

# National Senior Citizens Law Center



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## **Comments of the National Senior Citizens Law Center On Expanding Health Care Coverage Submitted to the Senate Finance Committee May 22, 2009**

The National Senior Citizens Law Center is pleased to submit comments on the Senate Finance Committee's Policy Options Paper: Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans. We recognize the amount of work that has gone into preparing these proposals and applaud the Committee's willingness to share them publicly and seek feedback.

NSCLC's mission for the last 37 years has been to advocate for America's low income older adults. From our work, our comments focus on four perspectives:

- We see a significant gap in affordable coverage for low income older adults who do not yet qualify for Medicare and are pleased that the Committee is looking at this problem.
- Because the poorest older adults are dual eligible beneficiaries, eligible for both Medicare and Medicaid coverage, we care about the impact of the options on beneficiaries of these programs.
- Low income Medicare beneficiaries with incomes just above current subsidy levels are drowning in the out-of-pocket costs associated with the Medicare benefit. We urge the Committee to consider providing relief to this population.
- Having worked closely with the Medicare Part D prescription drug benefit since its inception, we see important lessons to be learned from the Part D experience that can be applied to broader health care reform.

From those perspectives, we offer the following comments:

### **SECTION I: Individual Market Reform**

#### **Health Insurance Exchange**

NSCLC appreciates that the proposed options include measures to standardize information, forms and marketing requirements and to provide multilingual customer service.

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Looking at standardization, experience with Part D suggests that standardization of insurance options themselves, and not just standardization of comparison charts, is necessary if consumers are to have meaningful choice. If consumers are subjected to a blizzard of variations in plan design as happened with Part D, rational market choice becomes impossible.

On the issue of marketing regulation, we urge the Committee to only use the regulations for Medicare Advantage plans as one of many reference points but not as a model. As advocates, we have seen that the MA rules, both in their design and in their enforcement, have been inadequate in protecting consumers from unscrupulous agents and brokers, often with serious consequences for the health care of the affected beneficiary. We have particular concerns that the agent compensation structures for MA plans sometimes militate against enrolling individuals in plans best suited to their needs.

With respect to the information needs of individuals who do not speak or understand English well, we are pleased that the Committee made reference to the need for multilingual consumer service centers. We urge the Committee to also focus on the critical importance of translated written materials in an area as complex as health benefits. Oral interpretation at call centers is very important but consumers also need written documents that they can understand and refer to.

### **Role of State Insurance Commissioners**

NSCLC supports a vigorous oversight and enforcement role for state insurance commissioners. State insurance commissioners, with experience in regulating insurers and an understanding of the unique conditions in their own states, can play a vital role in ensuring transparency and accountability in the insurance marketplace. The Part D experience has shown that limitations on the authority of state insurance commissioners have exacerbated problems with marketing abuses.

We also believe that genuine consumer protection requires inclusion of a private right of action for consumers whose rights have been violated by plans.

## **SECTION II: Making Coverage Affordable**

### **Benefit Options**

When designing a set of benefit options for plans, we urge the Committee to do so with the following principles in mind:

- **Standardization:** Consumers cannot navigate a system with a large number of plans to choose from that are actuarially equivalent but otherwise widely different in design. For consumers to make meaningful choices among plans, they must be able to see the differences clearly.

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- Non-discrimination: Lack of standardization of benefit design also makes it difficult for regulators to police plans for benefit features that discriminate against individuals with high health needs.
  - Transparency: Consumers must be able to understand clearly what they are getting as a benefit and what they are paying. Mechanisms such as reference-based pricing for drugs, which make meaningful price comparisons difficult or impossible, should not be permitted.

### **Low Income Tax Credits**

NSCLC supports significant subsidy and co-pay support for individuals between 100 and 400 percent of the Federal Poverty Level. We urge the Committee, when considering various formulas for premium coverage and cost-sharing, to carefully evaluate the impact of each option on benefit stability. In Medicare Part D in 2008, because of the formula used to calculate subsidy levels, two million low income beneficiaries needed to change their prescription drug coverage in order to get full premium protection from their subsidy benefit. We urge the Committee to consider the Part D experience and adopt an approach that provides low income individuals with a stable benefit without yearly disruptions.

Part of the reason that subsidies need to be structured to reach individuals at 400 percent of the Federal Poverty Level is that, as is widely acknowledged, the FPL is not an accurate measure of economic security. We urge the Committee to use the implementation of health care reform as an opportunity to begin the process of using a more accurate measure of economic wellbeing in means-tested programs.

### **SECTION III: Public Health Insurance Option**

NSCLC strongly supports having a public health insurance option. We have seen in the Part D context what happens when a publicly financed program relies exclusively on the private insurance market. Confusion, instability and complexity define the program with no way of measuring the value beneficiaries and taxpayers are receiving for their sizeable investment.

We strongly support Option A, a Medicare-like plan. Medicare has a track record that includes low overhead expenses. Creating a public plan modeled on Medicare will ensure that federal money is spent on health care, not additional administrative expenditures associated with use of private contractors.

In addition to requiring Medicare providers to accept the public plan, NSCLC recommends that providers that choose to participate in the public plan should be required to participate in Medicare. Doing so will ensure that individuals maintain access to providers when transitioning from the public plan to Medicare.

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If the Committee decides to offer Americans the choice of a public plan option, this choice should be extended to Medicare Part D enrollees as well via the creation of a Medicare-administered Part D plan.

## **SECTION IV: Role of Public Programs**

### **Eligibility Standards and Methodologies.**

We strongly support the Committee's goal of simplification of Medicaid standards, particularly because the complexity of the program alone can be a barrier to participation. For this reason, we support removing income disregards but only if eligibility levels are raised to at least 200% of the Federal Poverty Level so that disincentives to work and pay for child care, which income disregards were designed to address, are offset.

### **Medicaid Program Payments**

NSCLC supports the proposal to federalize the costs of the eligibility expansion through 2015 and phase in state financing after that point. We are concerned, however, that, without making more optional benefits mandatory, states will have an incentive to cut services as they begin to share the burden of the eligibility expansion.

NSCLC also supports the proposal to set minimum provider reimbursement rates. We recommend that Medicaid provider rates be equal to Medicare reimbursement rates and that both rates be increased to levels that guarantee a broad provider network. Equalizing the payments will increase access for Medicaid beneficiaries, address access disparities between the two programs and simplify administration and payment procedures for providers.

### **Options for Medicaid Coverage**

NSCLC supports Approach 1, which increases coverage through the current Medicaid structure. Medicaid should provide the model for extending coverage to low income individuals aged 55 through 65. We do not support the proposal to allow or require states to provide premium assistance for ESI in lieu of coverage via Medicaid since the ESI may not offer the same level of benefits provided by Medicaid. If the Committee were to pursue this strategy, we recommend that the Medicaid coverage these individuals would be receiving should function as a wraparound benefit – covering co-pays and services covered by Medicaid, but not the ESI.

Our concerns about Approach 2 include the proposal to provide eligible Medicaid enrollees with a choice of Low Option plans. Experience has shown that Medicaid-eligible individuals need comprehensive coverage. Even the High Option plans leave 7 percent of health care costs uncovered, an amount that can be too much for individuals living below the poverty line, many of whom suffer from poor health.

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Approach 3 adds unnecessary complexity by creating different categories of Medicaid recipients. The eligibility limits for childless adults (many of whom are 55-65) should be the same as for other Medicaid populations. These individuals are no less deserving or in need of care as other categories. Similarly, there is no need to provide this population with different choices of how to receive Medicaid coverage. In other sections of the document the Committee admirably strives to simplify and standardize Medicaid benefits. Approach 3, as currently described, represents a move away from simplification and standardization.

### **Enrollment and Retention Simplification**

We support the proposals to simplify enrollment and retention procedures. In particular, we are pleased by the proposal to eliminate asset tests for programs that provide acute care services. Low income advocates have long argued that such tests create an unnecessary administrative burden. Most individuals with incomes low enough to qualify for Medicaid acute care services do not have significant assets.

Since it is not entirely clear from the proposal, we recommend that the Committee also eliminate the asset test for the Medicare Savings Programs and the Low Income Subsidy. Applying asset tests to programs that assist Medicare beneficiaries with costs punishes seniors who did the right thing and saved for retirement and, as mentioned above, creates an administrative burden for both beneficiaries and the agencies making the eligibility determination. Alternatively, asset limits for these programs could be raised to \$27,500 for an individual or \$50,000 for a couple so that those with modest savings could qualify for assistance without having to deplete those savings.

To further simplify enrollment in the MSPs and LIS, income standards for the two programs should be aligned. A number of additional administrative steps can be taken to ease enrollment, including increased outreach, more translations of application materials and more information sharing across federal agencies about potentially eligible beneficiaries.

### **Mandatory Coverage for Prescription Drugs**

NSCLC supports the proposal to make prescription drugs a mandatory benefit for both categorically and medically needy Medicaid beneficiaries. We encourage the Committee to examine other ways to standardize the Medicaid benefit across states to ensure that all Medicaid beneficiaries – regardless of where they live – are entitled to an adequate package of benefits. For example, optional benefits that currently are offered by more than half of the states could be treated as mandatory benefits going forward.

### **Change the Status of Some Excludable Drugs**

NSCLC supports this proposal. Benzodiazapenes and barbiturates are widely prescribed for Medicaid recipients. Coverage of smoking cessation drugs removes a barrier to adoption of healthier lifestyles.

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## **Transparency in Medicaid State Plans and Section 1115 Waivers**

NSCLC supports the efforts to make the waiver and SPA process more transparent. We recommend that, in addition to the requirements included in the proposal, the Committee require Medicaid stakeholder meetings as part of the process.

## **Changes to the FMAP Formula**

NSCLC supports the proposal to adjust the FMAP to allot more federal Medicaid money to states with a higher percentage of people living below the federal poverty level.

## **Automatic Countercyclical Stabilizer**

NSCLC supports the change in FMAP designed to ensure that increased FMAP is available during difficult economic times. It is essential, however, that the increased FMAP be accompanied by provisions which require states to maintain eligibility and services.

## **Waiver Authority of Dual Eligible Demonstrations**

NSCLC does not object to the establishment of a new waiver authority. However, the search for alternative approaches to coordinating care must include non-capitated, non-managed care centered projects. Too often coordinated care for dual eligibles is synonymous with capitated managed care models that restrict, rather than improve, access to care. The demonstration projects undertaken under this grant must be beneficiary-centered, truly new and innovative, and, once approved, part of the State Plan and optional for beneficiaries. States must not be permitted to waive benefits or protections available to Medicaid recipients.

## **Cost-Effectiveness Test**

NSCLC opposes making more funding available to states to contract with Medicare Advantage Special Needs Plans or other managed care organizations without provisions to ensure that the plans have sufficient capacity to serve vulnerable populations well and provisions to ensure better public oversight of plans' services.

## **Office of Coordination for Dually Eligible Beneficiaries**

NSCLC supports the creation of an office responsible for improving the care delivered to dual eligibles. Such an office should explore the full range of options for improving care – including non-managed care options.

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## **Phase-Out the Medicare Disability Waiting Period**

NSCLC supports Approach 2 or 3. We have signed onto the comments prepared by the Coalition to End the Two-Year Wait for Medicare. Please see those comments for further details of our position.

## **Temporary Medicare Buy-In**

NSCLC supports the attempt to provide a mechanism for the near elderly to receive coverage before insurance market reforms take effect and we support using Medicare to accomplish this goal. We are concerned, however, that the vast majority of uninsured people ages 55 through 64 could not be able to afford to buy into Medicare without some subsidy. Of course, raising the Medicaid income limits for childless adults would capture many of these people and provide a much more affordable option.

## **Low Income Medicare Beneficiaries**

NSCLC is disappointed that this coverage options paper does not include a proposal to make health care more affordable for low income Medicare beneficiaries. While the document discusses subsidies for the non-Medicare population up to 400 percent of Federal Poverty Level, there is no discussion of increasing the subsidies provided to Medicare beneficiaries (i.e. the Medicare Savings Programs and the Low Income Subsidy). Health care reform should not and cannot leave our nation's seniors worse off than the rest of the population. The income limits for the MSP and LIS should be raised to at least 200 percent of the Federal Poverty Level. Measures to protect those aging into Medicare at up to 400 percent of FPL also should be adopted so that these individuals do not find that qualifying for Medicare means that they are worse off and have less affordable health care options.

## **SECTION VI: Options to Improve Access to Preventive Services and Encourage Health Lifestyles**

### **Promotion of Prevention and Wellness in Medicare and Medicaid**

NSCLC strongly supports provision of preventive medical services and positive incentives to promote wellness for Medicare and Medicaid beneficiaries. We caution the Committee to ensure that wellness promotion is non-punitive and has a positive impact on even the most medically vulnerable beneficiaries.

### **Options to Prevent Chronic Disease and Encourage Healthy Lifestyles**

We support the Committee's proposal to offer grants to states to improve program integration, care coordination, and access to preventive services and treatments. The proposal to allow states to implement individualized health plans for the health and human services needs of low-income beneficiaries is particularly needed. We urge Congress (1) to provide adequate funding for these

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individualized plans and (2) to ensure that individualized health plans are optional and not burdensome. Low income beneficiaries should be offered assistance but should not be made to jump through special hoops in order to receive needed medical care.

The Committee should be sure to include the perspectives of low-income beneficiaries themselves in its study to improve wellness outcomes for low-income families.

We are interested in the Committee's proposal to require HHS to “review and make improvements in the administration of its low income programs,” and look forward to further details. In particular, we think that Congress should require CMS to improve the administration of the Medicare Part D program as it impacts low-income beneficiaries. We would be happy to provide the Committee with additional specific suggestions.

### **Section VII: Long Term Care Services and Supports**

NSCLC is pleased to see long-term services and supports (LTSS) included in the plan to reform health care coverage. As Senator Herbert Kohl declared earlier this year, “[A]ny serious health reform proposal must address [LTSS].” We are especially pleased to see the Committee’s attention to expanding home and community-based services (HCBS) opportunities. Medicaid is a critical source of LTSS coverage, but the program has historically favored institutional care over HCBS as method of LTSS delivery. The Committee’s proposal clearly aims to address this problem.

Here are specific issues NSCLC wishes to highlight regarding the Committee’s LTSS proposals.

#### **Enhancing Medicaid’s HCBS State Plan Option.**

NSCLC supports expanding the services that states can offer in a 1915(i) plan and increasing the income eligibility level for services above the current limit of 150 percent of the Federal Poverty Level. NSCLC also supports the proposed creation of a new special income category for individuals meeting a state’s 1915(i) plan clinical requirements, under which these individuals may automatically qualify for Medicaid coverage of HCBS state plan services and other Medicaid services if their incomes are below 300 percent of the Supplemental Security Federal Benefit Rate, instead of requiring that these individuals qualify under a medically needy category.

#### **Eliminating Existing Institutional Level-of-Care Requirements for eligibility for section 1915(c) waivers and requiring states to replace it with less stringent criteria.**

NSCLC supports making HCBS available to individuals who do not meet a state’s institutional level-of-care criteria. We would like to emphasize, however, that options or mandates to states to make HCBS available to such individuals should not be used by states as a method to narrow eligibility criteria for institutional services. CMS declared in regulations it proposed for the HCBS state plan option that “the purpose of section 1915(i) appears to be to expand access to

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HCBS to individuals who are not at an institutional level of care, rather than to reduce access to institutional . . . services.” Medicaid Program: Home and Community-Based State Plan Services, 73 Fed. Reg. 18676, 18678 (April 4, 2008). It should be made clear that state delivery of HCBS through 1915(i) services or 1915(c) waivers shall not be made at the expense of individuals who need institutional services.

### **Medicaid Spousal Impoverishment Rules**

NSCLC supports extending the spousal impoverishment protections to Medicaid enrollees receiving services under 1915(e), (i) and (k). The spousal impoverishment rules are a vital source of financial protection for those married to individuals in need of LTSS. Additionally, we support the Committee’s clarification that spousal impoverishment protections are available to the spouses of individuals enrolled in 1915(c) and (d) waivers who qualify as medically needy, as these protections have been extended to spouses of medically needy HCBS recipients in the past. NSCLC is pleased that, under the Committee’s proposal, the spouses of all recipients of HCBS services delivered through 1915(c), (d), (e), (i) and (k) will be afforded the spousal impoverishment protections, just as all spouses of institutionalized Medicaid enrollees are.

### **Medicaid Resources/Asset Test**

NSCLC supports expanding the asset test for individuals seeking Medicaid coverage for HCBS. HCBS services delivered through Medicaid are neither unlimited nor without cost to the individuals receiving them. HCBS recipients can be faced with coverage gaps that, left unfilled, could result in institutionalization. The standard \$2,000 asset limit is exceptionally low for *all* Medicaid applicants, and for those whose needs are persistent enough to require HCBS, the limit easily prevents the individual from meeting any contingencies or coverage gaps, the consequence of which is institutionalization.

NSCLC suggests that the Committee also consider reform in the post-eligibility treatment of income for HCBS recipients, specifically as those rules relate to single or unmarried individuals. Congress long ago recognized the precarious financial situation of a community-based spouse of a Medicaid LTSS recipient when it mandated that states extend spousal impoverishment protections to spouses of institutionalized Medicaid enrollees. The protections have helped these spouses avoid having to choose between poverty and divorce. The Committee itself now recognizes that the protections are equally necessary for the spouses of HCBS recipients. However, the single or unmarried individual receiving HCBS does not have any income guarantees. Under the Committee’s proposal (and under many current state Medicaid 1915 waivers), a married couple that has one spouse receiving Medicaid HCBS is *entitled* to preserve *at least* \$1,750 of their combined income (\$1,750 is the 2009 minimum monthly maintenance needs allowance). The single or unmarried Medicaid HCBS recipient, however, may be forced to maintain himself in the community on an amount that is less than half of this minimum. Without sufficient income guarantees, the single or unmarried Medicaid HCBS recipient may be forced to enter an institution.

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NSCLC also supports resetting the look-back period for asset transfers to 36 months. However, NSCLC believes this is insufficient. The *Deficit Reduction Act of 2005*'s mandate that all penalty periods be prospective from the point at which an individual meets all eligibility requirements is unnecessarily punitive and fails to distinguish between transfers made at the farthest point in the look-back period from those made immediately prior to the filing of a Medicaid application.

Additionally, the rule creates an absolute barrier to access to Medicaid HCBS coverage. CMS has informed states that a penalty period may not begin running for an HCBS applicant who has transferred resources during the look-back period until he or she is actually receiving Medicaid-covered HCBS. Because this individual is barred from receiving Medicaid-covered HCBS by virtue of the penalty, the individual may never receive Medicaid-covered HCBS unless he or she enters an institution. This is an absurd result which begs for a modification.

### **Long-Term Care Grants Programs**

NSCLC is pleased that the Committee proposes to make grants to states for new LTSS programs and supports Consumer Task Forces to help states develop initiatives. The Money Follows the Person program stemmed from Real Choice Systems Change Grants, and other innovative models may develop through continued federal support for new initiatives.

### **Money Follows the Person Rebalancing Demonstration**

NSCLC supports extended funding for the Money Follows the Person program through September 30, 2016. NSCLC wishes to point out that locating affordable, accessible housing will be one of the biggest challenges facing consumers in the implementation of the Money Follows the Person program. Continued federal support for the MFP program, and HCBS programs overall, must include a focus on housing options for those wishing to remain in, or transfer to, the community.

## **Section VIII: Options to Address Health Disparities**

### **Collection of Data**

NSCLC strongly supports the Committee's proposals to improve and standardize data collection and to increase public reporting of such data. We recommend further that states be required to collect such data on Medicaid recipients and share it with CMS and Medicaid providers, including physicians and hospitals, so that the information can become part of patient medical records.

### **Language Access**

NSCLC strongly supports the proposal to extend the 75 percent matching rate for translation and interpretation to all Medicaid beneficiaries for whom English is not the primary language, and to

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fund outreach and enrollment efforts for limited English proficient (LEP) individuals. Research shows that language barriers result in poor or inadequate communication about medical benefits and services, inferior decision-making for both patients and providers, ethical compromises, and, ultimately, poorer health for LEP populations.

We also ask the Committee to ensure that all private insurers and providers who receive federal funds, including private Medicare plans and participants in the proposed Health Insurance Exchange, fulfill their existing legal requirements to ensure meaningful access to services for limited English proficient individuals.

Thank you for the opportunity to submit these comments. The National Senior Citizens Center would be pleased to provide additional information to the Committee on any of the issues discussed.

Respectfully submitted,

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