MEDICARE SAVINGS PROGRAM

CHANGES AND OPTIONS

December 5, 2017

Overview for Agencies/Staff Supporting Older Adults and Persons with Disabilities

If this document is required on an alternate format in accordance with the Americans with Disabilities Act, please contact the State Unit on Aging at aging.sda@ct.gov or call 860-424-5274 so we may accommodate your request.
The State Unit on Aging has made every effort to provide accurate information relative to the content contained on this document which has been prompted by the state legislation reducing the income-eligibility limits for the Medicare Savings Program.

To that extent, the information, which has been gathered from various sources, is as accurate as possible on the date published.

For more information, contact CHOICES at the regional Area Agency on Aging at 1-800-994-9422.
Introduction

• Overview of Changes
• Overview of Medicare
• MSP versus LIS
• Medigap Policies
• Screening for Medicaid
• Resources
• Options to consider
State Budget Legislative Change

• Public Act 17-2, section 50, special session

• Changes the income-eligibility levels for the Medicare Savings Program, effective January 1, 2018.

• Only those who are income qualified may remain on MSP

• The federal government establishes minimum federal MSP income guidelines. CT is now at minimum federal income levels.

• **NOTE:** Federal Poverty Levels are announced in February. MSP income guidelines will likely change effective March 1, 2018.
### MSP Income Changes

<table>
<thead>
<tr>
<th>Medicare Savings Program Level</th>
<th>Income limits after January 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single</td>
</tr>
<tr>
<td>QMB</td>
<td>$1,025</td>
</tr>
<tr>
<td>SLMB</td>
<td>$1,226</td>
</tr>
<tr>
<td>ALMB</td>
<td>$1,377</td>
</tr>
</tbody>
</table>
How are Beneficiaries Notified?

• DSS sent out informational notices to MSP beneficiaries who may lose benefits or experience changes (sent November 19th)
  • Discontinuance notices will be sent to beneficiaries (around December 15th)
  • Change of benefit notices will be sent to beneficiaries (around December 15th)

DSS is required to provide a 10 day notice before changes in benefits
DSS Notice

• Sample of Informational Letter can be found at:
  • http://portal.ct.gov/DSS/Health-And-Home-Care/Medicare-Savings-Program/Medicare-Savings-Program/Documents

This notice is about changes to Medicare Savings Programs income limits.

We are writing to let you know that, starting January 1, 2018, a new law in the state budget (section 50 of Public Act 17-2, June Special Session) will lower income limits for the Medicare Savings Programs (“MSP”). We have determined that your MSP coverage is likely to end or change, effective January 1, 2018, because of this new law. We will send you another notice around December 15 to tell you if your MSP coverage ends or changes. This notice is intended to provide you with information to help plan for the coming changes.

There are three levels of MSP. The level you are on is based on your income. All levels of MSP cover your Medicare Part B premium. If you have the level known as Qualified Medicare Beneficiary (“QMB”), then your MSP benefit also covers the copays and deductibles for Medicare Part A hospital and Part B medical covered services. Currently, over 90% of Connecticut MSP recipients are at the QMB level. The chart below shows the income limits before and after January 1, 2018.
Numbers Affected & Impact (estimates)

82,000 lose MSP coverage
27,000 may change coverage from QMB to SLMB/ALMB

Not all eligible for ALMB will receive benefits

IMPACT FOR ALL

• Reduced Social Security income by $134/month
  (likely by February)

Loss of Extra Help/Low Income on December 31, 2018
  (unless eligible for Medicaid or Extra Help through SSA)
QMB and Medicare

• Approximately 90% of people on MSP are at the level of QMB

• QMB recipients lose help paying:
  • Medicare Part A and B deductibles
  • Medicare Part A and B cost-sharing assistance

  They lose balance billing protections

To better understand the impact to QMB recipients, an overview of Medicare costs may be helpful
Medicare – Title 18
A Federal insurance program since 1965

- Part A Hospital Insurance
  Premium free for most people

- Part B Medical Insurance
  $134/month premium for most

- Part C Medicare Advantage Plans
  Alternative Premiums & costs vary

- Part D Medicare Prescription Drug Coverage
  Premiums & costs vary
Qualified Medicare Beneficiary (QMB) helps with Medicare Part A & B benefits.

Extra Help/Low Income Subsidy helps with the Medicare Part D prescription costs.

If you join a Medicare Advantage Plan, you can’t use or be sold a Medicare Supplement Insurance (Medigap) policy.
Traditional Medicare

- Created in 1965 consisting of 2 parts:
  - Medicare A – Hospital
  - Medicare B – Medical

- People in traditional Medicare can receive their healthcare from any provider certified by Medicare
Medicare Part A Covers...

- Inpatient Care
- Skilled Nursing Care
- Home Health Care
- Hospice
## Medicare Part A Costs

<table>
<thead>
<tr>
<th>For Each Benefit Period in 2018</th>
<th>Consumer Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-60</td>
<td>$1,340 deductible</td>
</tr>
<tr>
<td>Days 61-90</td>
<td>$335 per day</td>
</tr>
<tr>
<td>Days 91-150 (60 lifetime reserve days)</td>
<td>$670 per day</td>
</tr>
<tr>
<td>All days after 150</td>
<td>All Costs</td>
</tr>
</tbody>
</table>
Part A Skilled Nursing Facility (SNF)

<table>
<thead>
<tr>
<th>For Each Benefit Period in 2018</th>
<th>Consumer Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-20</td>
<td>$0</td>
</tr>
<tr>
<td>Days 21-100</td>
<td>$167.50 per day</td>
</tr>
</tbody>
</table>

The benefit for SNF is triggered when an individual has an inpatient hospital stay of three overnight days. The person must require skilled services & meet the criteria of Medicare. 100 days of coverage is not guaranteed.

No additional benefits are paid after 100 days are exhausted.
Medicare Part B Covers...

- Physician Services
- Diagnostic Tests & X-Rays
- Durable Medical Supplies (DME)
- Observation status in the hospital & ambulance services
- Outpatient PT, OT and Speech Therapy
## Part B Costs

<table>
<thead>
<tr>
<th>2018</th>
<th>Consumer Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Premium</td>
<td>$134 (for most)</td>
</tr>
<tr>
<td></td>
<td>(single people with income over $85,000 or couples</td>
</tr>
<tr>
<td></td>
<td>$170,00 may pay more)</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$183</td>
</tr>
<tr>
<td>Medicare pays</td>
<td>20% of the Medicare approved rate</td>
</tr>
<tr>
<td>80% of approved rate</td>
<td>(+ potentially 15% excess charges)</td>
</tr>
</tbody>
</table>
Medicare Advantage Plans

Private insurance companies that contract with Medicare & provide all of the Medicare benefits

• To enroll in a plan you must:
  • Have both Medicare A and B
  • Reside in the plan’s geographic service area
  • Not have a diagnosis of End Stage Renal Disease

• Premiums & cost-sharing vary
• The plan uses a network of providers
• Same benefits of Medicare, but can offer additional benefits
  • (over the counter medications, limited medical transportation, dental and/or vision)

• QMB works with all Medicare Advantage Plans
• Providers cannot discriminate based on ability to pay
Medicare Advantage Special Needs Plan (SNP)

Designed for those in CT who have Medicare & Medicaid or Medicare and QMB. Additional benefits are often offered such as limited over the counter medications, medical transportation and vision services.

• To be eligible for enrollment:
  • Have both Medicare A and B
  • Be enrolled in Medicaid or QMB
  • Reside in the plan’s geographic service area
  • Not have a diagnosis of End Stage Renal Disease

No out of pocket costs for Medicare A & B benefits as long as they receive care in network
### Understanding MSP versus LIS

#### Medicare Savings Program
- DSS makes eligibility determination
- Pays Medicare Part A premiums (for those on QMB) and Medicare Part B premiums.
- QMB pays up to Medicaid rate for deductibles/co-pays of Medicare Part A & B
- Redetermination is annually
- DSS sends electronic information to SSA when individuals qualify for Medicare buy-ins

#### Low Income Subsidy
- Social Security makes eligibility determination for full and partial LIS status
- Pays Part D premium (up to $34.83 in 2018), cost-sharing & some or all of Part D deductible depending on level of LIS
- Income/asset requirements are different than those for MSP
- Redeterminations on a calendar year
- Those “deemed eligible” due to Medicaid/MSP status are granted FULL LIS
Two Ways to Obtain LIS/Extra Help

**Deemed Eligible by DSS**

- Apply to DSS - granted Medicaid (Husky A, MedConnect, Medicaid Waivers, Husky C)
- Apply to DSS - granted MSP, any level
- Everyone deemed eligible receives full LIS

**Apply through SSA**

- Apply with the Social Security Administration
- Decision on Full or Partial Low Income Subsidy is based on income and assets
## Low Income Subsidy Level Landscape

(Income will change when FPL is announced in February)

<table>
<thead>
<tr>
<th>Medicaid Waiver or those on Medicaid in an Institution (Level 3)</th>
<th>2018 LIS Resource Limit</th>
<th>Deductible 2018</th>
<th>Cost sharing 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td>* Includes $1500 burial</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare/Medicaid &amp; income is at or below 100% FPL+$20 (Level 2)</th>
<th>2018 LIS Resource Limit</th>
<th>Deductible 2018</th>
<th>Cost sharing 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td>$1.25 generic $3.70 brand (maximum $17/month)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare/Medicaid &amp; over 100% FPL (level 1)</th>
<th>2018 LIS Resource Limit</th>
<th>Deductible 2018</th>
<th>Cost sharing 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td>$3.35 generic $8.35 brand</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All levels of MSP (level 1)</th>
<th>2018 LIS Resource Limit</th>
<th>Deductible 2018</th>
<th>Cost sharing 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td>$3.35 generic $8.35 brand</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Applies with SSA: 135% FPL (1377/mo.; 1847 couple) with resources at or below FULL SUBSIDY</th>
<th>2018 LIS Resource Limit</th>
<th>Deductible 2018</th>
<th>Cost sharing 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*$9.060 single; $14,340 couple</td>
<td>$0</td>
<td>$3.35 generic $3.70 brand</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Applies with SSA: below 150% FPL (1528/mo.; 2050/mo.) with resources PARTIAL SUBSIDY (level 4)</th>
<th>2018 LIS Resource Limit</th>
<th>Deductible 2018</th>
<th>Cost sharing 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*$14,100 single; $28,150 couple</td>
<td>$83 (or standard deductible, whichever is cheaper)</td>
<td>Co-payment of 15% up to $5,000 Then $3.35 generic $8.35 brand</td>
</tr>
</tbody>
</table>
Summary of Who is Involved

- Social Security enrolls individuals into Medicare
- Social Security determines Extra Help level for those applying through SSA
- Centers for Medicare & Medicaid Services (CMS) oversees the administration of Medicare & Medicaid
- Department of Social Services administers the MSP program and arranges buy-in for Medicare Part A & B
- Department of Social Services administers the Medicaid program
- SDA contracts with 5 AAAs to administer the CHOICES program
Medicare Supplement Insurance (Medigaps)

- Supplement insurance plans offered by private companies that offset some of the costs related to traditional Medicare
- Medigaps are accepted by any provider (across the country) that accepts Medicare
- Plans range in cost based on coverage options you select
- Plans are standardized: All plans offering the plan offer the same coverage
- Overseen by the CT Department of Insurance
Medicare Supplement Plans

• Plans have continuous open enrollment in Connecticut

• Premiums are community rated & not based on health history or age

• Individuals below the age of 65 are limited to Plan A, B and C

• Individuals may have a waiting period before health conditions are paid by their Medigap policy

• Pre-Existing Conditions can be up to 6 months when they lose QMB coverage
Pre-Existing Conditions

• Medicare continues to pay for all Medicare covered medical conditions

• Claims forwarded to the Medigap would not be paid by the Medigap policy for medical conditions they had before enrollment – the beneficiary would be responsible for deductibles/co-pays for those claims related to the condition.

**Example:** Jane is 34 and has Multiple Sclerosis. She loses QMB on 12/31/17. She enrolls into Transamerica Plan C in December for a premium of $259.09 for the start of January 1. She is responsible for 20% of the cost of her injections for Medicare part B for 6 months.
The plan contact phone numbers are provided on the rate sheets. The 4th column from the left tells you if pre-existing conditions apply.

Rates sheets are available at [www.ct.gov/aging](http://www.ct.gov/aging) under publications.
How Can You Help?

• Only the CT Legislature can change the MSP income guidelines
  • Refer individuals to their legislature if they are upset
    Or call 211

• For those losing SLMB/ALMB
  • Provide Education: Although they will now pay their Medicare Part B premium, they remain eligible for Extra Help until 12/31/18. They can explore options for the best coverage possible.

• Identify those losing QMB to educate them on their options & refer them for help
Screen for Loss of QMB

- **Determine level of MSP**
  - Determine if they are Single or a Couple
  - Ask for sources of income: SS/SSDI and pension
  - Are they working?

  First $65 of earned income and $\frac{1}{2}$ of remaining earned income is not counted towards eligibility for those receiving Medicare

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<thead>
<tr>
<th>MSP Level</th>
<th>Income limits after January 1, 2018</th>
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<td>ALMB</td>
<td>$1,377</td>
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</table>
Screening Questions

Are you over the age of 65?

• Are you married or single?
• Is your combined monthly income at or below $1025 (single) or $1376 (couple)?
• Are you working?

Are you under the age of 65?

• Are you married or single?
• Is your combined monthly income at or below $1025 (single) or $1376 (couple)?
• Are you working?
Screen for Medicaid Options

- **Husky C** – persons with a disability, 65 years of age or older or blind

- **Med-Connect** – those working with a disability

- **Medicaid Waiver** –
  - CT Home Care Program for Elders for those 65 years of age who are at skilled nursing home level of care or other waiver programs

- **Husky A** – those who are a caretaker of minor child(ren). 138% FPL income limits. Apply through Access Health CT
Other potential Medicaid Groups

• Husky A – For a person who is pregnant
  • $3,558 /month for family of 2 (unborn child counted as 1)

• Medicaid for treatment of Breast or Cervical Cancer
  • At or below 250% FPL & under age 65
  • U.S. Citizen or Qualified non-citizen
  • Must not have ‘creditable’ private health insurance
  • For more information: CT Dept. of Public Health 860-509-8251

• Medicaid for those evaluated for or treated for Tuberculosis
  http://www.ct.gov/dph/cwp/view.asp?a=3136&Q=492600&PM=1

• Medicaid for Family Planning Services – limited Medicaid covering services related to birth control.
Husky C

Screen for Husky C Eligibility
(for those age 65 years of age or older or blind or those with a disability)

(W1-E) or online– supporting documentation needed

- $972.49/month single; $1493.09/month couple (Region A)
- $862.38/month single; $1374.41/month couple (Region B & C)

- Assets: $1,600 single; $2,400 couple
  - Exempt: home property, car, irrevocable burial account up to $8,000, term life insurance policies
Husky C Spend-Downs

• What is a Spend-Down?
  • When a client’s income is over income limits to qualify for medical assistance.
  • Allows excess income to be reduced by spending down the excess through owed or paid medical expenses.
  • Once the “spend-down” is met the person is active Medicaid (not usually the 1rst day of the month).
  • Spend-down is like a deductible, the deductible must be met before coverage begins.
Medical Expenses - Spend Down

- Acceptable medical expenses to meet Spend-Down:
  - Medicare Part B premium
  - Doctors, dentists, clinics and hospitals
  - Prescriptions (including co-pays)
  - Medical supplies and equipment
  - Private health insurance premiums (Medigap or retirement insurance)
  - Medical transportation
  - Lab fees and X-rays
  - Physical therapy
  - Medical expenses used to meet Medigap Plan F high deductible
Husky C Spend Downs

- Determined in six month time increments
- Medicaid becomes active once “spend down” is met up to the end of the 6 month cycle
- PAID or incurred medical expenses must occur within the 6 month spend down cycle
- Old unpaid bills are acceptable as long as a current bill with the old date of service is submitted & the person is still liable for the expense.
- If expenses for a 6 month period do not meet the spend down, they can be used in the subsequent 6 month period if they are still liable for them.
- Submitted bills must show current balance due and dates of service
Medical Expenses for Spenddown

- Medical expenses are sent to one location via fax or email to:

  Husky Spend-down Processing Center
  PO Box 280747
  East Hartford, CT 06128
  TDY: 1-866-492-5276 or 860-236-2371
  Fax 1-888-495-2897
  Telephone 1-877-858-7012

Individuals receive business reply envelopes & personal medical expense tracker form
How do they determine the Spend Down?

- Your income: $1200.00
- Medicaid Income Limit: $862.38 (amount includes disregard) $337.62

The Spend Down Amount: $337.62 \times 6 \text{ months} = $2025.72
Medical Expenses for Spenddown

- Medicare Part B premium
  - $134 X 6 mo. = $804.00

- Monthly cost-sharing Part D:
  - $8.35 X 5 brand drugs = $41.75 X 6 mo. = $250.50
  - Medigap Plan F USAA $250.55 X 6 mo. = $1503.30

- Met the Spenddown of $2,025.72
  - Medicaid can assist with dental, hearing aids, medical transportation, & will ensure ongoing Extra Help

- The person enters another spenddown every 6 months
MED-Connect
Medicaid for Employees with Disabilities (S05)

• Employed individuals with a medically certified disability or blindness

• Individuals who are not receiving SSI/SSDI can request consideration for disability

• Income limit for 1 person is $75,000 ($6,250/month)

• Assets: $10,000 a single person and $15,000 for a couple
  • IRA/Retirement Accounts are not counted as assets

• Apply using W1-E application or online with supporting documentation
## Premiums

Beneficiaries pay 10% premium when their income is over 200% of FPL:

- $2,010/single;
- $2,706/couple

**Premiums should be mailed to:**

DSS Premium Payment Processing Center  
PO Box 842109  
Boston, MA 02284-2109

Call Center 1-800-656-6684  
Can answer basic inquiries, such as if payment was received or to confirm amount of premium

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Additional information & frequently asked questions are located at:

How to Apply

Online at www.connect.ct.gov

By mail
At the DSS Office

- W-1E application with signature
- Phone number/Authorized Rep. information Form W298, if needed
- Request reasonable accommodation, if needed
- Supporting documents (put client id on each page or full name)

- New applications who are not known to DSS do not need Fastlink cover sheets.
- Those with DSS Client ID numbers can include a Fastlink cover sheet which can be printed at www.connect.ct.gov

Request 3 month retroactive coverage if eligible & needed

Mail documents to:
DSS Scan Center, PO BOX 1320
Manchester CT 06040
DSS Benefit Center

- The Benefit Center number: 1-855-626-6632
- TTD/TTY 1-800-842-4524 for persons with speech or hearing difficulties
Options to address Pre-Existing Conditions

• Enroll in a MA-PD for 6 months & then enroll in a Medicare Part D plan & into the Medigap policy once the pre-existing period has passed & enroll in a Medicare Part D plan

• Enroll in another Medigap policy without pre-existing conditions and then move to the preferred Medigap plan

• Example: Jane is 34 and has Multiple Sclerosis. She loses QMB on 12/31/17. She wants to enroll into Transamerica plan C but due to 6 months pre-existing exclusion, she enrolls into First Health at $236.74/mo. She changes plans in 6 months to Transamerica.
Educate on Options

• Submit new medical bills to landlord for possible rent reduction if they are in subsidized housing

• Submit new medical bills to DSS for a SNAP reconsideration in SNAP benefits

• Apply for SNAP benefits if appropriate

• Possible medical bills:
  Medicare Part B premiums, Medigap premiums, cost-sharing responsibilities for MA-PD plan
Medical Care Options

• Refer individuals to Federal Qualified Health Centers
  • Can treat regardless of ability to pay
  • www.chact.org – to find a health center

• Apply for Veteran’s Medical Benefits if eligible

  Will need DD214 Discharge Paperwork
  https://www.archives.gov/veterans/military-service-records

Call 203-932-5711 X 3131 to enroll
Co-pay Relief or other assistance

- Locate potential co-pay relief or other disease specific assistance on www.needymeds.org
  - Click “Advocates”
  - Click “Resources for You”
  - Click on “Diagnosis Assistance Program Update”
RESOURCES

For those losing MSP benefits
Fact Sheets on www.ct.gov/aging

Options over age 65

Options under age 65

Options over 65 enrolled in a Medicare Special Needs Plan

Options under 65 enrolled in a Special Needs Plan

Medigap, QMB and Medicare Advantage – Frequently Asked Questions

Making an Informed Decision: 2018 MSP Changes

Losing Qualified Medicare Beneficiary (QMB) coverage over age 65

If you are single and your monthly income is over $1,226 or married with a combined income of over $1,644, you may be losing your QMB benefits.

You may want to consider the following options if you do not have a secondary insurance such as Medicaid or Veterans Health Benefits:

Option #1:

Primary Coverage: Traditional Medicare (red/white/blue card), you will owe a monthly premium of $134

Secondary Insurance: Purchase any Medigap Plan directly from the plan. Plan F, High deductible Plan F, Plan G or Plan N are popular plans. When selecting, be aware some plans have a period of time where you must wait before your plan will pay for care for a medical problem you had before enrollment, called a pre-existing period. There are many Medigap Plans without pre-existing periods to choose from. Each have different coverage and premiums. Please seek help from a CHOICES Counselor for questions you might have about Medigap Plans.

Prescription Drug Plan – you may already be enrolled in a Part D drug plan. You will continue to receive the “Extra Help” with your drug plan for all of 2018.
Resources

• Frequently Asked Questions (FAQ) about MSP:
  • http://portal.ct.gov/DSS/Health-And-Home-Care/Medicare-Savings-Program/Medicare-Savings-Program/FAQ

• Informational Notice sent by DSS on November 19, 2017:
  http://portal.ct.gov/DSS/Health-And-Home-Care/Medicare-Savings-Program/Medicare-Savings-Program/Documents

• Medigap Rate Sheets:

• Medigap Fact Sheet – Department of Insurance
CHOICES

• Administered through five Area Agencies on Aging

• CT’s State Health Insurance Program “SHIP”

• Free, unbiased information on Medicare options

• Information and Referral Assistance

• Funded by the Administration for Community Living
When to refer to CHOICES?

- Those losing QMB coverage who need help exploring their options

- Those who may qualify for Medicaid and need help applying for benefits (if you do not provide that support)

- Those new to Medicare who need help exploring their benefits

- Refer those losing ALMB/SLMB only if the person needs education around Medicare options.
Consumers can locate information on Medicare.gov.
1-800-Medicare

- Available 24 hours seven days a week
Case Scenario

• Henry is a 45 years old. He collects SSD due to a mental health disability

• He receives $1,400 in SSD and a pension each month. He is losing MSP

• He doesn’t work, but is interested in working

• He has $5,000 in the bank.
Options for Henry

- Henry could be referred to BRS to explore returning to work & for potential MedConnect in the future

- Henry continues to get help with his prescription coverage until 12/31/18

- He receives a lot of medical care.

- What are his options?
Options – QMB in traditional Medicare if 64 years or younger

- **Purchase Medigap Policy A – C**
  - All three Plan C’s have pre-existing condition waiting period.
  - He might consider moving to a MA-PD plan or another Medigap policy without pre-existing conditions and then switching to a preferred Medigap policy once pre-existing condition period is met.

- **Enroll in a MA-PD plan**
  - He would want to enroll in a plan that has his medications on the plan’s formulary and ensure his providers are within the plan’s network.

- Discuss a referral to BRS for assistance in finding employment

- Consider enrollment into Husky C with a spenddown
QMB Recipients over & under 65 (no Medicaid)

Traditional Medicare & QMB

- **Outcome if no action is taken:**
  - Responsible for Medicare Part A & B deductible & cost-sharing.
  - Part B premium is removed from SSA check
  - Continues to receive LIS benefits for Medicare Part D through December 31, 2018
  - They continue to have a SEP while still eligible for LIS
Options – QMB in traditional Medicare
65+

**Education Beneficiary:**
- They can enroll into a Medigap policy at any point
- They can apply for Husky C later (if asset eligible) if they are subject to high medical expenses & then request retroactive coverage up to 3 months back

**Option to Purchase any Medigap policy**
- May be subject to up to 6 months pre-existing condition exclusion
  - May consider purchasing a MA-PD plan to meet pre-existing conditions or a Medigap plan without a pre-existing condition & then switch to their preferred Medigap plan once conditions are met
- Consider high deductible Plan F to lower costs

**Purchase a MA-PD plan**
- Beneficiary should consider network of providers & ensure medications are covered by the MA-PD plan
Options – QMB in traditional Medicare if 64 years or younger

- **Purchase Medigap Policy A – C**
  - All three Plan C’s have pre-existing condition waiting period.
  - They might consider moving to a MA-PD plan or another Medigap policy without pre-existing conditions and then switching to a preferred Medigap policy once pre-existing condition period is met.

- **Enroll in a MA-PD plan**
  - Consider medications and provider networks when making decisions.

- If working, **apply for Med-Connect**. If not, & interested in working, discuss a referral to BRS for assistance in finding employment.

- Consider enrollment into Husky C with or without a spenddown.
Options for those on QMB who have a Medigap regardless of age

• The person will receive benefits under their previous Medigap policy. They can elect a different Medigap policy after they lose QMB benefits

• They can choose to drop their Medigap policy and enroll in a MA-PD plan

• They continue to have LIS and a SEP through December 31, 2018

This group does not need to take action due to loss of QMB
QMB Recipients with Medicaid

Traditional Medicare & QMB & Medicaid

- **Outcome if no action is taken:**
  - Medicaid pays Medicare Part A and B deductible & cost-sharing
  - Part B premium will now be deducted from SSA check
  - Continues receiving LIS benefits for Medicare Part D while they remain active on Medicaid or if they become eligible for LIS under another category.
  - They continue to have a SEP while they have LIS/Medicaid

Those with a Medicare Advantage Plan & QMB & Medicaid:
May be responsible for a MA-PD premium

This group does not need to take action due to loss of QMB
QMB on MA-PD SNP (without Medicaid)

• **Outcome if no action is taken:**
  - Their plan will notify them they are no longer eligible for MA-PD SNP (they may be able to remain on benefits for up to 6 months)
  - Will be enrolled into LINET or auto-enrolled into a Medicare Part D plan because they remain on LIS through 12/31/18.
  - Will return to traditional Medicare & will be responsible for Medicare Part A & B deductibles & cost-sharing.
  - Will no longer be protected by balance billing protections
QMB on MA-PD SNP (not on Medicaid)

- Individuals will need assistance selecting a Medicare Part D or MA-PD plan best suited to their needs.

- Beneficiaries have the same options as those on QMB & traditional Medicare. Those below 65 have limited options for Medigap policies.

- This group would not be subject to a pre-existing waiting period when enrolling in a Medigap policy.
QMB on MA-PD SNP & Medicaid

- Will continue to be eligible for MA-PD SNP due to Medicaid status
- Will not be responsible for Medicare Part A & B deductibles or cost-sharing
- Will have their Medicare Part B premium deducted from their SSA/SSDI check
- Will continue to receive LIS as long as they remain eligible for Medicaid
- Continue to have a special enrollment period

- No action is needed due to loss of QMB
QMB Recipients on Medicaid

- Will lose Medicare Part B premium payments
- Medicaid covers Medicare A & B deductibles & cost-sharing
- They continue on LIS while they remain on Medicaid
- They continue to have a special enrollment period

- No action is needed due to loss of QMB
Questions????