

# Ensuring Equitable Access to Health Care for Low-Income Medicare Enrollees in Washington State

POLICY BRIEF • March 2019  
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**WHAT'S AT STAKE** Low-income Medicare enrollees face a disparity in access to care and coverage that they would not experience were they not aged or disabled. Medicare enrollees with incomes between \$772 and \$1436 a month would have more robust health care coverage and considerably lower out-of-pocket costs if they had access to Apple Health like their non-aged or disabled peers of the same income. While there is much room for improvement in Medicare and Medicare Savings Program policy at the federal level, many states are taking advantage of the latitude granted in these programs to close service gaps for their own low-income Medicare populations. After diligent review of recent national studies and informal consultation with low-income Medicare enrollees navigating these state programs, I have identified central issues and recommendations for advancing equitable access to care for low-income Medicare enrollees in Washington State.

## THE CHALLENGE

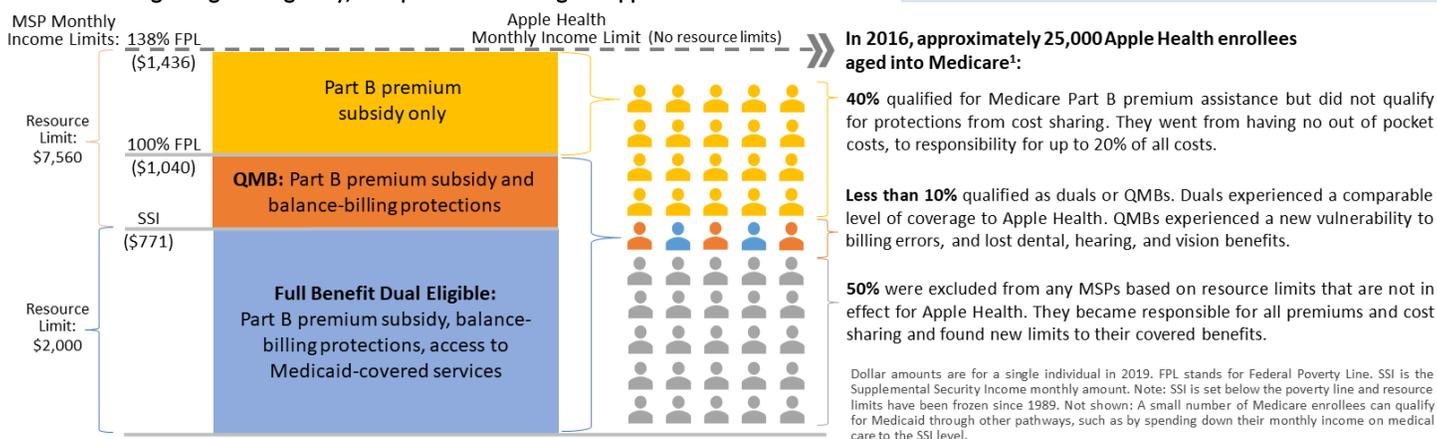
In 1988, Congress created the Medicare Savings Programs (MSPs) to ensure low-income Medicare enrollees could make meaningful use of their Medicare benefits. One MSP, the Qualified Medicare Beneficiary (QMB) program, mandated that Medicare enrollees meeting certain income and resource limits (see graphic below) could not be billed for Medicare premiums, co-pays, deductibles, or co-insurance amounts. Other MSPs were established to protect people at slightly higher income limits from responsibility for Medicare premiums. Medicare enrollees whose income is limited to Supplemental Security Income (SSI) are also Medicaid eligible; these are called “full benefit dual eligibles” (“duals”).

Under the Affordable Care Act, Medicaid was not expanded for Medicare enrollees. Despite MSPs, most low-income Medicare enrollees have poorer coverage and higher out-of-pocket costs than their peers of the same income who are covered under Expanded Medicaid. While Washington was one of the first states to expand Medicaid – implementing Washington Apple Health (WAH) – Washington has fallen behind other states in efforts to ensure equitable coverage for those excluded from the expanded benefits because of their age or disability status.

### KEY TERMS

- Medicare Savings Programs (MSPs)** – cost-saving programs for low-income Medicare enrollees
- Qualified Medicare Beneficiary Program (QMB)** – Medicare enrollees cannot be balance-billed under this MSP
- Full Benefit Dual Eligibles (“Duals”)** – Medicare enrollees who are also eligible for full Medicaid benefits
- Washington Apple Health (WAH)** – Washington’s Expanded Medicaid or income-based Medicaid program.

### Medicare Savings Program Eligibility, Compared to Washington Apple Health



In addition to the stricter income and resource limits outlined above, MSP administration policies also contribute to the inequities experienced by low-income Medicare enrollees. Even those Medicare enrollees who are duals or QMBs are at risk of being illegally balance billed or turned away from care. While some program issues may be best addressed at the federal level, states are granted considerable latitude in setting eligibility terms, supporting enrollees in navigating MSPs, and facilitating provider reimbursement for cost sharing. Through diligent literature review and informal consultation with low-income Medicare enrollees navigating these state programs, I have identified central issues for equitable access to care for low-income Medicare enrollees in Washington:

#### Enrollment and Renewal Obstacles:

MSPs remain obscure, and significant gaps persist in eligible versus enrolled populations. Washington requires active renewals for MSPs (as opposed to passive renewals in which enrollees simply verify nothing has changed), and MSP enrollees report often not being adequately notified that they need to renew.

#### Program Navigation Obstacles:

Many QMBs do not know about their protections. Many report they cannot advocate for their rights with providers out of fear of being dropped from care or other negative impacts to their provider-patient relationship.

#### QMB identification & Provider Knowledge Gaps:

Washington does not issue QMB-specific identification cards. The Center for Medicare and Medicaid Services introduced real-time QMB benefit-lookup tools, but errors around QMB identification and billing rules persist. When QMBs are wrongly billed, they often encounter billing representatives misinformed about QMB protections and feel pressured to pay bills to avoid collections.

#### Persistent Balance Billing:

Identification issues mean QMBs are often asked to pay co-pays upfront, which can be a barrier to care. QMBs are sometimes asked to sign waivers agreeing to be balance-billed and informed that refusal to sign means they won't be served.

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### Being Turned Away by Providers:

QMBs report being turned away by providers out of misunderstanding of their benefits. Many providers and enrollees alike incorrectly believe that QMB enrollees can only be seen by providers who accept both Medicaid and Medicare. Many providers limit acceptance of QMBs due to the low payment rates.

### Critical Benefits are Lacking:

Medicare coverage does not include dental, vision, or hearing benefits. While many can turn to low-premium Medicare Advantage (MA) plans for basic benefits in these areas, MA plans are not available in many rural counties in Washington. Medicare's limited coverage for mental health and durable medical equipment are also frequently cited gaps. Individuals who qualify for WAH have more expansive coverage in these areas than their Medicare peers with the same income.

### "Lesser of" Rates Disincentivize Acceptance of QMBs:

Washington is a "lesser of" state: when a provider bills Medicaid for cost sharing, the state will pay the remaining balance up to the service's Medicaid rate or the Medicare rate, whichever is lower. The Medicaid rate is often less than what Medicare has already paid, in which case Medicaid will not pay anything. Only providers contracted with Medicaid can bill the state for cost sharing. Providers without Medicaid contracts lose money serving QMBs.

### Access-to-Care Issues Increase Costs Downstream:

The issues QMBs face in accessing routine and preventative care results in higher use of more expensive emergency care than their lower-income duals and higher-income Medicare-only peers. A 2015 study<sup>2</sup> compared "lesser of" payment states to states that reimburse providers at the full Medicare rate. In "lesser of" states like Washington, QMBs were least likely to have office visits and most likely to have ER visits compared to duals and those with Medicare alone. The differences were much smaller in "full pay" states.

## ALTERNATIVES IN PRACTICE

While there is much room for improvement in Medicare and MSP policy at the federal level, many states are taking advantage of the latitude granted in these programs to improve outcomes for their own low-income Medicare populations<sup>3</sup>:

Maine, Indiana, Connecticut, and District of Columbia, among other states, have increased their QMB income limits to 150%, 150%, 200%, and 300% FPL, respectively. A dozen states, including Arizona, Mississippi, and New York, have increased or altogether eliminated their resource limits for QMB eligibility, eliminating the need to check resources as part of the eligibility process. Some states, including Maryland, North Carolina, Ohio, and District of Columbia, issue QMB eligibility cards so that cardholders can inform their providers of their QMB status, increasing the odds of provider compliance with billing rules.

District of Columbia and California also make it simple for providers who are not Medicaid-contracted to still submit for reimbursement as QMB-serving providers. Arkansas, Maryland, and New York, among others, are "full-pay" states. These states' investments in QMB reimbursement amounts result in QMBs accessing primary care at higher rates and emergency care at lower rates, shifting costs upstream to less expensive preventative care<sup>2</sup>.

## SOLUTIONS FOR WASHINGTON

I have drawn from Centers for Medicaid and Medicare Services reports, surveys of other states' programs, and informal consultations with individuals navigating MSPs to make the following recommendations for Washington to ensure equitable health care access for low-income Medicare enrollees:

### EXPAND ELIGIBILITY

#### Increase the income limit for QMB eligibility to 138% FPL

- Ensures a more comparable level of out-of-pocket costs between individuals of the same income with Medicare or WAH.

#### Eliminate or increase resource test for dual and QMB eligibility

- Comparable to WAH guidelines, so disabled or older adults are not being held to more strict rules than non-aged or disabled income peers.
- Increases enrollment rates across income levels.
- Simplifies program administration.

#### Investigate options for closing the gap in basic covered services between Medicare and WAH

- Ensure that a no-cost non-HMO Medicare Advantage plan covering basic dental, vision, hearing, and mental health is available in every county, or
- Expand Medicaid dual-eligibility income limit to 138% FPL.

### INCREASE REIMBURSEMENT

#### Increase state payments from "lesser of" to the full Medicare rate

- Closes payment gap between Medicare-only and QMB patients for providers able to bill the state.
- Helps shift costs upstream to less expensive care.

#### Establish alternative billing pathway for providers without Medicaid contracts

- Incentivizes acceptance of QMB patients for providers who do not serve Medicaid patients.

### IMPROVE PROGRAM NAVIGATION

#### Enact passive renewal procedures

- More comparable to WAH procedures, so disabled or older adults are not held to more strict guidelines than non-aged or disabled income peers.
- Simplifies program administration.

#### Distribute QMB rights wallet cards to empower enrollees and educate providers (example below)

- Avoids cost of printing individualized cards while serving the purpose of signaling to providers' offices that they should confirm a patient's QMB status.
- Empowers enrollees to know their protections and educate providers or billing representatives.
- Targeted to address most frequent knowledge gaps.

Example QMB Rights Wallet Card

**Qualified Medicare Beneficiary**

Under the Social Security Act, I *cannot* be billed for copays, co-insurance, deductibles, or any type of balance-billing.

My protections from balance-billing *cannot* be waived.

My QMB rights apply to me whether I have Original Medicare or a Medicare Advantage Plan.

These QMB protections apply regardless of my spenddown status.

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You can confirm my QMB status in Medicare HETS or in Provider1.

You may bill Medicaid as a secondary insurance if you are a contracted provider.

1. Flowers, L., Buettgens, M., Dev, J., *Transitioning from Medicaid Expansion Programs to Medicare: Making Sure Low-Income Medicare Beneficiaries Get Financial Help* (AARP Public Policy Institute, The Urban Institute, January 2015). Accessed at: <https://www.aarp.org/content/dam/aarp/ppi/2015/transitioning-from-medicaid-expansion-programs-aarp-ppi-health.pdf>

2. Centers for Medicare & Medicaid Services, *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)* (July 2015). Accessed at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access\\_to\\_Care\\_Issues\\_Among\\_Qualified\\_Medicare\\_Beneficiaries.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf)

3. Travitsky, P., *QMB Identification Practices: A Survey of State Advocates* (Justice In Aging, March 2017). Accessed at: [http://www.justiceinaging.org/wp-content/uploads/2017/03/QMB-Identification-Practices\\_A-Survey-of-State-Advocates.pdf](http://www.justiceinaging.org/wp-content/uploads/2017/03/QMB-Identification-Practices_A-Survey-of-State-Advocates.pdf) (page 2 of 2)