Jessica L. Fay
141 Spiller Hill Road
Raymond, ME 04071
Phone: (207) 655-5020
Jessica.Fay@legislature.maine.gov

HOUSE OF REPRESENTATIVES
2 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0002
(207) 287-1400
MAINE RELAY 711

April 20, 2023

Testimony of Representative Jessica Fay introducing

LD 1522, An Act to Provide Economic Justice to Historically Disadvantaged Older Citizens by Amending the Laws Governing the Medicare Savings Program

Before the Joint Standing Committee on Health and Human Services

Good afternoon, Senator Baldacci, Representative Meyer and members of the Health and Human Services Committee. I am Jessica Fay, and I represent House District 86. I am grateful to be before you today to introduce **LD 1522, An Act to Provide Economic Justice to Historically Disadvantaged Older Citizens by Amending the Laws Governing the Medicare Savings Program**.

This bill is both simple and complex at the same time. The complexity comes from the mechanisms of the Medicare Savings Program (MSP) and some of my favorite acronyms – QMB, SLMB and QI. The simplicity of this bill is that it will increase eligibility for MSP for low fixed-income older Mainers. This bill has the potential to increase their financial well-being. The MSP assists older people with lower incomes by paying for some or all of their Medicare premiums, deductibles, copayments and coinsurance. It can also pay for the Part B premium, which is usually taken from social security, which means the program actually puts this money back into the pockets of older Mainers.

LD 1522 – with a proposed amendment does two things:

- Provides for the removal of an asset test[1] in determining eligibility for Medicare savings programs; and
- Changes the percentage above the FPL at which people become eligible for MSP by using the Elder Economic Security Standard Index[2] developed by the Gerontology Institute at UMass Boston.

We heard from so many older Mainers last winter about the cost of heating, their concerns about inflation and the rising cost of groceries. We are hearing about older adults' worries about increased electricity costs and the affordability of home care.

[1] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/2023%20MaineCare%20Eligibility%20Guidelines%20%281%29_0.pdf
[2] https://elderindex.org/

By increasing eligibility for MSP, we can help alleviate at least some of the anxiety that older people on fixed incomes feel worrying about aging with dignity in the communities they are connected to. And much of the cost for the MSP program is covered using federal dollars. Income and financial security later in life is mostly determined by earning potential during our working years. People who have worked hard at lower wage jobs are at greater risk for poverty when they age. People who have been caregivers – either to children or older family members, which is mostly women who are frequently unpaid – are at even greater risk for financial insecurity later in life. The average Social Security benefit in the U.S. is a little less than $1,700.00/month which adds up to just about $20,000/year.

I invite you to read the report[3] published last year titled "Economic Security of Older Women in Maine" prepared by the Muskie School of Public Service. This report shares data and analysis regarding the economic security of older women in Maine – people who would benefit directly from this bill. I do want to point out that the small sample size related to older people of color made it difficult to report on racial and ethnic populations of women in Maine.

How am I going to afford to stay in my home? I am worried about burdening my kids. If only I had a little bit of help around the house, I could stay in my town. I used to be able to buy presents for my grandchildren. I can't afford all the medication prescribed to me. I'm worried about my electric bill. I keep my thermostat low because I can't afford heat.

These are all real-life worries of the older people – older women in particular – that I have heard expressed by people in my community, even before my time here in the Legislature. If I had to guess, each of us who have been elected to the Legislature have heard versions of these same worries.

One of the biggest topics of discussion each session is how we, as a Legislature, create policy to help older Mainers. This policy change is one way we can make a difference. This bill won't solve all these concerns, but it will certainly help to reduce some of the inequity in the system that is created over a lifetime of income inequality.

I mentioned an amendment earlier. Because of a discussion of the legality of removing SLMB, I request that the committee amend the bill to remove the elimination of SLMB and keep that part of the program in place.

I am excited to work on this issue with this Committee. MSP sounds really complicated, and it is. However, what it does is very simple: it helps older people on fixed incomes to afford their Medicare premiums, and I hope that is something we can all get behind.

[3] https://mainecouncilonaging.org/wp-content/uploads/2022/02/Economic-Security-Older-Women-in-Maine-Report-FINAL.pdf

Prepared by Legal Services for the Elderly
Medicare Part D Appeals Unit **1-877-774-7772**
Updated December 2022

QMB Fact Sheet

You have the Medicare Savings Program (the "Buy In") at the QMB level. This means:

- The state pays your monthly Medicare Part B premiums, so you don't have to pay them.

- The state also covers your copays and deductibles when you use Medicare A (hospital) or Medicare B (doctors, lab work, test strips, etc.) as long as you go to a Medicare provider and as long as the services are covered by Medicare. **Be sure your medical providers accept Medicare and will bill the state for QMB. Tell all your medical providers and your pharmacy that you have both Medicare and QMB, and show them your QMB letter. Because you have QMB, Medicare providers are not allowed to bill you for copays or deductibles for Medicare services.** Call the Medicare Part D Unit if you have problems with this. **(1-877-774-7772)**

- Because you have QMB, you may not need to pay for a Medigap Policy (also called a Medicare Supplemental Policy). If you have a Medigap policy, talk to your local Area Agency on Aging to decide whether to suspend it. (1-877-353-3771). If you suspend your Medigap policy but later lose QMB you will **only have 90 days from the day you lose QMB to get a Medigap policy again.**

- Because you have QMB, you automatically get the federal Low Income Subsidy (LIS). This is also called "extra help." LIS keeps your **Medicare prescription drug costs very low**. This means:

    - You do not have to pay a monthly premium for your Part D Plan, as long as you are in a "benchmark plan."
    - In 2023, you should pay **$10.35 for brand name drugs and no more than $4.15 for generics covered by your Medicare Part D plan, for a 30 day or a 90 day supply.** You have no deductible or Donut Hole.
    - You have certain Special Enrollment Periods to change your Part D Plan.

Important: Every year DHHS will send you Review papers. You must sign and send these back to DHHS or you will lose your benefits. If you need help, or don't understand a letter from DHHS, call the **Medicare Part D Unit at 1-877-774-7772.** We take calls Monday through Friday, 9 a.m. until noon, and 1 to 4 p.m.

There is no Estate Recovery with the Medicare Savings Program.

Prepared by Legal Services for the Elderly
Medicare Part D Appeals Unit, 2022

SLMB and QI Fact Sheet

You have the Medicare Savings Program (the "Buy In") at the SLMB or QI level. That means:

- You no longer have to pay your Medicare Part B premiums.
- You get the federal Low Income Subsidy (LIS). This is also called "extra help." LIS keeps your Medicare Part D prescription drug costs very low. That means:
  - ♦ You do not have to pay a monthly premium for your Part D Plan, as long as you are in a "benchmark plan."
  - ♦ In 2023, you should pay **$10.35 for brand name drugs and no more than $4.15 for generics covered by your Medicare Part D plan, for a 30-day or 90-day supply.** You have no deductible or Donut Hole.
  - ♦ You have certain Special Enrollment Periods to change your Part D Plan.

Important: Every year DHHS will send you Review papers. You must sign and send these back to DHHS or you will lose your benefits. If you need help, or do not understand a letter from DHHS, call the Medicare Part D Unit at 1-877-774-7772. We take calls Monday through Friday, 9 am to Noon, and 1 to 4 in the afternoon.

There is no Estate Recovery with the Medicare Savings Program

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: **November 1, 2021**

FROM: **Daniel Tsai, Deputy Administrator and Director**
Center for Medicaid and CHIP Services

Tim Engelhardt, Director
Federal Coordinated Health Care Office

SUBJECT: **Opportunities to Increase Enrollment in Medicare Savings Programs**

The January 28, 2021 Executive Order on Strengthening Medicaid and the Affordable Care Act directs the Secretary of the Department of Health and Human Services, among other things, to adopt policies consistent with current statute to reduce barriers to Medicaid coverage. This letter describes two ways states can help eligible individuals enroll in the Medicare Savings Programs (MSPs), making health care coverage more accessible and affordable.

MSPs cover Medicare Part A and B premiums and cost sharing for individuals with low income. In 2021, over 10 million individuals were enrolled in an MSP. Moreover, federal law prohibits all Medicare providers and suppliers – not only those that participate in Medicaid – from charging beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) MSP eligibility group for Medicare cost sharing.[1] QMB and other MSPs are essential to the health and economic well-being of those enrolled, promoting access to care and helping free up individuals' limited income for food, housing, and other of life's necessities.

This letter provides information on two opportunities for states to increase enrollment in MSPs. Specifically, this letter focuses on using Medicare Part D Low Income Subsidy (LIS) data to initiate MSP applications, and maximizing MSP Qualifying Individuals (QI) enrollment, for which there is 100 percent federal funding to states for the payment of Medicare Part B premiums.

Using LIS data to initiate MSP applications

The Medicare Part D LIS program (also called Extra Help) pays Medicare Part D prescription drug premiums and cost sharing for over 13 million individuals with low income who meet certain resource criteria. Beneficiaries with full LIS have income less than 135 percent of the federal poverty level (FPL) and resources under $7,970 for an individual and $11,960 for a couple in 2021.[2] Because full LIS and the MSPs generally target individuals with income less than 135 percent of the FPL and have the same limit on resources, we expect that most full LIS

[1] See sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.
[2] These amounts exclude burial expenses. With burial expenses, the amounts are $9,470 for an individual and $14,960 for a couple in 2021.

enrollees would also be enrolled in an MSP.[3] However, there are 1.25 million people enrolled in full LIS who are not enrolled in an MSP, despite likely being eligible.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) included several provisions intended to promote the enrollment of LIS applicants into the MSPs. Notably, MIPPA section 113 amended section 1144(c)(3) of the Social Security Act (Act) to require the Social Security Administration (SSA) to transmit data from LIS applications ("leads data") to state Medicaid agencies. As amended, section 1144(c)(3) of the Act requires that states "initiate" MSP applications using the leads data from SSA. Further, under section 1935(a)(4) of the Act, states must accept the leads data and "act on such data in the same manner and in accordance with the same deadlines as if the data constituted" an MSP application submitted by the individual.

We provided guidance to states on initiating MSP applications based on leads data in SMDL #10-003. In that letter, we noted that states must treat the leads data as if it was an application for MSP benefits submitted directly by the LIS applicant. However, despite our guidance, we have heard reports of state practices that would not meet the statutory standard because they do not meaningfully utilize the leads data and instead put the onus on the individual to separately apply for MSP, including sending a blank MSP application or a letter instructing the applicant how to apply for the MSPs.

In order to meet the statutory standards, set forth by section 1935(a)(4) of the Act, states must promptly act on leads data from SSA to determine eligibility for MSP. States must use the information contained in the leads data to the maximum extent possible and only request additional information that is not contained in the leads data, but is necessary to make an eligibility determination. If an applicant is found to be eligible based on leads data, states must base their effective date of coverage on the date the LIS application was submitted.

Per 42 CFR §435.952(c), when verifying eligibility, including information contained in the leads data, states must not request additional documentation unless information needed by the agency cannot be obtained through data sources available to the state, or the information obtained from such data sources is not reasonably compatible.

MIPPA aligned the MSP and LIS programs more closely by amending section 1905(p)(1)(C) of the Act to increase the resource limit for three MSPs (QMBs, Specified Low-Income Medicare Beneficiaries, and QIs) to the level of the resource limit for full LIS established at section 1860D-14(a)(3) of the Act. However, some statutory differences remain between LIS and MSPs regarding countable income and assets. In addition, in implementing the LIS, SSA adopted several administrative methodological simplifications that are not required federally for MSPs. Therefore, although MSPs and LIS have the same resource eligibility *level*, differences remain in the income and resource eligibility *methodologies* used to determine full LIS status and MSP eligibility in many states. States can further simplify the enrollment process from LIS to MSP and maximize use of the leads data by adopting Medicaid flexibilities to better align LIS and MSP eligibility criteria. For example, using section 1902(r)(2)(A) authority, states can choose to

[3] Excluding individuals eligible for full LIS because they are full-benefit dually eligible individuals residing in an institution or using Medicaid home and community-based services.

disregard certain income and assets that are counted for MSP but not LIS, such as in-kind support, cash value of life insurance, and burial exclusions. Similarly, using section 1902(r)(2)(A) authority, states can increase the effective income level needed to qualify for MSPs. Finally, states can adopt the family size definition for LIS when determining eligibility for MSPs.

There is significant variation among states in the percentage of LIS enrollees who are likely eligible for an MSP but are not enrolled, from two percent not enrolled to 24 percent not enrolled. A complete state-by-state listing of number and percentage of LIS enrollees who are likely eligible for an MSP but are not enrolled is available in *Medicare Part D Low Income Subsidy Program Enrollment and Medicare Savings Program Enrollment*.[4] We encourage states to review this list and assess whether their policies and procedures are compliant, and if they are using the LIS data to the full extent possible to support streamlined enrollment into an MSP.

Additionally, on May 7, 2021, the SSA sent each state a data file of individuals who were likely newly eligible for an MSP but not enrolled. We encourage states to use this information to support beneficiary outreach. Instructions on how states can access that list is available at https://www.integratedcareresourcecenter.com/e_alert/opportunities-support-enrollment-medicare-savings-programs-and-extra-help.

Maximizing enrollment in the Qualifying Individuals group

States receive 100 percent federal funding for the payment of Medicare Part B premiums for individuals in the QI group. Beneficiaries enrolled in QI are not eligible for other Medicaid program benefits, but coverage of their Medicare Part B premium helps individuals maintain Medicare enrollment and improves economic security. In 2017, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that only 15 percent of individuals likely eligible for the QI group are enrolled.[5] Applying that percentage to current enrollment figures means that over 3 million individuals may be paying Medicare Part B premiums despite having income levels that would qualify them for the QI group.

There are federal funds available to support this unmet need. In calendar year 2020, nearly $200 million of the federal funding available for the QI group remains unspent. We encourage states to implement policies and procedures to help more individuals enroll in QI and unlock this additional federal money.

There are several strategies states may consider to increase QI enrollment. Streamlining MSP enrollment processes, such as use of LIS leads data as laid out above, can help boost enrollment in all MSP groups, including the QI group. States can also accept self-attestation of types of income and resources for which providing documentation may be onerous, such as the cash

[4] We note that, in making this calculation, we did not include individuals who are enrolled in partial subsidy LIS and may be eligible for MSPs because they live in states that have higher income thresholds for MSP as a result of using authority under section 1902(r)(2)(A) of the Act to disregard income. We also assumed that LIS enrollees who were not enrolled in MSPs did not have significant other resources that are not accounted for in the LIS eligibility determination process, but would be captured by the MSP process.

[5] MACPAC August 2017 Issue Brief, "Medicare Savings Program: New Estimates Continue to Show Many Eligible Individuals Not Enrolled." Available at https://www.macpac.gov/wp-content/uploads/2017/08/Medicare-Savings-Programs-New-Estimates-Continue-to-Show-Many-Eligible-Individuals-Not-Enrolled.pdf.

value of whole life insurance. Outreach efforts such as contacting MSP applicants through multiple modalities (phone calls, e-mails, and letters) to obtain any additional information needed to complete an eligibility determination, as well as partnering with entities such as Aging and Disability Resource Centers (ADRCs), State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Centers for Independent Living (CILs) to reach those who may be eligible for QI can also help to maximize enrollment of eligible individuals. Finally, we also remind states of their obligation to comply with the requirements in 42 CFR §435.911 to screen Medicaid applicants for all bases of eligibility, including MSP eligibility, prior to making a final determination of eligibility.

By complying with federal law and maximizing eligibility and enrollment simplifications for dually eligible individuals as discussed here and in previous communications,[6] states can help more individuals with low income enroll in MSPs, which are essential to economic security and access to needed medical care.

Technical Assistance

We look forward to partnering with states to increase enrollment in the MSPs and better serve individuals with low income. If you have any questions regarding the information in this letter or suggestions on improving participation in MSPs, please email ModernizetheMSPs@cms.hhs.gov.

[6] SHO # 20-004, *Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency*. There is also an update to this guidance that was released on August 13, 2021 as SHO #21-002, Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency. However, that update does not list the dual eligible enrollment strategies.