By Diane Rowland

The **Medicare** and **Medicaid Partnership** at Age **50**

These two programs combined have made good progress on increasing access to care and reducing health disparities, but work remains, especially in long-term-care coverage.

Medicare is a critical source of coverage for our nation's older adults and for people with disabilities. Medicare provides health insurance protection and enables access to medical care for 54 million beneficiaries (U.S. Department of Health and Human Services, 2015). However, the coverage Medicare provides comes with premium and cost-sharing requirements as well as gaps in covered benefits, especially for long-term services and supports (LTSS). As a result, Medicare coverage often is supplemented by additional coverage from retiree benefits, Medigap policies separately purchased, and, for low-income beneficiaries, Medicaid. This article focuses on how Medicare and Medicaid work together for Medicare's low-income beneficiaries.

Income and Health Challenges for Medicare Beneficiaries

Most people with Medicare live on modest incomes. Many struggle on limited fixed incomes, often relying solely on Social Security payments, with little flexibility to accommodate an unexpected or extra cost for medical care. One out of every two Medicare beneficiaries lives on an annual income of less than $23,500, while more than four in ten (42 percent) Medicare beneficiaries live on less than $20,000 a year, and 12 percent struggle on less than $10,000 annually. Black and Hispanic beneficiaries, people ages 85 and older, non-elderly beneficiaries with disabilities, and women are disproportionately counted among the low-income Medicare population (Kaiser Family Foundation, 2014). These low-income older adults and disabled Americans depend upon Medicare for their basic healthcare needs, but Medicare alone is not sufficient to protect them from financial burdens associated with needed medical care. Gaps in the scope of Medicare benefits, combined with Medicare's financial obligations for premiums and cost-sharing, can result in onerous financial burdens.

Low-income Medicare beneficiaries are particularly vulnerable because they are more likely to experience health problems requiring medical services and ongoing care than those who are better off economically, but less able to afford needed care. Among individuals and couples on Medicare living on less than $20,000 per year, more than one-third rate their health as fair or poor, and nearly one-third have five or more chronic conditions. More than four in ten have cognitive or mental impairments and about the same share have one or more functional impairments (see Figure 1, page 36). Beneficia-

ries living on more than $20,000 annually tend to be in better health; they are less likely to have cognitive or mental impairments, functional limitations, or five or more chronic conditions.

Even routine care for physician visits or prescription drugs can require beneficiaries to make hard choices between needed health services and basic necessities (Kaiser Family Foundation, 2011). For those who need medical care and incur large out-of-pocket expenditures, medical expenses can lead to impoverishment. It is not surprising, therefore, that lower income beneficiaries are more likely than higher income beneficiaries to report delaying medical care because of cost. Specifically, 18 percent of beneficiaries with incomes below $20,000 said they delayed care during the year due to cost—more than three times the rate reported by those with incomes of $40,000 or higher (see Figure 2 on page 37). Similarly, greater shares of lower income than higher income beneficiaries report that they experience trouble getting healthcare services, forego a needed doctor visit, and have no usual source of care. Considering these findings, the extent to which additional coverage is available to supplement Medicare and assist with medical bills is a critical factor in how well Medicare works for its lowest income beneficiaries (Cubanski et al., 2014).

The Evolution of the Medicare–Medicaid Partnership

With the enactment of Medicare in 1965, basic health insurance coverage for hospital care, physicians, and related services was provided to nearly all elderly Americans. (Medicare coverage was extended to individuals with disabilities younger than age 65 with the 1972 Social Security

Figure 1.

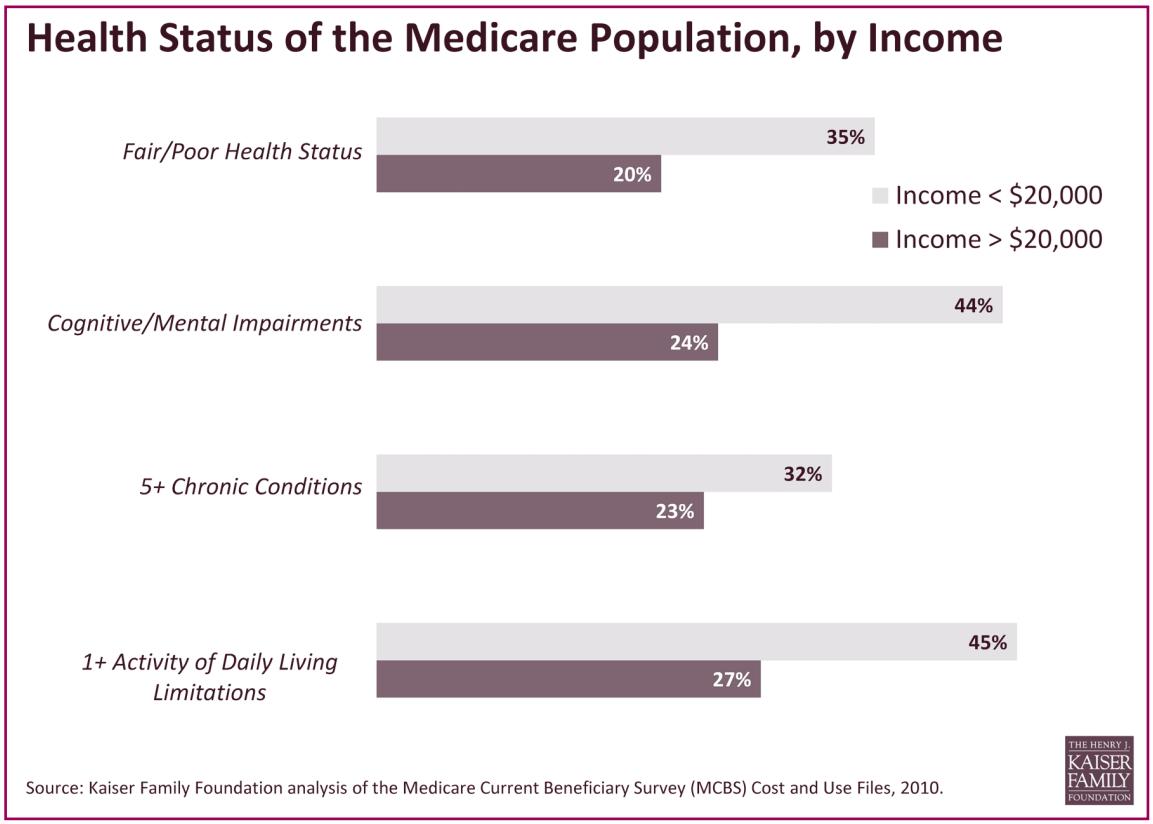
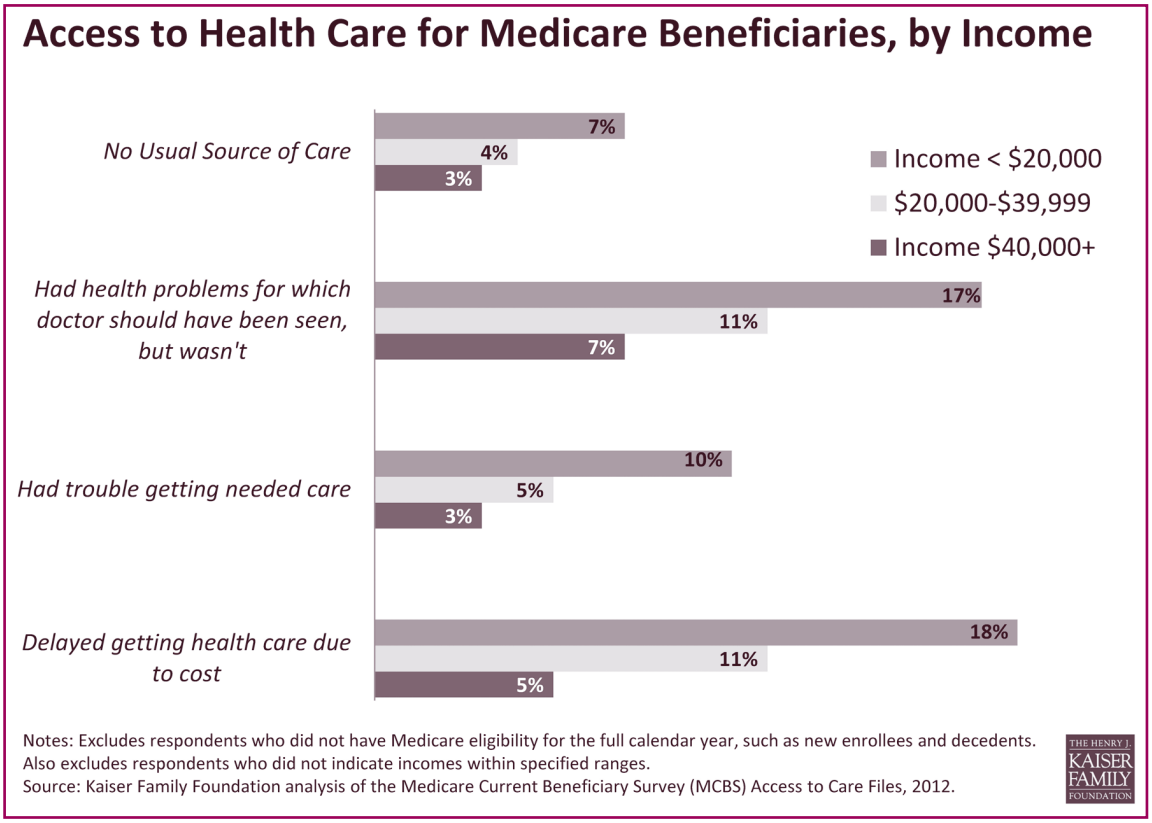


Figure 2.



Amendments.) While the basic coverage Medicare offers helps to assure access to health services for Medicare beneficiaries, Medicare coverage is far from comprehensive. Many of the financial burdens for care stem from the design and scope of the Medicare benefit package, as well as the premiums required for Part B coverage. In addition to the substantial cost-sharing and financial obligations for beneficiaries, Medicare's benefits are oriented to medical services covered under private insurance and do not include vision, dental care, and LTSS coverage—all important components of a health services package for older and disabled adults. Moreover, until 2006, Medicare did not cover prescription drugs, a central component of most medical care and treatment.

Most Medicare beneficiaries with incomes above $20,000 (59 percent) either rely upon employer-provided retiree health benefits to supplement Medicare, or they directly purchase Medigap supplemental health insurance to fill in for some of Medicare's cost-sharing obligations and limits on covered benefits. The cost and availability of private insurance policies to supplement Medicare are major barriers to coverage for many low-income Medicare beneficiaries. For low-income beneficiaries living on $20,000 or less, retiree coverage is rarely available, and a Medigap policy, when premiums average $2,172 per year, is hardly affordable (Jacobson, Huang, and Neuman, 2014).

Medicaid has evolved to help fill this gap by providing assistance with Medicare's financial obligations and providing extended benefits to many of Medicare's poorest beneficiaries. Enacted with Medicare in 1965, Medicaid was modeled on the 1960 Kerr-Mills legislation that

provided matching grants to the states for care of the indigent aged. Unlike the universal entitlement and federal administration of Medicare, Medicaid offered states federal matching grants to finance medical care for the poor on welfare—families with dependent children and the aged, blind, and disabled. Because Medicaid was originally intended as a source of coverage for the welfare population, it was designed as a means-tested program where eligibility is based on meeting income and resource criteria set at welfare levels. From these early welfare roots, Medicaid evolved to become a broader source of coverage for low-income families and for the low-income older adult and disabled population.

Even routine care for physician visits or prescription drugs can require Medicare beneficiaries to make hard choices between needed health services and basic necessities.

Medicaid's role for the low-income older adult and disabled populations has grown in terms of the numbers of people covered and the range of services provided, especially long-term-care services. The 1972 amendments to the Social Security Act added coverage of the permanently disabled entitled to Social Security Disability Insurance (SSDI) to Medicare and established the federal Supplemental Security Income (SSI) cash assistance program for the aged, blind, and disabled, replacing state standards with national eligibility criteria and income standards for Medicaid coverage of the aged, blind, and disabled. This enabled Medicaid to automatically enroll and provide full health coverage to the poorest Medicare beneficiaries. In addition, changes in the Medicaid benefit package shifted the program more directly into financing of long-term-care services, with the addition of federal matching funds for services furnished by intermediate care facilities and intermediate care facilities for the mentally retarded. These changes helped to make Medicaid the key player it is today as a full complement to Medicare for the poorest beneficiaries, and as a source of financing for long-term-care services for the elderly and disabled.

Beneficiary financial obligations for Medicare coverage continued to grow over time as Congress enacted budget reductions that imposed additional costs on beneficiaries. Federal legislators began also to use Medicaid as a source of financial protection for additional low-income Medicare beneficiaries. In most cases, Medicare beneficiaries receiving cash assistance through SSI were already covered by Medicaid for their Medicare premiums and cost-sharing and for additional benefits not covered by Medicare. As Medicare premium and cost-sharing obligations rose through the 1980s and 1990s, legislators were able to use Medicaid to protect more low-income beneficiaries from the increases in beneficiary responsibility without adding an income-related means test to Medicare. By using Medicaid to provide the means-test for the premium and cost-sharing coverage through the Medicare Savings programs, the Medicare program retained universal coverage for Social Security beneficiaries without any distinctions based on income or linked to welfare assistance.

Legislative changes over time have broadened Medicaid's role for Medicare beneficiaries, but also have made it increasingly complex. Among the 9.6 million dual eligible beneficiaries in 2010, 7 million were receiving full Medicaid wraparound benefits to supplement Medicare, while the remaining 2.5 million were "partial duals," receiving assistance through the Medicare Savings Program that provides Medicaid coverage to help with Medicare premiums and cost-sharing. As the eligibility chart (see Table 1 on page 39) shows, low-income Medicare beneficiaries receive various levels of assistance by different pathways largely determined by income and assets. While these changes have

Table 1.

Eligibility Pathways for Assistance for Low-Income Medicare Beneficiaries, 2014

	Income Eligibility	Asset Limit	Medicaid/Medicare Benefits in 2014
Individuals Eligible for Full Medicaid Benefits ("Full Dual Eligible Beneficiaries")			
SSI Cash-Assistance-Related (mandatory)	Generally 74% of the FPL for individuals and 82% of FPL for couples	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care, that "wrap around" Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost-sharing.
Poverty-Related (optional)	Up to 100% of the FPL	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care, that "wrap around" Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost-sharing.
Medically Needy (optional)	Individuals who spend down their incomes to state-specific levels	$2,000 (individual) $3,000 (couple)	"Wrap around" Medicaid benefits (may be more limited than those for SSI beneficiaries). Medicaid may also pay Medicare premiums and cost-sharing, depending on income.
Special Income Rule for Nursing Home Residents (optional)	Individuals living in institutions with incomes up to 300% of the SSI federal benefit rate	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care, that "wrap around" Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost-sharing.
Home- and Community-Based Service Waivers (optional)	Individuals who would be eligible if they resided in an institution. Several states do not use the special income rule for waivers, so eligibility levels may be lower than 300% of the SSI federal benefit rate.		Full Medicaid benefits, including long-term care, that "wrap around" Medicare benefits. Medicaid may also pay Medicare premiums and-cost sharing.
Medicare Savings Programs ("Partial Dual Eligible Beneficiaries")			
Qualified Medicare Beneficiaries (QMB) (mandatory)	Up to 100% of the FPL	$7,160 (individual) $10,750 (couple)	No Medicaid benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost-sharing.
Specified Low-Income Medicare Beneficiaries (SLMB) (mandatory)	Between 100% and 120% of the FPL	$7,160 (individual) $10,750 (couple)	No Medicaid benefits. Federal government pays Part B premiums under a block grant.
Qualifying Individuals (QI) (mandatory)	Greater than or equal to 120% and less than 135% of the FPL	$7,160 (individual) $10,750 (couple)	No Medicaid benefits. Medicaid pays Medicare Part B premium. Federally funded, no state match. Participation may be limited by funding.
Qualified Disabled Working Individuals (QDWI) (mandatory)	Working, disabled individuals with income up to 200% of the FPL	$4,000 (individual) $6,000 (couple)	No Medicaid benefits. Medicaid pays Medicare Part A premium.
Medicare Part D Low-Income Subsidy			
Part D Low-Income Subsides (LIS): Full Benefits	Up to 135% FPL	$7,160 (individual) $10,750 (couple)	Medicare (not Medicaid) pays Part D premium and cost-sharing assistance.
Part D Low-Income Subsides (LIS): Partial Benefits	Up to 150% FPL	$11,940 (individual) $23,860 (couple)	Medicare (not Medicaid) pays Part D premium and cost-sharing assistance.

Note: Asset limits for QMB, SLMB, QI, and Part D LIS exclude $1,500 per person for burial expenses.
Source: Young, K., et al. 2013. "Medicaid's Role for Dual Eligible Beneficiaries." Kaiser Family Foundation.
Source: The Centers for Medicare & Medicaid Services, Medicare Enrollment and Appeals Group. 2014. "Resource Limits for the Medicare Part D Low-Income Subsidy: Annual Adjustment for 2014."

helped protect many Medicare beneficiaries from the impact of rising premiums and costs, qualifying for assistance and the complexity of navigating between two programs and administrative structures is confusing and challenging for many, resulting in limited participation by some of the neediest.

The situation becomes even more complex with the enactment in 2003 of Medicare Part D, which added a prescription drug benefit to Medicare and provided a Medicare-administered low-income subsidy toward the cost of drug coverage. Historically, to avoid means-testing in Medicare, any income-related provisions were shifted to the Medicaid program in which eligibility was already based on income and assets. With the new Medicare drug benefit, the door opened for assisting low-income beneficiaries directly through Medicare. With Medicare Part D, Medicare both shifted drug coverage from Medicaid to Medicare for the lowest income beneficiaries and established its own low-income means-tested assistance program based on income and assets. With the enactment of the low-income Part D subsidy, as well as the introduction of income-related premiums for higher income Medicare beneficiaries, the forty-year tradition of keeping Medicare "free from income-based policies" ended. This opened new opportunities for directing assistance to low-income Medicare beneficiaries within Medicare.

Medicaid's Role for Today's Dual Eligible Population

The dual eligible population covered by both Medicare and Medicaid includes many of Medicare's most frail and medically challenged beneficiaries, many of whom are in need of long-term care. Among full dual eligibles, 63 percent require assistance with one or more activities of daily living (ADL), nearly a quarter (23 percent) have Alzheimer's Disease or senile dementia, and nearly a third (31 percent) live in an institution. This compares to 25 percent among all other beneficiaries who have one or more ADL, 9 percent with Alzheimer's Disease, and 5 percent living in an institution (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, 2015a). As a result of their greater health needs and higher services use, dual eligibles account for a disproportionate share of Medicare and Medicaid spending. Dual eligibles account for 20 percent of Medicare beneficiaries and 14 percent of Medicaid beneficiaries, but more than a third (34 percent) of spending in each program (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, 2015b). Two-thirds (65 percent) of Medicaid spending on the dual eligible population is for long-term care. Given the medical complexity and high costs of the dual eligible population, the Affordable Care Act provided authority to the Department of Health and Human Services to conduct large-scale, three-year demonstration projects to allow states to integrate Medicare and Medicaid services and test whether capitated managed care plans can improve coordination of patient care, control costs, and improve health outcomes.

Key Issues and Challenges

Since 1965, the Medicare–Medicaid partnership has helped millions of low-income Medicare beneficiaries to afford Medicare's premiums and cost-sharing, to gain access to needed health-care services, and, for many, to help fill gaps in Medicare's covered benefits. Without Medicaid's help, millions of Medicare beneficiaries would have gone without the prescription drugs, vision and dental care, and LTSS they needed to maintain their health and ability to live from day to day. But the partnership is not perfect, leaving many of the poorest Medicare beneficiaries without assistance.

Many low-income beneficiaries are falling through the cracks and not receiving support from Medicaid (or in the case of Part D, the Low-Income Subsidy) to fill in the gaps in Medicare and ease financial burdens. Among

the 20 million Medicare beneficiaries with incomes below 200 percent of the Federal Poverty Level, more than half—between 11 million and 13 million beneficiaries—do not receive any financial assistance with Medicare's premiums or cost-sharing through Medicaid or the Medicare Savings Programs (Kaiser Family Foundation, forthcoming analysis).

Legislative changes over time have broadened Medicaid's role for Medicare beneficiaries, but also made it increasingly complex.

Individuals with incomes above 135 percent of the Federal Poverty Level are not eligible for assistance with Medicare premiums, unless they have large medical expenses or qualify in other ways for full Medicaid benefits. Even among Medicare beneficiaries with incomes between 100 percent and 135 percent of the Federal Poverty Level who might receive help with Medicare premiums, many are not eligible for assistance with Medicare cost-sharing requirements. Additionally, not all beneficiaries with incomes below poverty qualify for or receive assistance from Medicaid, possibly because they have savings just above the eligibility levels.

According to an analysis by the Kaiser Family Foundation, nearly 3 million Medicare beneficiaries who receive assistance with Part D premiums and cost-sharing (and thus have incomes below 150 percent of the Federal Poverty Level) do not receive help with the cost-sharing required for Medicare Part A– and Part B–covered services.

One of the greatest challenges as Medicare enters its next fifty years is how to assure that those who struggle with inadequate incomes and resources are able to partake fully of the coverage and medical care Medicare extends. As new proposals that could increase beneficiary obligations under Medicare are considered, it is an opportune time to think about restructuring assistance for the low-income beneficiaries to simplify and upgrade their coverage. Options to consider include the following three strategies:

Revisiting the current law asset tests. Under current Medicaid and Medicare rules, eligibility for low-income assistance is based upon income and resources, and extensive documentation is required to establish eligibility. The allowable assets vary across assistance categories from $2,000 for an individual and $3,000 for a couple for full Medicaid coverage, to roughly $7,000 for an individual and $10,000 for a couple for the Medicare savings programs (Young et al., 2013). Basing assistance with premiums and cost-sharing solely on income would bring Medicare policy more in line with coverage for families in Medicaid and subsidy assistance through the Marketplace, and would facilitate participation by more low-income beneficiaries, while reducing administrative burden. For full dual eligibles in need of broader assistance, especially institutional long-term-care services, the asset test is necessary in the absence of broader long-term-care financing reforms.

Building on the Medicare platform to determine eligibility. To make the enrollment process more consumer-friendly, Medicaid eligibility determination and Medicare Savings Programs administration could be shifted from the Medicaid eligibility system to the Medicare program, as in the Part D Low-Income Subsidy. Aligning and streamlining assistance programs under Medicare would clarify and simplify the enrollment process for beneficiaries, provide assistance by income uniformly across the country, and enable direct adjustments in Medicare assistance to accommodate any changes in Medicare beneficiary obligations. Shifting the state's responsibility and share of costs to the federal government also would reduce administrative burden and cost for states.

Strengthening community-care options for long-term care. For those who need broader assistance beyond the financial obligations of Medicare, Medicaid plays a critical role in picking

up some of the cost-sharing and Part B premiums, but especially in decreasing the gaps in Medicare benefits for LTSS. For Medicare's poorest beneficiaries with incomes below the poverty level ($11,750 for an individual), waiving the asset test for community-based services could help enable those who need assistance to remain in the community without depleting all their resources and having to use institutional care. With states actively trying to rebalance their LTSS programs away from institutional care, these efforts, along with incentives to improve care coordination, could help augment family caregivers and keep the frail elderly and disabled in the community for as long as possible.

The Path Forward

These options offer a pathway toward improving and securing the coverage needed to supplement Medicare for low-income beneficiaries. However, it will take broader reforms to truly address healthcare for Medicare's poorest, often frailest and sickest beneficiaries. As discussions of restructuring the Medicare premium and cost-sharing policies are undertaken, including a sliding scale for assistance within Medicare could replace the current stair-step approach to assistance and increase the actuarial value of Medicare for those least able to afford supplemental coverage. One of the most notable gaps in Medicare's benefits is the lack of long-term-care coverage. National reform of long-term-care services has long been on the agenda, but solutions have not advanced beyond proposals, with the exception of the repealed CLASS Act.

As Medicare and Medicaid reach the fifty-year mark, we need to take stock of the notable progress these programs have made in improving access to care, reducing disparities, and easing financial burdens for the millions of beneficiaries who needed healthcare and help with medical bills over the years. Going forward, building on this progress will help assure that access to affordable high-quality healthcare for Medicare beneficiaries is sustained.

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