LEGAL SERVICES FOR MAINE ELDERS

Testimony of Legal Services for Maine Elders
John Brautigam

Supplemental Budget – Part A Initiatives and Language

Programs and Language Parts Under the Jurisdiction of the Joint Standing Committee on Health and Human Services

Before the Joint Meeting of the Committee on Appropriations and Financial Affairs and the Committee on Health and Human Services

February 26, 2024 10:00 am

Senator Rotundo and Representative Sachs and distinguished members of the Committee on Appropriations and Financial Affairs, and Senator Baldacci and Representative Meyer and distinguished members of the Committee On Health and Human Services.

My name is John Brautigam and I'm testifying today on behalf of Legal Services for Maine Elders.

First, I would like to let you know that Legal Services for the Elderly recently changed our name. Our new name is Legal Services for Maine Elders. With this change, we intend to encourage and challenge ourselves and others to be more intentional about the language we use when speaking about older adults. Consistent with our mission and values, our new name is intended to convey respect, reduce stigma, and encourage the full inclusion of older Mainers in their communities and in our policymaking. Though our name has changed, we will continue to pursue the same mission of providing free legal assistance to Maine's older adults when their basic human needs are threatened.

I want to devote most of my testimony to the Medicare Savings Program, but first I want to mention two other critical funding needs.

First, Maine's network of nursing facilities is at risk. We've lost nine facilities since 2020. It is very difficult to find a bed, and at least one county does not have a single facility. This is due to an ever-widening gap between the resources required for adequate care and the funding available. The supplemental budget would appropriate $10 million in "rate reform." Of course, we are grateful for this amount. But given the number of Mainers cared for by the people in our nursing facilities, this amount will not stabilize the system or stop the downward spiral. The Maine Health Care Association estimates that just to maintain the status quo we

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need to appropriate over $30 million in state funds – an amount which will be matched by over $60 million in additional federal funds. Many people are surprised to learn that over 52% of our friends, family members, and neighbors now living in these facilities have been diagnosed with dementia. We ask that you carefully consider the testimony today from those who face this challenge daily. We share their perspective on this issue of great importance to the clients served by LSE. And we support their request.

Second, we often hear that it is difficult for older Mainers – especially in rural areas – to connect with the services and assistance that is available to them. It is easy to think that creating a benefit means that people will instantly access it. But even the most generous programs won't succeed if eligible Mainers don't know about them or if there are administrative, logistical, or communications barriers to access.

In Maine, there are significant "care deserts" where older adults struggle to find affordable home care or homemaker services, exacerbating the need for assistance navigating the resources that do exist. Case management services designed for older adults are crucial because they enable access to supportive services that allow these Mainers to remain safely in their communities. Funding limitations have left case management services for older adults nearly non-existent. The need is urgent.

Case management as offered by the five Area Agencies on Aging is an excellent idea. "Coordinated Community Programming" can resolve the frustration we often hear from those who simply don't know about services or encounter obstacles trying to find them. It will ensure that programs are utilized to their maximum, addressing a wide range of issues that drive the well-being of older Mainers, including health care, food insecurity, transportation, and housing. HHS members will recall LD 1684, which sets forth a thoughtful, efficient proposal that would allocate $2.5 million for AAA's Coordinated Community Programing. We support this.

Our primary focus today is on funding for the Medicare Savings Program (MSP). Last year you strongly supported a cost-effective expansion of MSP and we celebrated that success. Unfortunately, Part NN of the supplemental budget would give up much of that progress. It would diminish benefits for many low-income households of older Mainers compared to what is required by current law, and it would forgo tens of millions in federal funding available for this assistance. The MSP is a targeted, effective, and affordable approach to keeping tens of thousands of Mainers in their homes living with autonomy and dignity. It can ameliorate the disadvantages faced by those – especially women – who did less work for pay – or who worked for less pay – during their working years.

On the bright side, we applaud the removal of the asset test from the MSP. The asset test was a barrier to participation for many low-income Mainers who had just a few thousand dollars standing between them and profound economic insecurity. We were relieved that the supplemental budget does not restore the asset test. Through hard experience, we have learned that allowing people on fixed incomes to hold on to a few thousand dollars in savings and assets is a crucial buffer against the all-too-predictable sudden expenses that could cause a cascade into financial despair, whether it is a leaking roof or an expensive car repair. We are glad the supplemental budget acknowledges this, and we thank the Chief Executive.

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Going into chapter and verse on the MSP may not be the best use of our short time together. You all know the benefits of the MSP from the First Session, and we remain grateful that you gave the expansion a strong vote of support just eight months ago. We especially honor and appreciate the leadership of Representative Fay who has long recognized the importance of this issue. Attached to this testimony is an explanatory memo if you need to refresh your memory on the details of the MSP, but here are a few highlights why the MSP is such a valuable program for those who rely on it and why we ask you to preserve the recent expansion:

- Recent data shows that 92,953 Mainers are eligible for both MaineCare and Medicare.
- Medicare is a good program but not a panacea. There are many costs for individuals who participate in Medicare, and for some low-income people the co-pays, cost-sharing, and deductibles are prohibitive.
- Many in MSP are from families described as the working poor. MSP beneficiaries are disproportionately older women.
- The changes you approved a short while ago after much work established income eligibility levels that more appropriately reflects how much households on fixed incomes are actually able to pay.
- MSP increases the cash available to participants because the benefit means less money is taken out of their Social Security check.
- Everyone in MSP receives reductions in their out-of-pocket costs for prescription drugs through the "extra help" program.
- For this population, evidence shows that reducing costs increases health quality, which in turns allows people to remain independent and in their homes, minimizing other forms of assistance.
- MSP alleviates financial stress for participants who have no other place to turn. For many of us an occasional $100 or $200 co-pay is a nuisance but not truly an obstacle. Participants living on fixed incomes must think long and hard before deciding whether they can afford even these amounts to safeguard their health.
- Financial assistance made possible by the MSP ensures that overwhelming out-of-pocket expenses do not deter these individuals from accessing medically necessary care.
- MSP also benefits the state. Part NN would eliminate over $50 million worth of health care while saving the budget only $14 million. The MSP injects new money into the state economy while supporting a healthier population and a more sustainable healthcare system.
- An Information Bulletin from the federal CMS dated November 1, 2021 urged the states to be as inclusive as possible in the design of the Medicare Savings Programs.

Current law extends the most generous MSP benefits to those making up to 185% of the federal poverty level. This benefit includes the premiums required for Medicare Part A and Medicare Part B as well as all deductibles, coinsurance, and copayments. If the supplemental budget is passed as written, some of these beneficiaries – those between 150% and 185% of the FPL – will only receive help with Part B premiums. Their Social Security check will be smaller because

their Part A premiums will be taken out. And at the doctor's office or hospital they will be hit with significant cost-sharing expenses.

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Tens of thousands of real Mainers in need will benefit, or will go without, depending on the decision on Part NN.

In these halls advocates always try to put a face on their argument, depicting these policy decisions in terms of real people. One person – Fran Seeley – has already told her story, which conveys far better what this really means. Ms. Seeley's testimony is in the Committee file for LD 1522 and I'm sure many of you recall her. At 82 years of age, she thinks long and hard before going to the doctor. She presented her household budget in detail, showing great creativity and impressive thrift. She grows her own vegetables, shovels her own driveway, and does her own minor plumbing and electrical work. She even described using Gorilla Glue to perform dental work on herself to save money. Her monthly income of $1531 could not cover her expenses of $1856, meaning that her modest savings would soon be depleted. She wrote eloquently about how the MSP could help her remain afloat and allow her to continue to volunteer 40 hours a week as a foster grandparent in the local schools, as she has for 21 years.

There but for the grace of God we all go. Today, these funds will help Ms. Seeley or a similarly situated older person in Waldo County or Somerset County. Tomorrow, it could be any of us, a neighbor, or a loved one, but for a turn of fate. After all, these programs are for all of us.

At LSE we value investing in a system that minimizes the hardship of those in our communities whose lot in life did not include the good fortune to accumulate the kind of wealth that might sustain them after they have aged out of their working years.

The budget is the most important statement of what we value as a state. We will be judged by how we treat the neediest among us.

Thank you, and I'd be happy to answer any questions.

Medicare and Medicaid Background Information

Tens of thousands of Mainers are eligible for Medicare but still cannot afford the healthcare they need. This is because Medicare is not a cost-free program for participants. Many Medicare participants are still responsible for paying thousands of dollars in premiums, deductibles, and co-pays. For a household on a fixed income, these added costs may put basic health care beyond reach. Even where household income approaches 250% of the Federal Poverty Level – or $36,450 per year – the out-of-pocket costs inherent in Medicare may impose a severe hardship.

The Medicare Savings Program was created to help these people. The MSP can help low-income Medicare participants pay their premiums, deductibles, and co-pays, depending on income level. Everyone participating in the MSP also gets a significant discount in their prescription drugs through the Low-Income Subsidy program, also known as "extra help."

The federal government pays a large portion of the MSP program. The expansion of the MSP enacted in P.L. 2023, ch. 412 is estimated to bring $52 million in benefits, with the federal government paying $38 million or about 73 percent of the total cost. (This percentage is higher than the ordinary federal match because the program includes benefits for which state cost-sharing is not required.) The legislature appropriated the state share, and the expansion was scheduled to take effect on March 1, 2024.

The supplemental budget proposes to roll back most of the expansion included in the 2023 biennial budget.

Medicare Out-of-Pocket Costs

Many people who are unfamiliar with Medicare may not realize that Medicare is not without cost to the user. Like private insurance, Medicare requires participants to pay premiums, deductibles and co-payments. The out-of-pocket costs vary between the different Medicare programs – Part A, Part B or Part D.

Medicare Part A pays for blood, inpatient hospital care, skilled nursing, rehabilitation, hospice and home health services. Part A requires some to pay premiums and all to pay deductibles and co-payments. The premium for Part A is not paid by most individuals because becoming fully insured by working over your lifetime satisfies that payment

obligation. For those not fully insured and who are able to buy-in to Medicare Part A the premium cost is between $278 and $505 each month.

The deductible for Part A represents that part of the bill that Medicare will not pay. In 2024 the deductible amount is $1600 for the first 60 days of hospitalization. Co-payments are fixed and depend on the number of days one is hospitalized or receives care in a skilled nursing facility. They range from $408 to $816 for hospital stays of more than 60 days or $204 per day in a skilled nursing facility after the patient has reached 20 days. While stays of over 60 days are uncommon, many older or disabled people require skilled care for more than 20 days or may need a short stay in a hospital. It would be quite easy for a Medicare beneficiary who needed hospitalization and a post-hospital stay in a Nursing facility exceeding 20 days to incur a debt of over $2,000 for Part A services.

Medicare Part B is a voluntary part of Medicare that covers a large array of healthcare services not provided by Part A. Some examples include doctor visits, lab work, emergency room visits, some prescription medications, durable medical equipment, home health services, kidney dialysis, occupational therapy, physical therapy, speech and language therapy, mental health and other services. The cost of Part B is reflected in premiums, deductibles and co-payments. This year the premium is $174.70 per month for most (i.e., a single person with modified gross yearly income of $103,000 thousand less or joint filers with $206,00 or less). The Medicare deduction from wages or the self-employment tax does not cover Medicare Part B.

The Part B annual deductible is $240 and the co-payment is 20% of the balance. Those who are eligible for Part A are automatically able to buy Part B. Anyone who is a citizen of the United States or a lawfully admitted alien who has lived in the US for five years may buy into Part B even if not enrolled in Part A.

The out-of-pocket costs for Part B can add up quickly. The monthly premium of $174.70 and the annual deductible of $240 means a total annual cost of $2336.40 even before considering the 20% co-pay for any Part B services. One diagnostic or treatment visit to a physician would easily cause the out-of-pocket costs for a person in Part B to soar.

Private Medicare Insurance – "Medicare Supplement"

Because the cost sharing for Medicare is a considerable burden, most people who can afford it choose to buy private insurance to help pay some of these costs. This type of private insurance is called Medicare Supplemental Insurance. Premiums vary depending on the coverage chosen.

Like other insurance, not everyone will be able to obtain a Medicare Supplement plan. For those who can qualify, the least expensive policy available to a new Medicare member in Maine that covers the same cost-sharing as the MSP covers currently has a price tag of $2496 per year for non-smokers and $2,745 per year for smokers (USAA-Life Plan G). This may not be affordable for those who rely on their Social Security check as their sole source of income, and many will gamble that they can get by without coverage.

Medicare Prescription Drugs – Part D

Medicare Part D pays for prescription drugs. If you are enrolled in Part A, Part B or Part C (Medicare Advantage) you may purchase Part D coverage separately. Private insurance companies sell Part D and there are many to choose from. Each must meet federal requirements to earn a Medicare Part D designation.

Part D plans have cost sharing in the form of a premium, a deductible and co-payments. In general, and depending on the Plan chosen, the national average for a Part D premium in 2024 is about $55.50 per month, and the deductible can be up to $505. The co-payment amount varies depending on how much you spend on your drugs. It's useful to think about this co-payment feature as progressing in three stages.

In the first stage you may have a copayment of as much as 25% of the retail cost of your drugs. This first stage begins with the payment of your deductible and ends when the total cost of your drugs exceeds $4660. When the drug costs surpass $4660, the patient is responsible for 25% of additional drug costs for both brand-name and generic drugs. Once the patient's drug costs reach the "catastrophic threshold" of $8000, all additional drugs are covered at 100%. However, because certain drug manufacturer discounts are counted in this cost, most Part D recipients who reach the $8000 catastrophic threshold have paid about $3100 in out-of-pocket costs.

Part D prescription drug costs can be high. There is, however, a good deal of Federal financial help for people enrolled in Part D and the Medicare Savings Program. Individuals who qualify for the full subsidy will have their monthly premium (if any) and deductible fully paid and have zero or reduced cost sharing for their generic or brand-named drugs. Those who do not qualify for full subsidies will still receive similar help with their premiums and deductibles. However, they will have less generous but still significant cost-sharing assistance with their out-of-pocket drug costs.

The Medicare Savings Program Overview

For older or disabled people on a fixed income, illness can cause catastrophic debt and financial collapse, with the loss of dignity, autonomy, and any hope for financial sustainability.

The Medicare Savings Program can help. Depending on a person's income, the MSP may pay the cost of Part A and B premiums, deductibles and co-payments. It especially helps those who can't afford to buy supplemental insurance.

The MSP benefit is usually delivered through an adjustment in the person's Social Security payment. For example, Many in Medicare have their Part B premium taken out of their monthly Social Security payment. If the MSP pays the Part B premium, the monthly Social Security check will be restored to its full calculated amount. This puts cash in the pocket of the participant.

The MPS may make the difference between forgoing care when it is medically required, or being saddled with debts that surpass the participant's ability to repay. Since hospitals are the only entities with an obligation to render uncompensated care, many individuals unable to cope with Medicare premiums, co-pays, or deductibles will end up seeking care in emergency rooms around the state. The result is inefficient care, cost-shifting onto other payers, and/or an increase in the amount of uncompensated care.

The Three Medicare Savings Program Levels: Qualified Individuals, Specified Low-Income Beneficiaries, and Qualified Medicare Beneficiaries

The MSP program has three levels of benefits and two levels of Federal participation in paying for these benefits.

The level with the least generous benefits is the Qualified Individual (QI) level. For anyone in the QI level, the program pays their premium for Part B coverage. In 2024 this is equal to $174.70 per month. Currently Maine has set the QI eligibility level at or below 185% of the Federal Poverty Level (FPL). This means that a one-person household with an income of $2321 or a two-person household with an income of $3,151 is eligible for QI benefits. The QI benefit is very attractive to the state since the federal government pays 100% of the cost.

The next level is the Specified Low-Income Beneficiary (SLMB) level. People in SLMB also have the entire cost of their Part B premium paid ($174.70 per month) but at this level the state must pay part of the cost of the premium. Like the people in QI, people in SLMB must

still pay their own Part A and B deductibles and co-payments. Until this year, the maximum monthly income that a one-person household in Maine could have to qualify for SLMB coverage is $2133 or 170% of FPL. The limit for a two-person household is $2895. The costs of the SLMB benefit are paid jointly by the Federal and State governments according to their share of Medicaid program costs as calculated under federal law and regulations.

The level serving the neediest individuals is called the Qualified Medicare Beneficiary level (QMB). This is the most generous level of the Medicare Savings Program. QMB beneficiaries receive payment for all costs for Part A and Part B including all premiums, deductibles, co-insurance and co-payments. Until this year, Maine has capped eligibility in the QMB benefit at 150% of FPL, which is $1882 for one person or $2555 for a two-person household. In Maine, the federal government covers approximately 64% of the cost of the QMB benefit and the State covers the rest.

The Low-Income Subsidy Prescription Drug Benefit

The MSP program does not include a drug benefit, but perhaps its most valuable feature is that everyone enrolled in MSP automatically receives substantial assistance with prescription drug costs through the Low-Income Subsidy (LIS) program's "extra help" provisions. This is the primary vehicle for helping Medicare-eligible people afford prescription drugs.

An important feature of the LIS is that the federal government pays 100% of the cost – there is no state share. The LIS is therefore a powerful added benefit that occurs when expanding the MSP program.

Conclusion

The MSP offers extensive benefits for participants and for the state, largely funded with federal monies. Cutting the MSP program would not only reduce the number of people who get assistance with their Medicare premium, cost-sharing, and deductible, it will also deprive many people of the valuable Low-Income Subsidy "extra help" benefit. It is easy to foresee that many older Maine people will struggle to afford their prescription drugs without this benefit. There is no longer a serious dispute whether increasing out-of-pocket costs for prescription drugs directly correlates to reduced utilization and increased office visit costs.