



August 24, 2021

The Honorable Kathy Hochul
Governor of New York State
NYS State Capitol Building
Albany, NY 12224

Dear Governor Hochul,

As advocates for older New Yorkers, people with disabilities, individuals covered by Medicaid and the uninsured, we are writing to strongly urge you to take decisive action in this year's state budget to prevent widespread Medicaid coverage loss and remedy a Medicaid eligibility disparity which penalizes older adults and individuals with disabilities. As you know from your travels around the state, the coronavirus pandemic has exposed longstanding racial disparities in health care, with poorer health status and higher death rates inflicted on people of color, older adults and people with disabilities – especially those living in poverty. Today, we urge you to follow the lead of other states and take action in the Executive Budget to address these health disparities by 1) expanding Medicaid eligibility for older New Yorkers and adults with disabilities shut out from protections of the Affordable Care Act (ACA), and by 2) expanding access to crucial Medicare subsidies. We also ask you to continue some of the flexible rules for accessing Medicaid that the federal government allowed states to use during the pandemic, which New York can and should continue. These easements enabled over one million New Yorkers to newly enroll in Medicaid, facilitating their access to health care.

We now face the specter of tens of thousands of people losing eligibility for coverage once the COVID easements end, only because they became enrolled in Medicare during the pandemic (either because they turned 65 or receive Social Security Disability). Many of these individuals, who are disproportionately people of color, could retain Medicaid if the changes recommended here are made. Tens of thousands more could have free Medicaid instead of “spending down” money they cannot afford. At a moment when disproportionate harm could be inflicted on vulnerable New Yorkers, you have the opportunity to create both immediate and long-lasting change to reduce health disparities in New York.

Stop the *Senior Penalty* – Expand Medicaid Income Limits for Medicaid and the Medicare Savings Program and Eliminate the Asset Test

- I. **Raise the Medicaid Income Level for those Age 65+ and Adults with Disabilities** – In 2014, the ACA increased the income eligibility level for Medicaid to **138%** of the Federal Poverty Level (FPL) – just \$17,131 annually for a single person. But older adults and adults

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with disabilities can only qualify for free Medicaid if their income is below **84% FPL**, \$10,600 a year for a single person. The income level for the NYS Medicaid Aged and Disabled Program has been revisited since the 1980s. As a result, they can only qualify if they “spend down” their so-called “excess income” on medical bills every month; the spend-down is the amount their income exceeds \$884 per month. However, the high cost of living in New York makes it impossible for the vast majority of these individuals to spend this income on medical bills instead of rent, food, and other basic necessities. It is time to fix the Medicaid Aged and Disabled income limit so that all New Yorkers have the same access to Medicaid coverage. We describe this proposal in more detail in Attachment I.

II. Eliminate the Asset Limit for Medicaid for Age 65+ and Adults with Disabilities – New Yorkers with disabilities and those who are 65 and older are the only populations subject to a Medicaid asset test.

Annie was 64 in 2019 and was eligible for Medicaid without an asset test. Ordinarily, she would have faced a \$15,900 asset limit when she turned 65. But because of special federal protections during the pandemic, upon turning 65 in 2020, Annie stayed on Medicaid even though she has \$40,000 in savings. However, once the public health emergency (PHE) is over, she will be thrown off Medicaid. With rent of \$1,100 per month and monthly Social Security of \$1,400, Annie depends on her savings to meet her expenses.

California has already eliminated the asset test for older adults and people with disabilities, which forces people to impoverish themselves in order to maintain health coverage. The current asset limit prevents older adults and individuals with disabilities from having adequate resources to weather a crisis, such as an eviction, a leaking roof, or a major vehicle repair, and makes it more likely they will need to rely on additional public benefits. The asset test rules exempt some assets, such as homes. This disproportionately punishes people of color because they are more likely to have cash savings as an asset, instead of an exempt home. This proposal is further outlined in Attachment II.

III. Increase Income Limits for the “QMB” Medicare Savings Program to 200% of the FPL.

Medicare Savings Programs provide crucial financial support for low-income older adults and individuals with disabilities, helping to defray Medicare premium costs and, in the case of the Qualified Medicaid Beneficiary (QMB) program, covering coinsurance and other costs. The QMB limit in New York is 100% FPL, or \$12,880 for a single individual. Raising the income limit to 200%, which Massachusetts and Connecticut have done, would make an immediate impact on low-income New Yorkers’ ability to use their Medicare benefits without accruing untenable debt. This change would also bring the income limit in line with New York’s Essential Plan, which provides low-cost coverage to almost 900,000 New Yorkers but is not available to older adults who qualify for Medicare.

Pat, age 87, receives \$1,900/month in Social Security and does not qualify for any Medicare Savings Program. Because Medicare only pays 80 percent of the cost of her doctors’ visits, Pat frequently delays or skips necessary appointments because of the cost. She also has \$200 deducted from her Social Security check each month for Medicare Part B and D premiums, money that she needs for her \$1,300 rent and other expenses. If Pat lived in Massachusetts or Connecticut, she would qualify for QMB, which would add \$200 to her monthly check.

Pat would also automatically receive the federal Extra Help subsidy with Part D, reducing her prescription costs to less than she pays with the NYS-funded Elderly Pharmaceutical Insurance Coverage (EPIC) program. Pat would also get help with Medicare coinsurance and deductibles for doctor's visits and other Medicare costs. Expansion of the MSP program would help Pat attain economic and health security and reduce the state's costs for the EPIC program. Please see our proposal in Attachment III.

Continue COVID-19 Flexibilities in Medicaid Applications and Services to Ensure Access to Healthcare

In order to avoid potentially catastrophic coverage losses at the end of the PHE, New York should not only implement the coverage expansions described above, but also should continue certain easements, some of which were initiated during the pandemic, which federal Medicaid policy allows states to continue after the PHE is over:

- I. Continue Use of Attestation for Eligibility.** States have the option of accepting self-attestation for non-financial eligibility criteria such as age and date of birth, household size, and state residency. Also, states may use post-enrollment income verification by self-attestation. While citizenship and immigration status must be verified, New York should exercise the option of extending the "reasonable opportunity" period for beneficiaries to verify status beyond the usual 90 days. These easements benefit all Medicaid applicants but particularly those who are homeless, unstably housed, or have other vulnerabilities that make preserving and providing documentation difficult.
- II. Eliminate and reduce prior authorization requirements, including those restricting prescription and over-the-counter drugs.** The suspension of these requirements during the public health emergency were important steps towards ensuring the health and stability of Medicaid beneficiaries during the pandemic. New York should maintain these policies to remove barriers that result in increased health risks and disparities, and cut down on administrative burden and waste.
- III. Extend automated renewal of MSP cases to New York City,** to give parity with upstate recipients, decrease paperwork burden on both MSP beneficiaries and local agencies, and decrease the likelihood that beneficiaries will lose coverage (NYS DOH directive 12-ADM-04).

* * *

We know that there are many critically important issues that you are tackling in the weeks to come and that you are skilled at developing policy platforms that are both pragmatic and compassionate. Given the urgency of the potential Medicaid coverage losses next year which will disproportionately impact elderly New Yorkers and individuals with disabilities, we hope that you will consider the three proposals attached as you develop your Executive Budget. We welcome the opportunity to meet with your staff to discuss these issues in more detail and to assist in any way we can help as you define your Administration's policy agenda to reduce poverty, expand access to health care and ameliorate racial and economic injustice.

Sincerely,

Maria Alvarez
Executive Director
New York StateWide Senior Action Council

Elisabeth Ryden Benjamin
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Community Service Society of New York

Valerie Bogart
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Rebecca Antar Novick
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The Legal Aid Society

Frederic Riccardi
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Medicare Rights Center

Other endorsing organizations (list in formation):

504 Democratic Club
Access to Independence of Cortland County, Inc.
The Arc New York
BRIDGES
Bronx Jewish Community Council, Inc.
Brooklyn Center for Independence of the Disabled
CaringKing, The Heart of Alzheimer's Caregiving
Center for Elder Law and Justice
Center for Independence of the Disabled, NY
Coalition for the Homeless
Community Health Care Association of New York State
Congregation of the Sisters of St. Joseph
Consumer Directed Personal Assistance Association of New York State
DOROT
Empire Justice Center
The Family Center
Finger Lakes Independence Center - Ithaca, NY
Fountain House
Gateway Hudson Valley

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Health and Welfare Council of Long Island
Health Care For All New York
Health People
Housing Works, Inc.
Independence Care System, Inc.
Independent Living, Inc.
Iris Bikel, Attorney at Law
JASA
JASA Legal Services for Elder Justice
Law Offices of Irina Yadgarova, PLLC
Lenox Hill Neighborhood House
LiveOn NY
Long Island Center for Independent Living, Inc.
Long Term Care Community Coalition
Mental Health Association of Nassau Co.
Mercy Haven, Inc.
Metro New York Health Care for All
MISN (Maternal Infant Services of Orange, Sullivan and Ulster Counties)
Mobilization for Justice, Inc.
Mothers and Babies Perinatal Network of South Central New York, Inc.
New York Association of Psychiatric Rehabilitation Services
New York Association on Independent Living
New York State Nurses Association
NY MetroVets
People Organized for Our Rights, Inc. (P.O.O.R.)
Primary Care Development Corporation
Selfhelp Community Services
Sickle Cell Thalassemia Patients Network
Southern Tier Independence Center
Special Support Services
Sundance SADC
Urban Justice Center Mental Health Project
Westchester Sickle Cell Outreach, Inc.
Western New York Independent Living
Western New York Law Center

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Robert Mujica, New York State Division of the Budget



Raise the NY Medicaid Aged, Blind & Disabled (ABD) Income Level End the Senior Penalty

Problem:

Most adult New Yorkers with incomes up to 138% of the Federal Poverty Level (FPL) (\$1,468 or \$1,983 for couples) are eligible for free Medicaid because of the Affordable Care Act (ACA). The ACA, however, did not change the income level for the Medicaid Aged, Blind & Disabled (ABD) Program, which in New York is only \$884 and \$1300 for a couple per month. While not based on the FPL, these amount to just 84% and 89% FPL, respectively. For over forty years, the ABD Medicaid levels have been tied to the Supplemental Security Income (SSI) State Supplement cash benefit level—well below 100% FPL. Older adults and younger adults with disabilities can only qualify for free Medicaid if their incomes are below those levels. Adults who are eligible for free Medicaid under the ACA fall off the Medicaid cliff when they obtain Medicare – when they turn 65, or earlier, after they have received Social Security Disability benefits for two years.

The only way for older adults and adults with disabilities with income above 84% FPL to access Medicaid benefits is to pay a monthly Medicaid “**spend-down**”—the difference between their countable income and the Medicaid ABD limit. Every dollar over these limits must be spent on medical care each month or paid directly to Medicaid—like a monthly insurance deductible—in order for Medicaid to pay any medical expenses *above* those thresholds.

Here are examples of who falls off the Medicaid cliff because of age or disability:

- **Jerome**, receiving free Medicaid at age 64 with Social Security of \$1,450/month, will fall off the Medicaid cliff when he turns 65, requiring him to spend down \$550/mo. on medical expenses he cannot afford. Nor can he afford a Medigap policy to subsidize the high out-of-pocket Medicare costs of his chemotherapy.
- **Josefina** received free Medicaid at age 43 when she began receiving \$1,400 in monthly Social Security Disability benefits because of Multiple Sclerosis. She will fall off the Medicaid cliff two years later when her Medicare begins, requiring her to spend down \$500 each month on medical bills that she cannot afford. She needs Medicaid for home care services to enable her to live safely at home.

Forced between paying for rent and food or their Medicaid spend-down, many older adults and adults with disabilities forego needed medical services, prompting them to move into nursing homes at a high cost to the state and an even higher personal cost to their own independence and well-being. Those who try to submit proof of medical expenses to “spend down” confront a byzantine Medicaid bureaucracy each and every month. This is a huge burden on the local Medicaid offices and results in

frequent errors and delays in authorizing coverage that harm consumers – and the process is repeated every month.¹

The Solution: Increase the Medicaid Limit to 138% FPL

New York must raise the income limit to 138% FPL, so that adults no longer fall off the Medicaid cliff when they turn 65 or obtain Medicare earlier based on disability. The abysmally low income limits hurt the poorest New Yorkers the most, who are disproportionately people of color. People with incomes above 138% FPL will still need to “spend-down” to the Medicaid limits, but they already shelter their “excess income” in a Pooled Income Trust, which *eliminates* their spend-down, and the trust in turn pays their rent and other living expenses. It is lower income people—with monthly incomes between \$900 and \$1,468—a large proportion of whom are people of color—who lack the cash flow to pay the upfront expenses of enrolling in these trusts, and to pay an elder law attorney to navigate the complex bureaucratic steps of gaining Medicaid approval of the trust. See <http://www.wnylc.com/health/entry/44/>.

The Technicalities

Federal Medicaid law requires a two-step process to increase the Medicaid level.

1. First, federal law sets a cap for the state “Medically Needy Income Level” (MNIL)—the income limit used for populations not covered by the ACA. The MNIL may not exceed 133 1/3 percent of the state’s 1996 AFDC cash benefit payment level adjusted by the Consumer Price Index. Most states comply with this limit by setting their MNIL at 100% FPL; New York sets it even lower, at the minimum required by federal law—the same level used for the SSI state supplement. We urge adopting 100% FPL as the MNIL because the FPL limits are adjusted annually, unlike the current formula requiring annual state legislative adjustments.
2. Second, federal law allows states to disregard a specified amount of income above the MNIL, effectively raising the Medicaid income limit. New York should follow California’s lead, where the MNIL was set at 100% FPL, and in 2020 California implemented a new disregard of all income above 100% FPL up to 138% FPL. Pending federal approval of that new disregard, California law set a specific disregard of the actual difference between 100% and 138% FPL.

Below is a proposed legislative amendment following California’s model.

The Cost

This change will reduce or eliminate the spend-down for older adults and people with disabilities already on Medicaid. More than half of all spend-down recipients are in nursing homes, and would not be impacted by this change, since all of their income except for a small personal needs allowance must be contributed to the cost of care. Any increased State cost from reducing the spend-down is only for people using Medicaid for community-based care or hospital stays, costs which are paid primarily by Medicare. The Manatt Report estimated that there were then only about 67,000 people using spend-down in the community, with an average spend-down of \$200/month and median of \$100/month, with a small minority with higher spend-downs.² Also, some of the 90,000 people now only enrolled in

¹ See Manatt Health Solutions, *Streamlining New York’s Medicaid Excess Income Program* (NYS Health Foundation May 2009), available at <https://www.manatt.com/getattachment/435f05c1-abbf-4e3e-8959-486c2a5b44fd/attachment.aspx> at p. 21 [hereafter “Manatt Report”].

² Manatt Report at p. 21. That report used 2007 data, at which time the FPL was \$851/month and the NYS ABD Medicaid level was \$700/mo. or 82% FPL. NYS GIS 07-MA-005 Attachment 1.

Medicare Savings Programs but not in Medicaid will qualify for free Medicaid, if their assets are within the Medicaid limits.³ Based on these figures, the proposal will help about 200,000 current and new recipients. If their average spend-down cost is \$250, see n 2, the State share will cost at most \$300 million (half of full cost). But since higher income people are already *eliminating* their spend-down with pooled trusts, and since not every eligible person will actually use Medicaid every month (since Medicare is their primary insurer) the actual estimated cost is \$150 million.

It is time to align New York's Medicaid programs to ensure that our low-income older adults and adults with disabilities are treated fairly and can afford to access medical care.

Proposed Amendments to Social Services Law § 366. Eligibility

2. (a) The following income and resources shall be exempt and shall not be taken into consideration in determining a person's eligibility for medical care, services and supplies available under this title:

(7) income based on the number of family members in the medical assistance household, as defined in regulations by the commissioner consistent with federal regulations under title XIX of the federal social security act and that does not exceed 100 percent of the Federal Poverty Level; calculated as follows:

~~(i) The amounts for one and two person households and families shall be equal to twelve times the standard of monthly need for determining eligibility for and the amount of additional state payments for aged, blind and disabled persons pursuant to section two hundred nine* of this article rounded up to the next highest one hundred dollars for eligible individuals and couples living alone, respectively.~~

~~(ii) The amounts for households of three or more shall be calculated by increasing the income standard for a household of two, established pursuant to clause (i) of this subparagraph, by 15 percent for each additional household member above two, such that the income standard for a three-person household shall be 115 percent of the income standard for a two-person household, the income standard for a four-person household shall be 130 percent of the income standard for a two-person household, and so on.~~

(i) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), all countable income over 100 percent of the federal poverty level, up to 138 percent of the federal poverty level, shall be disregarded, after taking all other disregards, deductions, and exclusions under federal and state law into account for those persons eligible pursuant to this section. The Commissioner shall seek federal approval to implement this paragraph.

https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/07ma005att1.pdf. Since then, both the FPL and the NYS Medicaid level have increased by 26%. Applying the same percentage increases to the 2007 spend-down amounts, the average spend-down would now be \$250/month and the median \$125/mo.

³ The Medicare Savings Program has no asset limit in New York State. 2020 data available at <https://public.tableau.com/app/profile/lauren.popham/viz/MedicareSavingsProgramEnrollment2007-September2020/Story1>.

(ii) Until such time as the Commissioner obtains federal approval for the income disregard described in paragraph (7)(i) of this section, an additional two hundred thirty dollars (\$230) for an individual or, in the case of a couple, three hundred ten dollars (\$310) shall be disregarded from countable income, in addition to all other disregards, deductions, and exclusions under federal and state law for those persons eligible pursuant to this section. Upon receipt of federal approval for, and implementation of, subparagraph (7)(i), this subparagraph shall become inoperative.



Eliminate or Increase the Medicaid Asset Test

Enable Self-Sufficiency for Older Adults and Adults with Disabilities on Medicaid

Problem:

The outdated Medicaid asset test drives financial instability for older adults and adults with disabilities in a racially inequitable way. An older adult enrolled in the NYS Aged, Blind & Disabled Medicaid program (ABD) is restricted to \$15,900 in a bank account and a couple to \$23,400. Except for miniscule annual cost of living increases, these limits were last increased in 2008 to align with the Family Health Plus asset limits – the NYS health insurance program for families and adults under age 65 that became the model for the Affordable Care Act (ACA). However, the ACA’s elimination of the Medicaid asset test nationally in 2014 excluded older adults and adults with disabilities, who still must meet a strict asset limit that denies them adequate resources to weather a crisis, such as an eviction or a leaking roof, or to supplement their income to meet everyday expenses. Denying them Medicaid until they have spent down their savings puts them at risk of further instability or homelessness when financial crises happen. These rules also disproportionately punish older adults of color and adults with disabilities because they are more likely to have cash savings, instead of an exempt home.

Falling off the Medicaid Cliff

Sam, age 63 with \$40,000 in savings, qualifies for Medicaid under the ACA. Once he becomes enrolled in Medicare, however, whether at age 65 or earlier if he is disabled, he will fall off the Medicaid cliff because his assets exceed the Medicaid asset limit. With Social Security benefits of \$1,400/month, he depends on his savings to pay his rent of \$1,100 and other bills. Forcing him to spend down his assets puts him at risk of eviction.

The elimination of the asset test in public programs reflects a shift away from requiring low-income people to deplete all their resources prior to receiving help. For example, NYS has no asset limit in the EPIC prescription drug program for older adults, eliminated the asset test in the Medicare Savings Program in 2008, and virtually eliminated the asset test for SNAP benefits for households earning less than 200% of the federal poverty level.

Both California and Arizona have eliminated their Medicaid ABD assets test completely to simplify eligibility determinations. One barrier to implementing the long-planned transition of ABD Medicaid cases from local districts to the state-administered NYS of Health exchange is the need to scrutinize assets for this population. NYS of Health administers Medicaid under the ACA only, which has no asset limit. Whether or not that transition of administration happens, aligning Medicaid asset eligibility for different populations will save millions in local administration costs.

Updating and expanding the Medicaid asset limits will decrease inequality. The Medicaid program has long allowed certain exclusions to the assets test, including the applicant’s own home. These policy choices lead to racial inequities given the disparities in homeownership between black and Latinx New Yorkers and white new Yorkers, as well as disparities for people with disabilities. For example, a low-

income older adult who owns an expensive co-op in Manhattan can qualify for Medicaid, limited only by an equity cap of \$906,000 if seeking long-term care services, but a renter with the same income would not get Medicaid if they had \$17,000 in the bank. New York is among the eight states with the highest “asset poverty rate,” which is defined as having three months’ of living expenses saved at the poverty level.¹ **New York has the highest asset poverty rate for Latinx households nationally**—53.4% compared to 17.2% for white households in NYS, compared to national rates of 35.4% for Latinx households and 18.5% for white households. Id. New York has the sixth highest asset poverty rate nationally for households of color—40.8% compared to 17.2% for white households, and the sixth highest asset poverty rate for households with an adult with a disability—47.4% compared to 25.3% for non-disabled households. Id. Eliminating or at least significantly raising the Medicaid asset limit will increase financial stability so older adults can save for a crisis and decrease inequality based on race and disability so older adults of color and with disabilities aren’t punished for disparities in homeownership. Given these high asset poverty rates, any concern about the floodgates opening if the asset limit is lifted is unjustified.

Finally, lifting or eliminating the asset limit will ameliorate the hardship caused if the 30-month “lookback” for Medicaid community-based long term care enacted in the SFY 2020-21 Budget, is implemented, which we strongly oppose. Sam, in the example above who has \$40,000 in savings, will not be required to spend \$24,000 in so-called “excess” assets in order to qualify for Medicaid or suffer a “transfer penalty” if he transfers \$24,000 to a trusted family member to hold for his future use. The transfer penalty would disqualify him from receiving Medicaid home care for 2.3 to 3.5 months (depending on where he lives in NYS).

Solution:

- Follow the lead of California and Arizona and eliminate the Medicaid asset test for older adults and adults with disabilities. Alternately, phase in elimination of the asset limit pending federal approval as California has done, by increasing it to \$130,000 for an individual plus \$65,000 for each additional family member.
- Repeal the lookback for community-based long term care enacted in SFY 2020-21, which has not yet been implemented because of a federal moratorium forbidding states from restricting eligibility during the Public Health Emergency.

¹ New York’s asset poverty rate, including the equity in a home, is 26.9 % higher than the national average of 24.1%, based on 2016 data. Prosperity Now Scorecard, available at <https://scorecard.prosperitynow.org/data-by-issue#finance/outcome/asset-poverty-rate>.



Expand Income Limits for the NYS Medicare Savings Program

Purpose

The three Medicare Savings Programs (MSP) provide crucial financial support for low-income older adults and adults with disabilities, defraying Medicare premium costs. One of the MSP programs—Qualified Medicaid Beneficiary (QMB)—also covers Medicare coinsurance and deductibles. All MSP members are automatically enrolled in the Full Low Income Subsidy (LIS) for Part D, also known as “Extra Help,” which is fully funded by the federal government, and by [SSA’s estimate](#) saves consumers \$5,000 per year. **It’s time to follow Connecticut’s lead and increase the QMB income limit from 100% to 200% of the Federal Poverty Line (FPL),** and cover the cost of the Part B premium through the two **other MSP programs up to 250% FPL.**ⁱ Now eligibility for those programs only extends to 135% FPL. The monthly Part B premium, now \$148.50, has increased 41.5% just since 2015. Paying this monthly cost is a huge burden, with a disproportionate impact on people of color and people with disabilities who are more likely to have low income and assets.ⁱⁱ

The following charts show the current and **proposed** MSP levels in NYS.

NYS Medicare Savings Program – Current Income Limits & Benefits 2021					
FPL ⁱⁱⁱ	Monthly Income Limit		Part B premium PAID (\$148.50/mo)	Pays Medicare Deductibles & Coinsurance	Gets Extra Help with Part D
	Single	Couple			
100% or below	\$1,094	\$1,472	YES	YES	YES
101 – 135%	\$1,469	\$1,980	YES	NO	YES
136% - 200%	\$2,128	\$2,884	NO	NO	NO^{iv}
201 – 250%	\$2,704	\$3,650	NO	NO	NO

NYS Medicare Savings Program – Proposed Income Limits & Benefits 2021					
FPL ²	Monthly Income Limit		Part B premium PAID (\$148.50/mo)	Pays Medicare Deductibles & Coinsurance	Gets Extra Help with Part D
	Single	Couple			
100% or below	\$1,094	\$1,472	YES	YES	YES
101 – 135%	\$1,469	\$1,980	YES	YES	YES
136% -- 200%	\$2,128	\$2,884	YES	YES	YES
201 – 250%	\$2,704	\$3,650	YES	NO	YES

For more information, contact Medicaid Matters Coordinator, Lara Kassel, at lkassel@medicaidmattersny.org

Justification

Older New Yorkers and those with disabilities with incomes below 250% FPL often experience similar financial burdens to the Medicaid population, but they are ineligible for Medicaid and cannot afford private Medigap premiums. The proposal would pay their Part B premiums and reduce their drug costs by automatically enrolling them in Full LIS or Extra Help. For those under 200% FPL, the QMB MSP benefit would also eliminate most out of their pocket Medicare health care costs.

EXAMPLE: Maria, whose income is \$2,148 (200% FPL) spends 6% of her income on the monthly Part B premium. She also has an annual Part B deductible and, if she is hospitalized, another deductible of \$1,484. Her Medicare coinsurance for outpatient costs can be thousands of dollars. She has an EPIC deductible of \$780 before EPIC will help with any prescription drug costs. With rent of \$1,400/month, she cannot afford an expensive Medigap premium, which run at least \$270/mo. Expansion of the QMB MSP limit would cover all of her Medicare costs and automatically enroll her in full Extra Help for Part D, reducing her drug costs—as well as those of the EPIC program.

States like Connecticut and Maine have already increased their QMB eligibility limit from 100% to 200% and 140%, respectively.^v Increasing the income limits reduces administrative burden and state administrative spending.^{vi}

Cost estimate

Approximately 384,000 New York Medicare beneficiaries have incomes between 135% and 200% FPL and would newly qualify for QMB under this proposal.^{vii} However, we can assume that only 40% of the eligible population (153,600 persons) will enroll, as this is the participation rate for MSP currently (excluding individuals who have both an MSP and Medicaid). **The estimated cost of paying for the Part B premium for the expanded population would be \$137 million** (a 23.4% increase to the current cost the state pays for QMB and SLMB Part B premiums, including for those who also have Medicaid). Estimates use the annual cost of the Part B premium in 2021 (\$1,782) and do not account for savings in administrative spending or in the NYS EPIC program.

There is a potential additional cost for QMB beneficiaries, since the program also pays Medicare coinsurance and deductibles. Moreover, in recent years, state law has reduced and even eliminated payment of coinsurance for QMB enrollees, since payment is made only at the “lesser” of the Medicaid or Medicare rate. When the Medicaid rate is lower, which it usually is, no payment is made to the provider. To the extent some payment is made, the federal share is 50 percent.^{viii}

An additional 137,000 New York Medicare beneficiaries would qualify for SLMB based on the proposed expansion. Adjusting for participation rates, there is an added cost of \$97 million for adding people whose income is between 201% - 225% FPL. The expansion of Q1-1 eligibility has no state cost because it is entirely paid by the federal share.^{ix}

Shifting almost 300,000 older adults from the NYS Elderly Pharmaceutical Insurance Coverage (EPIC) program, which is fully funded by the State, to the Full LIS Extra Help Part D subsidy, which is fully federal funded, will save the state millions of dollars when EPIC costs will drop significantly, offsetting the costs of the expansion. Based on available EPIC expenditure data, MSP expansion would save the state approximately \$76 million in EPIC costs.^x

For more information, contact Medicaid Matters Coordinator, Lara Kassel, at
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ⁱ Within the 201-250% FPL bracket, we propose those under 225% would qualify for the “SLIMB” MSP benefit, and those from 226& - 250% FPL would be in the “QI-1” program. The main difference is that the federal share for QI-1 is 100%, while the federal share for QMB and SLIMB is 50% as it is for Medicaid.

ⁱⁱ See 2019 report finding the overall poverty rate among older New Yorkers in 2017 was 14 percent. However, U.S.-born Latinx New Yorkers 65 and older had the highest rates of older adult poverty, at 26 percent. Asian American older adults have the second-highest poverty rate, at 22 percent, followed by African American older adults at 19 percent. The poverty rate for older immigrants is 20 percent statewide. Center for an Urban Future, *NEW YORK’S OLDER ADULT POPULATION IS BOOMING STATEWIDE*, Feb. 2019, available at <https://nycfuture.org/research/new-yorks-older-adult-population-is-booming-statewide>.

ⁱⁱⁱ These income limits include a standard \$20 disregard.

^{iv} Those with income between 135% - 150% FPL can apply to the Social Security Administration for “Partial” LIS or Extra Help. But the asset limit is lower than the NYS Medicaid asset limit, and the drug subsidy more limited.

^v [MACPAC 2016 report](#), page 293

^{vi} [MACPAC 2020 report](#)

^{vii} Using the 2019 American Community Survey 1-Year Estimates available at data.census.gov.

^{viii} [50% FMAP for SLMB and QMB](#)

^{ix} [100% federal match for QI](#)

^x [EPIC annual report from 2009-2010](#) totaled the state’s EPIC payments at \$333 million, with approximately \$310 million coming from participants with annual incomes of \$35,000 or less. The total cost of expanding QMB and SLMB is \$234 million. The resulting savings from LIS enrollment are an estimated \$76 million.