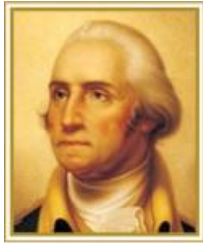

The Jacob Burns Community Legal Clinics
Health Insurance Counseling Project

FY 11 – 12 Performance Oversight Hearing
Department of Health Care Finance
Councilmember David A. Catania - Chairman
Committee on Health
April 19, 2012

Good afternoon Chairman Catania and distinguished members of the Committee on Health. My name is Chris DeYoung, Co-Director of the Health Insurance Counseling Project of the George Washington University Community Legal Clinics. HICP serves as the SHIP program for the District of Columbia, providing free health insurance information, education, counseling and legal services to older adults and people with disabilities, as well as their families and caregivers.

In June of 2005, there were 43 clients enrolled in the District of Columbia's Qualified Medicare Beneficiary (QMB) program, an obscure benefit that garnered little attention. There were an additional 1,150 residents participating in the Specified Low-Income Medicare Beneficiary (SLMB) and Qualified Individual (QI-1) programs; all three collectively know as the Medicare Savings Programs. These benefits provide assistance for Medicare beneficiaries whose incomes just exceed the Aged, Blind, Disabled Medicaid benefit limits. The SLMB and QI-1 programs only pay Medicare Part B premiums, while the QMB program pays for Medicare Part A & B premiums and eliminates any liability for Medicare cost sharing (premiums and deductibles). This is an important distinction, since SLMB and QI-1 have no impact on provider/client relationships, while the success of the QMB program hinges on both of these parties understanding the benefits and rights of the client.

In 2005, medical providers, community members, and even Medicaid staff had no idea what the QMB program was or what rights it provided for those 43 beneficiaries. With the introduction of the Medicare Drug Benefit (Part D) in 2006, the Medicare Savings Programs became a vehicle to automatically qualify participants for the Low Income Subsidy with Part D, a benefit that saves each person an average of $4,000 per year. The District seized on this opportunity to expand access to affordable prescription medications for seniors by consolidating the Medicare Savings Programs into one benefit, raising the income limit and later eliminating the tight restriction on assets. By January 2006, there were 1,200 QMB participants, a 2,700 percent increase in enrollment as the SLMB and QI-1 participants were rolled into QMB coverage. Six years later there are 7,000 older adults and individuals with disabilities enrolled in the QMB Only program, collectively saving over $35 million each year in Medicare cost sharing and prescription drug expenses.

The QMB program has grown at an average rate of 22 percent per year, representing community collaboration and a lot of hard work. The expansion of the benefit created the opportunity, but making the benefit more accessible has been integral for increasing

enrollment. The Health Insurance Counseling Project placed a quarter page add in the Senior Beacon for a fifteen month period (06/2011 – 08/2012), we mail over 1,100 QMB applications to clients each year and submit an average of 39 completed applications to the Economic Security Administration every month. Many of the applications come to us from social workers (e.g. Unity Health Care, DC Office on Aging, Davita Dialysis and mental health case workers) that we have collaborated with over the past three years. The electronic version of the Qualified Medicare Beneficiary application has been distributed throughout the District and thousand of residents have learned about the program from Ms. Holt and her staff at the D.C. Healthcare Ombudsman and Bill of Rights program.

The rapid growth of the QMB benefit created its fair share of problems and demonstrated how unprepared the District was to effectively administer this program. Over the past three and a half years, however, the Department of Health Care Finance and the Economic Security Administration has worked with us to address the most egregious problems. Identification cards are being issued to QMB beneficiaries, the file identifying the Part D subsidy level is submitted to Medicare on a weekly basis (instead of monthly), and a shortened two page 'QMB Only' application was created to simplify the enrollment process. The District is now working to address the inconsistent application of benefits to QMB clients, and within the next year will ensure that all dual eligible clients are fully insured under Medicare Part A and B coverage. Lastly, DHCF and ESA are holding bi-weekly meetings that stemmed from community groups pressing these agencies to take the administration of the QMB program more seriously, which requires greater interagency collaboration than we have seen in the past.

There are a number of QMB policy issues that still urgently need to be addressed, but I want to take this opportunity to commend the Department of Health Care Finance and the Economic Security Administration for taking steps to improve access to the Qualified Medicare Beneficiary program. There have always been louder issues and larger programs to drown out the voice of these residents – the Alliance and Adult waiver transitions or health care reform implementation. Yet through multiple administrations and numerous staff transitions; DHCF and ESA have given community organizations a seat at the table to advocate for improving this benefit. The process has been painfully slow at times and never as fast as we would like to see, but ultimately the program is improving and progress continues to be made.

In the coming months we strongly encourage the Department of Health Care Finance to address the urgent issue facing clients who are transitioning from the Childless Adult Waiver program to the Qualified Medicare Beneficiary program. As stipulated in federal law, participants in the Childless Adult Waiver program lose this Medicaid benefit on the first day of the month in which they gain Medicare eligibility. The federal regulations state that the QMB benefit begins the month after the eligibility determination is made, and the District currently misinterprets this to exclude Medicare beneficiaries from QMB eligibility during the first month of their Medicare coverage. This means that all beneficiaries losing the Adult waiver benefit will be fully liable for Medicare cost sharing during this month. That includes $1,156 deductible if they are hospitalized and 20 percent coinsurance payments for all Part B services (including dialysis, physician services, and anti-cancer medications). The Department of Health Care Finance can identify these clients before their Medicare eligibility beings and needs to make this determination prior to Medicare eligibility begins to allow QMB benefits to coincide with the Medicare effective date.

Thank you for the opportunity to address this committee, and we can provide any additional follow up information needed to further clarify this issue.