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Helping the Medicare Savings Programs Get Savings to Seniors
Alliance for Health Reform and the Commonwealth Fund
June 12, 2006

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ED HOWARD: —to offer help the low-income Medicare beneficiaries with some of the costs of their care that Medicare doesn't pay. Our partner in today's program is the Commonwealth Fund. We're happy to have Stuart Guterman of the Fund and Ann Gothier and some other folks from the staff with us today and we're grateful for their support, both for the topic and the program specifically. And everybody here probably has heard that Medicare pays just over half of the healthcare expenses of older people and people with disabilities who are in the program, not everybody here, I would guess, knows a lot about the programs that offer assistance in paying part of that other half of the healthcare expenses of that population, I mean the Medicare savings programs. [Inaudible] and QIs, they're terms only an acronym-phile could love. But the help they offer is pretty real for low-income Medicare populations, just like the extra help available to those with low incomes or the new Part D prescription drug benefit. So today, we're going to look at who participates in those programs, probably more importantly, who doesn't participate in those programs, why they do or don't and how those participation rates can be improved. And we're lucky to have as an excellent jumping off point for that discussion a brand new report from a study panel of the

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National Academy of Social Insurance, NASI, about which you will hear more presently.

A couple of quick logistic items, most of you who have been here before know about. A lot of material in your packets including the slides of the people we have slide copies for. Everything's going to be on our website at Allhealth.org and along with a web cast video of this session, all of those materials will also appear on the Kaisernetwork.org website and we're very grateful to the Kaiser family foundation for that service. There'll be a transcript available in a few days as well. And, as always, we want you to fill out two things, the green question form at the appropriate time if you would not choose to come to one of the floor microphones and the blue evaluation form so we can make these programs even better. I'd also ask you to put your pagers and phones on vibrate or whatever it is you put them on so we can have this discussion untrammeled by phone rings that only fourteen year olds can hear.

Now, as I noted, we have with us Stu Guterman of the Commonwealth Fund, where he directs their program on Medicare's future. He's also a veteran of Medicare from inside as Director of CMS's Office of Research, Development and Information and coincidentally, a valued member of the Study Panel from the National Academy of Social Insurance that we're

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talking about today and he'll be sharing the moderating duties with us today and we're very happy to have you. Stu—

STUART GUTERMAN: Thanks Ed. I was getting a little worried when you said I was a veteran of Medicare. I thought that I had slipped in as a beneficiary sooner than I was really eligible. But no, there's a ways to go. But I have spent a lot of time working on Medicare and I guess in a minute or two to introduce this session I can give you a little bit of where this report came from. The NASI and Commonwealth Fund looked at these issues and it's well known that there are a number of low income Medicare beneficiaries who are not currently taking advantage of provisions that are intended to help them get access to the healthcare that they need and this is always presented sort of a problem in the Washington scheme of things because you always have this notion. The bad news is that nobody's taking these programs up and so people are going without healthcare. The good news is that because of that, the government isn't spending as much money as we anticipated and it also creates a problem because when CBO scores these programs they make some assumptions about the take up rates of these programs and that means if you improve the take up rates beyond those levels you end up actually costing the budget money from CBO's perspective. And so what I'm asking you to do is suspend that reality for a little bit when you think about these programs and remember that these programs are not

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intended to avoid spending the money but in fact intended to make sure that people who need health services have access to those health services. So, that's sort of the underlying impetus of this session today and we have a terrific panel as Ed said. We're going to start off with Jack Ebeler, who was the chair of the NASI panel that produced the report and he's going to give an overview of the report and talk about the recommendations that the panel is making. And then we're going to follow that up with Jennifer Young, who's spent a fair amount of time on the hill and also in the administration, is now out in the private sector thinking about these issues from a different perspective so she'll bring the perspective of her experience on these issues and then Cathy Kuhmerker, who brings the state perspective. She worked for New York State Department of Health for a number of years and is recently retired from that position but still also thinking about these issues. And then Andy Schneider, who spent a number of years on the Hill working on Medicaid issues and related topics and he's going to give us his thoughts on these issues. So, without any further ado, I think we'll go to Jack and let him kick things off.

JACK EBELER: Thank you very much, it's a pleasure to be back at the Alliance and a particular honor to be here on behalf of the National Academy of Social Insurance and the panel, which is reporting to you today.

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The purpose of this panel was to identify ways to increase enrollment of the number of people in these Medicare savings and programs as Stuart flagged. In addition, after the panel was formed, many of you working on Medicare Part D, we passed that program and the panel began looking also at ways to link those two types of low income support programs. We were very generously funded by the Commonwealth Fund and we thank them for that and we thank them for their patience. This was an eighteen month project that started three years ago and with dissemination supported by the Kellogg Foundation, so thanks to them as well.

This is the Study Panel, a heavy focus here on implementation. The question is how do you get benefits to which people are entitled actually available to them, how do you actually get them enrolled? And we focused on those issues. We had liaisons with both CMS and SSA, Susan McNally and Craig Street. I would stress and were they here, they would stress even more that they were technical liaisons, they were not speaking for the Federal Government and they neither support nor oppose the recommendations of the panel. But they were really extraordinarily helpful in this process.

The project staff is presented here. This is a project of turnover. Any of you chairing a panel in the future is ask that the foundation program officers and the program staff have contract agreements. Cathy King was the initiator of the

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project, working with Barbara Cooper at Commonwealth and they didn't like what we were doing so Cathy went to GAO, Barbara retired. I took this all very personally, this is not—this is not funny. But we are very fortunate that Paul VanDeWater came and produced the vast majority of the excellent report you're looking at. Reggie Williams was actually the first project assistant, then Cayenne [Inaudible]. They also found this to be an appalling project and they left and went to advance their careers elsewhere. We had very good consulting support from Mark Merliss and Jim VerDeer. We have a number of reports on the website. Liz Cusick and Ken Nibali, who are panel members, did a paper that was the basis for a lot of our work with the only NASI produces [inaudible] titles like this current processes for enrolling Medicare Medicaid dual-eligibles and Medicare savings programs and efforts to increase enrollment. But that's available on the website and there's a very good reference guide. Mark Merliss did a very nice job laying out a framework for costing, the various options. Jim Verdeer turned that into some particular cost estimates and all of that again are on the NASI website, which I'd urge you to look at.

Just going back to where Ed and Stuart started us off, it's really important to go to the policy framework here. Medicare provides a basic benefit package for all the elderly and disabled and in looking at that benefit package since its inception, there's a policy clause tradeoff, which it is a

fairly limited benefit package available to everyone with some uncovered benefits and a substantial amount of cost sharing included in the basic benefit package and that model is included in the prescription drug plan as well. So, you have really two policy mechanisms that adapt to that, Medicaid in particular for the lowest income covers additional benefits in a particular long term care and covers the cost sharing and more to the point of this panel the Medicare savings programs and the low income support on the prescription drug plan are there to help lower income beneficiaries pay the premiums, pay the cost sharing, so that they can have the financial access to the services that the programs are designed to provide. It's an important model because I think as you look forward to the future of Medicare one has to presume that there are going to be spending constraints across the base program, making the policies for the low income to assure they have access within that model, all the more important in why it's important to implement these types of programs well.

Just briefly, I think this audience knows it well, the MSP programs we have, you know we have, this is acronym, [inaudible] but we have, you know QMBs, SLMBs, qualified individuals and then we have various Part D subsidy plans at different percentages of the poverty level. There are different resource limits under the programs, as we get into the report. This is the simple version of the chart because

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there are obviously different benefits that come, there are different mechanisms for counting income and administrative mechanisms are extremely complex. So you have a set of incremental policy and options that have been enacted over time, all with very good and positive intent, but that when you're done and that is a pretty complicated structure. You have a wonderful set of papers in your packet from the Alliance that lay out a variety of these issues. The problem of course is the policy structure is a good one. We have support for the lowest income individuals. The problem is we haven't' reached them. Our panel found that there's probably about one in three QMBs are in, about one in six of the SLMBs, which means that they're not getting protection they're entitled to and the research indicates that as a result, these folks who are the most vulnerable are the Medicare beneficiaries are accessing services at lower rates that equally situated individuals who are enrolled in these programs. The barriers we identified were in five categories, lack of awareness of the programs. I think something like 80 percent of the non-enrollees didn't know of their existence. It is a very hard to reach population by definition, this target group is hard to reach. The connection to welfare, the application processes are just extremely complicated and make it hard for folks to get to it. I think something like two-thirds of enrollees require assistance in filling out the forms and getting to it and in

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particular, the pieces on asset reporting tend to be barriers, both subsidively and administratively, they are harder things to document. That list is sort of a technical list. Underneath it all, the underlying program structure is just very confusing. This may be the wrong question in this room, but I typically would say, "Can anybody, off the top of their head, describe all the features of all the various programs?" And so we should not be surprised when we sit back and discover that a 78-year-old elderly individual has a little bit of difficulty figuring out how to access the programs or somebody implementing them out of the state or the federal government has trouble doing it, it is a complicated infrastructure to deal with.

We developed options in four categories. We do not have one recommended thing to do, we thought the most logical thing to do would be to present an array of options, making the current programs work better, simplifying and aligning the programs between MSP and drugs, changing the treatment of assets and moving towards a greater federal role and this, in our view, was sort of a mix and match set of options to look at. The report goes into them in detail, let me just touch on them briefly, taking the existing structure, logical or not, try to make it work better, trying to get Social Security to use data it collects on individuals' income and assets from the drug [inaudible] to target mailing and outreach. Social

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Security is doing some of this but it's a clear positive direction that can go farther than that and actually use some of that data provided to the states and have the states use that to make enrollment determinations under MSP. Third, there would be mechanisms to provide some personal assistance to those individuals who need help. Again, it's an inherently complicated process, folks need help, you've got to give it to them. And fourth there was a time period where there were some performance goals and demonstration projects underway. They showed some progress in improving enrollment in the programs and that's an option for the federal government to go back to. The second set of options is saying well the underlying structure could be improved and we have a couple of pieces here. One is to adopt much more uniform methods of counting income and resources for purposes of determining eligibility under the programs. Again, we lay those out in the report. I don't want to run on here too much. Sixth is the one where we step back and say this is just way too complicated and we suggest streamlining and aligning these programs into two categories: we suggested for purposes of example using the recently enacted drug categories and moving the QMB, SLMB qualifying programs into those two categories, where there's one for folks under 135 percent of poverty at one resource level, a second for folks up to 150 percent of poverty. It would make this a lot simpler to explain. There's an option

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connected to that, again, given that issue of resource limits where the panel suggests an option of just doubling those resource limits, again as a way to make enrollment easier and more available to individuals.

We've put in the report some cost estimates. The cost estimates are big numbers. They presume that everybody who is newly eligible enrolls in the programs, which even with the best intent, we don't think would be happening, but they're there to provide an order of magnitude. In general, you'd increase enrollment and eligibility for the programs by about five percentage points under these options. The third area is improving treatment of assets. The one is something this group has probably talked about before which is annuitizing liquid assets, especially in the world of 401K plans instead of defined benefit pensions. It's going to become increasingly necessary not to have individuals spend down, there 401K plan, but to count some of it as income against income tests rather than treat it as an asset. And finally, eliminating estate recovery is something that a number of states have done in the MSP programs; again it would eliminate both the subsidive and a perceived barrier to enrollment.

The final thing we look at here is allowing for a lot stronger federal administration. The states don't particularly want to do this, it's very complicated, in particular if you standardized the rules, you could create something like we have

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in SSI where there's a state option to allow SSA to administer the program on behalf of the states so that SSA, in collecting the income, could actually make the eligibility determinations on behalf of the individual. We also included in the report that if one does that one's going to have to presume that the federal government would absorb 100 percent of those costs. Again, the states cannot do that. We cannot expect to long term it's a policy direction that one should head. So that's the laundry list of options. Again, we're not picking one and saying do that, it's a mix and match set of things, but some options we would strongly encourage people to consider. Again, this is where the reports are available and I'm over and I'm done. Thank you.

JENNIFER YOUNG: Thank you. I appreciate the opportunity to talk with you today. Just to reiterate, I think there's a shared belief that these programs are an extremely important societal obligation to very vulnerable populations. The QMB and SLMB programs exist as entitlement programs to beneficiaries and I think everybody here today would agree that the entitlement ought to be fulfilled and if you were currently eligible for the program but not enrolled in it, we want you to sign up period. No questions about that.

Why people haven't signed up so far, the NASI study has done a good job looking at the departments. Some of the reasons that we would hit up against regularly would be things

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like a lack of the basic awareness of the programs existence and that's not hard to imagine. Seniors confront an array of choices and new experiences when they turn 65 to not know about this complicated and small program is not surprising and we all need to do more to make sure people know it's out there in the first place. Language and cultural barriers, the welfare stigma that we've heard so much about over the years are reasons that they contribute to people not signing up for the program and things that we all need to work on. We're hopeful at the department that all the work that has been done on Part D enrollment finding and encouraging seniors to enroll in the low income subsidies could have the spillover effect in promoting awareness of and enrollment in QMB and SLMB and the QI program. Too early to know how successful that hope has proved to be but I think there is a very logical assumption that if you find someone who's eligible for one type of special assistance, they would be more open to receiving another type of benefit for which they would also be eligible. When we're thinking about Part D though, we do need to be careful that all the sound and fury about the complexity and confusion of the Part D benefit doesn't have an unfortunate spillover effect as well of scaring people away from interaction with the Medicare add-ons. We don't want to further intimidate people who might already have a basic level of intimidation when interacting with the program. But now that we're behind the initial open

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enrollment period for Part D there's reason to hope that our message across the board should be supportive of encouraging beneficiaries to pursue all opportunities for additional benefits through Medicare. So when we look at the NASI recommendations I think we can agree that they've done a great job identifying some areas that need some further consideration but I do think we need to proceed with caution when we move to recommendations that would expand the scope of the current programs. Before going down that path it seems to make sense to stop and think about what that would mean in terms of the fiscal health of the overall program and the overall burden on taxpayers, many of whom we always need to remember do not themselves have health insurance. To take the ideas in sequence, when you look at things like increasing the partnership with the Social Security Administration. Absolutely, that's something that has worked very well in the Part D benefit and when you think about senior citizens, the gold standard in terms of beneficiaries satisfaction and comfort, is the Social Security Administration and the more these programs can be associated with Social Security, the more comfortable we anticipate seniors be in participating. When you think about providing information to the states for them to use in targeting their enrollment efforts, that again seems intuitively logical as long as patient privacy can be protected at the same time which probably means keeping the Veterans

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Administration entirely away [inaudible]. There's something empowering about no longer working for the Administration. You can say things like that out loud and not have a phone call when you get back to your office.

You can provide targeted casework to beneficiaries, that again is something that makes a lot of sense. Having people help you through the complicated enrollment process. And I think this is another opportunity to build on the momentum that was created through the Part D implementation process. Some really terrific community partnerships were formed with the advocacy community that really stepped up to the plate and did a phenomenal job. I'm thinking here of the National Coalition, Howard Bedlan's group, of the groundbreaking work they did with sitting down with beneficiaries on a one-to-one basis and helping them navigate the system. That same sort of passion and intensity applied to this population could again make a real difference and again should be taken advantage of. Implementation of performance goals, that couldn't sound more geek-ish, but it, does in fact matter. When the [inaudible] scores come out and OMB assigns each department, whether they're red, yellow or green, people take note of that and it's a good day if you're green and it's a bad day if you're red, and if you can get yourself on the goal list and people are thinking every day about how they need to get themselves on the right side of the government's score

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card, that can only be helpful and should be taken advantage of. So those ideas should all be jumped upon and pursued administratively. These aren't things that should require any legislative intervention. But it does get harder when you talk about things like simplification and alignment, that sounds innocuous but it can be code for expanding and you're right, I run the risk of sounding blasphemous, but I would suggest that I think you don't necessarily fix a program that has shortcomings in enrolling eligible beneficiaries by simply making more beneficiaries eligible. There's some logic to instead focusing on finding the people who are currently eligible and getting them enrolled before you think about expanding the base. In addition, when you talk about these ideas that become code for expanding I guess I'm just intrinsically incapable of suspending my budgetary hat. Those things do have costs and need to be considered. Those costs can be significant, wherein having the B's here ranging from 8.7 billion annually to almost 20 billion annually and for some of the recommendations it makes you stop and think is this really the time that we should be thinking about exempting income producing property from asset determinations, again remembering that ultimately these proposals' costs are born by the same taxpayers who are just committed enormous expenditures to providing the same population with the drug benefit only six months ago. By doing things like annuitizing assets and

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eliminating estate recovery I can see that you make it seem less intimidating to the population we're trying to target, but at the same time you are essentially allowing seniors to avoid spending some of their own money on healthcare services, with the assumption that they government's going to then step in. And once again, to reiterate, if seniors are genuinely without resources and are currently eligible for these programs, no matter what it costs, it's our obligation to bear those costs and serve them. But when we're talking about a programmatic expansion we should remember that there are other priorities competing for healthcare dollars, for instance I'm sure if we were to poll everyone in this room we would probably all agree that the population of people who are currently uninsured in this country is unacceptable. Now, I'm sure there's not a consensus for how we should use available funds to provide insurance coverage to them, but I imagine we would find that to be a compelling priority that needs to be weighed against doing more for this population for whom we just gave the drug benefits. The report's final recommendation in terms of federalizing administration. Absolutely, that makes a lot of sense. And again, we're talking about creating a bigger role for the Social Security Administration so perhaps as a former HHS-er it's easier for me to say yes, Social Security should do more since we're not talking about HHS. But again, because they have this gold standard of beneficiary comfort, they

probably are the logical federal home for an increased roll and because what they have done in doing eligibility determinations for the drug benefit low-income population. This is something on which they now have real experience that should be built upon. The question of how do you finance an increased federal role is something that will need to be wrestled with. There's not going to be any appetite within this administration to allow the states to shift that cost to the federal government nor, I'd imagine, would the states be jumping up and down with enthusiasm for taking more of a financial responsibility themselves. These are perhaps the sort of issues that as the Medicaid Commission completes its work and prepared recommendations for Congress and the Administration to consider next year and beyond that we can think about in the context of an overall discussion about the underlying partnerships of responsibility for this population and I think legislative changes in that regard are fair game and should be discussed. I thank you for allowing me to participate and once again, I think NASI did a great job, some very intriguing ideas.

KATHY KUHMERKER: Good afternoon. Can you all hear me? Great. I'm also very pleased to be here. I was the Medicaid director in New York State until the end of December and this is my first real trip back to Washington and I've missed it. So, I'm going to skip through a couple of my first presentations because why I'm really here today is to talk to

you about what state Medicaid agencies thing about the Medicare savings programs and the relationship that we have to them. Despite what many people think, state Medicaid agencies really believe in providing healthcare and giving people access to healthcare. At the same time, I certainly saw in the Washington Post today that there are, as usual and continuing, lots of changes in Medicaid programs. But really, as a Medicaid director one of your major goals is to ensure that everybody who should be getting care should be getting the appropriate care. So, access is really important. But there's no question that Medicare savings programs are very, very small part of what Medicaid agencies are asked to do and I can say now, they tend to get lost. There are 55 million people on Medicaid programs; there are less than a million people who are currently enrolled in the Medicare savings programs. We think of Medicaid as one large mammoth kind of program. I think it's about 55 or 60 different programs and an eligibility worker needs to know all of them and when someone comes in and says to an eligibility worker I'm interested in the Medicare savings program. He goes, that's fine, the Social Security Administration is down there. It's hard to get them to even remember that a Medicare savings program is something that Medicaid agencies are supposed to be responsible for. And the other issue is when you look at it, while Medicare covers both the elderly and the disabled and Medicaid agencies do see

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disabled individuals. One, because many of them have very little incomes and the other is because for the first 24 months when they are determined disabled, they're not covered by Medicare yet, so they do come to Medicaid. Most seniors don't come to a Medicaid agency. They come only when they need long-term care because basically Medicare covers all of their acute care costs. And that really comes back to so why don't they come in addition to the fact that Medicare covers their acute care costs is that Medicaid agencies are considered welfare in most states and New York, the Medicaid program is administered by local departments of social services where they also do [inaudible], where they do child support, where they do all of the child and adult protective services. Definitely they look, sound, walk, talk and basically are welfare agencies, even though Medicaid has gone far beyond being a welfare program. So seniors don't want to come. I think we were just talking about the gold standard of SSA and what they do for the supplemental security income population. Congress recognized back in 1972, when they passed PL92603, which actually is the first federal program I ever worked on at the state level and took the aid to age [inaudible] disabled program and turned it into an SSA administered SSI program. At least for those states that opted to do that. So there is a fairly long tradition of that kind of SSA involvement. And then I think when you take a look at Part D and what happened in Part D

where the statutes said both let SSA should be prepared to do [inaudible] subsidy determinations and state Medicaid agencies should be. Medicaid directors said basically we really don't think very many people are going to come to us. And even in those states I believe where there was really a tremendous effort to go out and talk to seniors and individuals who are disabled and on Medicare about the low income subsidy program virtually everybody went to SSA because they're familiar with it, they like it, they feel comfortable and again, it's not that welfare agency.

At a state level Medicare savings program eligibles are really hard to identify. States have little or no systemic information on them. We don't know who they are, we don't know who's in Medicare, we don't have their income and resources because basically if you're really low income you're not even filing tax returns. So there's really no way in any systemic kind of way to identify who they are. State pharmacy programs used to be a fairly decent information source when you could get beyond the fact that in some states, including mine, it was very difficult to share information between the two programs because it was considered to be protected health information and no one had signed over the rights for one part of the agency to talk to another. But what's happening now with Part D is some states are dropping their pharmacy programs and some individuals may actually be dropping out of those programs

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because they are actually getting now Part D coverage so there are even fewer people that states might be able to identify. And the last reason is that really outreach through aging and disability network is really very resource intensive. You need to train people, you need to answer their questions, you need to keep the trainers up to date, that's a very difficult expensive time consuming and staff intensive process and states are suffering just like everybody else with limited resources and having to decide where to put them. People talk about streamlining at the state level and that has some limitations. When you look a the report you will see that many states already have streamlined their application process, we did in New York and that's some small increase in the number of individuals but still the process is complicated. There are varying state rules and approaches and those can result in very inconsistent levels and degrees of improvement. It makes it hard to have any kind of national campaign and actually even at a state level, having a state level campaign is really complicated because the programs themselves as Jack talked about are really very complicated. And then CMS is starting as appropriate a program integrity program. But that really will discourage states from doing anything that streamlines in such a way that they perhaps have less information than they used to have before. They're going to be less likely to want to eliminate in person applications and again we talked about the

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fact that most individuals on Medicare don't want to come to a Medicaid office and do this. They're going to be less likely to be interested in allowing someone to attest to their incoming resources because while you can attest, you still have to go back and get the information and then how do you go back and get that information. Then finally whenever you have more than one agency or more than one place for someone to go you have a multi-step process and people get lost along the way. I think some of the reports on what's happened with Part D low income subsidy, we've seen where there are a fair number of people who applied for low income subsidy who were actually determined to be eligible but have not enrolled in the plans because again they had to go to Medicare and actually go to the plan and enroll. Now I'm also a budget person, I've had 25 years of experience in the state budget division so I couldn't quite get myself to think of some options that would include expanding a program, as I think many people here on the panel had similar difficulties doing. But when I first heard that I was going to be asked to come here, the first option I considered and I was very pleased to see that within the report was transferring the eligibility determinations to SSA. That really can eliminate or at least minimize the multi-step process. It clearly avoids that welfare stigma. It's the same thing as you have under SSI. SSA staff should know and understand Medicare. SSA now has that infrastructure under

Part D and all the processes and their data comparisons and all their relationships with the other agencies. I haven't talked to the other Medicaid agencies but we don't really like the clawback. I can now call it a clawback; I guess I always did call it a clawback except in front of Dennis, who didn't like that. But states might certainly be willing because the goal is to increase enrollment. There would very likely be some hopefully some increase in the number of individuals enrolled in the Medicare savings programs. But states would probably be comfortable with the maintenance of effort provision and if all you were doing, again, was moving to getting those individuals who are currently eligible for the program, there should be some limited financial impact. And something that's not on my list because I hadn't thought about it. Talking about it that way is when you think about this, the SLMB and the QMB programs are absolutely entitlement programs, the 2I1 program is not an entitlement program but we have a situation where we have entitlement programs that are Medicare programs but they're administered differently in states and they actually have different rules and while everybody is comfortable, not from what's comfortable but certainly everybody is aware that Medicaid programs are run as a partnership between the Federal and state government and Medicaid programs vary between and among the states. Medicare is supposed to be uniform, though

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having QMB and SLMB programs where you might be eligible in New York but you might not be eligible in Alabama is a bit odd.

The second option I was considering was really to improve the eligibility process at the state level. I mentioned earlier that states just don't have any data about the individuals in Medicare on the Medicare savings program. You certainly could, if there were efforts to try and streamline that process, if you couldn't get to moving to SSA taking over, minimizing the review workload by providing access to national databases would be good. As a former state Medicaid director, I can't stop myself. I'd think if you were going to be doing that kind of streamlining, that kind of checking, you'd need to clarify that the program integrity rules either permitted that kind of data as an acceptable standard to demonstrate that you'd done the appropriate work or not have the Medicare savings program eligibility determinations count in any assessments of how states were doing. And finally, states would be interested in fully funding any outreach and program expansion because otherwise there would be significant state financial disincentives to do that and states would find it more difficult to proceed.

ANDY SCHNEIDER, J.D.: I'm going to be very brief. This is really a good opportunity to talk about Medicare reform and Medicaid reform at the same time. Particularly because we have a lot of people here who already have a lot of skin in the

game and a lot of them are personally responsible and have been for most of their lives so there's a lot of consensus here about these are deserving individuals and we might want to think a little bit about how to make these programs work more effectively for them. And you guys on the hill have the benefit of some very good reports here. This piece that Commonwealth has funded and Jack and Paul and all the others has put together is actually readable. You might not agree with it, but at least you can understand what it's trying to say and this is a complicated area this is not so easy to do, I've tried to do this myself without much success so I'm very impressed. I'm very impressed and in your materials there's actually a lot of good stuff on a state-by-state basis. Trish Nemore and her colleagues have done something for Kaiser where they waded through what's going on at the state level and of course there's a lot of variation there as Kathy mentioned and it's important obviously to get an initial fix on what's going on in your own state and measuring some of these options that Jack and his colleagues have put out in front of you against that. Lora Summer, there's a report she did for AARP; there's some other materials. There's actually allot of the staff work has been done here and my personal point of view is the ball is in your court because we've got, the numbers are difficult here, so I'm just going to move backward from the participation rates that you see in the report. If the participation rate

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for QMBs is 33 percent and if the participation rate for SLMBs is 13 percent, then roughly, just linearly what you're talking about is about 800,000 people are enrolled out of about 4.1 million. These are all elderly and disabled Medicare beneficiaries with incomes below 135 percent of poverty. And, again, not to beat a dead horse, but that's not a lot of money. If you're just looking at, and this isn't laid out in the report, if you were just looking at the benefit from subsidizing that Part B premium at eighty-eight fifty a month this year. That's ten percent of a person's income. Now, the last time Congress looked at how to make people personally responsible in the case of families and kids it shows five percent as a ceiling on income of a contribution to be expected for not only premiums but cost sharing. And that was just this past February in the deficit reduction act. So here we've got something that's already on the books. Over three million people, who are eligible for it, as far as we can tell, are not getting it and as a result, they're incurring just premium expenses. Let's not talk about any of the other out of pocket expenses and that's just a ten percent of their income if they're at a hundred percent of poverty and I guess about eight percent of their income if they're at 135 percent of poverty. So, this is really a problem worth solving. You can help a lot of people, a lot of people and make their lives a whole lot

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better if you get a handle on this. So, that's my little pitch to the hill staff.

There are lots of ways to go about skinning this; I'm not as worried about putting more federal dollars as some of the other people up here are. I know that comes as a great shock, but in the grand scheme of things, we're not talking about a lot of money and you all know what the grand scheme of things is here. There are also—you know the notion of the federal government assuming more responsibility for the subsidies for this low-income Medicare population, not a terribly radical idea. It is a little expensive, but on the other hand, it would provide some states some fiscal relief and Kathy was too polite to say it but there are some state officials who are wondering why is this our responsibility? And maybe we might want to think about it. At the time these Medicare savings programs were first developed, of course, there wasn't the LIS subsidy under Part D that is operational now. We're learning more about the interaction between hose two, but it's pretty clear that if you get people into the MSP programs that we've talked about here, you have a much better chance of getting those same people enrolled in the low income subsidy, which is also a good thing because everybody wants the low income subsidy to work. So you can kill a lot of birds with one or two stones, some of them administrative and some of them may take some legislative activity. You have some time to

think about it, this is not likely to happen this fall but maybe in the next Congress you can get something done.

Now there is one little thing you might want to look into and then I will close. This is coming to your theaters July first. Citizenship Documentation. You think these folks are confused right now about what their options are or aren't. Well, you can just add on top of that on July first, if they show up as new applicants, these are Medicare beneficiaries citizens, they show up as new applicants for this program, you're going to be asked to document their citizenship. If they're already on Medicaid, and they're dual eligibles and they're already enrolled in the dual eligible part of this program, they're going to be asked to documents their citizenship. How are they going to do that? Well, they have to show a passport. If they don't happen to have a passport, then they're going to have to come up with a birth certificate, original, no copies or certified copy by the issuing agency. No notarized copies permissible. Plus an identification document. Now, it's not just the Medicare beneficiaries involved in all this, it's all 55 million Medicaid individuals. There seems to have been an effort made in the deficit reduction act to exempt Medicare beneficiaries from this requirement. It didn't work. There's no exemption in the CMS. Dear State Medicaid Director letter that was issued on Friday.

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This is something that can be fixed; it's called a technical correction. I would really encourage you to look into it.

ED HOWARD: Obviously discussion and legislative recommendations all in one. I want to encourage our panelists if they have anything they would like to say in response to something they've heard, that they can take that opportunity now. I want to encourage Stuart as a member of the panel as well as someone with a lot of experience in this to join in the discussion at any level he would like and I would like to encourage you, both [inaudible] green cards and to come to one of the microphones is you would rather make sure you're question is going to get asked than answered. One final thing, if you're going to have to leave, please fill out the blue evaluation form before you do it and let me try a question while you're writing and/or moving to the microphone.

Do we have, and I might ask whoever from the study group can respond to this, estimates of costs that might be based on less than 100 percent participation, which may be difficult to attain? Any cost estimates say on bringing things up the five percent or eight percent that come out of some of those pilot programs that the report describes?

ANDY SCHNEIDER, J.D.: Jim Verdeer gave us a rule of thumb which is in his memo, again which is on the website, but it is that a one percentage point increase in enrollment across

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the MSP programs would increase spending about 18 million dollars.

ED HOWARD: Million?

ANDY SCHNEIDER, J.D.: Million. A lot of the costs here are folks, brining them in, the numbers for the drug program are bigger because the subsidy level is bigger so I think a one percentage point in the drug subsidy program in his estimates about 102 million dollars. There wasn't anybody that we found willing to estimate what the various outreach activities would actually produce in terms of net increases in enrollment so instead we provided that scale. But my recollection of the data and some of it is in the Cusick Nebali paper. You saw increases in some cases of seven percentage points, ten percentage points, some interesting initiatives on those administrative pieces, but that's a scaling of it. To convert the hundred percent estimates to smaller that are the top line estimate here obviously if you assume 70 percent, it would be a smaller number, but we just didn't have that fine-grained analytic capacity.

ED HOWARD: Yes? Want to identify yourself?

JULIE STERN: Hi, my name is Julie Stern; I'm with Congressional Research Service. I just wanted to ask about what happens if Medicaid isn't paying the premiums, how are they getting paid? I think there are deductions from people's Social Security checks and if that's the case, about how much

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money are we talking about? And if someone isn't able to pay the premium, does that mean they don't have access to medical care? [Inaudible] right?

JACK EBELER: I think your mechanical analysis is right. I mean, it comes out of the Social Security check. It is slightly over a thousand dollars a year. One of the reasons we looked at this is, as one of the panelists mentioned, that's about ten percent of income at this income level so it is a very substantial amount of money that if the person isn't in part—I think the mechanics work the way you described it. And it's a nick over a thousand dollars a year. The part D premium for a single person, double that for a couple obviously.

ED HOWARD: Either I misunderstood the question or I have another question that follows from that. Once someone signs up and is qualified, does their Social Security check then go up by 88 dollars a month? Go ahead. If you're in part B.

KATHY KUHMERKER: If you have a Social Security check it's whatever it is per month. If you sign up for Part B, there's a premium and it's automatically deducted from your Social Security check. I think you can, as an individual, decide to drop your Part B coverage in which case there would no longer be a premium, but if you have to pay it yourself it comes out of your Social Security check. If you've got Medicare savings program, then a state will pay for it and you

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can often go retroactively for a couple of months and repay someone for what they spent during the application period.

JACK EBELER: But in that model your Social Security, if you were paying it out of pocket, then your Social Security would then go up because the state is now paying that part B premium for you.

JULIE STERN: The other part of my question was about the cost sharing. If someone isn't able to pay cost sharing, then what happens, do they lose access to medical care?

KATHY KUHMERKER: When you say cost sharing are you talking about the twenty percent?

JULIE STERN: Yes.

KATHY KUHMERKER: Speaking from my own personal information with my in-laws, who would go to doctors and say I need you to accept us on assignment so I need you to accept the eighty percent that Medicare pays and that is often what I think a lot of people do or they have a bad debt with the physician.

JENNIFER YOUNG: And then Medicare does provide some financial help for institutions that absorb that bad debt.

JACK EBELER: But one of the pieces of data researched that we looked at and again why this is an important subsidive issue is that the research indicates that those people who are income eligible for these programs but are not in the programs to pay their premium and their cost sharing are in—use less

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services. I mean the truth is the cost sharing does appear to be a barrier to access in particularly outpatient hospital and outpatient services not so much inpatient services. So the subsidive problem here is that folks that are not, recent enrollment is important, it appears that folks who are not enrolled are in fact not getting quite as much health care as they might otherwise get.

STUART GUTERMAN: And in addition whether or not the doctor writes off the cost sharing that they were supposed to get that the patient can't afford, the money ends up getting provided implicitly by those who are privately insured and that's one of the reasons that private insurance is so expensive is that they implicitly subsidize the parts of [inaudible] that providers can't collect.

ED HOWARD: Yes, go ahead.

TRISH NEMORE: Trish Nemore from the center for Medicare Advocacy. I think a lot of beneficiary groups would say that the single most effective thing that can be done to align these two programs is to eliminate the asset test for both of them. If you don't do that, if you tinker around the edges and try to align them some other way, you lose the benefit of what a lot of states have done to liberalize their MSP rules and so some people will end up worse off and we know from Social Security that over fifty percent of the people who have not been found eligible for the low income subsidy who

have applied for it have been denied based on their assets. The other piece of that, and I think Lora Summer ahs done a lot of work on this is that asset documentation is very administratively complex and time consuming, both for the beneficiary and for the agency doing the eligibility assessment so there are a lot of ways that that single thing makes things much simpler all the way around. My question for anyone on the panel is how feasible do you think that is in our lifetime and recognizing that it's probably not feasible to happen within the next few days, what are some reasonable steps to move toward that?

STUART GUTERMAN: I have the advantage of a bounded answer, which is that we have recommendations sitting here, but the data clearly indicates that much we can say that the issue is the one that tends to limit enrollment. We obviously did not recommend completely eliminating the asset test but just again to remind the audience, there are some other steps one can take, standardized definitions where you look at things like income producing properties and not count that as an asset, recognize you still count it as income so if it's a property that produces a lot of income the person loses eligibility on the income side. It's just not asset documentation. Second, this proposal to annuitize assets is something that at some point we're going to all have to come to grips with in these income support programs as we get to cash

account retirement rather than defined benefit retirements and then third we looked at this and thought of larger options not smaller incremental options, is that a state recovery would be something to consider eliminating. In particular, in programs like this where the value of the benefit is not this huge benefit that you often see in long term care so the policy arguments about state recovery are different for somebody getting QMB benefits than for somebody qualifying for institutional long term care. You can debate it both ways in either program but it's different so those were our incremental answers to your question. I'm sure there are other ideas at the table.

JENNIFER YOUNG: Can I follow up on the political likelihood of this happening unless we all live a really long time; I don't think it's something that we should be counting on. I think given the costs associated with the policy right now is not a particularly receptive environment for things of that sort but I think within the NASI report on the small end of the spectrum there's something that could be started right now that would make a difference and that is sitting down and providing intensive casework assistance. It doesn't even have to happen through the government. It could be through advocacy organizations to help individual seniors navigate a system that's difficult. I know it's small scale and labor intensive and not an overall systemic fix but it's something that could

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make a real difference on an individual basis starting right away.

BILL CLARK: My name is Bill Clark. I'm with CMS. Three quick questions. I was just curious if your study examined the administrative costs to either states or respectively for SSA and whether you have that as an offset in your projected expenses for the options. Number two, Medicare advantage health plans have, for quite a few years now, made terrific efforts to do outreach to these populations in order for them to sort of maximize the Medicare payment on one hand and also get state participation. I wonder if you looked at that at all. And then thirdly, it seems in some states where 1915C [inaudible] waiver programs have eligibility of 300 percent of SSI, that there are certain issues that conflict with access to these Medicare savings programs and wonder if you had looked into that at all. Thank you.

ED HOWARD: Good questions.

STUART GUTERMAN: It's always scary getting such well-informed questions in an audience like this. On administrative costs, when you go through the text of the report and on all of the administrative options we tried to very carefully say that while many of these are administrative, appropriations would be required that you just can't call up SSA or CMS or a state and say, oh by the way, here are 17 new obligations. We did not have the capacity to estimate what those cost, but your

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question, particularly for this audience is important. These would require appropriations and in some cases, authority for SSA in particular to do certain things and if Susan McNally and Craig Street were here, they would be standing on a table somewhere pointing that out to us and it's a very important point to look at. And so the cost offset is a nuance we just don't go into. The one place where we do talk about that in connection with this resource question is states that have moved to substantially change and simplify their resource tests or in some cases, their assets tests and eliminate them have in some cases, reported that while they spent more programmatic money, they saved a substantial amount on administration because that's very expensive to administer and in some cases they felt it was a tradeoff. In programs like this where the benefit payout is not huge, your value here, we talk a little bit in the report on MA plans on the outreach side in this area of, Jennifer just flagged it again, of how you provide reaching out to beneficiaries to provide assistance and enrollment looking at that. That was the only place we touched on that. Three hundred percent of SSI level issue and how that interacts here is a terrific question and I don't recall us going into that in particular. I'm looking over here at Judy who is actually one of our panel members but I'm afraid that's on the list of terrific questions—we just didn't look at that and it's a very good point. Thank you.

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JERRY BRAZDA: I'm Jerry Brazda, retired healthcare reporter. I'm uniquely qualified to say what I say because for 25 years I covered the passage of Medicare and the Medicaid and their development as programs. And now after a few more years I'm a Medicare beneficiary and I use the regular programs and my God, but I love it. I've used it a lot. I've had heart surgery, back surgery, other things. Now I'm particularly fortunate because I have retirement insurance that pays 80 percent of everything that Medicare doesn't pay including drugs though I don't need that. But I have something positive to say which will intrigue everybody here. My sister and husband in Omaha used the Part D and they love it, they think it's great. But I think these programs with my background, as I see the development of Medicare Advantage and things called that, I have looked back the source and I see what they are intended for, they're written by the same people who voted against Medicare. These are people who would like to kill it. I think that is what Medicare savings is. Medicare savings is to the idea is to get the people of the United states to learn how to pay their own medical bills and the government won't have to. But I would like to, along those lines, take advantage of what I think we have here is a unique opportunity to have Andy Schneider, one of the foster parents of Medicaid and Katherine, who as New York State Medicaid Director, to say what they have to say about the story that just came out in the papers today

about the various states who are dumping their Medicaid beneficiaries onto presumably for profit insurance companies.

ED HOWARD: And I know you mean that in the most nonpartisan way.

[Laughter]

Andy, Kathy? Anyone else?

ANDY SCHNEIDER, J.D.: When I first started doing work in this area I read Medicine and Health. It came to our office, this was in the early 70s and there was a reporter named Jerry Brazda who was writing it and it was really a wonderful window on what was going on in Washington at the time. So, I think because this is a panel about another issue, I don't think I'm going to answer your question, but I do not answer it with the greatest respect Jerry.

I guess his response was doesn't it have the same effect? I really think there are two different things. I think what we're trying to talk about today is we have this low income Medicare population, at the maximum 14 thousand dollars a year, less than a tenth of a Congressman's salary and we're trying figure out how to make the Medicare program work better for them and one of the problems is a lot of them, maybe three million or more could have their premiums paid for and keep an extra one thousand dollars a year for other needs, many of them which would be medical if we could just get them enrolled in this program and we need to figure out a way to do that. And I

think if we can make it work it makes Medicaid work better and Medicare work better.

KATHY KUHMERKER: I'm going to take a little clue from Andy, which is that I will probably pretty much respectfully decline to answer except to say that I've been a member of an HMO myself personally since 1978 when the first one opened where I live and I've gotten wonderful fantastic care all that time since then. It does happen to be a not for profit and it is one of the most highly rated ones in the nation but nonetheless I have firmly believed in health maintenance organizations since I was going to get my graduate study work. In New York we have wonderful healthcare plans. Some of them are for profit some of them are not for profit. We also make sure they are wonderful healthcare plans. We monitor them, we look at what they're doing, we make sure that their networks are strong and complete, that specialists are available, that people get care in a timely manner. And I think if Medicaid agencies are able to make sure throughout the nation that when they contract with other plans in providing care in deferent ways that they keep those healthcare standards there and I know that Medicaid directors will work to do that then I think that we may also be able to get better care for people who sometimes do get, particularly in Medicaid, thrown from pillar to post because they don't have a place to get care and they just go to clinics and they wait for hours and I think there's some real

potential here. I also think there are opportunities for things to not work out so well so we need to be very careful and watch it.

MARK STEINBERG: Good afternoon. Mark Steinberg, Families U.S.A. One of the quirks and there are only a few in the Part D legislation, but one of them is that although states, if they receive a low income subsidy application are required to screen and offer enrollment in the Medicare savings program. SSA is not required to do that. That's been a real source of frustration for advocates because we had hoped that the LIS would be an opportunity to increase enrollment in MSPs but since the vast majority of applications have gone to Social Security. Those applications have not been followed up with in any meaningful way. I was very pleased to see one of the recommendations is that Social Security offer more or federal government generally offer more information to states to be able to follow up but what are the barriers now that prevent Social Security from doing a good screen for Medicare savings programs and what can we do administratively to use the information we have from the LAS right now and take that information and convert it into a meaningful screen for Medicare savings programs.

KATHY KUHMERKER: I'll try and answer this because as I was leaving we still had not gotten everything completely defined in New York State about how our relationship was going

to be with SSA so I'm remembering back to what we were discussing and the information that comes in from SSA after they have when they're giving states leads is very, very general and doesn't provide any of that background that you need to actually say yes, I can see someone has "X" dollars in assets and "Y" in income and this is what it's from. And so what they're giving is leads saying this person has income below this level or whatever and you should go out and follow through with them. I believe the reason is that it's considered, even though I'm not sure it is, that the argument with that it was it's either protected health information or one, the low-income subsidy application was filled out. It didn't specifically say—it's not interpreted to mean that SSA could share specific information with states. I know there are some people who say that yes it is and that may be but I believe that's CMS, and that they have come down saying that. So, for clarification, that is something that specific information could be shared I think would be tremendously helpful and then again I also think and this might be something that CMS could do. States would need to have to be authorized to use that information and consider it to be acceptable, accurate documentation of what the information stood for.

ED HOWARD: I guess that's a good summary. Mark, again the paper that Liz Cusick and Ken Nebali wrote got into this issue. And the one question is the privacy question. You have

a very nice document in your packet from State Solutions at Ruckers University. I don't know if there's anybody here from there, but it really walks through this issue of how to deal with that. We mentioned it when we got to recommendation number two, but that's one. The second one is again administrative burden on SSA. When they're done with the person for purposes of determining LIS eligibility, if there are and it's very frustrating to watch, but if there are just four more questions, that would nail down MSP, you know, on the one hand you would say, "Ask them," but on the other hand, "Where's the Congressional appropriation for that?" And so they really don't have it and also you have to remember once again you're dealing with different income resource levels. You're dealing with different definitions of what constitutes income, you're dealing with different definitions of what constitutes resources so the package of recommendations, the reason we wanted our package of recommendations is that there's a series of interim steps you can take to try to make it better within the current framework but then there are some other things one would need to do to take it farther. But, that's because it's a very difficult—

ANDY SCHNEIDER, J.D.: Just one other factoid that I found interesting here. My mental image and I don't know if it's true for other folks is that the elderly person applies for Social Security and Medicare at the same time and the

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health program perspective is mostly, as a long-time, old-time Medicaid person, you picture that opportunity being the opportunity to collect lots of information. In truth, something like three-fourths of the Social Security beneficiaries come on to the program well before they're aged 65. So that the image you have in your head of that opportunity for that capture of information is actually lagged and I found it to be one of the most difficult administrative steps in this process that we need to look at.

ED HOWARD: Let me take the chance to use one of the cards. Someone has directed a question at Jennifer. Do you really think Social Security has been successful in getting people enrolled in the Part D Low income subsidy? Aren't most of the Medicare beneficiaries who are not enrolled and do not have prescription drug coverage thought to be low income?

JENNIFER YOUNG: And I guess the answer to that depends on how you define success, doesn't it? If you compare it against the baseline that shows that thirteen percent of people eligible for the SLMB program are enrolled, Social Security probably has done a better job than LIS than other populations have achieved. But given the importance of the subsidy to the very vulnerable population until a hundred percent of people who are eligible for LSI are enrolled. We still need to keep working harder and finding these people. I think the preliminary report is Social Security has done better than the

baseline but still has lots of room to go and they're rededicating their efforts to make sure their efforts to make sure that they continue to find and enroll this population, without penalty I might add.

AARON MARSH: Yes, I'm Aaron Marsh with the National Association for Home Care and Hospice. You're talking before about increasing the involvement of the Social Security Administration in these programs to help increase awareness of them and we mentioned how SSA was pretty successful in the recent Part D enrollment for those programs. I think another aspect of that success was CMS's extensive partnerships with providers and helping reach out to seniors and I was wondering in your recommendations and your report here how much thought has been given to that partnership as far as using the providers, maybe helping assist with administrative costs or something like that to help reach seniors and increase awareness of these programs?

JACK EBELER: Excellent question and again, I apologize for giving short shrift in a slide presentation but we did talk in this section about outreach. About really two things: one of the important questions is when do people typically come into these programs and they do typically—one of the characteristics of folks coming in is that they have touched a provider for relatively expensive services so that partnerships with provider groups, whether in the hospital or the long-term

care community, have been important and in our discussion of how you counsel folks and help them through a process, however difficult, administratively it is, that those types of partnerships are important, so we do talk about that a little bit in here. I gave it short shrift in the summary of the recommendation.

ED HOWARD: Jack, how important is the phenomenon that I had sort of forgotten about until I read it again in your report of states deeming the Medicare eighty percent payment as if it's higher than the Medicaid hundred percent, all the doctor is going to get, if you will?

JACK EBELER: I think it's very important policy and delivery phenomenon. I don't know that it's a huge deal here. I mean, I going to suppose provider groups on the outreach side could say, "Gee, it's not worth it for me to get them enrolled, they're a Medicare beneficiary. It's not worth it for me to get them enrolled because the net payment impact won't be there." I think that tends to be more on the physician's side frankly, than anywhere else. So I had not heard that as a barrier. Other folks may think of it as a barrier.

KATHY KUHMERKER: To come out with a little bit of New York State experience, after several years and because New York State's always looking for ways to save money. New York State actually changed its policy and it used to pay the full twenty percent and it then changes policy in many cases but

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particularly for physicians to only paying up to what the Medicaid rate was. I would say that we got a tremendous human cry from the physician community and particularly from psychiatrists because they only get fifty percent paid for by Medicare and a fair number of people and the organization suggesting that doctors and psychiatrists going to drop out of the program. Though we never did see that happen, but I would then again go back to the concept, two issues; one, these are really entitlement programs and the fact that you again are seeing differences between and among states because there's a Medicaid aspect to it and because states have changes in their own individual financial situations that make them do things one way or the other. I think is unfortunate and is inappropriate in an entitlement program and then again I would go back to Andy's comment when you think about that even for this population just the Part B premiums are ten percent of what an individual's income, never mind the co-payment requirements and the coinsurance requirements and again, right in the DRA again, that five percent limit on all cost sharing for kids and families and why we're not looking at the same kind of equity because we're talking about the same income levels. Actually for kids we're talking about even higher income levels, why are we not talking about that here?

STUART GUTERMAN: Actually I'll take the co-moderator's prerogative and ask a question to the whole panel. I can't

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help but notice that there's been no MSP bus tour and I'd like to know, given the amount of emphasis that's put on signing people up for the low income subsidy in Part D, is there anyway that we can use that infrastructure to really sort of boost outreach to enrollees who could be eligible for the MSP?

KATHY KUHMERKER: Let me just kind of, from a state perspective, I think one of the things that's would make it very difficult to have a bus tour on the MSP programs is that you need to have a different script for every state. When, a couple of years ago, there was and I think it's actually may be mentioned in one of the papers here or actually in the paper from NASI, that there was Medicare rights center, there actually was a statute that required SSA to go out and do outreach on this program and I know in New York State, just getting the instructions, getting the definitions of what was covered in the state's Medicare savings programs took us weeks of work with the Medicare Rights Center and with SSA. And that was talking to bureaucrats and then it took us even more weeks to go out and explain, to get it into something that effectively because this is where you need to do it, at the fourth grade level and then transplanting it was even tougher. And it just, it's just so complicated that I think it is a good idea, I think it would be very difficult to implement. And then, of course, you'd have states saying, "Oh my God, why are you doing that? Because we don't have the money to pay for it

when they come in or the staff to do the eligibility determinations."

JENNIFER YOUNG: Can I comment on that? Having ridden the bus, I think one of the components of the bus tour that I think was largely absent from the public eye, but actually will have the greatest impact in the long-term wasn't the secretary pulling up and doing a nice event with local dignitaries, it was the meeting that happened beforehand and afterwards with local community service with partners talking about what on the ground efforts everyone could undertake and assuming responsibilities for different components of outreach and education. I think that sort of community partnership paired with federal leadership and state buy in could certainly have a real impact on enrollment, even absent [inaudible].

KATHY KUHMERKER: Just on Jennifer's comment I would point out that there were appropriations to increase the state health insurance program activities that helped to fund some of that work so that was not done. So one of the reasons that that part of it was successful was that there was additional funding coming from the federal level to support those voluntary community-based efforts.

ED HOWARD: The other thing that I would note and I suspect it's one of the things you are leading to here Stuart is that our final recommendation where we talk about a substantially stronger federal role in the program, building on

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some of the other incremental pieces, in particular, points to the need for federal financing for the incremental costs of enrollment. One of the tensions and it would have been fun to put a bus tour right here, what one of the tensions obviously is you're in the midst of a federal state matching situation so if the feds fly into Omaha and have a big enrollment campaign, you know, depending on how you think of the [inaudible] programs, you know, the state gets annoyed or something and if you had a cleaner policy, somebody clearly responsible and the person responsible paying the bill, you could much more easily have the bus tour on MSP, like you did on drugs, where the feds were paying the bill so I actually think moving toward some variant of Option X would facilitate that type of more aggressive program and accountability for both the results and the spending.

KATHY KUHMERKER: I'd like to make one additional comment because there was the question earlier about the fact or the recognition that there are state variations and that if you were to standardize, you might actually find yourself and states might find themselves in a position where people that they had individuals like already enrolled in the program suddenly were not eligible. I think something that could be considered here would be a hold harmless for people who have already been determined eligible and until they no longer meet the original eligibility standards they get to stay on and new

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people come in at the new levels, grandfathering and hold harmless are longstanding traditions when you want to change a program.

ED HOWARD: Thank you Kathy. Actually this last card question we have anyway is directed to Andy Schneider, has elements of grandfathering in it implicitly. The questioner wants clarification, Andy, on whom or who is affected by the citizenship provisions that were released on Friday and become effective on July one. Who's going to have to come up with that proof? Anybody who newly enrolls in Medicare? Anybody who newly enrolls in Medicaid? Anybody who gets low income subsidies under Part D or anyone who newly enrolls in Part D or somebody else?

ANDY SCHNEIDER, J.D.: I'm sorry to have been unclear about this. This requirement applies to citizens, not legal immigrants, just citizens, anyone who applies for, initially applies for Medicaid on or after July first, whether they're a Medicare beneficiary or not and anyone who is currently a Medicaid beneficiary, that is, is enrolled in Medicaid, comes up for their re-determination or renewal, usually at six months or a year. At that point, they are also going to have to, if they are a citizen, document their citizenship and again, that would apply both to people who are on Medicare as well as Medicaid or just those who are on Medicaid and as far as I can tell, it also applies to people receiving the MSP subsidies as

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well. There is, in the guidance that was issued on Friday by CMS, implementing the DRA legislation, no exceptions were carved out for Medicare beneficiaries, whether they're full duals or whether they're MSP beneficiaries or partial duals or any other category. I think there was an effort to do that in legislation, initially there was a technical problem that would be great if it could be fixed.

ED HOWARD: Jerry has a follow up question. Go ahead.

[Inaudible]

ANDY SCHNEIDER, J.D.: No because you are not on Medicaid and unless you have applied for Medicaid—just Medicaid—right—yes—just anyone on or after July first applying for a Medicaid card or the kind of Medicaid assistance we've been talking about today.

ED HOWARD: You can relax Jerry.

KATHY KUHMERKER: If I can just—I think—

ANDY SCHNEIDER, J.D.: And who declares that they're a citizen, does not apply, they're a separate set of procedures and requirements for legal immigrants. Just citizens who are applying for Medicaid.

KATHY KUHMERKER: I think Andy's other point was it's not only the people who are newly applying but unlike Medicare, where once you're on, you're on, you have to come, you have to renew or recertify for Medicaid on a periodic basis and that varies depending upon the state and so if you had not provided

that appropriate documentation, that documentation that's now required at the time you originally applied, you are now going to have to demonstrate it and then you'll have to, you have a certain period of time to get the information in if you don't have it but if not, then you'll have to be determined ineligible and you will lose your Medicaid coverage.

ED HOWARD: Okay on that—go ahead Bob.

[Inaudible]

Bob, can you come to a microphone because it's being recorded and the throngs who will be watching the web cast will want to hear your question.

BOB: Okay, let's say someone in this room who's an American citizen, their mother or father is in a nursing home, stands down and after July first will go on Medicaid. Does that person then have to go to the nursing home director and provide a birth certificate for his mother or father to get on Medicaid? Is that correct? Is that what you're saying?

ANDY SCHNEIDER, J.D.: Well, first they're going to ask for a passport. If they don't have that, they'll have to come up with a birth certificate. Original birth certificate or certified copy by the issuing agency, no notarized documents acceptable plus an identifying document.

BOB: Okay. Or?

ANDY SCHNEIDER, J.D.: No, there's—

BOB: Or else I mean?

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ANDY SCHNEIDER, J.D.: Oh if that documentation is not made available then if the individual is not going to be allowed to—the initial applicant will not be enrolled in Medicaid because there will not be any federal matching payments available. It's a little different situation with someone who is in the nursing home after July 1st, comes up for renewal, they're also going to have to certify in the same way, but they will have a reasonable opportunity to gather documentation together before they are terminated for lack of documentation. But if you can't show it in the first place and you're not already on the program you will not get on the program until you can document your citizenship.

ED HOWARD: But Andy I want to clarify so that people don't leave with a misconception. You don't have to be a citizen to be on Medi—

ANDY SCHNEIDER, J.D.: No, okay, I'll say that again too. So, this does not apply to legal immigrants. Legal immigrants can qualify for Medicaid. They otherwise are eligible. Legal immigrants, they have a separate set of requirements, right, which have been in place for a while, right. And I'm trying not to get into that, right. They have to prove that they're legal immigrants. They have to have satisfactory documentation of their immigration status. That's been in place for a long time. Right.

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ED HOWARD: And which as Stuart points out, they are much more likely to have, than a longtime citizen is likely to have, the kind of proof you were describing. Okay.

ANDY SCHNEIDER, J.D.: Right. This is new. This is new for citizens; this has not been the case before.

ED HOWARD: On this sobering note—

JIM CRANWELL: Jim Cranwell, House Budget Committee. Andy, I just wanted to correct you, it is a provision that applies to citizens and illegal immigrants.

ANDY SCHNEIDER, J.D.: Jim, let me correct you. Illegal immigrants don't stand up and declare their citizenship. This is just people who are declaring their citizenship.

JIM CRANWELL: I just learned something new here then because I thought a lot of illegal immigrants were actually receiving Medicaid, and that's the reason when I went to the mark-up sessions, that's why that provision was put in. Thanks.

ANDY SCHNEIDER, J.D.: Okay. You might want to have another session—

ED HOWARD: One of the wonderful things about the Internet is that you can sort of carry on the discussion after the discussion ends, and I would welcome Jim or Bob or any of the panelists and any of the experts sitting in the audience to send us some information that provides background on this

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requirement, and we will post it on our website with the rest of the materials from this briefing. Go ahead, Stuart.

STUART GUTERMAN: And I want to, on behalf of the Commonwealth Fund, I want to thank everybody for participating in the panel and to thank the panel.

[Applause]

[END RECORDING]

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