Testimony of
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"Enrollment in Medicare Part D Low Income Subsidy and Medicare Savings Programs"

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Thank you Chairman Stark, Congressman Camp and distinguished members of the Subcommittee, for inviting me to discuss two very important programs for people with Medicare: the Low Income Subsidy (LIS) under the Medicare prescription drug benefit, and the Medicare Savings Programs (MSP) that leverage Medicaid resources to assist qualified beneficiaries with Medicare's out-of-pocket costs.

The new Medicare prescription drug benefit (Part D) is probably the single most important addition to benefits in the history of the Medicare program. Because of the extraordinary importance of this new benefit, CMS outreach to Medicare beneficiaries has been unprecedented. Beginning in 2005, Medicare embarked on a multi-faceted campaign to reach out to the more than 42 million people with Medicare, with a special emphasis on reaching those beneficiaries potentially eligible for LIS.

Medicare's partners, including grassroots organizations, local, State and Federal agencies, State Health Insurance Assistance Programs (SHIPs), the faith community, and individual volunteers sponsored and attended thousands of Medicare events and opportunities across the country for people to get personalized assistance. Some of our strongest partners were the organizations represented here today: the Social Security Administration (SSA), State Medicaid agencies, and beneficiary advocates. The one-on-one counseling and personalized attention these partnerships made possible enabled Medicare to reach tens of millions of people—one person at a time.

This ongoing Part D outreach effort has been part of the transformation in the way Medicare does business, from a bill-paying agency to a real partner in beneficiaries' health. Moreover, it is working. Today, more than 90 percent of people with Medicare have coverage for prescription drugs through Part D or another source. Additionally, more than 10 million low-income Medicare beneficiaries are getting comprehensive drug coverage for little or no cost. We estimate that this is more than 70 percent of those beneficiaries potentially eligible for LIS. By any measure, enrollment in Medicare Part D is impressive and participation by LIS beneficiaries is unprecedented for a new public sector benefit program.

Like the LIS program, the Medicare Savings Programs (MSPs) are also an important benefit to low-income Medicare beneficiaries. As we will discuss below, these programs assist low-income Medicare beneficiaries with their Medicare out-of-pocket expenses such as the Part B premiums. But, identifying and enrolling those eligible for these programs has historically been very challenging.

Overview of the Low-Income Subsidy

Prescription drug coverage is absolutely essential for older Americans and people with disabilities – but it's especially important that people with limited incomes have access to affordable prescription drug coverage. One of the main objectives of the Medicare Prescription Drugs, Improvement and Modernization Act of 2003 (MMA) was to provide the greatest assistance to those with the greatest need. The LIS provides substantial help to Medicare beneficiaries with limited incomes: a federal premium subsidy ranging from 25 to 100 percent of the monthly premium cost for qualified plans, and minimal cost-sharing for covered drugs.[1]

By "qualified plan" we mean a plan with a premium at or below the LIS benchmark. Note that LIS beneficiaries may select any plan in their service area, but will have to pay an additional premium for plans that bid above the LIS benchmark. As required by law, the Low-Income Subsidy is a means-tested public benefit. In order to apply and qualify, Medicare beneficiaries generally must meet both an income and asset test. In **2007,** the maximum income to qualify for the LIS is **$15,315** for singles without dependents or **$20,535** for married individuals without dependents. Assets may not exceed $11,710 for a single person or $23,410 for a couple (this includes $1,500 per person for burial expenses).

Three groups of beneficiaries are automatically eligible for LIS, meaning they do not have to fill out any sort of additional application to receive the subsidy:

- Beneficiaries who are eligible for and enrolled in both Medicare and Medicaid due to their income level—the "full-benefit dual-eligibles."
- Beneficiaries enrolled in the Medicare Savings Program. These are the Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs) under a State's Medicaid Plan.
- Beneficiaries receiving Supplemental Security Income (SSI), but not Medicaid.

Beneficiaries not falling into one of these categories must apply for the LIS. This means they must submit an application to their state Medicaid agency or SSA, which is responsible for determining eligibility. Upon receipt of approval from SSA, beneficiaries may begin receiving subsidized benefits. Of course, these individuals need to be enrolled in a prescription drug plan to get these benefits. CMS automatically enrolls – or facilitates enrollment – into a plan those beneficiaries who have been approved for LIS but have not enrolled in a plan on their own.

CMS was extremely successful in enrolling LIS-eligible individuals into Part D plans in the first year of the program. Of the approximately 13 million beneficiaries CMS estimates were eligible for the LIS in 2006, 10 million now have coverage for prescription drugs. Through ongoing outreach that continues even today, CMS is building upon the successes of 2006, when over 300,000 new LIS-beneficiaries were enrolled in Part D. With a special election period that allows LIS-approved beneficiaries to enroll through the end of 2007 without penalty, these numbers should continue to grow.

Our work to identify and enroll these beneficiaries is a multi-faceted, continuous effort that did not stop with the end of the first enrollment period; rather it has been a sustained and ongoing effort. We continue to target potentially eligible LIS individuals with a multi-pronged education and outreach campaign that leverages existing information

intermediaries and resources**.** Initiatives include direct mailings and targeted telephone calls to beneficiaries, along with local outreach from community groups, intergovernmental partners, and health care providers, including pharmacists. Given that many beneficiaries may be difficult to reach through traditional means, CMS has special initiatives targeting both urban minority beneficiaries, and beneficiaries in rural areas who may be isolated from general community outreach efforts.

Reaching out to People with Medicare: Partnership Is the Key to Success

As noted, CMS began preparation for outreach and education on the low-income subsidy immediately following enactment of the MMA. CMS partners, including grassroots organizations, local, state and federal agencies, SHIPs, the faith community, and individual volunteers sponsored and/or attended more than 12,700 Medicare outreach events providing opportunities for people to get personalized assistance during fall open enrollment. In addition, the Medicare "Mobile Office Tour" logged more than 70,000 miles to 165 cities with more than 200 stops.

CMS' efforts to reach people who might be eligible for extra help have consistently been among our highest priorities. Partnerships continue to play a significant role in reaching the LIS population, and they have been instrumental in providing the one-on-one counseling and personalized assistance that continues to make Part D a success. CMS is committed to maintaining open lines of communication and dialogue with our partners in order to tailor our outreach efforts. One example includes our relationship with SSA, a partnership critical to reaching the LIS population. CMS collaborated with SSA for numerous LIS education and outreach events, as well as direct mailings and follow-up phone calls to potential LIS beneficiaries. We maintain this very close relationship with SSA in working to continue to identify potential LIS eligible beneficiaries.

In addition, the U.S. Administration on Aging (AoA) has been crucial to both the success of LIS beneficiary enrollment, as well as the success of Part D in general. Prior to the open enrollment period, AoA granted a contract to assist with the enrollment of beneficiaries into Part D. A large part of this contract supported grassroots efforts to

target hard-to-reach populations, especially in minority and disability communities. Partner organizations included National Adult Day Services Association, Meals on Wheels Association, National Alliance for Hispanic Health, and American Association of Homes and Services for the Aging, just to cite a few.

Also, CMS has worked collaboratively with the USA Freedom Corps and the U.S. Department of Housing and Urban Development to distribute LIS literature and materials to people living in subsidized housing, and the US Department of Agriculture to identify individuals through the food stamp program who might be eligible for the LIS.

The SHIPs and the Health Assistance Partnership (HAP) that supports them also have been invaluable partners to CMS in helping LIS eligible beneficiaries. SHIPs in each State offer local one-on-one counseling and assistance to people with Medicare and their families. Through CMS funded grants directed to States, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. Although SHIPs have a diverse portfolio of health care issues for which they help beneficiaries, the CMS grant provided to SHIPs directed them to increasingly focus their attention and efforts during enrollment opportunities on hard-to-reach populations, including the LIS eligible population.

Further, SHIPs are expanding their Part D targeted outreach initiatives—especially those that provide education and expand enrollment opportunities for dual-eligible, low-income, hard-to-reach beneficiaries, and beneficiaries who lack coverage for their prescription drug expenses. In support of SHIPs, CMS and HAP are discussing how to develop ways to coordinate HAP services so that the SHIP network effectively reaches all populations. Further, HAP convenes monthly informational MMA forums, and has assisted several SHIPs with volunteer recruitment and training. For instance, they are working with the Ohio SHIP on a technology tool to better manage volunteers and to support data entry. They also worked with the Iowa SHIP on a web-based counselor recertification program and they are currently working with the Maine and Kansas SHIPs on strategic action plans.

CMS is also grateful for the assistance of the National Council on Aging (NCOA) and ABC-Rx in supporting our outreach efforts. CMS and AoA worked together to contract with NCOA to develop an on-line Low-Income Subsidy application service from June 2005 to September 2006. In addition, NCOA received a CMS-funded grant to reach and assist beneficiaries in applying for LIS, and subsequently enroll beneficiaries in a plan. Also, as part of its coalitions – ABC-Rx and Benefits Checkup Rx -- NCOA came up with innovative outreach strategies to find and help people file for the low-income subsidy.

Another critical component of CMS' outreach initiatives was the direct engagement of the provider community, and especially the pharmacy community. In our initial effort that began in May 2005, CMS partnered with chain and independent pharmacies in an education and outreach program for the LIS. This effort, which preceded the implementation of the drug benefit, was designed to provide information to potential enrollees about the coming Medicare drug benefit and to encourage low-income beneficiaries to take advantage of personalized help in applying for the subsidy. Information and assistance was provided in more than 30,000 chain pharmacy stores across the country. CMS was able to reach and enlist the help of many thousands of additional pharmacists and independent pharmacies through efforts with state and national pharmacy associations and buying groups.

The communications between CMS and pharmacies marked the beginning of an extensive and lasting effort to exchange information and educate the pharmacy community. During open enrollment, pharmacists held thousands of in-store informational days, provided medication reviews, offered community presentations and events, and have helped beneficiaries compare their plan options.

CMS continues to leverage existing relationships with hundreds of community-based organizations around the country. These include schools, senior-centers, community centers, and places of worship. Having a unique relationship with the community, these organizations are able to understand the populations they serve and can best identify their

needs. CMS has also conducted over 1,200 “train-the-trainer” events with local and national partners on LIS-specific outreach, including SHIP counselors, physicians, pharmacists, Federal/State/local government partners, and hundreds of community organizations across the country to reach LIS beneficiaries and provide individual guidance. In addition, as natural partners, CMS works in ongoing efforts with physicians, providers and their staff to provide counseling services and enrollment activities for the low-income population.

Medicare Savings Programs

Under Medicaid, the term ‘‘dual eligibles’’ generally refers to low-income Medicare beneficiaries who also qualify for medical assistance from the State. Those entitled to full benefits under Medicaid generally have most of their health care expenses paid for by a combination of Medicare and Medicaid. However, Federal law also specifies several groups of elderly and disabled Medicare beneficiaries whose income and/or resources are too high to qualify for full Medicaid benefits but who need assistance with Medicare premiums and cost-sharing requirements. While these beneficiaries are not entitled to full Medicaid benefits, they are entitled to more limited medical assistance, specifically payment of Medicare Part A or Part B premiums or cost sharing, such as payment of Medicare deductibles and coinsurance. These state-run programs are referred to collectively as Medicare Savings Programs (MSP). The specific groups that make up the MSP programs are Qualified Medicare Beneficiaries (QMBs), Specified Low-income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). These programs enable low-income Medicare beneficiaries to afford Medicare coverage and thus promote access to necessary health care.

Qualified Medicare Beneficiary (QMB)

Through this program, States are required to provide assistance to Medicare beneficiaries with resources at or below twice the standard allowed under the Supplemental Security Income (SSI) program ($4,000 single, $6,000 couple) and income at or below 100% ($851 single, $1,141 couple per month) of the Federal poverty level (FPL). Benefits under this program are limited to payment of Medicare Part A and B premiums,

deductibles, and coinsurance (excluding Medicare Part D cost sharing). The federal government matches the costs of this assistance at the same rate that it matches the costs of the full benefits package.

Specified Low-Income Medicare Beneficiary (SLMB)

Through this program, States are required to provide assistance to Medicare beneficiaries with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% ($1,021 single, $1,369 couple per month) of the FPL. The benefit under this program is limited to payment of the Medicare Part B premiums, which is $93.50 per month in 2007. The federal government matches the costs of this assistance at the same rate that it matches the costs of the full benefits package.

Qualifying Individuals

Qualifying Individuals (QIs) are those who are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program, and if their income exceeds the SLMB level, but is less than 135% ($1,149 single, $1,541 couple per month) of the FPL. QIs receive assistance in the form of payment of their monthly Medicare Part B premiums. Unlike QMB and SLMB, the QI program is not an entitlement. Unlike QMB and SLMB, federal funding for QI is capped each year so States serve eligible people on a first-come, first-served basis until the State reaches its federal funding limit. The QI program is completely federally funded: States are not required to provide a State match.

Program	**Income Limit**	**Resource Test**	**Benefit**
Qualified Medicare Beneficiary (QMB)	Less than 100% FPL ($851 single, $1,141 couple per month)	Twice the standard allowed under the Supplemental Security Income (SSI) program ($4,000 single, $6,000 couple)	Part B premium; Part A premium (if any); Part A and Part B deductibles and coinsurance
Specified Low-Income Medicare Beneficiary	More than 100% FPL but less than	Twice the standard allowed under the	Part B premium

(SLMB)	120% FPL ($1,021 single, $1,369 couple per month)	Supplemental Security Income (SSI) program ($4,000 single, $6,000 couple)	
Qualifying Individuals	At least 120% but less than 135% FPL ($1,149 single, $1,541 couple)	Twice the standard allowed under the Supplemental Security Income (SSI) program ($4,000 single, $6,000 couple)	Part B premium

Enrollment in Medicare Savings Programs

Rates of enrollment in MSPs are well below those of other means-tested programs. According to the Congressional Budget Office (CBO), enrollment in the QMB program was only 33% of the expected QMB eligible-population and SLMB enrollment was at a 13% of the estimated eligible population.

Identifying and enrolling Medicare beneficiaries in the MSP is difficult, as well as time- and resource-intensive. The programs are difficult to explain and understand. The need for education extends beyond potential eligibles to county workers, health care professionals, aging service providers, and volunteers. Cultural values of self-reliance, an unwillingness to disclose personal circumstances, and a distrust of government are particularly strong in many ethnic communities where potential MSP-eligible beneficiaries reside. The welfare stigma associated with government programs is a significant barrier to enrollment for many older Americans. Contacting and informing potential beneficiaries about the program is particularly challenging in geographically isolated and sparsely populated regions.

Increasing enrollment is crucial to relieving the financial burden of healthcare to our most vulnerable population. Research consistently shows these beneficiaries are more likely to be old, female, African-American, or Hispanic, and living alone. Their health status is more likely to be fair to poor. However, we continue to strive to help these people enroll

in the MSP program as enrollment in a MSP helps improve access to healthcare services, ultimately improving one's health status.

In 1999, under the Government Performance and Results Act (GPRA), CMS launched an initiative to "improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance." As part of its efforts to achieve this goal, CMS convened a group of federal and state representatives to create a national strategy for increasing enrollment in the MSPs. To support these efforts, CMS contracted with researchers to profile the characteristics of enrollees and those eligible but not enrolled, assess the effectiveness of state and federal outreach programs, and estimate the enrollment rate in the Medicare Savings Programs. To further this CMS GPRA goal, CMS contracted with RTI International to provide information on the effects of the Medicare Savings Programs, as well as factors that influence program participation.

Looking Ahead: Reaching the Those Yet to be Enrolled in LIS and MSP

Despite all the progress made to date, CMS is committed to doing more. Working with our partners, we will continue our outreach and education effort beneficiaries who could be eligible to apply for LIS or one of the Medicare Savings Program. We continue to believe that the best way to learn about these benefits is to receive personalized assistance on getting the most out of their Medicare benefits.

CMS' partner engagement goals for 2007 strive to make Medicare a permanent grassroots program. CMS is working with its various partners and key stakeholders in this evolution, and is increasing proactive outreach. By connecting partners and sharing resources nationally and in the field, CMS will continue to help people with Medicare make the most of their benefits through personalized assistance and ongoing outreach.