Medicare Rights Center

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"Medicare Savings Plans and Low Income Subsidy: Keeping Medicare's Promise for Seniors and People with Disabilities"
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Committee on Energy and Commerce
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Chairman Pallone, Ranking Member Deal, distinguished members of the subcommittee on health of the House Energy and Commerce Committee, thank you for this opportunity to testify on the Medicare Savings Programs and Extra Help, the low income subsidy under Medicare Part D. I am Monica Sanchez, Deputy Director of the Medicare Rights Center.

The Medicare Rights Center is the largest independent source of health care information and assistance in the United States for people with Medicare. Based in New York City, we have been working for nearly two years to sign as many people up for Extra Help as possible. With private funding from the Starr Foundation and Robin Hood, among others, but with no federal financial support, we have enlisted hundreds of volunteers to reach out to likely candidates for Extra Help, explain the program to them and, whenever possible, enroll them online. We also have a longstanding partnership with New York City to help enroll individuals in the Medicare Savings Programs.

The Medicare Rights Center knows, from our direct experience with the people we serve, that the financial assistance available through Extra Help or the Medicare Savings Programs enables impoverished older adults and people with disabilities to obtain the medical care they need and the medicines they are prescribed. Literally, access to these programs can mean a healthy life instead of illness and premature death.

Let me begin with a story that illustrates the kind of assistance the Medicare Rights Center provides to people with Medicare. This true story illustrates vividly the importance of Medicare Savings Programs to people trying to get by on limited, fixed incomes. It also illustrates the pitfalls and problems that low-income people with Medicare face in getting that help.

Last week, an MRC counselor was on her daily visit to one of the senior centers that serve low income people with Medicare. At the One Stop Senior Center on West 90th St., in New York she met Altagracia Lopez. Ms. Lopez is 72 years old. She was born in the Dominican Republic and has lived in the U.S. for forty years, spending most of her working life in a factory stitching together children's clothes. She gets by on $343 a month and $100 in food stamps and lives in public housing.

Last spring, Ms. Lopez was accosted on the street by a salesman for a Medicare Advantage HMO. After talking his way into her home, the salesman convinced Ms. Lopez that she would have better drug coverage under the HMO he was selling than under her current plan, and, since Ms. Lopez receives both Medicare and Medicaid, he enrolled her effective May 2006. In her new HMO, Ms. Lopez has been paying copays of up to $25 for doctor visits; with Original Medicare and Medicaid, her copays were zero. Things got worse in 2007 when her HMO switched her to a new plan. During the switch, the HMO lost its record of Ms. Lopez's eligibility for Extra Help, which she receives because she is enrolled in Medicaid. Instead of copayments of a few dollars under Extra Help, she had to pay $127 for Plavix, a blood thinner, and $42 for her diabetes medicine.

Ms. Lopez still owes $90 on her deductible and was trying to find a way to pay for her hypertension drugs.

It's a good thing we ran into Ms. Lopez at the senior center. The Medicare Rights Center counselor faxed the proof of Ms. Lopez's Medicaid eligibility to her HMO and convinced customer service that the plan is required, under federal guidelines, to accept this proof and inform the pharmacy to charge Ms. Lopez the $1 and $3 Extra Help copayments. Now, Ms. Lopez can buy the medicine to control her high blood pressure. We have also enrolled Ms. Lopez in the Qualified Medicare Beneficiary (QMB) program, disenrolled her from her HMO and helped her find a Part D drug plan that covers her medicine. As a result, she will no longer have the $93.50 Part B premium deducted from her Social Security check, she will be automatically enrolled in Extra Help and she will not be charged a copayment when she goes to see her doctor.

The issues surrounding Ms. Lopez's enrollment and disenrollment from her Medicare Advantage plan are not the specific focus of this hearing, although I do hope this committee will look into how dual eligibles—people with both Medicare and Medicaid—have been the particular targets of aggressive marketing by HMOs and other Medicare Advantage plans. For unscrupulous sales agents, people with Medicare and Medicaid can be a gold mine, since they are allowed to change plans on a monthly basis. In fact, another Medicare Advantage HMO parks a van outside the One Stop Senior Center and hounds people who are waiting to go into the Center.

Ms. Lopez's story does illustrate a common problem: persistent breakdowns in data exchanges between state Medicaid offices, the Centers for Medicare & Medicaid Services, the Social Security Administration and the companies providing the Part D benefit result in low income people with Medicare who should be receiving Extra Help instead facing deductibles and copayments that they cannot afford.

Ms. Lopez's story also shows how the complicated interaction between Medicaid, Medicare Savings Programs and Extra Help, and how failure on the part of government—in this case the state of New York's failure to enroll Ms. Lopez in the QMB program—means very poor individuals do not receive the help they need with their medical expenses.

Ms. Lopez's story shows how crucial it is to get eligible people with Medicare enrolled in low income assistance programs. Once enrolled in QMB, Ms. Lopez will be able to go to the doctor without worrying that she cannot afford her copayment. If the doctor recommends treatment, the ability to pay will not prevent her from following her doctor's plan of care. Like other QMB enrollees, she will be automatically enrolled in Extra Help, the low incomes subsidy under Part D. Instead of facing a doughnut hole, when she must pay both premiums and the full cost of her prescriptions, she will pay just $1 for a generic drug and $3.10 for a brand name medicine. If she can afford her medicines, she is more likely to take them as prescribed, preventing complications that send her to the hospital for expensive emergency care.

People who are eligible for Medicare Savings Programs are more likely to be African American or Latina. They are more likely to be older, female, living alone and in poor health. Those who are eligible and enrolled are more likely to see a doctor or other health care provider; as a result they have improved health.

But Ms. Lopez's story should not cause us to congratulate ourselves. For every client that the Medicare Rights Center enrolls in MSPs or Extra Help, there are millions more that do not know the help that is available or do not know how to apply. The following statistics tell the story.

Over the last two years, the Social Security Administration, working in cooperation with State Health Insurance Assistance Programs, community organizations and advocacy groups like the Medicare Rights Center, has enrolled about 2.2 million people into the Extra Help Program. To qualify, an individual must earn less than $1,276 per month, and have less than $11,710 in savings and other financial assets. Despite these efforts, there are still between 3.4 million and 4.7 million people who qualify for this program but are not enrolled.

In the counties that make up New Jersey's Sixth District, which Chairman Pallone represents, there are nearly 22,000 older adults and people with disabilities that are eligible, but unenrolled in Extra Help, according to CMS estimates.

In the 15 counties of Georgia's Ninth District, which Congressman Deal represents, there are over 15,000 people with Medicare who qualify for Extra Help but are not enrolled.

The same story, district by district, can be told about low income people who qualify for Medicare Savings Programs but are not enrolled.

There are roughly 430,000 people enrolled in the QMB program, not counting those individuals who receive full Medicaid benefits. QMB pays the deductibles, premiums and cost sharing under Medicare A and B. That is roughly one-third of the number eligible.

Only 13 percent of people with Medicare, or 370,000 out of 2.8 million, who qualify for SLMB are enrolled. In 2005, fewer than 200,000 were signed up for QI-1. Both programs pay the Part B premium, which is $93.50 per month, a sizable expense for someone earning $1,041 per month, the upper limit for the SLMB program. In all but a handful of states, even individuals who earn this little will not receive assistance if they have more than $4,000 in assets.

How do we fix this situation?

Congress should remove the asset test from both the MSP and Extra Help programs and allow people to qualify based solely on income criteria. These are poor people; let's not

begrudge them a small nest egg. In almost all cases, truly large nest eggs produce income to disqualify people without true need from MSPs and Extra Help eligibility.

The asset test complicates the application. For individuals with low literacy or limited English proficiency, it can make the application an insurmountable obstacle. Many individuals who qualify for the help just do not want to reveal the extent of their savings, and refuse to fill out the application, even though their assets fall below the limits.

The asset test creates additional administrative burdens and expense on the states that administer Medicare Savings Programs and on the Social Security Administration, which is processing Extra Help applications.

But most importantly, the asset test is unfair. Hard-working Americans who have scrimped and saved for their retirement are penalized for doing the right thing. $24,000 is a small sum to provide a couple security through their old age, but it disqualifies them for Extra Help with their prescription drug costs.

We know removing the asset test will extend both Extra Help and MSPs to people who need them. According to the Social Security Administration, 42 percent of individuals who were rejected for Extra Help were denied solely because of their assets. The Congressional Budget Office estimates that 1.8 million low-income older adults and people with disabilities will not qualify for Extra Help solely because of the asset test.

Because the Medicare Rights Center works to sign up low-income people with Medicare for both Part D Extra Help and the Medicare Savings Programs, our experience provides a unique picture of the impediments to enrollment that exist in both these programs. We witness first-hand how the presence, or absence, of an asset test can determine whether our low-income clients obtain access to the medical care and medicines they need.

Fortunately for some of our clients, New York State has removed the asset test for the Qualified Individual program, making this Medicare Savings Program available to all individuals with incomes up to 135 percent of the poverty line. Because Medicare Savings Program recipients are automatically eligible for Extra Help, these individuals receive vital assistance with their prescription drug costs as well as payment of their Part B premiums.

One of our clients is Ms. H., a widow who lives in Manhattan, N.Y., is 74 years old and a typical example of someone whose assets disqualify her for Extra Help. She receives a $400 monthly Social Security check and works part-time to earn an additional $500 a month to make ends meet. Because she has $12,000 in assets—just $290 over the limit–she is ineligible for Extra Help. But because she lives in New York State, she is eligible for the QI program, which serves as a back door to getting her Extra Help.

Another Medicare Rights Center client is Ms. S., a widow who lives in Brooklyn, N.Y. She supplements her monthly Social Security income of $800 by slowly depleting her

savings. When she came to us last year, her assets were $500 over the limit for Extra Help. But because she lives in New York State and was eligible for QI, she now receives Extra Help and can maintain her savings for an emergency.

Legislation introduced by Rep. Lloyd Doggett, Democrat of Texas, takes a small but meaningful step in the right direction by raising the maximum in allowable assets to $27,500 for an individual and $55,000 for a couple.

Representative Doggett's bill, H.R. 1536, the Prescription Coverage Now Act of 2007, also takes some important steps toward simplifying the Extra Help application and removing eligibility tests that needlessly penalize people with Medicare:

- The cash value of life insurance policies would no longer be counted in the asset test. People often don't know what kind of life insurance policy they have, or what its value is even if they were to cash it in. Many question why a life insurance policy is counted as a cash asset when they bought it with the intention of protecting their family in their absence.
- IRAs and 401(k)s would no longer be counted as assets. Some of our clients over-estimate their assets by counting their retirement account as both income and an asset. Under the law, if they are required to take money out through a periodic distribution, then it is considered income and if not, then it is an asset.
- People with Medicare would no longer be asked to estimate the value of in-kind contributions, such as living rent-free with a relative or receiving groceries from a friend free of charge, and have that help count against the income limit.

We recently heard from a woman who told us about the experience of her 95-year-old mother-in-law. "She has no burial money, no life insurance, no pension—no money," she wrote. "The only income she has is her Social Security check of a little less then $1,000 per month. However, she has four people who donate money to help pay her assistive living room and board. This counts as 'in-kind support' and puts her over the income level so she was rejected for Extra Help." [1]

As Congress moves to improve the Extra Help program, it should also take steps to bring the eligibility criteria for MSPs in line with these new, more reasonable, standards for Extra Help.

Medicare Savings Programs are administered by states. Funding for benefits for the QMB and SLMB (Specified Low Income Medicare Beneficiary) programs comes jointly from the federal government and the states, according to the Medicaid match rate that applies for each sate. The QI (Qualified Individual) is a block grant, funded entirely by the federal government. Although there are minimum federal standards for MSP eligibility, states have leeway to increase enrollment by modifying income and asset criteria.

[1] Story submitted to the Part D Monitoring Project, Medicare Rights Center, November 2, 2006.

Currently, individuals enrolled in MSPs are "deemed" eligible for Extra Help. If criteria were aligned, then deeming could go both ways, whether they applied through their state Medicaid offices, which administer MSPs, or through the Social Security Administration, which has primary responsibility to administer Extra Help. With two-way deeming, people with Medicare would receive all the help to which they are entitled.

Alignment of eligibility criteria entails a number of changes, some major and others that are smaller, but still significant:

- The major change is alignment of income eligibility thresholds. When Congress passed the Medicare Modernization Act, it recognized that people with Medicare living below 150 percent of the Federal Poverty Line (in 2007, $1,276 for an individual, $1,711 for a couple) would need additional help paying for their premiums and prescription drugs under Part D. The income limits for MSPs stop at 135 percent of poverty. A consistent policy would recognize that individuals earning less than this income level—the population that Congress, in the MMA, decided should benefit from full premium subsidies and low copays under Part D—should receive the full MSP benefit—having all part A and B cost-sharing and premiums paid for through the QMB program. Individuals earning between 135 percent and 150 percent of the poverty line would have their Part B premiums subsidized.
- Align asset thresholds. Six states—Alabama, Arizona, Delaware, Mississippi, New York and Connecticut—have eliminated the asset test for at least one of the Medicare Savings Programs. Florida, Maine and Minnesota have raised the maximum amount of allowable assets. The remaining states have asset thresholds pegged to the statutory maximum, $4,000 for an individual, $6,000 for couple, levels which are not indexed to inflation like those for Extra Help. These maximum levels should be brought into alignment with the Extra Help program.
- Count the same things and in the same way. Ten states allow their residents to keep more valuable life insurance policies, especially policies meant to defray burial expenses. Congress should build on these initiatives and eliminate the value of life insurance policies from the MSP asset test. Eighteen states no longer count in-kind income, which penalizes families that help their loved ones in need. The federal MSP standards should reflect the same fair policy. Extra Help accounts for the full size of the family when determining income so that grandparents who are raising grandchildren are given the help they need. At least ten states have already adopted this policy, which should be extended to federal MSP standards. Finally, MSP programs should exempt IRAs and 401(k) accounts from the calculation of assets, eliminating the penalty that now applies to individuals with defined-benefit retirement programs compared to the dwindling number with traditional pensions.
- Eliminate estate recovery for MSPs. Less than half the states even attempt to recover outlays for Medicare cost-sharing and premiums after an MSP recipient is deceased. The amount recoverable is not worth the cost of collecting. But estate recovery dissuades one in five potential enrollees from applying and it prevents

states from deeming individuals who are determined eligible after applying for Extra Help—no person can be automatically enrolled in a program that might seize the family home or modest savings they hope to pass on to their children.

- The QI program should be folded into the SLMB program. Unlike QMB and SLMB, QI is a block grant, subject to annual or biannual reauthorization and appropriation, and fully funded by the federal government. It expires September 30, 2007. Congress should show its support for this vital assistance by combining the QI and SLMB programs and arriving at a funding formula that does not add to states' financial burdens.

If the criteria for MSPs and Extra Help are aligned, an individual who applied for Extra Help with the Social Security Administration could be automatically enrolled in an MSP. This would leverage the outreach efforts of SSA and grassroots organizations for Extra Help by using it to increase enrollment in a vital assistance program that has abysmal participation rates. It would also reduce states' administrative expenses—income and asset information would already have been verified by SSA.

To make this work, the MSP application process needs to be brought into the twenty-first century. Only five states currently allow MSP applications to be submitted online. Online applications have proven to be a critical tool for community organizations and caregivers that help individuals apply for Extra Help. SSA allows Extra Help applicants to self – attest for their income and assets instead of imposing burdensome documentation requirements. Many states are already moving in this direction although a few states, including Alaska, require individuals to travel to Medicaid offices to apply. Older adults and people with disabilities should not have to run the Iditarod to get help with their medical expenses.

In addition to removing these eligibility and application barriers, we must also recognize that enrollment is low because this population is hard to reach. There are language barriers, literacy barriers; many poor older adults lead isolated lives. Intensive outreach is needed, by states, SSA and community-based organizations but such outreach is only practical if it can be targeted. The Office of Inspector General has recommended using IRS data to target outreach by SSA. Representative Doggett's bill includes sensible proposals to use such data, already in the government's possession, while protecting the privacy of people with Medicare.

However, we will only succeed in getting full enrollment in both MSPs and Extra Help through some method of automatic enrollment or presumptive eligibility. When Congress decided to charge higher Part B premiums to wealthier people with Medicare it decided to use tax data to determine who should pay the higher premium. There is no application or documentation requirement; individuals have to appeal *not* to pay the surcharge. A similar use of income data already in the government's possession could find and enroll everyone who qualifies for MSPs and Extra Help.

Let me conclude by returning to a couple of issues that are raised by Ms. Lopez's case.

Ms. Lopez was enrolled in the Medicaid program, but New York State had never signed her up for the QMB program, even though it had information on her assets and income and she clearly qualified. From our client work, this appears to be a widespread problem, not only in New York, but in other states as well.

Not only does it result in the denial of important financial assistance to people like Ms. Lopez, who are struggling to get by, but it also results in interruptions in assistance from Extra Help that affect hundreds of thousands of individuals. When poor people cannot afford to fill their prescriptions, they stop taking their medicine, often with dire health consequences.

Last fall, 630,000 enrollees in the Extra Help program received letters from CMS and SSA warning them that they were going to lose this valuable assistance on January 1, 2007 and informing them they should apply directly to SSA. These individuals had been deemed eligible for Extra Help for 2006 because at some point in 2005 they were on state rolls for Medicaid or MSP. By January, very few individuals had applied. Once they were hit with high copays at the pharmacy, over 240,000 had applied to SSA, with two-thirds determined eligible. Another 106,000 had been "redeemed" by states; omissions in data files sent to CMS were corrected, while others were requalified for MSPs or Medicaid.

SSA expects that we will see a repeat this fall, with hundreds of thousands of people again dumped from the Extra Help rolls. Many of these men and women receive Medicaid at some point in the year because they are determined "medically needy"—their medical expenses are so high that, even though their incomes are above the cutoff,, they qualify for Medicaid at some point in the year. But because their Medicaid coverage is intermittent, they risk being omitted in the state data files sent to CMS.

Most of these individuals likely qualify for MSPs, which have higher income thresholds. If states made a concerted effort to enroll all Medicaid recipients into an MSP, and if the MSP eligibility criteria were aligned with Extra Help, we would virtually eliminate the problem in this annual "redeeming" process.

In addition, the annual redetermination process for MSPs , particularly in those states that require resubmission of documentation, results in eligible individuals getting dropped from the MSP rolls. Very few low-income older adults with little in the way of financial assets ever experience a change in circumstance. They are poor and they will remain poor for the remainder of their days. Requiring annual redeterminations for MSPs just creates additional bureaucratic hassles for these individuals and additional administrative burdens on states. At the very least, the MSPs should adopt the annual redetermination process SSA now uses for Extra Help. Enrollees are asked if their circumstances have changed, and if nothing has, they are not required to reapply.

Many of our low-income clients, and the clients of other advocacy and community-based organizations around the country, had the same experience as Ms. Lopez when she went to the pharmacy. Though they are enrolled in the Extra Help and should only pay around $5 at most for their prescriptions, they are charged over $100 for their medicines. Because of persistent data exchange problems between CMS, SSA, states and the Part D plans, their eligibility for Extra Help is no longer in the plans' database.

Part D plans have been told repeatedly by CMS that they must accept "best available evidence" of Extra Help eligibility. This means, for example, that a dual eligible should be able to present her Medicaid card to the pharmacist, who in turn will inform the plan that it should correct its database. Part D plans are not following these instructions. As a result, without the services of an advocate knowledgeable enough to read the relevant regulation to the customer service department, low-income people with Medicare are being overcharged for their prescriptions and, too often, walking away from the pharmacy counter without their medicine.

It is inexcusable that 17 months into the Part D benefit, this situation persists. The immediate solution is for CMS to exercise its oversight responsibilities and ensure the plans are not overcharging their low income enrollees. For the longer term, the data exchange problems need to be fixed. The alignment of eligibility criteria between MSPs and Extra Help will simplify and streamline these programs and contribute to this solution.

We are grateful that the committee is looking into how the Medicare Savings Programs and Extra Help programs can better serve low-income people with Medicare and encouraged that members of this committee are developing legislative proposals to get this valuable financial assistance to older adults and people with disabilities struggling with high medical and prescription drug bills. The Medicare Rights Center stands ready to work with members of both parties in support of these efforts.