NAMD
National Association of Medicaid Directors

October 14, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 201510

The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Paul Ryan
Chairman
House Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
House Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Hatch, Ranking Member Wyden, Chairman Upton, Ranking Member Pallone, Chairman Ryan, and Ranking Member Levin:

We write to respectfully urge Congress to take immediate action to nullify the impact for states from the pending Medicare Part B premium and deductible increases for calendar year 2016. Federal officials project this increase could be as high as 52 percent for millions of Medicare enrollees -- many of whom have their premiums paid for by the Medicaid program. Enclosed is a chart prepared by the Federal Funds Information for States (FFIS), which provides preliminary estimates of the state-by-state costs in excess of $2 billion in the near term.

Shifting state resources to accommodate this unprecedented increase will put undue pressure on state Medicaid programs, as well as other state programs and priorities. Further, the timing

of the increase – which comes in the middle of most state fiscal years, and in some cases biennial budgets– further exacerbates the challenge for state budgets and Medicaid leadership.

On a more fundamental level, we question the policy reasoning for making the states, via their Medicaid programs, responsible for Medicare's fiscal solvency. States are not in a position to influence Medicare policies or spending in any meaningful way, yet are nonetheless accountable for providing significant contributions to the Medicare trust fund.

In circumstances like the ones leading to the 2015 Medicare Trustee Report projections, driven by high Part B spending and federal policy changes beyond state control, Congress should develop a mechanism for keeping the impact on states predictable, reasonable, and sustainable. Requiring the states to subsidize the benefits of 70% of Part B beneficiaries in an environment of ever-increasing Part B spending is not a sustainable long-term solution. Cost savings within the Medicare program itself should be the primary contributor to solving its fiscal troubles, not cross-subsidizations from the Medicaid program.

NAMD stands ready to work with you to address the immediate cost shift to states for 2016 as well as potential solutions to address the longer term Medicare Part B premium policy issues. We appreciate your consideration of this time sensitive issue.

Sincerely,

Matt Salo
Executive Director

Enclosure:
Federal Funds Information for States, "Medicare Part B Premiums for Dual Eligibles Projected to Increase 52% in CY 2016," September 28, 2015

FEDERAL FUNDS INFORMATION FOR STATES
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Issue Brief 15-30, September 28, 2015

Medicare Part B Premiums for Dual Eligibles Projected to Increase 52% in CY 2016

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Summary

A recent Medicare Trustees report estimated a substantial increase in monthly Medicare Part B premiums in calendar year (CY) 2016 for some beneficiaries due to a hold-harmless provision and to maintain adequate contingency reserves. According to the report, Social Security beneficiaries are expected to see a 0% cost-of-living adjustment (COLA) in 2016. If this occurs, it would trigger a hold-harmless provision that prevents most Medicare beneficiaries (those that have Medicare Part B premiums deducted from their monthly Social Security benefits) from seeing an increase in their monthly Medicare Part B premiums.

Under this scenario, remaining beneficiaries, including those individuals who qualify for both Medicare and Medicaid (dual eligibles), could see a 52% increase in their monthly premiums, from $104.90 in CY 2015 to $159.30 in CY 2016. Because Medicaid pays the Part B premiums for dual eligibles, FFIS estimates that the state share of Medicaid costs would increase by $2.3 billion in CY 2016 if the monthly premiums increase to $159.30. The Department of Health and Human Services (HHS) is expected to announce the final 2016 monthly premiums in mid- to late October.

Background

Medicare Part B is the voluntary portion of Medicare that pays all or part of the cost of physicians' services, outpatient hospital services, certain home health services, services furnished by rural health clinics, ambulatory surgical centers, outpatient rehabilitation facilities, and other medical and health services not covered by Medicare Part A, Hospital Insurance. Part B beneficiaries share in the cost of the program through the payment of premiums and cost-sharing. Low-income individuals may qualify for subsidies through Medicaid, which cover all or part of their Part B premiums.

Those low-income beneficiaries that receive full premium assistance fall into one of the following dual-eligible categories:

- **Qualified Medicare Beneficiaries (QMBs).** QMBs are aged or people with disabilities with incomes at or below the federal poverty level (FPL). QMBs are entitled to have their Medicare cost-sharing charges (premiums, deductibles, and coinsurance) paid by Medicaid. These beneficiaries are not entitled to coverage of Medicaid plan services unless they are otherwise eligible for Medicaid. The federal

government reimburses a portion of state spending on this group based on the Federal Medical Assistance Percentage (FMAP).

- **Specified Low-Income Beneficiaries (SLIMBs).** SLIMBs meet the QMB criteria, except that their income is above the QMB limit. The SLIMB income limit is 120% of FPL. Medicaid coverage is limited to payment of the Medicare Part B premium (unless the individual is otherwise entitled to Medicaid). The federal government reimburses a portion of state spending on this group based on the FMAP.
- **Qualifying Individuals (QIs).** These individuals meet the QMB criteria, except that their income is between 120% and 135% of FPL. These individuals are not otherwise eligible for Medicaid. Medicaid is limited to payment of the Medicare Part B premium. The federal government pays 100% of these costs, up to a capped allotment. States are not required to provide QI cost-sharing to the extent that doing so would exceed their capped allotment.

Premium Increase

HHS determines the monthly Part B premium amount on a calendar year, based on the amount required to cover 25% of the expected average total cost of Part B coverage for aged enrollees, which includes a contingency reserve. Federal general revenues cover the remaining Part B program costs.

The Social Security Act includes a hold-harmless provision that prevents Medicare beneficiaries who have their premiums deducted from their monthly Social Security benefits from seeing a reduction in Social Security payments compared to the previous year as a result of Medicare Part B premium increases. When the hold-harmless provision is triggered, beneficiaries not covered by the hold-harmless provision must pay an even higher premium to satisfy the requirement that 25% of the financing comes from beneficiary premiums.

The National Health Policy Forum estimates that approximately 69% of Part B beneficiaries are subject to the hold-harmless provision in CY 2016. Those beneficiaries not covered are:

- new enrollees and beneficiaries who do not participate in Social Security (8%)
- higher-income individuals who are required to pay an income-related surcharge in addition to the monthly premium (6%)
- individuals who are dually eligible for Medicare and Medicaid (17%)

The standard monthly Part B premium rate is $104.90 in CY 2015, the same as CY 2014. The 2015 Medicare Trustee Report estimates that beneficiaries not covered by the hold-harmless provision would face a premium of $159.30 for CY 2016, a 52% increase.

According to the report: ‘‘Under current law, Part B premiums for other beneficiaries must be raised substantially to offset premiums foregone due to the hold-harmless provision, to prevent asset exhaustion, and to maintain a contingency reserve that accommodates normal financial variation.”

Without the hold-harmless provision, the report estimates that beneficiaries

would see monthly premiums of $120.70 in CY 2016, a 15% increase due to higher-than-expected costs.

Medicaid Impact

Table 1 shows the estimated state impact of the premium increase on Medicaid costs if the hold-harmless provision is triggered and monthly premiums for dual-eligibles are $159.30. Overall, the state share of Medicaid would increase by approximately $2.3 billion in CY 2016. Table 1 also shows the estimated state impact if the hold-harmless isn't triggered and Part B premiums increase to $120.70. Under this scenario, the state share of Medicaid would increase by approximately $678 million in CY 2016.

The estimates rely on fiscal year (FY) 2015 total expenditures for Medicare Part B premiums as reported by states in the May 2015 CMS-37 report. **Alaska**, **Connecticut**, **Pennsylvania**, **Vermont**, and **Virginia** did not report Medicare Part B premium data in the May 2015 CMS-37. For these states, FFIS relied on the November 2014 CMS-37 report. **Puerto Rico** and **American Samoa** reported $0 expenditures in both reports so FFIS was unable to calculate estimates for these jurisdictions. The state share is determined by applying final FY 2016 FMAPs for January 1, 2016-September 30, 2016, and FFIS projections of FY 2017 FMAPs for October 1, 2016-December 31, 2016. (Note: FFIS will update the estimates provided in this brief when it calculates final FY 2017 FMAPs based on the Bureau of Economic Analysis release of per capita personal income data on September 30, 2015.)

Next Steps

On October 15, the Bureau of Labor Statistics will release the final data needed for the Social Security Administration to calculate the CY 2016 COLA adjustment. HHS will announce the final standard and income-related Part B premiums for 2016 by the end of this calendar year. (Typically, the announcement is made in October.) According to news reports, the secretary of HHS said the final decision about the 2016 rates will be based on the preliminary projections, subject to additional data, and the administration's consideration of policy options. In addition, Congress could pass legislation to address this issue and modify the rates.

FFIS will report on the final Part B premiums and their impact on state Medicaid costs once they are released.

Table 3

Estimated Medicaid Impact of Part B Premium Increase, CY 2016

(dollars in thousands)

State	Total FY 2015 Medicaid Spending on Medicare - Part B Premiums	With Hold-Harmless: Estimated Total Cost of Premium Increase	With Hold-Harmless: Estimated State Cost of Premium Increase	Without Hold-Harmless: Estimated Total Cost of Premium Increase	Without Hold-Harmless: Estimated State Cost of Premium Increase
Alabama	$236,290	$122,540	$36,817	$35,585	$10,692
Alaska*	22,945	11,899	5,950	3,456	1,728
Arizona	209,510	108,652	33,655	31,552	9,773
Arkansas	144,248	74,807	22,500	21,724	6,534
California	1,457,141	755,673	377,837	219,445	109,723
Colorado	111,712	57,934	28,608	16,824	8,308
Connecticut*	189,991	98,529	49,265	28,613	14,306
Delaware	31,556	16,365	7,377	4,752	2,142
District of Columbia	37,003	19,190	5,757	5,573	1,672
Florida	870,118	451,243	176,696	131,040	51,312
Georgia	249,775	129,533	41,933	37,616	12,177
Hawaii	34,075	17,671	8,120	5,132	2,358
Idaho	42,564	22,074	6,373	6,410	1,851
Illinois	357,240	185,265	90,979	53,800	26,420
Indiana	205,377	106,509	35,545	30,930	10,322
Iowa	96,522	50,056	22,459	14,536	6,522
Kansas	75,650	39,232	17,258	11,393	5,012
Kentucky	210,000	108,906	32,326	31,626	9,387
Louisiana	195,061	101,159	38,276	29,376	11,115
Maine	102,304	53,055	19,791	15,407	5,747
Maryland	145,690	75,555	37,777	21,941	10,970
Massachusetts	271,222	140,656	70,328	40,846	20,423
Michigan	302,079	156,658	53,910	45,493	15,655
Minnesota	162,965	84,514	42,257	24,543	12,271
Mississippi	183,830	95,334	24,546	27,685	7,128
Missouri	167,982	87,115	32,013	25,298	9,296
Montana	27,320	14,168	4,933	4,114	1,432
Nebraska	43,836	22,733	11,080	6,602	3,218
Nevada	59,669	30,944	10,820	8,986	3,142
New Hampshire	26,477	13,731	6,865	3,987	1,994
New Jersey	246,041	127,597	63,798	37,054	18,527
New Mexico	88,624	45,960	13,603	13,347	3,950
New York	798,299	413,998	206,999	120,224	60,112
North Carolina	330,211	171,247	57,779	49,730	16,779
North Dakota	11,967	6,206	3,103	1,802	901
Ohio	333,603	173,007	65,055	50,241	18,892
Oklahoma	119,620	62,035	24,259	18,015	7,045
Oregon	134,496	69,750	24,906	20,255	7,233
Pennsylvania*	425,782	220,811	105,967	64,123	30,773
Rhode Island	41,630	21,589	10,715	6,269	3,112
South Carolina	157,140	81,493	23,547	23,665	6,838
South Dakota	21,625	11,215	5,388	3,257	1,565
Tennessee	325,358	168,731	59,009	48,999	17,136
Texas	715,083	370,842	159,406	107,691	46,291
Utah	39,680	20,578	6,136	5,976	1,782
Vermont*	2,304	1,195	552	347	160
Virginia*	188,406	97,707	48,854	28,374	14,187
Washington	218,693	113,414	56,707	32,935	16,468
West Virginia	96,350	49,967	14,258	14,510	4,141
Wisconsin	135,180	70,104	29,300	20,358	8,509
Wyoming	8,328	4,319	2,159	1,254	627
Puerto Rico	N/A	N/A	N/A	N/A	N/A
Virgin Islands	147	76	34	22	10
American Samoa	N/A	N/A	N/A	N/A	N/A
Guam	1,180	612	275	178	80
Northern Mariana Islands	545	283	127	82	37
TOTAL	**$10,710,444**	**$5,554,436**	**$2,333,986**	**$1,612,993**	**$677,783**

Note: FFIS calculations based on total FY 2015 expenditures for Medicare Part B premiums as reported by states in the May 2015 CMS-37 report. For those states with an "*", data wasn't reported in the May report so FFIS relied on the November 2014 CMS-37. No expenditures were reported in either report for Puerto Rico or American Samoa.