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Improving the Medicare Savings Programs Would Help Low-Income Seniors Cope With Higher Medical Expenses

By Edwin Park and Danilo Trisi

Bipartisan Senate negotiators are crafting Medicare legislation that would avert a cut in physician payments scheduled to take effect at the end of June. This legislation could also include long-overdue improvements to the Medicare Savings Programs, which help low-income Medicare beneficiaries pay their premiums and cost-sharing.

Medicare beneficiaries age 65 and over have much higher out-of-pocket health care costs than the non-elderly. So substantial are these costs, in fact, that if the federal government's official poverty measure were to start taking them into account — as a National Academy of Sciences expert panel recommended — the number of elderly Americans who are poor would jump by 2.4 million and the poverty rate for the elderly would rival that for children. The Medicare Payment Advisory Commission (MedPAC), Congress's official, expert advisory body on Medicare payment policy, has recommended a series of improvements in the Medicare Savings Programs that would help low-income seniors pay their out-of-pocket health costs.

Out-of-Pocket Medical Costs Place Significant Burden on Seniors

The Kaiser Family Foundation estimates that in 2003, out-of-pocket medical expenses were nearly three times as high for the typical (or median) elderly individual ($1,939) as for the typical non-elderly adult ($664). As a result, the typical senior spent 12.5 percent of his or her income on health care, compared to only 2.2 percent of income for the typical non-elderly adult.

KEY FINDINGS

- Seniors pay a much larger share of their income in out-of-pocket health costs than non-seniors do. The burden is especially great for seniors with low incomes; taking into account medical expenses would push an additional 2.4 million seniors below the poverty line.
- The Medicare Savings Programs, which help low-income Medicare beneficiaries pay their premiums and cost-sharing, have low participation because program rules are complex and many people are unaware of the programs.
- MedPAC, Congress's official advisory body on Medicare payment policy, has recommended several improvements to the Medicare Savings Programs to boost enrollment. Congress could include these long-overdue improvements in legislation now being prepared to avert a cut in Medicare physician payments.
- In sharp contrast, continuing to overpay private Medicare Advantage insurers so they can use a portion of the overpayments to potentially reduce cost-sharing for all enrollees represents a poorly targeted approach to helping low-income beneficiaries.

Low-income seniors face even greater cost burdens. The typical senior with income between 100 and 150 percent of the poverty line spent 16.1 percent of his or her income on health care in 2003, or nearly eight times the percentage that the typical non-elderly adult paid.[1]

The Medicare Part D drug benefit should have lowered seniors' out-of-pocket health care costs somewhat since it became available in 2006, particularly for beneficiaries who previously lacked prescription drug coverage. Yet seniors still face substantially higher out-of-pocket health care costs than the non-elderly. The Kaiser Family Foundation notes that even if out-of-pocket prescription drug spending is omitted, the typical elderly individual in 2003 spent 9.7 of his or her income on health care in 2003.[2]

Census data also shed light on the impact of out-of-pocket medical expenses on low-income seniors. The Census Bureau's official poverty statistics do not take individuals' medical expenses into account, but if those expenses are subtracted from seniors' incomes, the number of seniors living in poverty rises by *2.4 million.* Stated another way, out-of-pocket medical expenses push an additional 2.4 million seniors below the poverty line. (See the box on page 3.)

MedPAC-Recommended Steps Would Assist Low-Income Beneficiaries

Several federal programs, known as the Medicare Savings Programs (or MSPs), provide some help to poor and near-poor Medicare beneficiaries in paying their substantial out-of-pocket health care costs. There are three such programs:

- the Qualified Medicare Beneficiary (QMB) program, which pays Medicare premiums, deductibles, and co-payments for poor Medicare beneficiaries with incomes below 100 percent of the poverty line; and

- the Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI-1) programs, which pay Medicare premiums (but not deductibles or co-payments) for beneficiaries with incomes up to 135 percent of the poverty line.

To qualify for these programs, beneficiaries generally must also have assets of no more than $4,000 for individuals and $6,000 for couples. These limits have remained unchanged since 1989.[3]

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[1] The typical *non*-elderly adult with income between 100 percent and 150 percent of the poverty line spent 3.8 percent of his or her income on health care. Katherine Desmond *et al.*, "The Burden of Out-of-Pocket Health Spending Among Older Versus Younger Adults: Analysis from the Consumer Expenditure Survey, 1998-2003," Kaiser Family Foundation, September 2007. The AARP Public Policy Institute has reported starker results. It found that in 2003, Medicare beneficiaries age 65 and older spent an average of 22 percent of their income on out-of-pocket medical expenses. Again, low-income seniors faced the largest financial burdens: seniors with incomes between 135 percent and 200 percent spent 28 percent of their income on health care, on average, while seniors below 135 percent of the poverty line spent 33 percent. Craig Caplan and Normandy Brangan, "Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older in 2003," AARP Public Policy Institute, September 2004.

[2] Kaiser Family Foundation, *op cit.*

[3] Several states have used their flexibility under Medicaid to increase these limits. The Medicare Savings Programs are technically part of Medicaid.

Adjusting the Poverty Measure to Reflect Medical Expenses Demonstrates the Burden They Place on Low-Income Seniors

The Census Bureau's official poverty statistics, which have been subject to considerable criticism, are based on households' cash income before taxes. The official poverty measure also sets the poverty line at a *lower* level for elderly individuals and couples than for *non*-elderly individuals and couples, because the elderly consume less food, on average, than younger adults. (When the poverty line was established 50 years ago, it was based solely on household food costs.) Thus, the official measure of poverty does not take into account the higher out-of-pocket medical expenses that many seniors face, which can leave them with inadequate income to afford other necessities.

In the 1990s, the National Academy of Sciences (NAS) convened an expert panel to examine the poverty measure and recommend improvements. The NAS panel called for income and payroll tax payments, work expenses such as child care and transportation, and out-of-pocket medical expenses to be *subtracted* from household income, since those resources are not available to the household to meet other basic needs. It also called for non-cash benefits and refundable tax credits (such as food stamps, housing assistance, and the Earned Income Tax Credit) to be *counted* as part of a household's income. In addition, the panel recommended the elimination of lower poverty thresholds for seniors, as well as various adjustments to the poverty thresholds.

Under the *official* poverty measure, 9.4 percent of seniors 65 and over who do not reside in institutions lived in poverty in 2006. Under the full set of NAS-recommended parameters, in contrast, the elderly poverty rate would be 16.6 percent — almost twice as high (and actually higher than the child poverty rate under the NAS parameters).[a] The NAS recommendation with the biggest impact on the elderly poverty rate is the subtraction of out-of-pocket medical expenses; that change alone would increase the elderly poverty rate by 6.5 percentage points.[b] This reflects the large share of seniors who are "near-poor" and the substantial out-of-pocket health care costs they incur.

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[a] The NAS recommendations call for adjusting the poverty threshold based on the differences in housing costs in different geographic areas, but *not* based on whether an individual or family owns a home, has a mortgage, or rents. Many analysts believe — as did the NAS panel itself — that some adjustment ought to be made to reflect these factors related to mortgage payments. The NAS panel did not recommend such an adjustment because the data needed to make it do not currently exist. If such an adjustment could be made, it would somewhat reduce the elderly poverty rate below the 16.6 percent level (for 2006) that the NAS measure otherwise produces.

[b] CBPP tabulation of March 2007 Current Population Survey and 2006 Census Experimental Poverty Measures Research Data File. Figures may not add due to rounding.

The National Academy of Social Insurance has reported that these programs "have been shown to improve access to medical care services. Use of all types of medical service is greater for MSP enrollees than for eligible non-enrollees, even when accounting for differences in health status and other characteristics."[4] One study found that QMB enrollees were only half as likely as eligible individuals *not* enrolled in the program to forgo seeing a physician because of cost concerns; they also were less likely to avoid going to the hospital or refilling a prescription.[5]

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[4] Jack Ebeler, Paul Van de Water, and Cyanne Demchak, "Improving the Medicare Savings Programs," National Academy of Social Insurance, June 2006.

[5] Alex Federman, Bruce Vladeck, and Albert Siu, "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program," *Health Affairs*, January/February 2005.

Unfortunately, most individuals eligible for the Medicare Savings Programs do not participate in them. Prior to the establishment of the Medicare drug benefit, only 33 percent of eligibles were enrolled in QMB[6] and an even smaller share — 13 percent — were enrolled in SLMB, according to Congressional Budget Office estimates.[7] The main reasons, MedPAC reports, are lack of awareness of the programs and the complexity of the eligibility rules and of the application and retention processes.[8]

To increase MSP participation substantially while also expanding eligibility, MedPAC unanimously recommended several changes in its March 2008 report to Congress. These recommendations are also expected to increase participation in the Low-Income Subsidy (LIS) program, which helps low-income Medicare beneficiaries pay their premiums, deductibles, and co-payments under the Medicare prescription drug benefit. The MedPAC recommendations include:[9]

- *Align the MSP income and asset eligibility limits with the LIS's more generous limits in order to simplify procedures for both programs.* MedPAC notes that aligning the income and asset criteria for both programs at the LIS's higher levels[10] would make more people eligible for the MSP, ease the documentation requirements for beneficiaries, and make it simpler to screen and enroll individuals for both programs simultaneously. It also would generate administrative savings for both the federal government and the states. This recommendation is based, in part, on the successful experience in Maine, where MSP enrollment jumped more than threefold between 2006 and 2007 (from 9,000 to 30,000) after the state significantly expanded eligibility.[11]

- *Require the Social Security Administration to enroll beneficiaries not only in the LIS but also in the MSPs.* The Social Security Administration shares responsibility with state Medicaid programs for determining LIS eligibility. If MSP and LIS eligibility criteria were aligned, SSA could enroll beneficiaries in the MSPs as well. While the state Medicaid programs that determine eligibility for the LIS are required to screen individuals for MSP eligibility at the same time and to enroll those found eligible, SSA is not subject to that requirement. Having SSA determine eligibility for the MSPs would provide another pathway for low-income beneficiaries to participate in the programs.

- *Increase federal outreach funding through the State Health Insurance Assistance Programs (SHIPs).*

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[6] This estimate of QMB participation does not include the so-called "QMB-plus" Medicare beneficiaries, who are enrolled in full Medicaid and thus are readily connected to QMB. Participation by this population in QMB is estimated to be very high.

[7] Congressional Budget Office, "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit," July 2004.

[8] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2008.

[9] Medicare Payment Advisory Commission, *op cit.* The National Academy of Social Insurance has made similar recommendations. See Ebeler, Van de Water, and Demchak, *op cit.* A number of the NASI recommendations were included in a version of SCHIP reauthorization legislation (H.R. 3162) that the House passed in 2007.

[10] To qualify for the LIS, beneficiaries must have incomes below 150 percent of the poverty line and assets of no more than $11,990 for individuals and $23,970 for couples in 2008. Individuals with incomes below 135 percent of the poverty line and assets of less than $7,790 for individuals and $12,440 for couples receive greater assistance.

[11] Technically, Maine modified the MSP eligibility criteria to make them even more generous than those applied by the LIS but because MSP enrollees are deemed eligible for the LIS, the eligibility criteria for the MSPs and the LIS were effectively aligned. Medicare Payment Advisory Commission, *op cit.*

According to MedPAC, many Medicare beneficiaries and providers do not know about the MSPs, and many beneficiaries who are eligible may be particularly difficult to reach because they live in rural areas, are homebound, have limited English proficiency, or have vision, hearing, or cognitive difficulties. State Health Insurance Assistance Programs are federally funded programs operated by states, usually in partnership with non-profit senior advocacy organizations, to provide one-on-one informational, educational, outreach, and counseling services to Medicare beneficiaries and their families. Additional federal funding would allow SHIPs to expand their outreach efforts and thereby increase participation in the MSPs.

Medicare Advantage Overpayments Constitute Poorly Targeted Approach to Aiding Low-Income Beneficiaries

Some of the private plans that serve Medicare beneficiaries through the Medicare Advantage program have argued that they play a significant role in reducing low-income beneficiaries' out-of-pocket costs because they use a portion of the overpayments they receive to reduce premiums and/or cost sharing and provide extra benefits. (MedPAC has determined that Medicare Advantage plans are paid 13 percent more, on average, than it would cost traditional Medicare to cover the same beneficiaries;[12] these overpayments average approximately $1,000 per year per private-plan enrollee, according to an analysis conducted by George Washington University researchers for the Commonwealth Fund.[13])

This claim is unpersuasive. For several reasons, large overpayments to private plans are an extremely costly and inefficient way to reduce out-of-pocket costs for low-income beneficiaries.

- Only a portion of the overpayments goes to extra benefits and lower cost-sharing. For example, MedPAC has found that among private fee-for-service plans — the fastest growing type of Medicare Advantage plan — about *half* of the overpayments go to profits and marketing and administrative costs (which are much higher than under regular Medicare) rather than to additional benefits.[14]

- The overpayments are poorly targeted. The additional benefits and lower premiums and cost-sharing apply to *all* enrollees in a plan, including those who are affluent.[15]

- Certain less healthy beneficiaries who are enrolled in private plans — such as those who require hospital care, home health care, or other specialty services — may end up paying significantly *more* for such services (or receiving less of a covered service) than beneficiaries in traditional

[12] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," *op cit.*

[13] Brian Biles, Lauren Hersh Nicholas, Barbara Cooper, Emily Adrion and Stuart Guterman, "The Cost of Privatization: Extra Payments to Medicare Advantage Plans— Updated and Revised," The Commonwealth Fund, November 2006; Brian Biles and Emily Adrion, "The Cost of Privatization: Extra Payments to Medicare Advantage Plans; Updated Tables for 2007," George Washington University, May 1, 2007; and Brian Biles, Emily Adrion and Stuart Guterman, "The Cost of Privatization: Extra Payments to Medicare Advantage Plans in 2008," (forthcoming 2008).

[14] Mark Miller, "The Medicare Advantage Program and MedPAC Recommendations," Testimony before the House Budget Committee," Medicare Payment Advisory Commission, June 28, 2007 and Glenn Hackbarth, Oral Testimony before the Senate Finance Committee, April 11, 2007. See also Medicare Payment Advisory Commission, *op cit.*

[15] Glenn Hackbarth, "Report to the Congress: Medicare Payment Policy," Testimony before the Health Subcommittee of the House Ways and Means Committee, March 11, 2008

Medicare. This is because some private plans impose higher cost-sharing charges than traditional Medicare does for certain services used by people in poorer health.[16]

- Low-income beneficiaries disproportionately rely on Medicaid, rather than Medicare Advantage, for supplemental coverage and help with Medicare charges.[17]

MedPAC has emphasized that "if the justification for higher payments to [private] plans is that extra payments are being provided to low-income beneficiaries who choose such plans, there are less costly and more efficient ways to achieve this result," such as by improving the Medicare Savings Programs.[18] Similarly, the Government Accountability Office has concluded that "if the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost-sharing for all [Medicare Advantage] beneficiaries, including those who are well off."[19]

For a number of years, MedPAC has recommended that Congress equalize payments between the private plans and regular Medicare to create a level playing field. That would save $149 billion over ten years (2008-2017), based on CBO estimates from last year.[20] The Chief Actuary at the Centers for Medicare and Medicaid Services (CMS) testified this year that the overpayments advance the date when the Medicare Hospital Trust Fund will become insolvent by 18 months and raise Medicare beneficiary premiums by about $3 per month per person (or $72 a year for a couple).[21]

Conclusion

Senator Max Baucus (D-MT) and Senator Charles Grassley (R-IA), the chairman and ranking member of the Senate Finance Committee, along with Senate Majority Leader Harry Reid and Senate Minority Leader Mitch McConnell, are currently discussing legislation that would delay for up to 18 months a scheduled cut in Medicare physician payments. That legislation is expected to include other Medicare provisions related to payments to rural health care providers, as well as other providers.

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[16] Medicare Rights Center, "Too Good to Be True: The Fine Print in Medicare Private Health Plan Benefits," April 2007; Brian Biles et al., *op cit*; Medicare Payment Advisory Commission, "Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans," December 2004; Patricia Neuman, "Medicare Advantage: Key Issues and Implications for Beneficiaries," Testimony before the House Budget Committee, Kaiser Family Foundation, June 28, 2007; and Government Accountability Office, "Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs," February 2008.

[17] See Edwin Park and Robert Greenstein, "Low-Income and Minority Beneficiaries Do Not Rely Disproportionately on Medicare Advantage Plans," Center on Budget and Policy Priorities, Revised April 12, 2007.

[18] Mark Miller, "The Medicare Advantage Program and MedPAC Recommendations," Testimony before the House Budget Committee," Medicare Payment Advisory Commission, June 28, 2007 and Hackbarth, *op cit*.

[19] Government Accountability Office, *op cit*.

[20] Congressional Budget Office, "Preliminary CBO Estimates of Policies Capping the Medicare Advantage Benchmarks," April 15, 2008.

[21] See Fawn Johnson, "Stark, Camp Disagree Over Paths to Keep Medicare Solvent," *Congress Daily*, April 1, 2008 and BNA Health Care Policy Daily, "Cutting Managed Care Pay Would Prolong Medicare Trust Fund Solvency, Actuary Says," April 2, 2008.

It could also serve as a vehicle to provide needed improvements to the Medicare Savings Programs, such as those recommended by MedPAC, that would help significantly more low-income Medicare beneficiaries who are struggling with substantial out-of-pocket medical expenses. If these improvements are enacted, fewer low-income seniors would effectively be driven into poverty by their medical expenses.