



Statement of

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On

Medicare Programs for Low-Income Beneficiaries
Before the Subcommittee on Health
U.S. House of Representatives
Committee on Ways and Means

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Mr. Chairman, Representative Camp, distinguished members of the Subcommittee. Thank you very much for this opportunity to testify about the Medicare Savings Programs (MSP) and the Part D low-income subsidy (LIS), programs that, together, provide extra assistance to low-income Medicare beneficiaries for some or all of their cost-sharing in Medicare Parts A, B, C and D.

The Center for Medicare Advocacy has a long history of serving dually eligible Medicare beneficiaries in the state of Connecticut and nationally. From our daily connection both with beneficiaries directly and with their advocates around the country, we know first hand about the frailty of this population and the challenges they face getting the health care they need. We know of the challenges of finding and enrolling them in programs that make a huge difference in their access to care.

The Center is grateful to the Committee for its oversight of and legislative concern about these issues and to Mr. Doggett and Mr. Altmire for the important pieces of legislation they have introduced, H.R. 1536 and H.R. 1310, respectively, both of which we support.

I would like to begin my testimony with a story.

My husband turned 65 in the summer of 2005. He was reasonably healthy at the time (and still is). A few months prior to turning 65, he had retired and lost his employer-based health insurance. By filling out a very simple form, he and I were added to my employer's insurance for which we make a monthly contribution that is deducted from my paycheck. Shortly before he turned 65, he received notice from the Social Security Administration of his impending Medicare eligibility with a simple form for him to complete, including a way to inform SSA if he did *not* want Medicare Part B. My husband's switching to my insurance and then enrolling in Medicare required almost nothing of him; what was required could be done by mail and phone.

Contrast his story with that of a 58 year-old disabled New Yorker with emphysema who we'll call Mr. Gonzales. Mr. Gonzales receives \$800/month in Social Security disability payments. After his 24-month waiting period to be eligible for Medicare, he receives the same packet of information that my husband received. The question about whether he wants Part B is a hard one for him to answer because it costs \$93.50/month this year, nearly one eighth of his monthly income. Since he does speak and read English, unlike many low-income Medicare beneficiaries, he is able to read his *Medicare & You*

Handbook and finds, near the front, a reference to help paying health care costs on pages 63-70. On page 63, he sees a reference to help paying premiums, discussed on page 67. On page 67, he sees that to get this help you have to have income less than \$1,123 (so he qualifies on that score) and resources of \$4,000 or less. He has a checking and savings account and a couple of small life insurance policies and thinks the accounts don't add up to \$4,000, so he might be okay.

Mr. Gonzales follows the instruction to turn to page 90 to find out how to apply and there is directed to call 1-800-MEDICARE to get the number for his state Medicaid agency. When he calls the number, he is directed to call his local Department of Social Services. When he calls that number, none of the voice menu choices sounds like the right one for information about help paying Medicare premiums, nor does it tell him how to reach a live agent with his question, so he listens for where the closest office is. He starts the voice menu over again, because he hears one choice that tells him what documents to bring to apply, although again, it does not speak specifically about help paying Medicare premiums.

Mr. Gonzales decides to take his chances and go to the office, which, fortunately for him, is only about 60 blocks away. He waits for two hours before seeing a caseworker. The caseworker he finally sees is not familiar with a program to help pay Medicare premiums, but, again, luckily for him, a caseworker nearby overhears them and tells his caseworker what to do. She asks what papers he has brought to document his name, date of birth, home address, other health insurance and income and resources (actually she is incorrect in asking him to document resources, but she never heard of the program before so didn't know that).

Mr. Gonzales realizes he has left some papers at home and asks how he can get them to her. She says he can fax them, but he doesn't have a fax machine, or he can copy them and send them to her. He leaves the office; it is now late in the day and he is having trouble breathing. He will go to a copying place tomorrow, if he is feeling up to it. If, for some reason like illness or another emergency intervening, he fails to send the papers back to her, his case will be closed for failure to follow up. He is fortunate that he speaks and reads English because he was able to find the program to help him, something that millions of beneficiaries are not able to do. If Mr. Gonzales is found eligible for benefits, he will have to requalify each year by completing forms and documenting his income and resources again.

Mr. Gonzales' story is not nearly as complicated as those of other low-income beneficiaries, who might be sicker, less literate, not speak English, not have a telephone or in other ways be less able to find the program and take the steps needed to enroll in it, but nevertheless, it demonstrates the extreme demands placed on those attempting to qualify for necessary benefits and support, often at a time when they actually need health care.

Mr. Chairman and distinguished members, I ask that we make our policy and implementation goals the creation of parity between wealthier Medicare

beneficiaries and low-income beneficiaries in ease of enrollment in health insurance programs Right now, the burden is much heavier on those who are poorer and sicker and far less able to endure the rigors of complex processes.

Most of the rest of my testimony will suggest ways to move toward that parity by expanding benefits and aligning eligibility rules of the programs, by improving identification of and outreach to beneficiaries, and by addressing enrollment challenges. I will also comment briefly on issues that arise for beneficiaries who are enrolled in these programs in using those benefits.

Medicaid

But before I talk about MSP and LIS, I want to remind us all that the program that most comprehensively serves low-income Medicare beneficiaries is Medicaid. Medicaid was passed in 1965 as a companion to Medicare, in large part to act as a supplement to Medicare's coverage for older people. More than 6 million Medicare beneficiaries get, through Medicaid, such services as long-term care, dental care, foot care, and eye care that are not available under Medicare. They get Medicare Part B premiums paid for them. Until 2006, they got prescription drugs from Medicaid. Now, their Medicaid status entitles them to the full Part D low-income subsidy. Medicaid is the single largest program of extra assistance to low-income Medicare beneficiaries, serving more people with more extensive benefits than, for example, Medicare Advantage plans.¹ Its creation, early on, is a recognition that Congress has long been concerned about assuring access to care for this very vulnerable population.

Low-Income Beneficiaries and Other Programs to Help Them

Medicaid recipients and other low-income Medicare beneficiaries are frailer, more disabled, higher users of health services, have less education, and are more likely to be minorities, more likely to be females, more likely to live alone or in an institution than better off beneficiaries. Over the past two decades, beginning in 1986, Congress has responded to their health care needs by creating programs to increase their access to care. These are the programs we know today as the "Medicare Savings Programs" (Qualified Medicare Beneficiary or QMB, Qualified Disabled and Working Individual or QDWI,² Specified Low-Income Medicare Beneficiary or SLMB, Qualified Individual or QI) and the Part D Low-Income Subsidy or LIS.

Medicare Savings Programs

The Medicare Savings Programs are operated through state Medicaid programs. The benefits are Medicaid benefits, paid for with federal and state dollars, using each state's

¹ Edwin Park and Robert Greenstein, "Low-Income and Minority Beneficiaries Do Not Rely Disproportionately On Medicare Advantage Plans: Industry Campaign to Protect Billions in Overpayments Rests on Distortions." Center on Budget and Policy Priorities, April 12, 2007 at 2.

² The QDWI program, enacted in 1989, is little used and is not part of the discussion in this testimony.

Medicaid matching rate for federal financial participation. In determining eligibility for benefits, states must use at least the federal standards for measuring income and resources, but are allowed to be more generous. States differ in the ways they choose to be more generous, if at all.

The salutary effects of Medicaid and Medicare Savings Programs on low-income beneficiaries were noted by the National Academy of Social Insurance (NASI) in its June 2006 report “Improving the Medicare Savings Program.”³ NASI cites the Medicare Payment Advisory Commission’s (MedPAC) finding that *while 23% of Medicare-only beneficiaries report that they delay seeking medical care because of costs, only 8% of those with Medicaid so report.* Other research cited by NASI finds that QMB enrollees, for whom Medicaid assumes responsibility for all Medicare cost-sharing, are half as likely as non-enrollees to avoid visiting a doctor because of concern about cost. (NASI 2006)

Despite the identified health benefits associated with these programs, participation rates for MSPs have been abysmal (33% for QMB-only, 13% for SLMB-only, according to the Congressional Budget Office⁴). Barriers to MSP enrollment, which have been documented in countless studies and reports over the past nearly two decades, include health, literacy, language and transportation deficits of the target population; lack of awareness of the programs on the parts of potential beneficiaries, community-based organizations and agency workers; and the complexity of eligibility rules and enrollment processes, including requirements to report and document assets and, in some cases, requirements, such as Mr. Gonzales experienced, for face-to-face interviews with eligibility workers.

Differences between the Part D Low-Income Subsidy and Medicare Savings Programs

Part D’s fully federal low-income subsidy and its implementation were modeled on MSPs, with slight, but nonetheless significant, differences. These differences, or non-alignments, make it difficult to assure that low-income Medicare beneficiaries get all the benefits that will best help them gain access to the health care they need. Differences include:

- LIS applications can be taken at both the state Medicaid agency and at the Social Security Administration; MSP applications are taken only at the state Medicaid office.
- LIS applications can be submitted on-line; this is true only in a few states for MSPs.

³ Report of the Study Panel on Medicare/Medicaid Dual Eligibles, “Improving the Medicare Savings Programs,” National Academy of Social Insurance June 2006. http://www.nasi.org/usr_doc/Improving_the_Medicare_Savings_Programs.pdf (last visited April 29, 2007).

⁴ Congressional Budget Office, “A Detailed Description of CBO’s Cost Estimate for Medicare Prescription Drug Benefit.” July 2004 <http://www.cbo.gov/showdoc.cfm?index=5668&sequence=0> (last visited April 30, 2007).

- LIS applicants can certify to the truth of the statements in their applications, without having to provide documentation with the application; this is true only in some states for MSPs.
- LIS application process does not require a face-to-face interview; a few states do for MSPs.
- LIS income and resource counting rules are uniform throughout the country; MSP rules vary by state.
- LIS resource levels are higher than those of most states' MSPs and the income level for the partial LIS subsidy is higher than that of MSP in all but two states.
- LIS does not count non-liquid assets such as vehicles and equipment; MSPs vary by state.
- LIS does not seek to recover benefits from the estates of deceased beneficiaries; in some states, MSP benefits are recovered.
- LIS is effective the first day of the month in which an individual expresses an interest in applying; the MSP QMB benefit is effective only the first day of the month after a beneficiary's eligibility has been determined; SLMB and QI can be effective up to three months prior to the month of application, if the beneficiary was eligible in those months.
- LIS measures income against the poverty level for the actual size of the applicant's family; MSPs in most states use a measure of one or two person families only.⁵

It was hoped and perhaps expected by policy makers and advocates that the streamlined enrollment process and higher income and resource eligibility standards of the LIS would help overcome some of the barriers that have plagued MSP enrollment over the years. Yet enrollment numbers tell us something different. More than 3 million of the estimated 13.2 million thought to be eligible for the low-income subsidy have not applied for the benefit; indeed only 14% of those CMS estimates are eligible for the benefit have enrolled through the processes created for applying for LIS.

*By contrast, nearly 8.5 million people, or 80 % of those who were receiving LIS in June 2006 received it because they are deemed eligible by virtue of their enrollment in full Medicaid, a Medicare Savings Program, or the federal income benefit, Supplemental Security Income (SSI) and did not have to take any action themselves to get it.*⁶

This “automatic” enrollment, through deeming by virtue of eligibility for another benefit, corresponds more closely to my husband's experience of signing up for Medicare Parts A and B than it does to Mr. Gonzales' experience of trying to get MSP benefits in New York. In fact, we know that Medicare Parts A and B have among the highest participation of any benefit programs (99% and 95.5% respectively, according to one

⁵ For a detailed discussion of these differences, see Patricia B. Nemore, Jacqueline A. Bender and Wey-Wey Kwok, “Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules.” Kaiser Family Foundation May 2006.

⁶ “Medicare: Prescription Drug Coverage Among Medicare Beneficiaries,” Kaiser Family Foundation June 2006. Source: HHS, June 14, 2006. www.kff.org/medicare/upload/7453.pdf (last visited April 28, 2007).

source⁷); eligibility for Part A is automatic for most beneficiaries; for Part B, beneficiaries must opt out if they do not wish to participate.

This knowledge suggests that while we might take many steps toward improving participation rates, the ones that will be most effective are those that put the least burden on the beneficiary, just as signing up for Medicare placed little burden on my husband.⁸ This, in turn, suggests a stronger federal role in MSP and expanded federal screening opportunities for LIS, which I will discuss further.

First, I would like to talk about program expansions and modifications that will promote ease of enrollment.

Expanding Program Benefits

Make the Qualified Individual program (135% FPL) permanent and align MSPs with LIS income levels.

The QI program, originally scheduled to sunset in 2002, has been extended for short periods of time over the past five years. Each time it is scheduled to end, states and beneficiaries suffer great turmoil with the uncertainty of its existence. Congress, in setting the full LIS benefit at 135% FPL, established that level as a minimum for full benefits. MSPs should be amended to reflect that development in Congressional thinking.

Several approaches have been discussed among advocates and policy makers to achieve this. One is to roll the QI program into the SLMB program, so that QMB would go to 100% FPL and SLMB would go to 135% FPL. The 135% aligns them with the LIS full subsidy; the partial subsidy would remain at 150%, with no corresponding MSP.

A variation on increasing SLMB to 135% FPL, suggested by NASI in its 2006 report, is to increase QMB to 135% FPL so that those who receive the full subsidy for LIS under Part D would also get full cost-sharing assistance for Parts A, B and C. This approach is the most logical one, again reflecting Congress recognition that people with this amount of income need full benefit assistance, not merely help with their Part B premiums, as SLMB provides. Under this approach, QMB and full LIS would be aligned vis a vis income; SLMB might be expanded to 150% FPL to align with the partial LIS.

Make QMB benefits retroactive to three months before application.

This is a relatively small change that could be very significant for beneficiaries.

⁷ Dahlia K. Remler and Sherry A. Giled, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," The Commonwealth Fund, May 2003.

⁸ See National Council on Aging, "Cost-Effective Strategies for Finding and Enrolling Low-Income Medicare Beneficiaries in the Limited Income Subsidy (LIS) And Other Key Public Benefits" for discussion of creative state strategies to reach across programs to identify and enroll beneficiaries in low-income programs. Submitted as Appendix to Testimony of Howard Bedlin before U.S. Senate Special Committee on Aging, January 31, 2007. Copies are available through pnemore@medicareadvocacy.org.

Currently, QMB is the only Medicaid program that does not provide retroactive coverage to three months prior to application if the beneficiary was eligible during those months. In fact, QMB coverage is available only beginning the month after eligibility has been determined. The significance of this is that many beneficiaries become aware of programs at the point of need (see NASI study), i.e. when they are using health benefits. They will need the benefit to pay for the services they are receiving; if it cannot be granted with retroactive coverage, it is less valuable to them.

Expand and align, or eliminate the assets test.

For years, advocates and researchers have identified assets tests as a barrier to benefits for several reasons.⁹ To meet the test itself, beneficiaries must engage in time consuming and sometimes complex documentation of the value of various things they own, from bank accounts to vehicles to other property, other than their home. This process results in administrative costs to agencies processing applications and can result in beneficiaries being denied, not for being over assets but for failure to complete the process, such as might have happened to Mr. Gonzales if he didn't get his papers back to the caseworker. Moreover, some potential beneficiaries are unwilling to divulge their assets to anyone and will forego benefits rather than having to reveal the value of what they own.

As part of a program (such as MSP) whose income eligibility increases each year with new poverty guidelines, the MSP asset test (like those in other parts of Medicaid) is especially unfair because it is not indexed. Thus, while income limits for 100% FPL have nearly doubled since 1988 when the QMB program became mandatory (\$5,770 in 1988 to \$10,210 in 2007 for one person), the asset level has remained the same over that 20 year period. Once again, Congress has finally recognized the unfairness of an unindexed asset level; the LIS level changes each year according to the Consumer Price Index.

The asset test excludes many low-income beneficiaries. In 2002, researchers identified that 40% of all Medicare beneficiaries, not just those with low-incomes, had assets less than \$12,000.¹⁰ Other research, reported the same year, identified that only 48% of those who met the income requirements in effect that year also met the asset requirements.¹¹ Modest assets exclude many people from program benefits: SSA found that about 40% of those who did not qualify for LIS in 2006 were over assets, but the average total

⁹ For discussions of the effects of the asset test on Medicare Savings Programs and on the LIS, see NASI, *supra* note 2, Thomas Rice, PhD and Katherine A. Desmond, M.S. "Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test," prepared for the Henry J. Kaiser Family Foundation, April 2005; Laura Summer and Lee Thompson, "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits," The Commonwealth Fund, May 2004; Laura Summer and Robert Friedland, "The Role of the Asset Test in Targeting Benefits for Medicare Beneficiaries," Commonwealth Fund, October 2002; Marilyn Moon, Robert Friedland and Lee Shiry, "Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs," Henry J. Kaiser Family Foundation, June 2002.

¹⁰ Moon, *supra* note 9.

¹¹ Summer and Friedland, *supra* note 9.

amount of assets of those disqualified was only about \$25,000.¹² Most State programs for pregnant women and children do not consider assets at all in determining eligibility for help with medical care.¹³ Only six states have eliminated the asset test for MSPs.¹⁴

The most streamlined way to proceed would be to eliminate the asset test for both programs. This approach, coupled with increasing QMB or SLMB to 135% of FPL would bring the two programs into closest alignment and make cross-deeming easy and logical. Mr. Doggett's bill proposes to increase the assets test to \$27,500 for the partial subsidy. This level, indexed, would capture many of those denied eligibility in 2006 due to being over assets. The bill includes changes to counting assets, described earlier, to eliminate consideration of life insurance and of retirement accounts. Such modifications will be important if the asset test is not eliminated. Any asset test, however, retains the barriers of administrative complexity and beneficiary reluctance to divulge information. I know Mr. Doggett is aware of those limitations.

Closer alignment would, in turn, make screening and enrolling at either a Medicaid office or a Social Security office more efficient and effective.

Screening, Enrolling, and Deeming

Screen and Enroll. Mr. Doggett's legislation, H.R. 1536, includes an important provision to expand screening: a requirement that CMS inform all new Medicare beneficiaries of the Part D LIS and give them an opportunity to be screened for the benefit, including through the use of IRS data about income and assets. Mr. Doggett also proposes to have SSA screen all LIS applicants for MSP eligibility. The next step is to determine a streamlined way to enroll them.

Screen (and enroll when eligible) all SSI applicants. Even under current law and program rules, the Social Security Administration could screen for LIS and basic MSP¹⁵ all applicants (or at least those 65 and older) for SSI who are found ineligible for that benefit. While SSA already does this screening for those who are Medicare beneficiaries, some applicants may not have Medicare because they didn't "earn" it through quarters of coverage and they cannot afford the Part B premium. If they were found eligible for MSP, they could then get Medicare and be eligible for Part D and deemed eligible for LIS. According to NASI, SSA already screens for MSP eligibility, but it does not enroll beneficiaries in those programs. It refers them to their state Medicaid agency; advocates

¹² Social Security Administration, "LIS Denial Studies," 12/11/06.

¹³ See ChipCentral chart on SCHIP eligibility at http://www.chipcentral.org/catdisp_page.cfm?LID=121 (last visited April 28, 2007). See also Donna Cohen Ross and Caryn Marks, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," The Kaiser Commission on Medicaid and the Uninsured, January 2007 at <http://www.kff.org/medicaid/upload/7608.pdf> (last visited April 28, 2007).

¹⁴ AZ, AL, DE, ME, MS, VT. In addition, MN has raised its asset limit to \$10,000.

¹⁵ By basic MSP, I mean MSP based on federal rules, rather than the varying more liberal rules used by the states. Such a screen and enroll by SSA would capture many MSPs; those found ineligible through this process could be referred to their states for further consideration.

report that requiring this entire second process makes it unlikely that beneficiaries will follow up. SSA's experience, as reported by NASI, confirms this view. In addition to requiring screening for unsuccessful SSI applicants, the law could be amended to provide for automatic QMB eligibility for all SSI recipients.

Cross-deem. Under current law and implementation, all MSP beneficiaries are deemed eligible for LIS without having to file an application; the same is not true for LIS enrollees to receive MSP. Even without the proposed expansions described above, Congress could allow for cross-deeming that would improve enrollment in both programs by assuring that whichever "door" to eligibility beneficiaries entered, if found eligible for one program, they would also receive the benefits of the other.

Avoid adverse consequences. Any process that deems or auto-enrolls beneficiaries into a public program must include the assurance that the beneficiary will be protected from losing other public benefits as a result of the program. With respect to MSPs, this would require amending the law to ensure that MSP benefits are not subject to Medicaid estate recovery requirements, as they currently are at the option of the state. With respect to LIS, a change in the law might assure that so-called medically needy Medicaid recipients would not cycle on and off Medicaid and the low-income subsidy from year to year.¹⁶

Other Steps to Improve Program Participation

Additional steps to improve enrollment and continued participation might be categorized as

- Identifying/reaching out to beneficiaries and providing help with applications, and
- Simplifying enrollment and redeterminations.

Identify, reach out, and help beneficiaries.

Advocates believe that potential beneficiaries could most accurately be identified through IRS data; Mr. Doggett's legislation proposes a one time review of IRS data for current Medicare beneficiaries to improve identification of low-income beneficiaries, with a prospective use of the data, for new beneficiaries, only with their permission. IRS data would more precisely target potential beneficiaries who are, under current law, identified

¹⁶ The plight of medically needy Medicaid recipients is particularly complex and difficult with respect to Part D and the LIS. The medically needy must show their state that they have accrued certain medical bills before they are entitled to Medicaid. Once they have accrued their "spenddown" amount, Medicaid will pay the rest of their health care costs for a certain period of time, usually between one and six months. A medically needy person who met spenddown at any time in 2005 was deemed eligible for LIS for all of 2006. But if they had met spenddown in 2005 with high prescription drug bills, they did not have those bills for 2006 because of LIS. So they may have lost Medicaid in 2006 and thus not have been deemed for LIS for 2007. If they do not know to apply for LIS, or if they do not qualify, they will again have high drug bills in 2007, requalify for Medicaid and likely then be deemed eligible for LIS for 2008 (at least, if they are on the Medicaid rolls in the months that CMS looks at them to determine who will be deemed eligible for LIS. This roller coaster eligibility for Medicaid and LIS would be substantially mitigated, if not fully resolved, if the amount Medicare pays for the LIS counted toward their medically needy spenddown.

by SSA only by reference to their sources of federal income (from Social Security, Railroad Retirement, Civil Service and Veterans).¹⁷

While it is important to notify beneficiaries of their entitlement to benefits that can help them, experience tells us that a letter informing individuals of a benefit and how to apply for it, without more, has limited success. To the extent that beneficiaries must continue to be faced with the challenges of navigating complex eligibility rules and requirements, federal funds must be provided either directly to the entities that are the “trusted” source for specific hard to reach populations, or to states to provide grants to such entities, so that those entities can help potential eligibles apply for benefits. Congress, SSA and CMS should explore the possibilities of providing private, non-profit beneficiary-oriented “trusted sources” with specific beneficiary identifying information, by zip code to promote enrollments.

Simplify enrollment and redeterminations.

Application

- **In-kind support and maintenance.** The LIS application asks for information about help the applicant gets from other family members – what SSA calls In Kind Support and Maintenance (ISM). The question is confusing and advocates report from experience that clients often don’t understand what is being asked of them and give wrong answers that may disqualify them. Moreover, the consideration of ISM in determining eligibility provides a disincentive for families to help their members. More than a third of the states have eliminated this inquiry from their MSP eligibility considerations. SSA could probably do the same under existing law through the Medicare Act of 2003’s directive to it to create a simple application process.
- **Value of life insurance.** Similarly, SSA asks applicants to report the cash surrender value of life insurance, an amount that is not known from the face value of the policy. Advocates believe this question poses a stumbling block, slowing down the application completion while the beneficiary tries to figure out how to find out what is asked of her or him. Moreover, research shows that about one-third of people with incomes at the poverty level would be disqualified because they have a life insurance policy above the allowed amount of \$1,500.¹⁸ Some states have eliminated this requirement for MSPs; others allow a higher amount of life insurance. SSA could probably eliminate this requirement for LIS under existing authority; it has already exercised discretion to modify the SSI rules to which LIS is linked by not counting non-liquid resources. Mr. Doggett’s bill would eliminate consideration of life insurance for LIS; it would also eliminate consideration of retirement accounts in determining eligibility. This provision

¹⁷ Section 1144 of the Social Security Act directs SSA to identify Medicare beneficiaries potentially eligible for MSPs and LIS and to communicate that information to those beneficiaries and to the state in which they reside. The information upon which SSA makes such determinations does not include non-federal sources of income, nor does it include any estimate of resources.

¹⁸ Laura Summer and Lee Thompson, *supra* note 9.

creates parity between those whose retirement benefits are through a company pension program (value not counted for LIS) and those whose benefits are primarily from an Individual Retirement Account or a 401(k) type account (value counted for LIS). While states are free to eliminate consideration of both of these resources, they are not required to do so. Better aligning MSP and LIS would require legislation addressed to this issue for both programs.

- **Attestation under penalty of perjury.** While SSA's LIS application does not require documentation of the information provided, its attestation clause is overly precise and frightening. It suggests to applicants that if they make an honest mistake, or forget to include some requested information, they can go to prison. This language should be softened.
- **Authorization of information sharing between SSA and states.** Currently, SSA plans to send brief identifying information about LIS applicants to states to allow them to screen for MSP eligibility. But the information to be provided is not precise enough for the state to determine eligibility without finding the potential beneficiary. SSA's LIS application could include a check off box by which the applicant authorizes SSA to share details of the application with the state so the applicant can be screened for other benefits.

Eliminate Estate Recovery for MSP Benefits

Nearly half the states require recovery of MSP benefits from the estates of deceased beneficiaries; federal law authorizes but does not require this. Estate recovery has long been identified as a barrier to enrollment for MSPs. Its elimination would promote greater interest in the benefits and make various automatic enrollment opportunities more salient. As noted above, it is essential to make this change if beneficiaries are automatically enrolled in MSP programs through other connections.

Redeterminations

The law requires the Commissioner of SSA to redetermine eligibility for the subsidy at least once after initial determination and after that, as he determines necessary. Advocates encourage programs to use processes that require the least amount of response from a beneficiary. SSA sent beneficiaries letters asking them if their circumstances had changed and if not, they were not required to do anything more. Once the initial redetermination is completed, SSA might consider, as it has authority to do, requiring nothing more of beneficiaries than that they report changes in circumstances.

Additional paths exist for requalifying for LIS can be confusing, especially for those whose circumstances fluctuate over the course of a year. Those who were deemed eligible for LIS – that is, those who are also enrolled in Medicaid, a Medicare Savings Program, or SSI - were re-deemed for 2007 if they were on the rolls in one of these programs in July of 2006. If they had been eligible earlier in the year, but not in July, they were informed they would not be deemed again and sent an application to apply for LIS through SSA. If they became eligible through Medicaid, MSP or SSI later in the year, they were once again deemed. So much moving in and out of deemed status, and

having applications pending results in errors in plans' and pharmacies' knowledge of the correct cost-sharing to apply to beneficiaries. This, in turn, results in beneficiaries being unable to get drugs because they cannot afford the non-LIS co-pays charged.

When a Medicaid beneficiary loses eligibility for Medicaid benefits, states have an obligation under Medicaid law to determine if that person is eligible under another category of the state's program. For example, someone losing Medicaid eligibility might, nonetheless, still be eligible for a Medicare Savings Program, since these income and resource limits are higher than Medicaid in most states. If states routinely undertook these new determinations of eligibility for other Medicaid benefits before terminating people from the program, fewer LIS recipients would find themselves in the limbo of not knowing about their LIS status. Similarly, even for those individuals no longer eligible for any benefits under the state Medicaid program, the state or the Social Security Administration (SSA) could undertake independently to determine their eligibility for the LIS, the income and resource limits for which are higher than those of most states' Medicaid programs.

CMS could remind states of their obligation to screen for eligibility for other Medicaid programs when a recipient loses Medicaid in one category and monitor their compliance. Congress could amend the law, if necessary, to require states to undertake independent determinations of LIS eligibility when a beneficiary loses benefits under the state Medicaid program.

Making the Benefit Better for those who are Enrolled

While I know the Committee's focus for this hearing is on opportunities to increase enrollment and expand eligibility, it is impossible for me not to talk about ways to improve the benefits themselves, both so that they are perceived to be valuable and so that they are valuable. Three areas warrant particular attention:

- Failure of LIS co-pay information to be available at the pharmacy
- Lack of clarity about whether and how states pay cost-sharing for QMBs in Medicare Advantage plans and
- Lack of clarity about Medicare providers' obligation to serve QMBs without charging them cost-sharing or balance billing.

LIS fails to be available at the pharmacy counter.

Too often low-income beneficiaries with full LIS arrive at the pharmacy to discover that the pharmacist does not have access to their correct co-pay level. Some of these beneficiaries take 20 medications, or have co-pays for one prescription of over \$500. They often leave without the medication(s). The lucky ones find advocates who will work the system for them and get the problem corrected. Even "corrected" problems are sometimes only corrected for the transaction at hand; the same problem occurs when the beneficiary seeks to fill another script.

The failure of LIS eligibility and co-pay level to be available at the pharmacy is among the most common complaints we hear both directly from beneficiaries and from advocates around the country. It happens in part because of the lack of real time information exchange among all parties to a Part D transaction for low-income beneficiaries: states, CMS, SSA, the Part D plan and independent contractors who track LIS information. It also results from plans' failure to follow CMS policies which direct them to use the best available information to determine proper cost-sharing amounts.

There is a lack of clarity about whether and how states pay cost-sharing for QMBs in Medicare Advantage plans.

CMS policy directs that states pay copayments for QMBs in Medicare Advantage plans.¹⁹ But states do not necessarily have systems to fully identify all the benefits in the plan in which a QMB is enrolled, nor do they all have systems for paying either the plan or the plan's providers any copayments required under the plan.

Correcting this lack of clarity and oversight for QMBs in MA plans will improve the benefit for all such individuals. It will also mitigate the damage done by marketing scams where agents of health plans go door-to-door at senior housing facilities to solicit enrollment in MA plans, enroll beneficiaries with diminished capacity or limited English proficiency, or enroll beneficiaries in an MA-PD when they wanted to enroll in a PDP. Under such circumstances, low-income beneficiaries end up in plans they did not intend to choose. Moreover, we know that, while MA plans purport to provide better and more benefits than original Medicare, their relative value depends in large measure on what services are used. We know of plans, for example, that have \$90/day co-pays starting at day 4 of a skilled nursing facility benefit; under original Medicare, by contrast, days 1-20 have no cost-sharing at all. Some plans charge 25-30% coinsurance on Part B-covered drugs, which are often expensive. Such a coinsurance would be unaffordable to someone with \$850/month income, as a QMB would have. Cost-sharing assistance would be critical to making the benefit work. CMS must assure that states have systems to identify QMBs in MA plans and to pay their cost-sharing.

There is a lack of clarity about Medicare providers' obligation to serve QMBs without charging them cost-sharing or balance billing.

Medicare does not permit providers to pick and choose for which Medicare beneficiaries they will bill Medicare and for which they will bill privately. If they take care of a patient with Medicare, they must bill Medicare and can bill the beneficiary only the remainder up to the Medicare allowed amount. For a person with QMB, the beneficiary's portion is paid by the state, or in some cases, not at all. It is not the responsibility of the person with QMB. CMS policy, however, seems to permit providers to decide that they

¹⁹ DHHS, Health Care Financing Administration, Medicaid Letter Number: 00-09, Subject: Medicaid Obligations to Pay Medicare Cost-sharing Expenses for Qualified Medicare Beneficiaries in Medicare Health Maintenance Organizations or Competitive Medical Plans or Medicare Plus Choice Organizations – INFORMATION. August 2, 2000. Available from pnemore@medicareadvocacy.org.

will serve a person with QMB as a private pay patient and not bill Medicare at all.²⁰

This policy, together with a provision of law that permits states to forego paying the person with QMB's share of cost-sharing if the state's Medicaid payment for the same service is less than what Medicare has paid has resulted in people with QMB being denied access to health care providers, according to a federally-mandated study released in 2003.²¹ Perhaps Congress could direct CMS to correct its policy of allowing providers to bill people with QMB as private patients; such action would promote greater access to health care providers for people with QMB and make the benefit more valuable.

Conclusion

In summary, we recommend that Congress expand the benefits, make the enrollment processes easier, with greater emphasis on deeming and other nearly automatic methods of enrollment and promote improved implementation of both programs, so that low-income beneficiaries can actually use the benefits once they are enrolled.

I thank the members of this Subcommittee for an opportunity to speak on behalf of the Center for Medicare Advocacy and the thousands of beneficiaries we represent. I look forward to working with you further on these important matters.

May 3, 2007

²⁰ State Medicaid Manual, Part 3 Eligibility Section 3490.14 B at <http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10> (last visited April 23, 2007).

²¹ Report to Congress, State Payment Limitations for Medicare Cost-Sharing, Tommy G. Thompson, Secretary of Health and Human Services 2003, transmitted by letter of May 20, 2003 to Speaker of the House of Representatives, J. Dennis Hastert.

Appendix

MEDICARE SAVINGS PROGRAMS (MSPs)

Basic Subsidy Eligibility:

- **Qualified Medicare Beneficiary (QMB).** Income at or below 100% federal poverty level (FPL) (\$10,210/year in 2007); resources at or below \$4,000/individual or \$6,000/couple.
- **Specified Low-Income Medicare Beneficiary (SLMB).** Income at or below 120% FPL (\$12,252/year in 2007); resources as QMB.
- **Qualified Individuals (QI).** Income at or below 135% FPL (\$13,784/year in 2007); resources as QMB.

Indexing: Income levels change each year when federal poverty levels are announced between January and March; states must use the new levels by July 1. Asset levels are not indexed.

Income/Resource Counting Rules: Start with rules for Supplemental Security Income program, but states, under a statutory provision known as 1902(r)(2), can use more liberal rules.

Enrollment Path: The State Medicaid Agency.

Payment: Federal and state dollars. MSP benefit is medical assistance, eligible for the state's matching rate for federal financial participation (FFP). FFP for administrative costs is 50%.

2007 MEDICARE SAVINGS PROGRAM GROUPS

Category	Year Enacted	Income Limit	Resource Limit	Medicaid Pays	Entitlement
<i>Qualified Medicare Beneficiaries (QMBs)</i>	1988	100% of poverty	200% of SSI limit (\$4,000/individual, \$6,000/couple)	Part B premium; Part A premium, if any; all deductibles and coinsurance	Yes
<i>Specified Low-Income Medicare Beneficiaries (SLMBs)</i>	1990	120% of poverty	200% of SSI limit (\$4,000/individual, \$6,000/couple)	Part B premium only	Yes
<i>Qualifying Individuals (QIs)</i>	1997	135% of poverty	200% of SSI limit (\$4,000/individual, \$6,000/couple)	Part B premium only	No

Chart Source: "Report of the Study Panel on Medicare/Medicaid Dual Eligibles: Improving the Medicare Savings Programs,"

National Academy of Social Insurance, June 2006

<www.nasi.org/usr_doc/Improving_the_Medicare_Savings_Programs.pdf>

MEDICARE PART D LOW-INCOME SUBSIDIES (LIS)

Basic Subsidy Eligibility: Full subsidies for beneficiaries with incomes at or below 135% of federal poverty levels (FPL) (\$13,784/year in 2007); resources up to \$7,620/individual and \$12,190/couple in 2007. Partial subsidies for those with incomes at or below 150% of FPL (\$15,315/year in 2007); resources of not more than \$11,710/individual or \$23,410/couple in 2007.

Indexing: Income levels based on federal poverty levels announced between January and March; increases retroactive to January. Asset levels adjusted prior to January, based on the Consumer Price Index.

Income/Resource Counting Rules: Generally, those of Supplemental Security Income (SSI) program.

Enrollment Paths:

- **Deemed status.** For those who receive benefits of full Medicaid (dual eligibles), Medicare Savings Programs (QMB, SLMB, QI), or SSI.
- **SSA door.** By application, through a local SSA office, through the SSA toll-free number, or through the SSA website at www.socialsecurity.gov.
- **Medicaid agency door.** By application at the state Medicaid agency. If a beneficiary applies for LIS with the state, the state must also screen for MSP and other Medicaid benefits.

Payment: Benefit is all federal dollars. When states enroll beneficiaries, the states are paid at the Medicaid administrative match rate of 50%.

2007 LOW-INCOME SUBSIDY GROUPS AND COSTS

<u>Out-of-Pocket Costs</u>	<u>Standard Benefit</u>	<u>Group 1</u> Dual Eligibles	<u>Group 2</u> MSP (QMB, SLMB, QI) SSI w/o Medicaid	<u>Group 3</u> Income ≤ 135% FPL Resources Below \$7,620/\$12,190	<u>Group 4</u> Income ≤ 150% FPL Resources Below \$11,710/\$23,410
Premium	Varies by plan (\$27.35 national average in 2007)	\$0	\$0	\$0	Sliding scale: \$0 up to “benchmark” (Based on income)
Deductible	\$265 per year	\$0	\$0	\$0	\$53
Cost Sharing*	Up to \$3850 out-of-pocket	Co-pays: \$0 if institutionalized \$1/\$3.10 ≤ 100% FPL \$2.15/\$5.35 > 100% FPL	\$2.15/\$5.35 co-pay	\$2.15/\$5.35 co-pay	15% coinsurance
Catastrophic Coverage	Greater of 5% or \$2.15/\$5.35 co-pay	\$0	\$0	\$0	\$2.15/\$5.35 co-pay

*Individuals in the four LIS groups do not have the “Donut Hole” gap in coverage.