Testimony Before the

Senate Special Committee on Aging

On

Medicare Programs for Low-Income Beneficiaries

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Chairman Kohl, Ranking Member Smith, distinguished Committee members, I am N. Joyce Payne, a member of AARP's Board of Directors. On behalf of AARP's nearly 40 million members, I thank you for inviting us to testify on the need to strengthen Medicare's low income programs – the Part D Low-income Subsidy (LIS) and Medicare Savings Programs (MSPs).

One in four people in Medicare live on incomes of 150 percent or less of the poverty level ($15,600 for individuals, $21,000 for couples). They desperately need the help these programs provide in order to afford the care they need.

The LIS covers up to 95 percent of drug costs, according to the Center for Medicare & Medicaid Services, and closes the Part D coverage gap ("doughnut hole") for people with incomes below 150 percent of poverty. This assistance to those least able to pay for drugs is one of Part D's most important features and one of the key components of the Medicare Modernization Act.

The Medicare Savings Programs (MSPs), administered by state Medicaid programs, pay Part B premiums for people below 135 percent of poverty, and all Medicare cost sharing for those below the poverty level. MSPs include:

- The Qualified Medicare Beneficiary (QMB) program, which pays all Medicare premiums, deductibles, and copays for individuals with income below 100% poverty (annual income below $10,400);

- The Specified Low-income Medicare Beneficiary (SLMB) program that pays Medicare premiums for individuals with income between 100 and 120 percent of poverty (annual income below $12,480); and

- The Qualified Individual (QI) program that gives states limited annual allotments to pay Medicare premiums for individuals with income between 120 and 135 percent of poverty (annual income below $14,040).

Part B premiums are now $96.40 per month, so the programs save enrollees more than $1,156 each year, and much more for those below poverty.

However, millions of older Americans who need the help LIS and MSPs provide are not getting it because these programs have a serious flaw – an asset test. To be eligible for LIS, beneficiaries can have no more than $11,990 in savings, or $23,970 for a couple, no matter how low their income or how high their other living expenses. These amounts are hardly enough to get people through retirement, and anyone who has saved even one dollar over these limits is not eligible for LIS. That is why AARP has consistently opposed the asset test.

For MSPs the asset limits are even more unreasonable -- $4000 for individuals and $6000 for couples in most states – a limit that has not changed in 20 years.

Penalizing Savers

Asset tests directly contradict efforts to encourage people to save by penalizing those who, despite very limited incomes, manage to put away a small nest egg for retirement. We should encourage people to save for retirement, not penalize those who do.

The Kaiser Family Foundation has estimated that more than 2.37 million beneficiaries who meet LIS income criteria do not meet the asset test. Almost half exceed the asset limit by $25,000 or less. And almost half were widows whose income typically plummets when their husbands die, but whose assets are above the lower threshold set for single people.[1]

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[1] Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test, Thomas Rice, Ph.D,.UCLA School of Public Health and Katherine A. Desmond, M.S.Consultant, Henry J. Kaiser Family Foundation April 2005

Creating Red-tape Barriers

Asset tests are also a serious barrier to enrollment, even for those who meet its limits, because it makes the application process daunting and invasive. The LIS form is eight pages of questions that are difficult for many people to answer, including:

- requiring people to report not just savings but such obscure details as the current cash value of any life insurance policies – information people simply do not have on hand;

- asking people whether they expect to use savings for funeral or burial expenses, but not explaining that individuals can only have up to $1,500 ($3,000 for couples) in savings above the asset limits for such expenses; and

- asking invasive questions -- such as whether applicants get help with meals or other household expenses from family members or charities -- which can be difficult to estimate and embarrassing.

Applying for the LIS thus can seem overwhelming and require many hours, extra help from family members or insurance counselors, and often repeated efforts to find all of the required information.

The red tape barrier created by the asset test is a key reason why millions of people who should qualify for the LIS are not getting it. CMS initially projected that 14.4 million beneficiaries would be eligible for the LIS.[2] However, to date, fewer than 10 million have enrolled.

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[2] CMS-4068-P, Medicare Program: Medicare Prescription Drug Benefit, 69 Fed. Reg. 46632: August 3, 2004

That means roughly 4 million or more people who are eligible for LIS are not getting the help they need.

The same kind of barrier to enrollment seen with the LIS exists in the majority of states that still impose an MSP asset test requirement. The result, not surprisingly, is that the vast majority of people eligible for MSPs are not getting needed assistance. Research has estimated that only one third of beneficiaries who are eligible for QMB, and only 13 percent who are eligible for SLMB, are actually enrolled in these programs.[3]

Inadequate LIS and MSP Coordination

In addition, there is limited coordination between LIS and MSP, even though they serve primarily the same populations. Beneficiaries enrolled in MSPs are automatically enrolled in the LIS. However, the Social Security Administration (SSA) does not screen LIS applicants to see if they are also eligible for MSPs in their state. This is a serious missed opportunity for two reasons. First, many LIS enrollees need and are eligible for the assistance MSP provides, but are not getting it.

Second, MSP eligibility criteria in several states are less restrictive than LIS criteria, and some states have eliminated the asset test altogether. Since people enrolled in MSP automatically receive the LIS, this means that many individuals eligible for the LIS under their state's MSP rules are improperly rejected when they apply for the LIS because LIS applications are not cross-checked for MSP eligibility.

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[3] Dorn, S. and Kenny, G.M., *Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers* (New York, NY: The Commonwealth Fund, June 2006).

The Medicare Payment Advisory Commission recently recommended alignment of LIS and MSP income and asset rules, as well as having the SSA screen LIS applicants for MSP eligibility.

Improving the LIS and MSPs helps not only eligible beneficiaries, it also helps Medicare's overall financing -- people who need assistance but do not receive it are more likely to postpone needed care when they cannot afford the cost sharing. Beneficiaries' health declines as preventable complications arise, driving up total Medicare costs in the long term. Strengthening the LIS and MSPs can help prevent these higher long-term costs.

Improving the LIS and MSPs also is particularly important in rural areas. More than one in four people in Medicare live in rural areas and are more likely to be poor – 14.7% vs. 11.8% in urban areas. In fact, almost half of rural Medicare beneficiaries have incomes below 150% of poverty ($15,600 per year for individuals/ $21,000 for couples).

AARP Position

AARP believes there should be no asset tests in Medicare – including both the LIS and MSPs. As a matter of public policy, we should encourage people to save for retirement, not penalize those who do with an asset test.

AARP also believes that there should be full coordination between the LIS and MSP programs. Applicants for either the LIS or MSP should be screened for both programs. Eligibility criteria should be simplified and standardized to reduce confusion and unnecessary barriers. In addition, the QI program should be made permanent by folding it into the SLMB program so eligible people can rely on this assistance without worrying that their state may run out of its limited allotment.

First Steps

AARP is firmly committed to eventually eliminating asset tests in Medicare. However, there are interim steps Congress should take now to reduce the asset test barrier for LIS and MSP. AARP supports the Part D Equity for Low-Income Seniors Act (S. 1102) introduced by Senators Jeff Bingaman of New Mexico and the ranking member of this Committee, Senator Gordon Smith of Oregon. Key provisions of this bill should be included in any Medicare legislation enacted this year, including:

Raising the Limits: Most importantly, this legislation would increase the asset test limits for the LIS to $27,500 for individuals and $55,000 for couples. This will provide relief to millions of beneficiaries who truly need the help the LIS provides. Even those who did not oppose an asset test in Medicare's drug plan agree that current limits – $11,990 for individuals, $23,970 for couples – are far too low.

Streamlining the Application: The legislation would simplify the LIS application in two important ways. First, it would eliminate the question about cash value of life insurance. This is information that people – regardless of income – simply do not have on hand. Asking for this data needlessly lengthens the application form and often requires individuals to make multiple calls to obtain the cash value figure. Life insurance also is something responsible people purchase to protect their families after they have died; it is not something the government should require people to cash in to purchase drugs they need to stay alive.

Second, it would delete the confusing and embarrassing question about occasional help from family or charities with expenses like groceries. People often get assistance from family, churches, and food banks on a highly irregular, as-needed basis in very limited amounts.

This question, however, requires applicants to enter a specific average monthly amount – a figure that many people are unlikely to know with any degree of accuracy. And those who rely on such assistance are the same individuals who are most in need of the LIS.

Targeting Outreach: The bill would also help target efforts to find and enroll people eligible for the LIS by letting SSA officials use Internal Revenue Service (IRS) data – information SSA already uses to determine income-related Part B premiums -- to also determine who meets LIS income criteria. This would much more efficiently and effectively target outreach efforts to these individuals. Currently, the IRS verifies income data submitted by LIS applicants, but SSA does not have authority to use the IRS data it already has to determine who meets LIS income criteria for outreach purposes. The HHS Inspector General has already stated that legislation authorizing this limited use of income data would help target LIS outreach.[4]

Coordinating the LIS and MSP: The Bingaman-Smith legislation takes an additional important step of allowing the Social Security Administration to screen LIS applicants for MSPs. This is important for two reasons. First, people eligible for LIS also need the assistance provided by MSPs. Second, MSPs provide an additional avenue for entry into the LIS in states that have adopted higher MSP income and asset limits, since eligibility for MSP automatically triggers LIS enrollment. Improved coordination between the LIS and MSP would provide needed help with both Part D and traditional Medicare premiums and cost-sharing obligations to many more low-income beneficiaries.

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[4] Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy, Daniel R. Levinson, Inspector General, November 17, 2006, http://oig.hhs.gov/oei/reports/oei-03-06-00120.pdf

Maintaining LIS Affordability: Finally, the legislation would keep LIS cost sharing more affordable by indexing it to general inflation. Now cost sharing rises based on increases in overall Part D costs that are rising much faster than general inflation, requiring low-income seniors' to pay increasingly higher rates.

AARP also supports legislation to:

- increase funding for State Health Insurance Programs, which provide the one-on-one counseling that is most helpful to beneficiaries applying for the LIS and MSPs;

- make the QI program a permanent and reliable source of assistance by no longer subjecting this program to annual capped allotments and increasing the income eligibility level to 150 percent of poverty so there is parity between the LIS and MSPs;

- eliminate co-pays for Medicaid beneficiaries who get long term care services in Home and Community Based Service (HCBS) programs, as is done now for beneficiaries receiving these services in nursing homes; and

- count payments by federally qualified health clinics, AIDS drug assistance programs, the Indian Health Service and drug company Patient Assistance Programs (PAP) toward the Part D "doughnut hole" coverage gap.

Conclusion

The Medicare drug benefit represents the most significant change to Medicare since the program began in 1965. The extra help provided to people who most need it through the LIS is a key component, but its success is far from complete.

Similarly, MSPs provide vital assistance necessary to ensure that people with limited incomes can afford access to care, but far too many who need this help are not getting it. It is critical that we eliminate the LIS and MSP asset tests that penalize people who save for retirement and impose barriers to assistance.

We are committed to seeing enactment of first steps towards that goal this year, and we look forward to working with members of Congress from both sides of the aisle to improve the Medicare prescription drug benefit and to ensure that all older Americans have access to affordable prescription drugs and health care.