollment process for dually eligible beneficiaries.

CONCLUSION

Low-income elderly and disabled individuals are arguably among the Nation's most vulnerable. Their health care needs and consumption of services are greater than average, and they face higher than average obstacles, both financial and organizational, in obtaining the medical and related services they require. This article has attempted to make sense of one small piece of the total picture—how low-income Medicare beneficiaries may qualify for relief from Medicaid for their out-of-pocket health care costs. Other issues related to dually eligible beneficiaries are even more challenging: how to improve outreach and enrollment, how to coordinate actual provision of services under the two systems, and how to ensure seamlessness for such special subgroups as dually eligible beneficiaries in managed care or in long-term care. Improved understanding is essential to figuring out how to improve how we deliver and pay for health care for this group. Finally, Medicare reform cannot succeed unless it is based on a firm grasp of this special group.

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