Thank you for this opportunity to testify on the Medicaid program and its importance to America's seniors. I am Howard Bedlin, Vice President for Public Policy and Advocacy for the National Council on the Aging (NCOA), the nation's first organization formed to represent America's seniors and those who serve them. Founded in 1950, NCOA is a national network of organizations and individuals dedicated to improving the health and independence of older persons and increasing their continuing contributions to communities, society and future generations.

Over 5 million of the oldest, lowest income, most vulnerable seniors in our nation receive some form of assistance from the Medicaid program. This assistance provides an essential safety net that meets critical health and long-term care needs not covered under Medicare.

In 2001, Medicaid spent an estimated $64 billion on the elderly. Approximately 9% of Medicaid enrollees are elderly, while about 26% of Medicaid dollars are spent on seniors. On average, Medicaid spends over $13,000 per year per elder enrollee, more than any of the other three categories of eligible groups (people with disabilities, children, and pregnant women and families). This is largely because Medicaid is the nation's primary payer for long-term care, including nursing home care that cost the program an average of over $124 per day in 2002, or over $50,000 per year in 2005. Medicaid also pays for some home and community services to help maintain independence and provide relief to family caregivers – the primary providers of long-term care in the country.

Another major Medicaid category of service for seniors is the Medicare Savings Programs, which pay for Medicare premiums and cost sharing. These include:

- The Qualified Medicare Beneficiary (QMB) program, which pays for Part B premiums and Parts A and B deductibles and coinsurance for beneficiaries with incomes below 100% of the Federal Poverty Level (FPL - $9,570 for singles; $12,830 for couples), and non-housing assets below $4,000 for singles and $6,000 for couples (twice the standard under the Supplemental Security Income (SSI) program); and
- The Specified Low-Income Medicare Beneficiary (SLMB) program, which pays for Part B premiums for beneficiaries with incomes between 100% and 120% of FPL, and assets levels similar to QMBs.

A third major category of services for seniors under Medicaid had been prescription drug coverage. This, however, will effectively end on January 1 when the new Medicare prescription drug benefit becomes available. States may continue to cover some drugs and receive a federal match for those Medicare will not cover, such as benzodiazepines, barbiturates, medications for weight gain or loss, and over-the-counter products. Unfortunately, states will not be able to receive a federal Medicaid match for helping low-income beneficiaries pay their cost sharing which – again unfortunately – for many will rise more rapidly than the general rate of inflation (at the rate of Medicare Part D cost increases).

State Medicaid programs also cover a number of other important services for seniors, such as dental services and dentures, respiratory care, prosthetic devices, orthotics, durable medical equipment, hearing aids, optometrist services and eyeglasses, podiatry and chiropractic care.

Seniors who also rely on Medicaid are known as "dual eligibles," or eligible for both Medicare and Medicaid. This group also includes younger persons with disabilities who have met the two-year waiting period criteria for Medicare eligibility. We appreciate the attention this Committee has already paid to dual eligibles by holding a hearing earlier this year on dual eligibles and the new Medicare prescription drug benefit, as these individuals face difficult and unique transition issues, and challenges in our health and long-term care systems in general. It is significant to note that over half of dual eligibles (52%) are in fair or poor health – more than twice the rate of other Medicare beneficiaries (24%) – and about one-third of dual eligibles have significant limitations in Activities of Daily Living (ADLs), compared with 14% of other Medicare beneficiaries.

Most of the seniors on Medicaid are women. The average woman over age 65 lives six years longer than the average man. As a result, she is often widowed and living alone. According to the Older Women's League (OWL), older women have average annual incomes of $15,615 compared with over $29,171 for men, with correspondingly lower assets. Not surprisingly, over 70% of adults ages 19 and older on Medicaid are women. The reality is, the typical senior on Medicaid is a very poor, chronically ill widow.

Mandatory and Optional Populations and Services

A primary focus of today's hearing is the traditional distinctions in the Medicaid program between mandatory and optional populations and mandatory and optional services.
In our view, these categories are not helpful in evaluating how to reform the Medicaid program. Many optional beneficiaries are among our nation's most needy and vulnerable. They are not less worthy. Many optional services are essential. They are not less valuable.

Unfortunately, a number of Medicaid reform proposals over the past five years have recommended treating these populations and services very differently, to the potential detriment of the elderly. Essentially, these proposals have suggested that minimum federal consumer protections should be eliminated for optional populations and services. In 2001, the National Governors Association (NGA) under Policy HR-32 suggested that for mandatory populations and services: "The federal government has essentially already defined this core group by establishing minimum standards below which no state is permitted to go. Therefore, for all of the populations covered under the federal minimum standards, states would guarantee both eligibility as well as the federal minimum requirements with respect to benefits." These guarantees and standards would not have been assured for optional benefits and optional populations. We were pleased, however, that the June 15, 2005 NGA *Medicaid Reform Preliminary Report* stated that the traditional distinction between mandatory and optional populations "are arbitrary distinctions when it comes to the need for health care services." We agree.

In its January 2003 budget proposal for FY 2004, the Administration proposed that states be given "carte blanche" flexibility to determine eligibility, services, cost sharing, and consumer protections for optional populations and services. The proposal also suggested that federal Medicaid contributions be capped. The Leadership Council of Aging Organizations, a broad coalition of over 50 national senior organizations, responded by stating: "The proposal would create incentives for states to underserve high cost enrollees, such as older Americans in need of long-term care. Persons needing the most expensive care, who are most likely to cause states to exceed their spending cap, would be at greatest risk of being targeted for potentially harmful cost containment strategies, such as limiting access or services."

The coalition also expressed serious concerns about undermining critical consumer protections for optional populations and services, asking:

- Would essential federal nursing home quality standards for optional groups be eliminated?
- Could a state choose to charge 50% coinsurance for home and community services to a frail senior with income at the poverty line?
- For an optional beneficiary, could a state choose to eliminate current spousal impoverishment protections?
- Could a state require families of optional Medicaid nursing home residents to supplement the payment to the nursing home?

These concerns illustrate the problems inherent in Medicaid reforms that might eliminate federal standards protections for optional populations and services, as well as the stake that seniors and their families have in this debate. With the federal government paying an estimated 57% of Medicaid expenditures, it is not unreasonable that certain minimum federal standards be met in return. While greater flexibility is desirable in some areas, we need to remember that the program is complex, the populations served are vulnerable, states are under budget pressures to cut the program, and significantly greater flexibility in certain areas could lead to discrimination against needy populations or harmful reductions in quality of care. It is also important to note that states already have a great deal of flexibility in administering the Medicaid program. As the June 2005 Kaiser Family Foundation report discussed in today's first panel concluded: "The legal distinction of services by mandatory and optional classes imposed by federal statute may not provide a useful roadmap for Medicaid restructuring."

Seniors may well have the most to lose if Medicaid "reform" results in the elimination of federal protections for optional populations and services. Fully **84.4% of Medicaid spending on the elderly is optional –** far more than for any other eligible category group. In addition, 48% of the elderly qualify for Medicaid through optional eligibility groups, again greater than for any other category.

It is also important to remember just how difficult it is for a senior to qualify for Medicaid in the mandatory category. Excluding MSP recipients, most of these individuals must need nursing home care, have income below the SSI level (only 74% of FPL, or annual income of only $7,082 for singles and $9,494 for couples) and non-housing assets below $2,000 for singles and $3,000 for couples. Surprisingly, the **asset limits are not adjusted annually for inflation and have not been updated in over 20 years**.

An important optional eligible group can access Medicaid in 35 states through the medically needy program. The program was designed for those with income somewhat above the eligibility levels, but who incur significant health costs. People can "spend down" by incurring medical expenses that reduce their income below the state's eligibility level. This option is particularly important for elderly nursing home residents. Fifteen percent of elderly Medicaid enrollees are medically needy, a higher percentage than for any other group. In 2000, $10.9 billion of the $23.8 billion spent on the medically needy were elderly enrollees (46%).

Medicaid and Long-Term Care

The primary issue America must address regarding seniors needing Medicaid is simply: Who will pay for long-term care? Long-term care is expensive and those who need it most – persons over 85 years of age – are the fastest growing segment of our population. The future is scary. The states do not want to pay for it. The federal government does not want to pay for it. And seniors and their families cannot afford it.

Our nation faces a long-term care crisis that is rapidly growing worse. After working hard throughout their lives, millions of seniors are forced to bankrupt themselves before receiving help. Overburdened caregivers are sacrificing their mental, physical, and economic health. America's so-called long-term care "system" is characterized by limited choices, fragmentation, confusion and institutional biases. And the lifeblood of our nation's long-term care system is the Medicaid program.

Medicaid pays for an estimated 43% of our nation's long-term care costs – more than any other source. In 2001, 57% of total Medicaid spending for optional populations and services was for long-term care. Of the $83 billion Medicaid spent that year for long-term care, fully 85% of the amount was for optional populations and services ($70.7 billion). An estimated 60% percent of nursing home residents are on Medicaid and about 46% of nursing home revenues are derived from the program.

Our nation spends far more Medicaid long-term care dollars on institutional care than for home and community services, despite consumers' and families' strong preferences for the latter and the generally lower per capita costs for these services. Medicaid spends about 70% its long-term care dollars on institutional care. The nursing home bias for seniors on Medicaid is even more alarming. According to the Urban Institute, **only 16% of Medicaid's long-term care expenditures for the elderly are spent on home and community services**. The time for empty rhetoric on this problem is over. Congress needs to take action on Medicaid's institutional bias this year.

NCOA is very concerned about the prospect that the federal and state governments may attempt to shift even more of the burden for the cost of long-term care on to those in need and their families. Congress is proposing to cut Medicaid by $10 billion over the next 5 years. The NGA *Medicaid Reform Preliminary Report* stated: "Medicaid can no longer be the financing mechanism for the nation's long-term care costs and other costs for the dual eligibles." A recent survey by the Kaiser Family Foundation found that 17 states have targeted long-term care for Medicaid cuts. A February 2005 *Business Week* article on Medicaid stated: "Seniors and the disabled are pushing the program to the breaking point" and "policymakers in Washington and in state capitals increasingly have their eye on the looming cost of caring for the elderly and disabled."

Improving Access to Medicaid Home and Community Services

Rather than cutting benefits for low-income seniors and people with disabilities who need long-term care, more must be done to address the institutional bias in Medicaid. The two primary programs for accessing home and community services are the Home and Community-Based

Services (HCBS) waiver program and the Personal Care program. Both programs are optional and provide a broad range of services including important relief to family caregivers through respite and adult day services. Ideally, the programs should be mandatory. Congress in 1981, under section 1915(c) of the Social Security Act, authorized states to waive certain federal requirements and provide home and community services to those who would otherwise qualify for institutional care under Medicaid. All states have HCBS waiver programs. In 2002, an estimated 74% of HCBS waiver dollars spent were for Mentally Retarded/ Developmentally Disabled (MR/DD) enrollees. States have also had the option to offer personal care services under their state plan since the mid-1970s. In 2000, 27 states covered these services. In 2002, Medicaid spent $16.4 billion on HCBS waiver services and $5.6 billion on personal care.

Unfortunately, Medicaid home and community services – so critical to maintaining independence, dignity and choice for millions of frail seniors and persons with disabilities - fall far short of meeting the needs of these population and their families. A 2000 report from the University of California, San Francisco estimated that more than half the states had waiting lists for HCBS services. The Kaiser Family Foundation found that Texas, for example, has almost 75,000 people on its waiting list, with an average wait time of 2 years.

There is also great variation among states in the level of coverage for home and community services provided. An Urban Institute study found that Medicaid long-term care spending in 1998 in the highest spending states was about four times greater than in the lowest spending states. A 2003 Government Accountability Office report found that differences in state policies have tremendous consequences for those who need long-term care. Two of the best state home and community service programs in the nation are in Oregon and Wisconsin. We are hopeful that the Chairman and Ranking Member of the Committee will hold future hearings on how others can learn from and replicate the successful programs in your states.

Another example of Medicaid's institutional bias is the fact that under current federal Medicaid law, protections that keep the spouses of Medicaid enrollees from also becoming impoverished are mandatory for nursing facility services, optional for HCBS waiver programs, and appear to be prohibited under the Personal Care program. In general, Medicaid will cover a beneficiary's

nursing home care and permit the spouse who does not need benefits to keep one-half of the couple's countable assets, up to a ceiling. The monthly income allowance ranged from $1,492 to $2,267, with asset allowances ranging from $18,132 to $90,660, in 2003. An estimated fifteen states do not provide spousal impoverishment protection for HCBS waiver programs. It makes no sense for federal law to prohibit a state from providing spousal protections for personal care. Providing spousal protections for home and community services will alleviate a huge financial and emotional burden for many married couples. It should be noted that a much higher percentage of Medicaid home and community service recipients are married than nursing home residents. The failure to provide spousal protections can bankrupt a healthy spouse or split families apart, providing incentives for divorce, lawsuits and other serious conflicts. We need a more family-friendly policy. States should be given the flexibility to provide spousal impoverishment protections under the personal care services program. In addition, incentives should be created for states to provide spousal protections under both the personal care and HCBS waiver programs.

We are pleased, however, that state Medicaid programs increasingly are making consumer directed services available, such as cash and counseling. But much more can and should be done. Consumer directed programs offer maximum choice and control for people to select, manage, and dismiss their workers. Consumers can decide which services to use, which workers to hire, and what time of day they will come and leave. They can decide whether to hire family members and whether to spend the available funds on things other than services. Evaluations from the initial three cash and counseling demonstration projects in Arkansas, New Jersey and Florida have provided significant and meaningful results in finding that consumers experienced improved quality of life and satisfaction with their care.

NCOA testified in April before the House Energy and Commerce Committee on encouraging seniors to use the equity in their homes to stay at home through increased use of reverse mortgages. In January, NCOA released a report entitled: *Use Your Home to Stay at Home: The Role of Reverse Mortgages to Pay for Long-Term Care at Home*. Based on our analysis of the 2000 Health and Retirement Study, NCOA estimates that almost half of households age 62 and older - 13.2 million - are candidates for using a reverse mortgage to pay for long-term care at home (defined as being able to receive a minimum of $20,000 from this loan). The amount of

funds that could become available if these older homeowners liquidated a portion of their home equity is substantial. By calculating the amount of funds that could be available from reverse mortgages for individual households, we estimate that these loans could increase private sector funding for in-home services and supports in total by $953 billion.

Payments from a reverse mortgage can help reduce dependence on Medicaid and reduce the risk of institutionalization. Increased use of this financial option for long-term care could result in savings to Medicaid ranging from about $3.3 to almost $5 billion annually in 2010, depending on market penetration rates increasing from 4 percent to 25 percent of older homeowners.

Congress and the states have an important role to play in encouraging the appropriate use of reverse mortgages. Within the context of Medicaid reform, the federal government can give states a variety of tools to use to promote reverse mortgages, including:

- Permitting states to use Medicaid dollars to reduce up front reverse mortgage costs;
- Permitting states to allow seniors to protect a certain amount of assets from estate recovery if they take out a reverse mortgage;
- Clarifying the priority of liens to enable spouses of nursing home residents to take out reverse mortgages; and
- Clarifying that proceeds from reverse mortgages will be treated as loans and not income for purposes of determining Medicaid and other means-tested program eligibility.

There are a wide variety of other Medicaid long-term care reforms that would promote greater independence, dignity and choice, while reducing per capita costs. For example, NCOA supports:

- The President's "Money Follows the Person" rebalancing proposal (S. 528). Under the proposal, for persons transitioning out of institutions, the federal government would cover the entire first year of costs for Medicaid home and community-based waiver services in select states;
- Permitting states to provide Medicaid home and community-based services (HCBS) under a state plan amendment, rather than having to go through an often burdensome waiver process;
- Giving states more flexibility by eliminating the current requirement that Medicaid HCBS coverage be linked with a need for nursing home level of care;

- Recognizing under the Medicaid eligibility asset test that persons in need of HCBS must pay for housing, food, clothing, utilities, and transportation, while nursing home residents do not incur these costs;
- Permitting states to include savings from Medicare and other federal programs in their Medicaid HCBS waiver budget neutrality calculations;
- Reducing barriers for states to provide consumers with greater opportunities to choose consumer directed models of Medicaid home and community services; and
- Permitting Medicaid recipients in need of long-term care to receive community attendant services as an alternative to institutional care (S. 401).

A final note of interest on Medicaid long-term care optional vs. mandatory services: few realize that home *health* services are a mandatory Medicaid benefit for individuals entitled to nursing facility services under state Medicaid plans. Services must be medically necessary and ordered by a physician as part of a plan of care. In 2001, Medicaid payments for home health services totaled $3.5 billion for more than 1 million beneficiaries. Beneficiary eligibility does not depend on the need for institutional care. According to a 2000 report from George Washington University:

> "Misperceptions [about the Medicaid home health benefit] are common, however, that additional Federal requirements do further restrict who may receive home health services…[M]any assume that individuals must be *eligible* for nursing facility care in order to receive home health services (i.e., that they must meet a state's nursing facility level-of-care criteria). This misunderstanding has most likely arisen because people have misinterpreted the word *entitled* to nursing facility care to mean *eligible* for nursing facility care. The Federal requirement specifies only the minimum coverage group and does not require that the individual meet a nursing facility level of care (i.e., be eligible)." [*Understanding Medicaid Home and Community Services: A Primer*, George Washington University, Center for Health Policy Research, October 2000]

We know of no evaluation of how the Medicaid home health benefit is actually working in the states. It may be desirable for the Government Accountability Office to evaluate the Medicaid Home Health program.

The Medicare Savings Programs (MSPs)

As stated earlier, the MSPs provide critical protections against out-of-pocket costs for the lowest income Medicare beneficiaries. Medicaid pays for this protection under the QMB and SLMB

programs. We agree with the NGA and many others that, ideally, these programs should be a federal Medicare responsibility.

It is important to understand that a third MSP is the Qualified Individual (QI-1) program. It is similar to the SLMB program in that it pays for Part B premiums, but for beneficiaries with incomes between 120% and 135% of FPL, with similar SLMB asset levels. However, the program is not under Medicaid and is not even permanent. The QI-1 program was established under the 1997 Balanced Budget Act and is 100% federally funded, up to a capped allocation to the states. It was initially created for a 5-year period, and has been extended for one year each time it was scheduled to expire. NCOA is pleased that the Administration has again supported extending the program for a year, but we strongly believe the program should be permanent and combined in some fashion with the SLMB program. At a minimum, we urge Congress this year to extend the QI-1 program for at least five years. We are particularly grateful to Senator Bingaman for his continued efforts to protect and extend the program.

Although MSP programs are mandatory, there is no requirement that the federal and state governments make the efforts necessary to find and enroll beneficiaries in these programs. According to CBO, **QMB take-up rates are only 33%, while SLMB take-up rates are an abysmal 13%.** In addition, according to a 2003 report for CMS by the Research Triangle Institute, QMB and SLMB enrollment rates vary significantly by state – from 26% to 88%. *Far more* needs to be done to find and enroll these vulnerable beneficiaries in MSP programs, whose value has been demonstrated in improving access to care. This also applies to Medicaid itself where, even after 40 years, enrollment among eligible seniors is only 60%. It is NCOA's fervent hope that outreach and enrollment efforts to provide extra help to low-income beneficiaries under the new Medicare prescription drug benefit will create opportunities to improve MSP and Medicaid take-up rates as well.

A number of relevant lessons have been learned and should be applied from a recent *State Solutions* demonstration, directed by the Rutgers Center for State Health Policy. Additional important lessons can be learned from the first nationwide study, issued last week by the NCOA-chaired Access to Benefits Coalition, of best practices on local and national outreach and

enrollment strategies: *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes*. NCOA also supports the creation of a National Center on Senior Benefits Outreach and Enrollment in the Older Americans Act to help focus our attention and efforts, and address these serious shortfalls.

NCOA urges Congress to review and take action to strengthen the Medicare Savings Programs in order to: (1) simplify and consolidate the programs; (2) improve outreach and enrollment efforts; (3) index the asset test to account for inflation; (4) increase federal contributions; and (5) improve the levels of protection consistent with those under the Medicare Part D prescription drug benefit.

Finally, few realize that coinsurance under the QMB program is paid to providers at the Medicaid reimbursement rate, not the Medicare rate. In almost every instance, the Medicaid payment rate to providers is lower than the Medicare rate. This is particularly true of skilled nursing facility care. We continue to wonder whether these lower QMB cost sharing payments are contributing to provider access problems for QMBs.

Conclusion

Our nation's moral compass should be guided by how we treat our poorest and most vulnerable citizens. Medicaid is the essential health care safety net for over 5 million frail seniors. The vast majority of dollars spent on seniors under Medicaid are for services and populations that are technically identified as optional. These distinctions are not helpful in reviewing alternatives for reforming the program.

As Congress looks to reform Medicaid it is important to understand what is driving Medicaid cost increases and how these relate to the broader challenges facing our nation's health care system in general. For example, Medicaid has been more successful than the private sector in controlling health care spending per person. From 2000-2003, per capita Medicaid acute care spending increased 6.9% vs. a 12.6% average increase in monthly premiums for employer sponsored insurance, even though Medicaid serves a sicker population. Medicaid spending growth has predominantly been driven by enrollment growth. The aged and disabled accounted for only 10%

of the 8.4 million increase in Medicaid enrollment from 2000 to 2003. Much of the spending growth reflects a shift from private to public spending, not additional health care dollars spent overall.

Decision-makers must deal with the fact that Medicaid is the primary source of payment for long-term care and that these services are expensive. NCOA fears that the growing number of seniors who become impoverished and rely on Medicaid may cause major cuts in Medicaid services and coverage for younger people who lack basic health insurance. With the aging of the baby boom generation, there is a great need and opportunity for a national dialogue and debate about how to best address our nation's growing long-term care crisis. America needs a comprehensive national strategy and a universal long-term care program that includes a strong public sector safety net and foundation of support, supplemented by a variety of high quality private sector funding mechanisms. Additional federal revenues should be on the table, as should the appropriate roles of Medicare, Social Security, and the Older Americans Act. We should also look to other countries for the lessons that can be learned from their long-term care program experiences. NCOA is also hopeful that the December White House Conference on Aging will jumpstart this important national dialogue by underscoring the importance of these challenges, reflecting on the best use of public and private resources, and beginning to develop the outline of a plan for our nation in dealing with the growing long-term care crisis.

NCOA looks forward to working with members of Congress and others to address these Medicaid and long-term care challenges in a manner that protects the most vulnerable, provides quality services, spends dollars as efficiently as possible, and promotes choice, independence and dignity.