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HELPING THOSE WHO NEED IT MOST: LOW-INCOME SENIORS AND THE NEW MEDICARE LAW

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

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CONTENTS

	Page
Opening Statement of Senator Larry E. Craig	1
Opening Statement of Senator John Breaux	2

PANEL I

Mark McClellan, M.D., Ph.D., administrator, Centers for Medicare and Medicaid Services	3

PANEL II

Gail Wilensky, Ph.D., John M. Olin senior fellow, Project Hope, former administrator, Health Care Financing Administration, Bethesda, MD	44
Byron Thames, M.D., trustee, American Association of Retired Persons, Orlando, FL	59
Jane Delgado, Ph.D., M.S., president and CEO, The National Alliance for Hispanic Health; founding member, The Access to Benefits Coalition, Washington, DC	71
Patricia B. Nemore, attorney, Center for Medicare Advocacy, Inc., Washington, DC	91

APPENDIX

Material submitted by Laura Summer and Lee Thompson, Center on an Aging Society, Georgetown University Health Policy Institute	121

HELPING THOSE WHO NEED IT MOST: LOW-INCOME SENIORS AND THE NEW MEDICARE LAW

MONDAY, JULY 19, 2004

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 2 p.m., in room SD–628, Dirksen Senate Office Building, Hon. Larry E. Craig (chairman of the committee) presiding.

Present: Senators Craig, Breaux and Stabenow.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG, CHAIRMAN

The CHAIRMAN. Good afternoon, everyone, and welcome to the Senate Special Committee on Aging. The new Medicare law enacted last fall represents the most substantial expansion and improvement in the program since its creation 39 years ago. Not surprisingly, debate about this new law was and remains quite spirited. However, there is one aspect of the new program about which few should disagree. It is this: the new Medicare law offers dramatic new assistance, billions of dollars of it, for seniors of modest and low income.

Those seniors who are struggling the hardest to pay for their prescriptions are precisely the seniors whom this bill targets most generously and that is as it should be.

We are here today to explore the specifics of what this legislation will mean for seniors in greatest economic need. Our discussion will begin with an updated look at how the new prescription drug card is doing and in particular ways in which CMS and its partners are working to bring the low income $600 transitional assistance to as many seniors as possible.

On this front, we will hear encouraging news from CMS Administrator Mark McClellan—Mark, welcome to the committee—who we are pleased to have with us today. I understand, for example, that seniors are now signing up for the cards at a rate of 25,000 per day. Yes, that is right. Twenty-five thousand per day and also that the drug price savings continues to be impressive.

CMS meanwhile continues to aggressively expand its outreach and enrollment efforts including improvement in the Price Compare web site and also through grant assistance to community-based organizations and to national coalitions. One of these, the Access to Benefits Coalition, will also be providing testimony today.

Even more importantly, we will also hear testimony about the new law's full drug benefit schedule to begin in 2006, and the ways in which low-income seniors stand to benefit tremendously under the new assistance that is now just 17 months away.

Nearly half the new law's funding is targeted especially to low-income seniors and more than one in three seniors will qualify for assistance. For the vast majority of these seniors, this will mean zero premiums, zero deductibles and no gaps in coverage and copays of just a few dollars per prescription.

It is difficult to imagine a stronger package. It is not to say this will be easy. This is a tremendously complex program, and it is being implemented on a very ambitious time table.

Our witnesses today will offer guidance on such critical questions as how we can tailor our outreach efforts more effectively. Reaching as many qualified beneficiaries as possible should be a top goal.

When debate over adding prescription drug benefits began several years ago, the guiding motivation was first and foremost to help those seniors who were struggling to make ends meet, to those seniors who were sometimes forced to choose between food and prescriptions. For those seniors in the greatest need, this new law is truly a godsend.

We have a remarkably accomplished panel of witnesses today, but before I turn to our panel, let me turn to my ranking colleague and partner here, Senator John Breaux of the great state of Louisiana.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman, and thank all of our witnesses who will be presenting testimony in what is an incredibly important subject for all of our nation's seniors. The Medicare legislation that Congress passed arguably was the most important change in Medicare since 1965 when we passed Medicare. It was very significant.

People do not run to Canada for hospitalization. They do not seek off on bus trips to Canada to see doctors in Canada. Why? Because Medicare covers both hospital visits and Medicare covers doctor visits. When Medicare is completely fully implemented in the drug program, the necessity of seniors to go to Mexico or to Canada or to an internet to order drugs from who knows where will cease to exist because for the first time in the history of the program seniors will have an adequate guarantee of drugs available to them and their families at a price that is affordable just as Medicare covers adequately the cost of hospitalization and the cost of doctor visits.

Getting from where we are today to where we want to be is not an easy task. Neither was it an easy task to implement Medicare back in 1965 when we created a national insurance program that covers hospitalization or later when the program was expanded to cover doctors as well.

You do not do these things overnight. That is why the first part of the journey toward complete insurance coverage for pharmaceuticals was a stopoff, if you will, with a Medicare drug discount card. I said at the time we were working on the program that the thing that I feared the most was that we would give seniors too

many choices. I am a big believer in people, particularly in the health care field, of having choices to choose the program or the plan, the hospital, the doctor, that is best for them.

I said at that time it would be very confusing for a senior to walk into the local drugstore and pull out his wallet or her purse and have 10 or 12, 15 different discount cards trying to figure out which one is best for them.

Truth is now there are over 70 discount cards. There are not 15; there are 70 to pick and choose from. So in the beginning of this program, it is not going to be easy, but the assistance that is offered is certainly worth the effort to try and ensure that you are, in fact, picking the best card for your needs. Or children who are helping their parents or grandchildren who are helping their parents or senior citizen centers and various parts of the country that are helping the senior pick the best card for them.

Mr. McClellan and Medicare, to their credit, as I understand it now, there is a program where you can sort of dial in, give a list of the drugs that you are on, and the computer system will kick back to you which is one of the better cards for you to utilize.

So this is a monumental and historic accomplishment. No accomplishments of that size and scope can be done without a few bumps in the road. So I am glad, Mr. Chairman, we are having a hearing today to see where those bumps are, how we are going to smooth them out, until we get to that point in time where prescription drugs are treated from an insurance standpoint just like hospitals and doctors are today. Thank you.

The CHAIRMAN. John, thank you very much for that fine statement, and now we will search for the bumps in the road because I think your analysis of it is very apropos.

Our first witness today is Dr. Mark McClellan, the new Administrator for the Centers for Medicare and Medicaid. As we all know, Dr. McClellan has what may well be the hardest job in Washington these days: overseeing implementation of the vast and complex new Medicare law. But if anyone is up to the task, I suspect you are, Mark. A former Commissioner of the Food and Drug Administration, Senior White House Health Advisor, professor and medical doctor, Dr. McClellan brings to this job an unprecedented array of experience. So we welcome you before the committee and are anxious to receive your testimony.

Please proceed, Mark.

STATEMENT OF MARK MCCLELLAN, M.D., PH.D., ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Dr. MCCLELLAN. Mr. Chairman, Senator Breaux, thank you for having me here this afternoon to discuss the new Medicare prescription drug benefit and thank you for your leadership in working together to bring overdue comprehensive drug coverage to the millions of low-income Medicare beneficiaries who too often have to struggle with paying for the cost of their drugs, on the one hand, and paying for their other basic necessities on the other.

While Medicare beneficiaries can get relief from high drug prices and high costs, the comprehensive help available for low-income beneficiaries is especially important, as you all noted. We deeply

appreciate the strong and constructive interest from so many people involved in policymaking and advocacy from so many perspectives in helping us implement the new law.

The new prescription drug relief for beneficiaries of limited means is critically important to get out as soon as possible, and we look forward to further public discussion and comment after we publish our proposed rules on the drug benefit to help make sure we are providing these comprehensive benefits as effectively as possible to the most vulnerable seniors and people with disabilities and Medicare.

While we are working to implement the new prescription drug benefit, we are also using the authority that Congress gave us to provide relief right now to beneficiaries who do not have good drug coverage through the Medicare prescription drug discount card. I am pleased to say that in a little over a month, as you mentioned, Mr. Chairman, approximately four million people have signed up for the program enrolling at a rate of about 25,000 every business day.

This includes close to a million lower income beneficiaries who are receiving the $600 credit in transitional assistance and some additional discounts. These beneficiaries are all receiving substantial savings on the drugs they need with prices for brand name drugs about 11 to 18 percent lower than what Americans pay on average even with the discounts they get from private insurance and Medicaid programs and they are getting much larger savings on mail order and generic drugs.

We are also pleased that seven major drug manufacturers are now offering large wraparound discounts for the low-income beneficiaries who use up their $600 credit.

The many brand name drugs with wraparounds include six of the top ten in terms of beneficiary spendings: Zocor, Lipitor, Celebrex, Fosamax, Norvasc and Vioxx. Generally, these prescriptions will cost at most $5 to $15, even after the $600 credit has been used. So this amounts to literally thousands of dollars of low-income assistance with drug costs available right now this year and again next year before the full drug benefit starts.

In addition, the Office of Management and Budget has provided guidance to all Federal agencies that transitional assistance available to low-income beneficiaries does not affect eligibility or benefits for any other Federal program.

Since the drug card program started just 6 months after the Medicare law was enacted, we continue to take steps to improve it, including new steps to make it easy to start getting real savings quickly on line at Medicare.gov and to make sure that when you call us at 1–800–MEDICARE anytime 24/7, you can quickly reach a trained customer service representative to get the personalized help you need and then find out about how to get real savings from the drug card, generally all done in well under 20 minutes.

We have also started some unprecedented collaborations with state health insurance assistance programs and private advocacy groups such as the groups making up the Access to Benefits Coalition to educate beneficiaries about this important new help. This is all leading up, as you mentioned, Mr. Chairman, to the comprehensive benefits that will be available to low-income bene-

ficiaries who enroll in the new Medicare prescription drug program beginning in 2006.

Although this voluntary benefit will be available to all of Medicare's 41 million beneficiaries, Congress specifically provided very generous help to those who need it the most, those with limited means or catastrophic costs.

Of those beneficiaries expected to enroll in the drug benefit, three groups of low-income beneficiaries will receive premium and cost-sharing subsidies such that their drug costs will range from almost nothing to only a few hundred dollars depending on the type of assistance for which they qualify.

The first group of approximately 6.4 million full benefit dual-eligible individuals will pay no premium or deductible and only have $1 to $3 copays for each prescription.

The second group, an estimated three million individuals with incomes lower than about $12,600 for an individual and $16,900 for a couple who meet the assets test, will pay no premium or deductible and only a $2 to $5 copayment for each prescription.

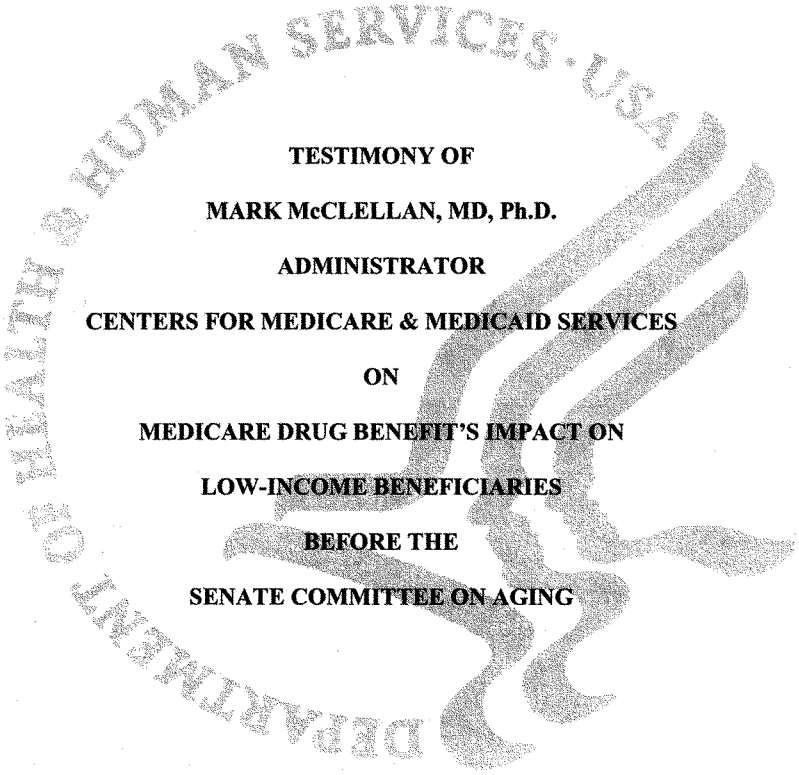
The third group of approximately 1.5 million Medicare beneficiaries with incomes of about $14,000 for an individual and $18,700 for a couple who meet the asset test will pay premiums based on a sliding scale, a $50 annual deductible and a 15-percent copayment on each prescription.

Institutionalized persons who are full benefit dual-eligibles are exempt from this cost sharing completely. When dual-eligible beneficiaries move from the Medicaid system to the new Medicare benefit, millions will no longer be subject to restrictions that many states have had to impose to limit costs but that may also limit quality of care such as restrictions on the number of prescriptions that can be filled each month or very strict formulary requirements.

So that is better, more comprehensive coverage for millions of Medicare beneficiaries and new comprehensive coverage for millions more with limited means. All together about a third of beneficiaries and almost half of minority beneficiaries can get the security of paying only a few dollars for the prescription drugs that they need.

We are moving ahead to use the new law to bring overdue relief to Medicare beneficiaries who are now struggling with the cost of prescription drugs. We look forward to continuing to work closely with you to provide more and more effective relief. Thank you for your time and I'm happy to answer any questions that you all may have.

[The prepared statement of Dr. McClellan follows:]



TESTIMONY OF

MARK McCLELLAN, MD, Ph.D.

ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICARE DRUG BENEFIT'S IMPACT ON

LOW-INCOME BENEFICIARIES

BEFORE THE

SENATE COMMITTEE ON AGING

JULY 19, 2004

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

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JULY 19, 2004

Chairman Craig, Senator Breaux, distinguished members of the Committee, I thank you for inviting me here this afternoon to discuss the new Medicare prescription drug benefit created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As you are well aware, with passage of the MMA, Congress took substantial steps in updating the Medicare system to reflect modern medical practice. For the first time, Medicare beneficiaries will be able to obtain significant assistance with the costs of outpatient prescription drugs. In addition, these same beneficiaries will be using their market clout to drive prices down so that the dollars spent by them and by the government on their behalf will be able to provide more medications than before. We at the Centers for Medicare & Medicaid Services (CMS) are particularly excited about the substantial assistance available to low-income beneficiaries under this new program.

Early Success

The Medicare-approved prescription drug discount cards, which became available one and a half months ago, are already providing substantially lower drug prices for almost four million individuals, almost a million of whom have low–incomes and qualify for literally thousands of dollars in additional assistance from the $600 credit this year and next, and from "wraparound"

deep discounts from eight major drug manufacturers if they use up their credit. About 25,000 additional beneficiaries are signing up every business day. CMS' analyses have shown that the cards generate savings on brand name drugs of between 11 and 18 percent from the average price paid by all Americans, even those with health insurance. This same study showed steeper discounts off of generic drugs, in the range of 35 to 65 percent from what is paid, on average, for prescription drugs by all Americans.

Savings for low-income beneficiaries are even more significant. The CMS' analysis found that low-income beneficiaries can save 32 to 86 percent over national average retail prices over a 7-month period, when both the discounts and $600 transitional assistance are taken into account. The analysis further found that Medicare beneficiaries do not have to choose the Medicare-approved drug discount card with the very best price to realize substantial savings. Low-income beneficiaries choosing the Medicare-approved card with the 10th best price, rather than the best price, could still save 28 to 72 percent over a 7-month period, when both the discounts offered and $600 are taken into account. Low-income beneficiaries enrolling in Medicare-approved drug discount cards also benefit from having the enrollment fee paid by Medicare; free (plus a dispensing fee) or low, flat-fee, prices ($12 or $15) on many commonly-used brand name drugs like Lipitor or Zocor when the $600 is exhausted; and, coordination between Medicare-approved drug discount cards and state low-income programs to make sure beneficiaries are enrolled to the extent possible.

To give a concrete example of how these savings are working, consider Mr. Vincent Casisi, who lives in Kansas City, Missouri. Prior to receiving his drug card and transitional assistance, Mr.

Casisi had monthly drug costs of $343 for the five medications he takes. Had the MMA not passed, he would be paying $6,174 over the next eighteen months for those drugs. With the savings generated by his card and the private program available through Pfizer, his monthly expenses will drop to $163. The additional $1,200 in transitional assistance lowers his expenses further, so that his total drug costs for the 18 months go from $6,174 to $1,734 for a savings of $4,440.

Ms. Claudine Jones, of Wynne, Arkansas, has used her card to purchase refills of the six medications she takes. Normally, these medications cost her about $100. The discounts available through her card lowered the cost to $66, a 34 percent reduction. When the transitional assistance she qualified for was added to the bill, her total costs dropped to $6.58, a 93 percent savings. Ms. Jones, who said she about fell over when she heard the final cost, had a credit card ready to pay her bill, but she was able to pay cash instead.

Outreach to Beneficiaries

The findings from CMS' studies and the relief obtained by real people like Mr. Casisi and Ms. Jones, underscore the importance of outreach to Medicare beneficiaries, particularly those with low incomes, to ensure that the maximum number of eligible beneficiaries follow the simple steps to enroll in a Medicare-approved drug discount card.

Enrollment in the drug card is a simple process. As we have emphasized in our educational materials provided to beneficiaries, as well as in materials to those who counsel beneficiaries, help is available 24 hours a day, 7 days a week by calling 1-800-MEDICARE. When

beneficiaries call, they just need to know their zip code and information on the drugs they take. If they think their level of income qualifies them for the $600 annual credit, they can provide that information as well. Beneficiaries can also get information on the subset of cards that most interest them. For example, they can tell the representative at 1-800-MEDICARE preferences they may have, such as their preferred pharmacy or whether they are interested in low-cost or no-cost cards.

We will continue to work to provide beneficiaries accurate and easy-to-understand information about the Medicare-approved drug discount cards. Indeed, on May 27, we announced that we were making $4.6 million available to assist community-based organizations inform and enroll seniors who qualify for the $600 annual credit, including working with the Access to Benefits Coalition, a group of over 75 diverse, national non-profit organizations, all of which are committed to helping low-income Medicare beneficiaries find significant savings on their prescription drugs. These organizations have extensive experience and credibility with the low-income beneficiary population. The CMS believes that this additional outreach will produce real results in terms of getting the benefit to seniors who are most in need.

In addition, HHS has called for applications from community-based organizations to help low-income beneficiaries learn about the Medicare-approved drug discount card and how to enroll. HHS will award up to $15,000 to grassroots organizations for innovative programs that will best reach people where they live. Community organizations that band together to reach these seniors and people with a disability could receive as much as $50,000. These contracts are in addition to the $21 million previously made available to the State Health Insurance Assistance Programs

(SHIPs), which provide one-on-one assistance to Medicare beneficiaries through trained volunteer counselors who are provided training from CMS. Furthermore, HHS' Administration on Aging (AoA) and Indian Health Service (IHS) are reaching out to their constituencies to encourage beneficiaries to sign up for the program.

I might note that CMS has already begun the process of informing beneficiaries about the formal drug benefit to be made available in 2006. On July 7, Secretary Thompson announced $125 million in grants to states to help educate low-income Medicare beneficiaries who currently get their prescription drugs through State Pharmaceutical Assistance Programs (SPAPs) about the new Medicare drug benefit coming in 2006.

The predetermined grant amounts, which are distributed to states based on the number of participants enrolled in each program, are to be used to educate SPAP participants about prescription drug coverage available under prescription drug plans or Medicare-Advantage prescription drug plans; provide technical assistance, phone support, and counseling in order to help SPAP participants select and enroll in Part D plans; and, support other activities that promote effective coordination of enrollment, coverage, and payment between SPAPs and prescription drug plans.

Website Enhancements

Now Medicare beneficiaries will find it even easier to choose the lowest priced Medicare-approved drug discount card that best fits their individual needs. The updated www.medicare.gov features an improvement to the Price Compare tool that lists the five lowest

priced Medicare-approved drug discount cards that fit each beneficiary's individual drug needs. In addition, beneficiaries now will be able to sign up for a drug card on the Internet. These changes will also help beneficiaries get the same information faster when they call 1-800-MEDICARE.

CMS is continuing to improve www.medicare.gov to make it more useful. In fact, there is a feedback button on each page of the web site so CMS can hear directly from users. Many of the enhancements were generated from suggestions and comments received from beneficiaries and their family members, individuals who work with older Americans, such as the State Health Insurance Assistance Programs, and health care providers. On the updated web site users will find:

- A "Top 5 – Best Choice" list of the five cards that offer the lowest aggregate prices for an individual's drugs;
- Added "enrollment information" buttons to provide easy-to-access, easy-to-use information on how to enroll. This includes online enrollment for 36 different cards;
- Significant improvements to the drug entry tool making it easier and quicker for users to enter their drug information;
- An improved display of drug pricing information making it easier for users to compare the price differences among brand and generic drugs;
- More easy-to-understand information about state pharmacy assistance programs;
- More details about manufacturer "wrap-around" programs that offer additional discounts for beneficiaries who qualify for the $600 credit;

- A new "special features" link that provides updated card sponsor information such as online enrollment availability and manufacturer "wrap-around" programs; and
- A new tool under "resources" allowing users to select their state and immediately see a listing of all drug card sponsors in their area.

Each of these enhancements will also make it easier and faster for callers to get information about drug cards by calling 1-800-MEDICARE. There are now 3,000 operators answering an average of 50,000 calls a day at 1-800-MEDICARE. Average wait time is less than 2 minutes, making it even faster for callers to reach a customer service representative. The Medicare customer service representatives answer questions about the drug card and walk callers through the information available at www.medicare.gov. Beneficiaries who call can also get the information they need in a personalized brochure mailed to them the next day. Then, signing up for a card requires only filling out a two-page form or calling the card sponsor's toll-free number.

In our efforts to take all possible steps to help low-income beneficiaries without good drug coverage take advantage of these large savings, we have looked into the possibility of auto-enrolling Medicare Savings Program beneficiaries into the drug discount card program. However, our autoenrollment options for this population are limited. The MMA (Section 1860D-31(f)(2)(A)) provides that a transitional assistance applicant must certify that the individual's income, family size, and alternative sources of drug coverage (if any) meet required criteria. By regulation, we permit the individual's authorized representative to step into the shoes of the applicant and make this attestation on the individual's behalf. Consequently, either the individual or his or her authorized representative must certify as to the accuracy of such

information. This authorized representative authority is what we have worked to enable any interested State Pharmacy Assistance Programs (SPAPs) to use to autoenroll their Medicare members in drug discount cards. However, most States do not have authorized representative status for their Medicare Savings Program beneficiaries.

While we work with states on autoenrollment, however, the Administration is also committed to ensuring that each eligible beneficiary has the opportunity to enroll in the drug card program that best meets his or her needs. We are supporting a number of outreach efforts to assist beneficiaries in enrolling in a drug card of their choice, including reaching out to community based organizations to work with them to educate and enroll low income people with Medicare in a Medicare approved drug card and in the $600 credit.

Finally, in our continuing efforts to facilitate enrollment for low-income beneficiaries, CMS plans to allow electronic enrollment (via the internet) for the drug card with Transitional Assistance. Internet based enrollment will be a big help in the outreach we are doing particularly with the community based organizations.

Further Relief: Self-Administered Drugs

On June 24 this year, CMS announced the inception of a new program, created under section 641 of the MMA. This program will provide coverage for up to 50,000 Medicare beneficiaries for self-administered drugs for cancer and certain other chronic conditions. Currently Medicare does not cover drugs that are usually self-administered. This program will begin enrolling beneficiaries in August and providing coverage as soon as September of this year. The program

will run through the end of 2005, when the full Medicare drug benefit will begin. Beneficiary cost-sharing for self-administered drugs covered under this program will be roughly equivalent to that which will apply to drugs covered under the new drug benefit beginning in 2006. Low-income beneficiaries are expected to realize significant savings. For example, those individuals with incomes below 135% FPL will be able to get very costly but potentially life-saving drugs like Gleevec and Tracleer for at most $60 per year, and in many cases even less – a savings of nearly 100 percent of the cost.

Prescription Drug Benefit and Subsidies

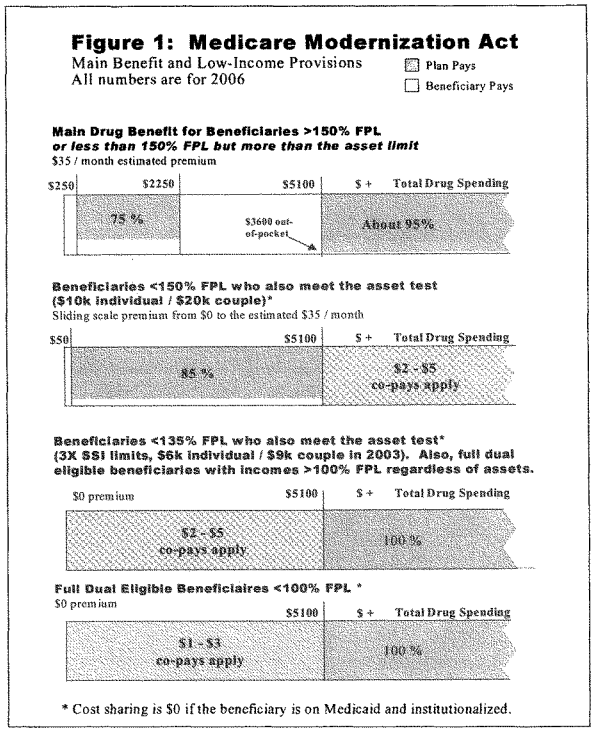
The drug card and the self-administered drug program, however, are only precursors to the full drug benefit that will become available to all Medicare beneficiaries, beginning in 2006. The new drug benefit has been targeted to provide the greatest assistance to seniors and people with disabilities who are most in need – people with very low incomes and people with very high drug costs. Dual eligible beneficiaries have the opportunity to enroll in a program of their choice, but to ensure that they receive the substantial benefits available to them, will be auto-enrolled if they are unable to do so in time to enjoy those benefits. Other beneficiaries will be able to voluntarily select a drug benefit that best meets their needs. Beneficiaries may stay with Medicare fee-for-service without drug coverage, as they have now, or they may select a drug plan to supplement fee-for-service coverage, or they may enroll in a Medicare Advantage plan that includes drug coverage. Beneficiaries choose the best plan for their individual needs.

Level of Assistance

Under the new drug benefit, full benefit dual eligible individuals – those qualifying for Medicare who also receive the full range of benefits under Medicaid - will receive drug coverage through Medicare. Full benefit dual eligible individuals will automatically qualify for low-income subsidies covering premiums and most cost sharing for the drug plan they select. State Medicaid programs will no longer provide prescription drug coverage for full benefit dual eligible individuals except, at state option, for certain drugs that Medicare will not cover. This change provides significant fiscal relief for states since states currently pay for prescription drugs for full benefit dual eligibles. These expenditures are substantial, amounting to nearly $7 billion in state spending in 2002. The law provides for a continued state contribution to the cost of providing prescription drug benefits to these individuals through a monthly payment from the states to the Federal government similar to the mechanism through which states pay Medicare Part B premiums on behalf of dual-eligible individuals. Dual eligible individuals -- including those in Medicare Savings Programs (QMBs, SLMBs and QIs) -- will automatically qualify for Federal low-income subsidies for drug plan premiums and cost-sharing.

Specifically, the three groups of low-income beneficiaries who will receive premium and cost-sharing subsidies include approximately 6.4 million full benefit dual eligible individuals; an estimated 3 million individuals with incomes lower than 135 percent of the Federal poverty level (FPL) ($12,569 for an individual and $16,862 for a couple in 2004) and assets up to $6,000, or $9,000 for a couple; and approximately 1.5 million Medicare beneficiaries with incomes at or over 135 percent but less than 150 percent FPL ($13,965 for an individual and $18,735 for a couple in 2004) who also meet the resource standard of $10,000 for an individual or $20,000 for

a couple in 2006. The chart below outlines the level of benefits for each group. Institutionalized persons who are full-benefit dual eligibles are exempt from cost sharing.



As can be seen from these figures, low-income beneficiaries - those who need it most - will receive substantial assistance under the new drug benefit. In addition to reductions in their costs,

low-income Medicare beneficiaries will have choices about where they want to apply for their new coverage. A streamlined process to determine eligibility for low-income subsidies will be available to beneficiaries.

Minority Populations and the MMA

While the provisions for low-income individuals will be important to all who qualify, they are especially important to the minority population who as a group tend to have greater needs than other groups have. The MMA provides over 7.8 million minority Medicare beneficiaries with access to a prescription drug benefit for the first time in the history of the Medicare program. The poorest minority beneficiaries – the nearly 2 million with incomes below 100 percent of FPL who are eligible for full benefits under Medicaid – will pay no premiums, no deductibles, and only nominal cost-sharing of $1 for a generic drug or a preferred multiple source drug and $3 for all other drugs. In addition, by moving out of their current Medicaid programs and into the new Medicare drug benefit, they will not be limited to any state imposed restrictions on the types or amounts of drugs they can receive.

The group of over 2.5 million low-income minority beneficiaries – all other seniors who are eligible for full benefits under Medicaid, as well as other seniors with incomes below 135 percent of FPL with assets of no more than $6,000 per individual and $9,000 per couple – will pay no premiums, no deductibles, and only nominal cost-sharing of $2 for a generic drug or a preferred multiple source drug and $5 for all other drugs.

An additional group of nearly 480,000 low-income minority beneficiaries – those with incomes below 150 percent of FPL and assets of no more than $10,000 per individual and $20,000 per couple – will get sliding scale subsidies for their premiums, and pay both a lower deductible and lower cost-sharing compared to the standard benefit.

The MMA stabilizes and helps expand the current Medicare+Choice program. Aged minority beneficiaries, particularly Hispanics, have enrolled in Medicare+Choice plans at a higher rate than the general Medicare population. That's because Medicare+Choice plans mean substantially lower out-of-pocket payments for beneficiaries who don't have access to generous supplemental "Medigap" coverage from their former employer, and have incomes too high to qualify for Medicaid. According to recent studies, these beneficiaries can save on average around $800 and (if they have significant illnesses leading to fair or poor health status) around $1900, compared to their total out-of-pocket payments in fee-for-service Medicare. The MMA renamed Medicare+Choice to Medicare Advantage and has already expanded the participation of private health plans in Medicare and (because the additional payments are passed on in better benefits and reduced cost sharing) has led to even greater beneficiary savings, and will ensure even greater access to integrated health plans to populations who have valued these plans the most.

Beginning in 2005, all newly enrolled Medicare beneficiaries will be covered for an initial physical examination. Minority Medicare beneficiaries, who are disproportionately at risk for cardiovascular disease and diabetes as compared to all Medicare beneficiaries, will benefit considerably by being able to take advantage of new preventive services, including

cardiovascular screening blood tests and diabetes screening to understand and improve their own health.

These new benefits can be used to screen minority beneficiaries for many illnesses and conditions that, if caught early, can be treated and managed, and can result in far fewer serious health consequences.

Disease Management, a service that exists in most integrated health plans, is being introduced into both the original Medicare program and PPO-style MA plans. These programs will provide beneficiaries the tools and support systems to help them manage their chronic illnesses and they are likely to substantially benefit minorities.

Which Drugs Are Covered?

Medicare prescription drug plans will cover drugs in every therapeutic class of FDA-approved drugs and biologicals, as well as insulin and supplies associated with its administration. Unlike current optional Medicaid coverage, Medicare drug plans may offer coverage for drugs that help people to stop smoking.

Medicare prescription drug plans will be able to set up selective formularies for their plans. These formularies may be closed, in which the plan only covers certain drugs, or open, in which all drugs are covered, but beneficiaries receive preferred drugs for lower co-pays than non-preferred drugs. Regardless of the formulary structure, the plans are required to include, when available, at least two drugs in every therapeutic category, unless the category includes only one

drug. Beneficiaries will know which drugs are on the formulary when selecting plans.

In establishing a formulary, the plan must have a pharmacy and therapeutic committee consisting of practicing doctors and pharmacists, including providers who have expertise in the treatment of seniors and the disabled. The U.S Pharmacopoeia, a nationally recognized clinically based independent organization, will develop, in consultation with other interested parties, a model guideline of therapeutic categories and classes. When choosing drugs for a formulary, a plan must also be mindful of the drug's specific therapeutic advantages. Plans will have an incentive to offer multiple drugs in a therapeutic class in order to attract enrollment. When approving plans, CMS will review all proposed formularies to ensure that they are not designed to discourage enrollment by people with certain types of medical conditions.

Furthermore, if beneficiaries find that the drug they need is not on their plan's formulary (or is on a non-preferred cost-sharing tier), an appeal is possible. A doctor would need to certify that the drugs on the formulary are not as effective as the desired drug or would adversely affect the beneficiary. If the appeal is successful, then the beneficiary can get the drug as though it were on the formulary (or preferred tier), and any cost-sharing amounts paid will count toward the out-of-pocket limit.

The MMA also allows state Medicaid programs to continue to provide the so-called excluded drugs, such as certain anti-anxiety drugs, weight loss and gain drugs, and over-the-counter drugs, and still be paid the regular matching amount by the Federal government.

Pharmacy Access

All prescription drug plans will be required to meet a strict pharmacy access standard in their service area to give beneficiaries convenient access to retail pharmacies. This standard ensures that, at a minimum, the pharmacy network is broad enough so that:

- 90 percent of urban enrollees live within 2 miles of a network pharmacy,
- 90 percent of suburban enrollees live within 5 miles, and
- 70 percent of rural beneficiaries live within 15 miles.

Help to States

According to a recent Office of Inspector General report, states have identified prescription drugs as the top Medicaid cost driver (FY 2002, Federal and state Medicaid prescription drug expenditures totaled approximately $29 billion with nearly $12.5 billion of that figure coming from the states. Prescription drug spending accounted for 12 percent of the Medicaid budget). From 1997 to 2001, Medicaid expenditures for prescription drugs grew at more than twice the rate of total Medicaid spending. These pressures on state budgets have led to coverage restrictions.

Some states currently contain Medicaid drug costs by limiting the number of prescriptions filled in a specified time period or limiting the frequency of dispensing a drug. Some states also limit the number of refills. In contrast, such policies will not be permitted under the new Medicare prescription drug benefit; thus most beneficiaries will have greater access and choice under the new drug benefit than they previously had under their state Medicaid program.

As I noted earlier, starting in 2006, full benefit dual eligibles will receive prescription drug coverage through the Federal Medicare program. Because states will no longer incur prescription drug costs for these beneficiaries, states will be required to make payments to the Federal government to defray a portion of the Medicare drug expenditures for full-benefit dual eligibles. Even after these payments and new enrollment of previously un-enrolled, but Medicaid-eligible beneficiaries, CMS estimates that states will realize a net savings of approximately $8.2 billion over five years.

In addition, the new drug benefit will permit state pharmacy assistance programs (SPAPs) to "wrap around" the comprehensive coverage for many beneficiaries. As a result, states can provide the same or better coverage for the beneficiaries currently covered through state programs.

States will also receive new assistance with the costs of drug coverage for their retirees, just like other large employers. Medicare intends to work closely with all states, through regulatory comment processes, the new "SPAP Commission," and many other forums, to ensure that the drug benefit provides better coverage and lower costs for beneficiaries.

How The Prescription Drug Benefit Works

Seniors will have two basic ways to receive the new drug benefits. First, they may choose to receive their full Medicare benefits (including hospital care, physician services, home health care, preventive services, and others) and the new voluntary prescription drug benefit through a "Medicare Advantage" plan. These plans may be preferred providers organizations (the most

popular choice among federal employees), health maintenance organizations, or other styles of private plans. Alternatively, seniors may enroll in CMS' original fee-for-service program, and choose to receive drug benefits through private drug plans that will be approved by CMS to provide the new prescription drug benefit. The plans will bid to provide drug coverage to seniors for a specific area of the country. These areas may be local, as is the case with Medicare+Choice plans today, but most bids are expected to include larger regions to be defined by CMS. The law requires that there be at least ten, and no more than fifty such regions. We are analyzing the information that we have available today to define regions that will provide the greatest opportunity for high quality and good value for our seniors.

Eligibility and Enrollment

All 41 million Medicare beneficiaries will have the choice of enrolling in the new Medicare drug benefit. Anyone entitled to Medicare Part A *or* enrolled in Part B is eligible to join. Joining will involve selecting an approved PDP or MA plan offering drug coverage, and enrolling in that plan for the year. While full dual eligible beneficiaries will be auto-enrolled after having the opportunity to select a plan themselves, enrollment for all other beneficiaries is entirely voluntary. However, beneficiaries who choose not to join at the first opportunity may face a late enrollment penalty if they later choose to enter the program. This penalty is similar to a penalty currently in place for late enrollment in Medicare Part B and is meant to make sure that people don't wait until they are sick to sign up, thus skewing the risk pool.

Beneficiaries who have other sources of drug coverage – through a former employer, for example – may stay in that plan and not enroll in one of the new drug plans under Medicare. If

their other coverage is at least as good as that offered under Medicare (and therefore considered "creditable coverage"), the beneficiary can avoid any late enrollment penalties when or if they lose that coverage and choose to enroll in a Medicare plan at some later date.

The new drug benefit has an "opt-in" rule. That means that, with limited exceptions, beneficiaries will need to make an affirmative statement to enroll in a prescription drug plan by filling out an enrollment form and joining an approved plan. This will be different from the "opt-out" rule that exists in Part B, where people are deemed to have enrolled in the program when they turn 65 unless they notify Medicare otherwise.

The statute allows people with Medicare to file for subsidy eligibility determinations with the Social Security Administration (SSA) or with the States. To be successful, these processes need to be as parallel as possible. To facilitate rapid and simplified enrollment of these individuals, CMS has worked closely with SSA to consider options to implement a consistent and timely system that accommodates the States and SSA.

SSA is developing a simplified application that will be scannable and able to be used via the Internet. State personnel assisting beneficiaries with the SSA application will be able to use the internet-based form. These applications would be processed through SSA and SSA would own the associated development/redetermination/appeals for applications submitted to SSA. CMS will also make the scannable forms and the Internet application available to State Health Insurance and Assistance Programs, community based organizations and other partners to assist people enrolling in the subsidy.

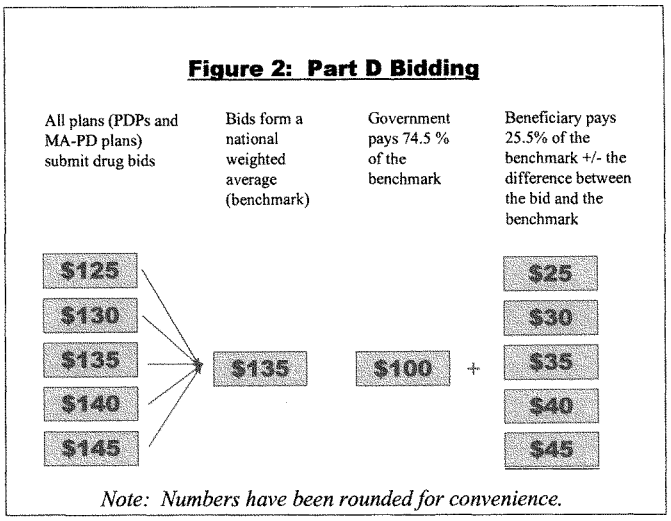
States may also take and process applications directly; however, we believe there will be significant economies for States in using the SSA application and associated processes. SSA and CMS have agreed that in order to make the drug subsidy available by January 1, 2006 there needs to be a pre-authorization process beginning in the summer of 2005.

The new prescription drug coverage begins on January 1, 2006. Initial open enrollment will begin November 15, 2005 and will run for six months to May 15, 2006. In later years, open enrollment will run from November 15 to December 31 for the next benefit year. The enrollment periods for PDP and MA plans will run concurrently.

Premium, Deductible and Cost Sharing

Beneficiaries who do not fall into one of several low-income categories, and therefore do not qualify for additional assistance available to these individuals, will be responsible for monthly premiums, annual deductibles and cost sharing up to a certain point.

Beneficiary premiums will be determined through a competitive bidding process. Premiums are expected to average about $35 dollars per month in 2006. Premiums will vary by plan and will be determined by the plans' bids. Beneficiaries may be able to save money by choosing a lower-priced plan, as illustrated below in Figure 2.



In the plan bidding sequence, all plans submit a bid for the cost of providing the drug benefit to a typical beneficiary in the service area. The typical beneficiary is a statistical average of age and health status for the nation.

CMS will then review the bids, and all approved bids will be compiled into a national weighted average. Premiums for a given plan will be set at 25.5 percent of the national weighted average plus or minus any difference between the national average and the plan's bid. This last point is important because plans whose bids are lower than the national average will end up charging their enrollees lower premiums, thus giving beneficiaries an incentive to sign up and increasing their market share. The competitive element among plans will give them motivation to drive the hardest bargains they can with drug manufacturers, in order to be able to underbid their competitors and thereby attract more customers. In each succeeding year, plans will compete

with each other. This competition will push prices down, just as it has in the prescription drug card program.

Three other factors will affect the premium that each beneficiary pays. First, as discussed earlier, if the beneficiary qualifies for low-income assistance, then the premium will be reduced on a sliding scale or eliminated entirely depending on the beneficiary's income. Second, if the beneficiary does not enroll in a drug plan at the first opportunity and does not maintain creditable coverage, than a late enrollment penalty may apply. Finally, if the beneficiary chooses a plan that features supplemental coverage over and above the standard D benefit, a supplemental premium may apply.

The standard benefit features a $250 annual deductible and 25 percent beneficiary cost sharing up to an initial coverage limit of $2,250. After that, catastrophic coverage begins once a beneficiary reaches $3,600 in out-of-pocket expenses ($5,100 in total drug spending). To be counted as out-of-pocket expenses, the beneficiary (or another individual, such as a family member) must actually be paying the costs. In general, the costs cannot be paid by another insurer and count toward the $3,600 limit, though contributions by state pharmacy assistance programs do count. In the catastrophic coverage range, the beneficiary pays the greater of 5 percent cost sharing or $2 and $5 co-pays. This catastrophic coverage is something that has not been available to most Medicare beneficiaries, even those with supplemental coverage, since the Medicare-approved Medigap plans did not allow such coverage.

Currently, Medicare beneficiaries without coverage pay full retail prices, the most expensive way to obtain drugs. With coverage under one of the Medicare prescription drug plans, beneficiaries will save in two ways – first through the direct coverage, and second when they pay for drugs out of their own pockets, they will be making purchases based on prices that are substantially reduced from what they otherwise would pay as a result of their plan's negotiated discounts with manufacturers. These discounts provide real value – so their dollars will go further. We have seen exactly this dynamic in the prescription drug discount card and are encouraged by its success.

Conclusion

The new prescription drug benefit will provide substantial new protections for Medicare beneficiaries, and particularly for those low-income beneficiaries who often struggle with the cost of prescription drugs. The Medicare prescription drug card provides low-income seniors with transitional assistance of $600 in 2004 and an additional $600 in 2005 for a total of $1,200. In addition, these seniors also benefit from the lower prices negotiated by the drug card sponsors. When implemented in 2006, the comprehensive prescription drug benefit will provide even greater coverage for low-income seniors. We look forward to keeping the Congress informed as we move toward implementation of this very important program. Thank you for your time, and I look forward to answering any questions you may have.

The CHAIRMAN. Mark, thank you very much for that testimony and opening comments. During debate on this bill, I think the biggest focus was on those seniors who did not otherwise have drug coverage and who just could not afford it themselves. Does the new low-income assistance in the 2006 benefit meet that need?

Dr. MCCLELLAN. It does. As I mentioned before, there are over six million dual eligible beneficiaries who will be able to get access to a comprehensive benefit that must cover all classes of drugs, very broad formulary, very important and national and universal appeals rights, plus millions more who have limited means but who are not able to enroll in state programs now because the states have not been able to provide coverage for them.

So all together it is about a third of Medicare beneficiaries, as you said, who are going to have access to a comprehensive benefit as part of this overall Medicare legislation.

The CHAIRMAN. In that category, most of the qualifying low-income seniors in 2006 will pay, so we now understand, zero premium, zero deductible and a few dollars per prescription. How does that compare to the kind of drug coverage the average non-senior is likely to find out in the private marketplace today? Is there a comparison?

Dr. MCCLELLAN. Yes, very favorably. The drug coverage available to many people with limited means today has significant copayments. Usually the copays are lower for generic drugs than for brand name drugs, and the Medicare benefit has that same structure. But this is a more comprehensive benefit for people with limited means and these millions of beneficiaries do not have access to this kind of coverage in the private markets today and that is why it is so important to bring it into Medicare right now.

The CHAIRMAN. Mark, weeks prior to the ability to enroll and then following that, there was a considerable amount of criticism as it relates to seniors just were not signing up. The figure I used in my opening comments and you have used it of 25,000 now signing up per day, when I first saw that figure I thought they must be thinking about 2,500. So talk to us about that. Has enrollment accelerated recently? What are the reasons for this?

Dr. MCCLELLAN. Well, it is definitely continuing at a steady clip. We went back and looked at previous experience when the Federal Government tried to implement other major new benefit programs that offer very affordable coverage and help people with their health care costs substantially. In general, it takes some time. For example, in the CHIP program, the Children's Health Insurance Program, which now provides coverage to many millions of lower income children and their families, that program took more than a year to reach the million enrollees mark because of issues with states working with the Federal Government to set up access to the program and important issues about education and outreach, letting people know that these benefits are there and helping them through the decision process so they could sign up, so they could decide this was a really good deal for them and sign up for it.

So it took a little time, but enrollment picked up, and these kinds of barriers to enrollment are present anytime a new Federal program starts, and we are working harder than ever to overcome them. So in this case, we tried to look back on that experience and

learn from it. In addition to the steps that we are taking through our 800 number, through advertising, through mailings to beneficiaries, through mailings from the Social Security Administration, we form new partnerships with state health insurance assistance programs and recently we have been getting partnerships underway with many private organizations that are very good at doing outreach and education for low-income beneficiaries.

I think this is a win-win effort for us. It helps get people informed and enrolled in the Medicare prescription drug benefit program. It also is a good foundation for the education and outreach that we intend to do as part of the comprehensive low-income drug benefit that is coming next year. We have got a little bit more time to do that, but we want to take full advantage of all of that time.

So with new partnerships, with proven effective approaches to doing outreach, I think the numbers are picking up, but you know no program works unless it delivers real benefits, and this program is delivering real savings when it comes to the prices that beneficiaries who get the drug card can pay when they go to their local pharmacy, and it is especially delivering benefits in terms of literally thousands of dollars in help this year and next year for the low-income beneficiaries who do not have drug coverage today.

That is the ultimate thing that is driving the significant enrollment in this program, and that is why we are so pleased to have so many partners on the outside in this unprecedented effort to get millions of people signed up faster than ever for a new Federal benefit program.

The CHAIRMAN. Back in March, CMS testified before this committee that you anticipated savings from the cards of between I think 10 to 15 percent on total spending and with about 25 percent on individual drugs. Your testimony today suggests that actual savings are in many cases proving better and that especially is true of I believe generics.

Dr. MCCLELLAN. Yes.

The CHAIRMAN. What are the reasons why the savings seem to be even better than expected and do you expect price savings to continue to go down as the program stabilizes?

Dr. MCCLELLAN. Well, we are seeing significant new savings I think for two main reasons. One is that seniors are able to band together now more effectively and stick together long enough to get negotiated discounts on prices from drug manufacturers.

So seniors are very good comparison shoppers now and many of them have been able to find through a pharmacy discount card or something like that some small sources of discounts at their local pharmacies. Well, this does better. It adds to that by getting them those negotiated discounts which are being passed on from the drug manufacturers.

The other very important step is making the price information available. Now not every senior goes and looks at every piece of price information on the 60,000 drug products at the more than 50,000 pharmacies around the country, but the fact that that information is out there has created a new ability to comparison shop for drugs much like people in the past have done for many other products and services, their groceries, their vacations, their mortgages, you name it. We have seen over the past 2 months with this

program that prices available come down, come down, especially for cards that were initially higher priced, but across the board, we have seen reductions, not increases in drug prices, prices for brand name drugs, over the first couple of months that our price comparison has been active. So it is a new way of comparison shopping coupled with a new ability for people to band together and get the big discounts.

The CHAIRMAN. Great. That is good news. Let me turn to my colleague, Senator Breaux. John.

Senator BREAUX. Thank you, Mr. Chairman, and thank you, Dr. McClellan, for your testimony. We had authorized in the Medicare bill automatic enrolling for low-income Medicare beneficiaries, and you all were considering that approach. Can you bring us up to date on what you all have decided on on automatic enrollment?

Dr. MCCLELLAN. Yeah, I sure can. Auto enrollment can be a good way of getting the enrollment numbers up quickly. It means that we do not have to do the retail process of going door to door, which we are doing right now with a lot of these outside organizations to get the numbers, to get people informed and get those who can benefit to enroll.

We started an auto enrollment process with states that have pharmacy assistance plans and those auto enrollments have already resulted in more than 100,000 beneficiaries getting into this program and qualifying for the low-income assistance in a very straightforward way.

We are also talking with states about using the same kinds of auto enrollment tools for other populations. Under the statute, however, states are allowed to do auto enrollment when they have got so-called authorized representative status for beneficiaries. That means they can act on behalf of the beneficiary for decisions like choosing to enroll in this program.

It turns out that most states do not have the legislative authority to do that now, so we are working with those states on finding other ways to overcome any barriers to information, barriers to enrollment. A number of states, for example, have sent out pre-filled out applications that just require a beneficiary's signature and that has led to tens of thousands of more people signing up as well.

But we are looking for every avenue that we can take under the statute to get people informed and enrolled in this program. I should add, too, that when it comes to the full drug benefit in 2006, there is an automatic enrollment authority that applies to all Medicaid beneficiaries, the full dual-eligibles as well as those in the QL and SLMB and QMB programs, too, that we are going to be asking for comment on how we can use that as effectively as possible when it comes to the full benefit in 2006.

Senator BREAUX. So there is still apparently a large number of people who are eligible for the $600 person discount that are not taking advantage?

Dr. MCCLELLAN. They are not yet enrolled. That is right. We are up to close to a million enrolled in that program, but we aim to get a lot higher than that, and that is why we are really focusing new efforts on working with states and working with these outside advocacy organizations that are very well connected to these beneficiary groups.

Senator BREAUX. Do you have an idea of how many that are eligible for the discount, a full discount, that are not getting it simply because they have not enrolled?

Dr. MCCLELLAN. Well, the projections were that about 7.3 million people would take advantage of the card program between now and when it ends at the end of 2005 and a little bit over 4 million people out of that 7 million would be eligible for the low-income assistance as well. So we are definitely still trying to get those numbers up and to do it faster than other previous new Federal benefit programs have achieved in the past.

Senator BREAUX. About 25 percent ball park figure?

Dr. MCCLELLAN. Right now in the first month, and I intend to keep doing all we can to really increase that number.

Senator BREAUX. Well, I would really urge you to do it. I mean this is the easiest thing to take advantage of that you can possibly imagine.

Dr. MCCLELLAN. Yes.

Senator BREAUX. Here is $1,200 a year for prescription drugs for a couple that is lower-income that is there just for signing up, and they really need——

Dr. MCCLELLAN. Right.

Senator BREAUX [continuing.] The maximum amount of encouragement to sign up for it because the program is three.

Dr. MCCLELLAN. That is right.

Senator BREAUX. It is available. Tell me a little bit about the interaction between the Medicare discount card? How is working when you have the various companies coming in with their own discount card? Back to my example in the beginning of the little couple that comes to their local pharmacy with 10, 12 different discount cards available to them. I mean tell me a little bit about how is it working with the interaction between the company discount cards and the Medicare card itself?

Dr. MCCLELLAN. Well, there are two ways that that can work. There are now more than 100 manufacturer programs out there that have their own cards, that have their own enrollment process.

Senator BREAUX. These are the manufacturers?

Dr. MCCLELLAN. These are manufacturer programs of one kind or another, and one of the things that we do to try to make it easier for people to find out about enrolling in those programs is give them the information they need to connect with those programs when they call us up at 1–800–MEDICARE, so when you call us, you hear not only about the drug card and the transitional assistance that we offer but also about state programs and manufacturer programs that can help out as well.

What I think is really important though is the fact that many of the major drug manufacturers, seven so far, are now offering wraparound discounts on any card that meets some basic terms, basically just passing on the full value of the manufacturer discounts, and those prices for drugs even after you use up your $600 are now $5 to $15 for a drug that can retail price for more than $100. This includes drugs from Lilly, like Lipitor, drugs from Merck like Zocor, many other commonly used drugs. As I said, 6 out of the top 10 spending drugs for beneficiaries now and when you call us up or go to our web site, we will tell you about all of these specific drugs,

the prices that you can get for them after you use your full $600 credit and all the cards that are offering this wraparound help. So as you said, it is literally thousands of dollars in new help right now that people can qualify for and they should be finding out about it and we want to get that help to them as quickly as possible.

Senator BREAUX. My last question, Mr. Chairman, is again when I made some opening comments, I talked about the fact that a person who is confused or not knowledgeable, if you will, about how this process works, if they call the 1–800–MEDICARE and can they give someone a list of the drugs that they happen to be taking, four or five, and their prescriptions and say here is what I am taking, can you tell me which card best would fit the needs that I have to meet each month?

Dr. MCCLELLAN. That is exactly right. The easiest way to get connected to the help you need is to call us up and be ready with just a few pieces of information—your zip code, your income level if you think you may qualify for any of these kinds of assistance programs, and the drugs that you are on and the dosages that you can get usually from your pill bottles. We have recently made some improvements in the web site which are also being used by the customer service reps at our 1–800 number to make it even easier to enter all the drug information, and no matter how obscure the prescription is, whether it is an oral medicine, or otherwise, so that can be as straightforward as possible.

Senator BREAUX. Give them that and what do you get back from Medicare?

Dr. MCCLELLAN. You can get back several things. We can either tell you right then and there which cards look like they are going to be a great deal for you and what you would end up paying under those cards for your drugs so you can compare that to what you are paying now and make an informed decision about whether this is a good program for you. Or a lot of people like to see something in writing, so we will send them out a personalized brochure that is the Medicare drug card program for that specific beneficiary that gives them information on the top programs for their needs, and they can customize it to be just about one or two or three card programs. They can focus in on the pharmacies that they care most about or they can get a lot more information if they want.

We have also listened to concerns that you and others have expressed about not having too many choices, not having too much information to sort through, so now when you go to our web site or call us up at 1–800–MEDICARE, we focus in first on the top five choices. So it is like a special five-card program just for you, but it is honed in on the five best choices for your needs. You do not have to look at any of the other programs at all.

Senator BREAUX. Thank you, Dr. McClellan.

The CHAIRMAN. John, thank you. We have been joined by our colleague on the committee, Senator Stabenow. If you wish to make any opening comments and questions of Dr. McClellan, please proceed.

Senator STABENOW. Thank you, Mr. Chairman, and I apologize for not being here in time to hear your testimony, and I may, in

fact, be a little redundant, but I appreciate your time, Mr. Chairman.

The CHAIRMAN. That is OK.

Senator STABENOW. This is an extremely important subject and so I appreciate the fact that you are holding this and with my colleague as well, Senator Breaux.

First, I would say Mr. McClellan, would you agree that this is a pretty complicated process for seniors to wade through?

Dr. MCCLELLAN. Senator Stabenow, it is good to see you again, and we are, as we have just been discussing, trying to take all the steps that we can to make it as straightforward as possible. It does not have to be complicated. Seniors who call us can now generally get the information they need in well under 20 minutes to find out not just about which cards can help them save a lot of money, but how much they can save and what it exactly takes to start getting those savings. So we do not want it to be complicated. We want to do everything we can.

We have tried to learn from comments, suggestions and so forth to make it as straightforward as possible to start getting help right now.

Senator STABENOW. Well, of course, the best way to make it the least complicated would be to have one card and for Medicare to be able to negotiate a group discount to get the maximum discount possible, as the VA does. That is not what this law does. Instead we have multiple cards, and on the cards for a moment, would you not agree that it is a concern, I am wondering how you are going to handle when people sign up for an individual card based on the medicine that they need and with the help of your agency work through which card gives them the best coverage maybe for five medicines that they are on, but then what happens when they find out that the discount list can change every 7 days or the price can go up every 7 days?

Do you have a plan for how you are going to address or have you already had calls from people who are locked into a card for a year and find that the five medicines that were covered are now maybe only three medicines that are covered?

Dr. MCCLELLAN. Senator, it is very important to us that the benefits that beneficiaries expect to get under this program actually do come through. That is why we have been monitoring closely what has been happening to prices, what has been happening to drugs covered and monitoring closely all calls and complaints that we get and handling them promptly.

On prices, it has been the case in this program from the beginning that they can only go up when costs go up, not for any reason, which is the case outside of Medicare today, and we have seen prices for brand name drugs actually come down on average since this program was started and we are going to continue to monitor that closely.

In terms of drugs that are covered, we have had virtually no complaints. I do not know of any complaints about a particular drug that was listed as being on a formulary, not being there for a discount, and, in fact, in monitoring what the card sponsors have been doing over time, we have seen no cases, no significant cases, of drugs that were listed coming off.

In talking with the card sponsors, many of them are saying that, well, you know, the only times that we think we might even think about changing some of the drugs that we cover are if a generic version is approved, in which case seniors get a lot more savings for it, or if the FDA changes the reasons that it thinks the drug should be used, in which case there would be a good medical reason for a change, but we are monitoring that closely and so far we have not seen any substantial complaints about either prices, because they have been coming down or drugs covered because they have been staying stable under this program.

Senator STABENOW. Well, I think that is good news if, in fact, the drugs do not change once a senior signs up. Would you not agree that that would not be a very fair situation if somebody signed up for a card based on certain medicines being discounted and then found that that changed down the road? Would you not agree that that would not be, at a minimum it would not be fair, even though right now it may be legal under this?

Dr. MCCLELLAN. That is right. That is why we made clear to the companies that we will be monitoring them for any kind of bait and switch activities and tracking customer complaints, which we are doing now, and we are also making sure that customers know about it, the cards that are doing the job of keeping prices down and offering a broad range of prescriptions, so that those cards are the ones that attract beneficiaries. That is why it is so important I think to get good information out about actual prices that people are paying and actual drugs that are being covered, so that people do not just have a discount card or they do not know what it means. That is the way that too many of the existing discount cards have operated before this program came along.

Senator STABENOW. You speak about the prices having gone down since the program was instituted. Have you monitored or looked at the studies—AARP has done a study, Families USA and others—about the dramatic increases in prices before the discount cards came into being?

Dr. MCCLELLAN. They are looking at a slightly different thing. They have been tracking before and during the list prices for brand name medicines. Seniors should never be paying anything close to the list price for brand name medicines with the programs out there thanks to us and thanks to other options that are available to them as well.

We have looked at prices for brand name, commonly used brand name drugs going back as far as early 2003 and comparing to the discounts that we are seeing now, and again, we are seeing savings of 10 to 30 percent for commonly used brand name drugs even compared to the list prices, the list retail prices from way back before this program started in early 2003. But that is why I think it is so important for seniors to get into a card program like this, that they never have to pay anything close to retail prices again.

Senator STABENOW. Well, this reminds me a little bit—some of the price increases I have seen reminds me a little bit, Mr. Chairman, of a store who ups their prices 30 percent and then puts a sign out and says 15 percent off. There is a lot of concern about that kind of thing happening since between the time the law was passed and the discount cards.

But a couple of other questions, if I might, Mr. Chairman?

The CHAIRMAN. Surely.

Senator STABENOW. Regarding the assets test, we, and again I apologize if you spoke to this, and I did not hear your comments earlier.

Dr. MCCLELLAN. No, go right ahead.

Senator STABENOW. But when we look at the fact that for $6,000 for a low-income senior, they can be removed from what is really the maximum help. I mean we all agree that under this legislation, while I would certainly design the entire bill differently, do it differently, we I think all agree that for low-income seniors, there is the maximum amount of help, and we would want that to be for low-income seniors.

I have to say as a caveat that it very much disturbs me in a state like Michigan where someone under Medicaid is going to go on to Medicare and actually pay a bigger copay than they did under Medicaid. But could you speak to the fact that right now we are looking at a calculation for a low-income senior and an assets test that basically says if you have $2,000, if you exceed $2,000 on household goods or personal effects, and that could be your wedding ring, that could be your furniture, if you exceed $1,500 on a life insurance policy, which my guess would be most people today if you have life insurance, it would be more than that, or funds set aside for burial expenses that would exceed $1,500, you disqualify as a low-income senior for the help, so that you have, maybe you have a small insurance policy, put aside a little bit so your children do not have to pay for your burial, you have a wedding ring, maybe you have a little bit of furniture, and this program does not help you? Does that make sense?

Dr. MCCLELLAN. That would not make sense, and that is why I want to make sure we implement the asset test effectively. You know the point of this legislation, as you said, was among other things to target the best, the most comprehensive assistance, to the people that have the least ability to pay. While there are many seniors that have some ability to pay because they have got a lot of financial assets and other resources available, there are millions who do not, and that is why under our estimates, I think this is going to definitely be borne out in practice. A third of all Medicare beneficiaries are going to qualify for this comprehensive low-income help.

Now we have got some work to do to make sure that we implement this asset test effectively, but I can tell you right now, even before we go through the full notice and comment and have discussions about what should count and what should not count, I am not going to be taking away benefits based on seniors keeping their wedding rings. That is not the way that this program I think was intended to operate and that is not the way it is going to operate. There may well be some other financial assets. You know if they have got tens of thousands of dollars in the bank, yeah, I think that that is—in an era when we are worried about not spending too much money in Federal Government programs—that might not be the best person to target all this comprehensive assistance to.

But we are going to be very careful about doing this asset test in a way that is fair, in a way that focuses on seniors' true ability

to pay, not because they have got a family heirloom or a wedding ring or some other special prized asset that should not be counting for purposes of these important benefits.

Senator STABENOW. Well, you may make light of that, but the law does not say that. That is not what the law says.

Dr. MCCLELLAN. Well, that is why it is very important for us to implement the law effectively. We have some discretion within the law on how we interpret things like what counts for an asset and what I think and what we will ask for comment about is that Congress intended for us to do a reasonable application of an asset test for people that are not truly of limited means just because they happen to have low-income in a particular year. They might be expected to contribute to some of the costs, you know, 25 percent of the costs of the premium just like higher-income beneficiaries would. But for beneficiaries who are truly low income but for a small life insurance policy or a wedding ring or something like that, that is who we really want to help.

Senator STABENOW. But the law refers to categories and calculations regarding funeral plots and life insurance policies, and by definition, let us say someone gets to keep their wedding ring—thank goodness. You are saying and the law says that if you have $6,000 worth of assets, you do not qualify as a low-income senior. That is not very much; is it?

Dr. MCCLELLAN. It is not very much, but it is much more, Senator, than millions of beneficiaries have today, millions of beneficiaries who are paying full cost for their drugs and who do not have any help right now from Medicare or anybody else with their drug costs, and that is what we are trying to change.

Senator STABENOW. You are suggesting that when you are done, a third of those on Medicare will qualify under your definition of someone who has $6,000 or assets or less?

Dr. MCCLELLAN. About a third of Medicare beneficiaries can get the additional assistance envisioned in this law, being able to get your drugs for as little as a few dollars for prescription or at most a few hundred dollars a year; that is right.

Senator STABENOW. Well, we will be watching very closely on that, Mr. McClellan.

Dr. MCCLELLAN. I will look forward to working with you on this. I know how important that assistance for people with limited means is to you. We are going to have a broad discussion of this when we put out our proposed regulations. We are working with the Social Security Administration, other experts, on thinking about what should and should not be counted in terms of coming up with a workable fair asset test and we are going to do that as effectively as we can under this law.

Senator STABENOW. Well, just for the record, Mr. Chairman, I do not believe there is a way to come up with a $6,000 assets test that is really fair, no matter how good intentions are, how many good intentions there are. That amount is an extremely limited amount of money to say to seniors of this country in terms of giving them the help that they need.

One other quick question. That is last week we read in the paper about another group of people I am very concerned about, and that is those who have private retiree coverage now. There are a lot of

those folks in my state who worked their whole life, have retiree coverage, have given up pay raises and given up other kinds of bonuses to be able to get health care during their retirement years. Originally we saw numbers before this bill passed that about 2.7 million people were likely to use retiree coverage because of the way this is structured, and now we are hearing at least internally that there are numbers that say that that is more like 3.8 million people who will lose retiree coverage.

This is just one of a series of reasons why I did not support the original Medicare bill because I believe in addition to not really giving the help to low-income seniors because of all the bureaucracy and the assets test and so on, I have a very deep concern and belief that the first rule should be do no harm.

That if anybody is losing their retiree coverage as a result of this, we are doing them harm. I am wondering if you would respond? I understand you had put out a statement saying——

Dr. MCCLELLAN. I did.

Senator STABENOW [continuing.] Saying that those numbers were not accurate.

Dr. MCCLELLAN. That is right.

Senator STABENOW. It is difficult for us when we look at the budget numbers that were put out that were not accurate, and then different numbers come out after the bill passed, and we hear from the actuary that he was threatened with losing his job. So it is very difficult, and I certainly want to have confidence in the numbers that come out, but it is very difficult given the kinds of information and changing of numbers and so on that have gone on as it relates to this new law, but I wanted to give you an opportunity to speak to why this number evidently put together by someone within the department which is substantially higher, in fact 1.1 million more retirees that would lose private coverage, why you are indicating that that is not accurate?

Dr. MCCLELLAN. Yeah. Senator Stabenow, let me reiterate very clearly that that that is not our policy and that what we are doing as a lead up to implementing this new retiree assistance effectively is considering a range of options, and we are going to put out for public comment a range of options about how best to increase the strength and the security of retiree benefits. I have talked to a lot of those seniors as well—I probably do not get as much of a chance to in Michigan as you do—and I know how worried they are about their benefits. They have seen the trends over the last decade of declines in coverage and less employer contributions and higher costs that they have to pay, if they get to continue their benefits at all. We intend to stop that.

We intend to stop that decline. We intend to end up with a policy that not only preserves but increases the support for retiree coverage, that adds existing employer contributions to the new help from Medicare, over $70 billion in new assistance, for employer programs like GM, Ford and others in your state, and we are going to have a very public process.

We are getting comment on this from Members of Congress like you, we are getting comment from retiree organizations, we are getting comments from the employers themselves about how we can use all the tools in this bill to get them the maximum addi-

tional help in continuing to provide strong effective retiree coverage. It includes coverage that people get through the retiree drug subsidy which is what was the particular subject of that New York Times article.

It also includes new assistance that retirees can get by employers wrapping around the Medicare Part D benefit or offering an enhanced Part D benefit themselves, one that is a comprehensive benefit and that they will now be able to do for a much lower cost, than if they are footing the whole bill on their own.

So all of those approaches are important ways of augmenting employer coverage, and we are going to have a full discussion of all the options for doing this with a single goal in mind of how do we get the most additional help to retirees for the least additional cost to the Federal Government.

Senator STABENOW. Well, I am certainly hopeful that your statement that no one losing their private coverage as a result of this will, in fact, happen. Finally, are you going to support our re-importation bill?

Dr. MCCLELLAN. Well, that is outside of my current jurisdiction, Senator. I am sure that we are going to keep working together as close as we can on finding all the safe and proven and effective ways of lowering drug costs for our seniors and I look forward to continuing to work with you on all of these ideas.

Senator STABENOW. Thank you. Thank you, Mr. Chairman, for your patience.

The CHAIRMAN. Thank you, Senator.

Senator Breaux.

Senator BREAUX. I just have two follow-up points. I mean the fact about employer retirees losing their retiree coverage as a result of this bill, they were losing it way before anybody even thought about this.

Dr. MCCLELLAN. They are losing coverage now. That is what we are trying to stop.

Senator BREAUX. My own father had his own dramatically reduced, and his company told all of their future retirees they would have zero coverage long before we even started thinking about this idea.

Dr. MCCLELLAN. Yeah.

Senator BREAUX. Another point is the means test was not dreamt up in this Medicare bill. I mean we have means test for Social Security. We have means test for Medicaid. In fact, is it not true that the Medicaid means test is substantially more restrictive to be eligible for a full ticket for prescription drugs under Medicaid? The assets test is $2,000 for an individual, $3,000 for a couple, and it is not indexed?

Dr. MCCLELLAN. That is right.

Senator BREAUX. This is $6,000 of an individual for a full ride, $9,000 for a couple, and in addition to that, is it not indexed as well?

Dr. MCCLELLAN. That is right. As you said, the Medicaid tests are stricter in very many states. The Medicare act means test is based on an SSI test so it's very similar, same kind of indexing and so forth.

Senator BREAUX. So I mean is it not clear that the means test that we used in this Medicare bill for prescription drugs, in fact, is substantially more generous than the existing Medicaid means test and the SSI means test?

Dr. MCCLELLAN. As is the coverage that will be provided under this bill for millions of Medicaid beneficiaries who currently face restrictive formularies and other limits on the numbers of prescriptions they can fill.

Senator BREAUX. I mean there was some argument for, I would say, Mr. Chairman, for no means test. But when you have a limited amount of money, which is $400 billion, we could have had no means test if we could have gotten, you know, $600 billion. I got people complaining now because somebody scored it at 800 billion. I mean we could have spent a trillion dollars and covered everybody who is over 65 with free drugs, but we do not have the money to do it.

The CHAIRMAN. Thank you for those questions. Let me ask one that deals, and I am pleased that we have looked at that assets test. I will submit for the record the conference agreement and how it applies. It doubled the SSI test and it excluded specifically certain items like the house, like the car for transportation, up to $2,000 worth of household goods. It does exclude the wedding ring and life insurance up to $1,500, and so I think there is a substantial increase in the general generous character of the test.

Mark, both with respect to the drug card going on right now and with respect to the 2006 benefit, lower income seniors are often the most challenging to reach and you have talked about a variety of scenarios and groups you are involving. Answer this for us if you would, please. What are the reasons for this difficulty and what outreach strategies are best for reaching the low-income seniors and is your outreach effort being tailored for both rural populations and for specific minority populations?

Dr. MCCLELLAN. It absolutely is. Just picking up on your point, I think that looking back over the history of programs, well-intentioned programs intended to help people with limited means who are really struggling to get by. Outreach, I think, is one of the most critical barriers and problems that often does not get the attention it deserves. That is why there have been previous Federal programs that can take many years to get up to even 50 percent of eligible enrollment. We are going to do better than that this time, and we are also going to take steps to increase enrollment in those other Federal programs by taking many unprecedented outreach steps.

This includes steps that we have tried already and that have been proven to be effective, steps like mailings from the Social Security Administration and Medicare that are targeted with some simple facts that people can use to figure out how to start taking advantage of the new benefits, advertising, especially advertising targeted in communities that have a high preponderance of these lower income beneficiaries can help as well. Broadcast advertising in particular and not just English language. We are doing Spanish language and other advertising now as well.

Working with private groups. Around the country, many of these individuals have connections in one way or another in their com-

munity, connections to faith-based organizations, connections to seniors organizations, connections to other types of ethnic organizations. All of those sources can be great opportunities for outreach and connection.

For example, we have been working with the National Alliance for Hispanic Health, and they have just come up with a new instruction manual in Spanish on how to use the Medicare approved drug discount card and how to get thousands of dollars' worth of additional assistance beyond the discounts available for low-income beneficiaries.

We cannot do this by ourselves, but because they have a tremendous amount of experience and connections with community groups that reach and deal with low-income beneficiaries on an on-going basis, we can talk to and connect with a lot more people. That is the philosophy behind the new grants that we are awarding. We just announced $4.6 million for community-based organizations recently. That is the philosophy behind doubling our support for the state health insurance assistance plans, and also doing new grant programs for the Administration on Aging, the Indian Health Service, and other Federal agencies that also have good connections and good experience in outreach.

All together, I think these efforts will not only help us boost enrollment from the people who can get the most out of these new programs for the drug benefit but will also end up increasing enrollment in many of these other Federal programs that for too often have fallen short of the maximum benefits that they can provide. So this is a huge outreach effort. We are looking at all of the approaches that can be proven effective. We are even working some with the USDA and some of their local agricultural offices which is a good connection point for people in rural communities.

We are going to keep that up and redouble our efforts over the coming year for both the drug card transitional assistance which people can get and use right now and for the full drug benefit in 2006.

The CHAIRMAN. Senator, yes.

Senator STABENOW. Thank you, Mr. Chairman. I just have to comment more than a question and say I appreciate and fully believe that you are doing maximum outreach as it relates to all of this, but we would not need to spend all this money to do this and all this time if we had taken the approach of one Medicare card, allowing Medicare to negotiate maximum discounts for everyone, and then making that available to people so that this approach is the most complicated and the most costly way to go on this.

I would also say if we allowed the pharmacist in my great state and around the country to negotiate and bring in prescription drugs, to do business with those in Canada, we could drop prices in half tomorrow, which is a bigger discount than any card we are going to come up with.

Dr. MCCLELLAN. I know how strongly you feel about these issues, and I would just like to add on this point that by having multiple cards available, we can make sure that people get the formularies they want. It is true that there are some government programs out there that just have one set of benefits, but I am not sure that is going to deal effectively with all of our diverse beneficiaries. The

VA formulary, for example, that gets mentioned a lot does not cover drugs like Vioxx and Lipitor and many of the other drugs that are commonly used by many millions of seniors. So what we are trying to do with our improvements in the card program is make it possible for you to hone right in on just the one or two or three programs that are best for your particular needs.

So it is like having just one or a few choices, but they are choices that are actually going to match up with the kind of drug assistance that you get, and in terms of prices, this negotiation approach seems to be making a real difference. There was a Consumer's Union study recently that found that the prices available through the Medicare endorsed drug cards are lower than the prices in California for Medi-Cal drugs and, you know, Medi-Cal is a very big state government run program that negotiates lower prices for their beneficiaries. The Medicare cards are doing better than that program. So there are certainly more steps that we should think about doing, but I think there is a lot of help available right now that we need to connect up with seniors, and we will keep trying to make the program work even better.

The CHAIRMAN. Mark, thank you very much. As Senator Stabenow said, and as John and I certainly also agree, we are going to keep a very close eye on you.

Dr. MCCLELLAN. Well, thank you very much. I think this kind of dialog is extremely helpful for us in focusing our efforts effectively, and we definitely appreciate your support for getting real relief right now to people who have already been waiting too long with high drug prices. Thank you very much.

The CHAIRMAN. Well, we know that you have a very difficult task in front of you with a very complicated bill, and we will always expect you to be on time and on schedule.

Dr. MCCLELLAN. I will do my best.

The CHAIRMAN. Thank you very much.

Dr. MCCLELLAN. Thank you.

The CHAIRMAN. Now let us ask our second panel to come forward, please. Thank you all very much. Our second panel today we will hear from Gail Wilensky, a former administrator of the Health Care Finance Administration. That is the old HCFA versus the new CMS. Currently the John M. Olin Senior Fellow at Project Hope, where she is one of the country's foremost authorities on Medicare, Medicaid and health care policy.

Next, we will hear from Dr. Byron Thames.

Dr. THAMES. Thames.

The CHAIRMAN. Thames. A family physician from Orlando, Florida, joining us today as a trustee of AARP, an organization, of course, whose support and counsel was critical to the enactment of the Medicare legislation we are discussing today.

Next will be Dr. Jane Delgado.

Ms. DELGADO. Yes.

The CHAIRMAN. Is president and CEO of the National Alliance for Hispanic Health and also a founding member of the new Access to Benefits Coalition that Dr. McClellan talked about, an organization dedicated to promoting outreach and enrollment of low-income seniors in the new Medicare drug program.

Last, today Patricia Nemore, an attorney and Medicare expert, who is with the Washington Office for the Center of Medicare Advocacy, an organization focused on improving access to Medicare and quality health care. Well, we thank you all very much and, Gail, we will start with you.

STATEMENT OF GAIL WILENSKY, PH.D., JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE, FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, BETHESDA, MD

Ms. WILENSKY. Thank you. Mr. Chairman, Senator Breaux, thank you for inviting me to testify. I would like to re-enforce some of what has been said about how the new Medicare legislation will help the lowest income and the most vulnerable populations. I also want to stress the importance of allowing the full benefit to be implemented before introducing new legislative changes.

As it is, it will take a Herculean effort to implement the major provisions of the legislation as it is now specified in law. I know. I have been there and I can now say it in a way that Mark McClellan cannot. The Medicare prescription drug card began enrolling beneficiaries in early May and started operations June 1, as you know.

CMS estimates that about four million have enrolled, a really remarkable number given that it is only 2 months out. The card provides a way to get immediate assistance, especially for those who have no outpatient coverage which, of course, is not the majority of seniors, but even more important is the cash assistance that has been provided for those who are below 135 percent of the poverty line, the $600 that they will have as well as no enrollment fee.

CMS has found that low-income beneficiaries are saving substantial amounts of money—you have been hearing that already from Dr. McClellan—when you think about both the discount and the cash assistance. There is some very important provisions of the cash assistance which I hope will be considered as precedent for future policy changes.

The first is that the entire $600 is available even though the program started June 1, but more importantly is the provision to be able to roll over unused dollars into next year. I keep hoping that the Congress will consider that for the provisions and flexible spending accounts rather than the current use it or lose it provision which only encourages employees to spend their money however they may at the end of the year.

Cards and assistance that can be used by these low-income seniors are people who will also have access to state pharma programs or some of the special discounts that the manufacturers make available so that their help may even be greater than it now appears.

The real benefit, of course, though, starts in January 2006. A lot of attention has been given to the gap in coverage, the so-called "donut hole." Although, as you well know, the fact is that 14 million low-income seniors will not have to face that gap in coverage provided that they also have low assets. People who are below the poverty line pay only a small copay up to the catastrophic coverage. Those who are institutionalized dual-eligibles pay nothing at all.

People who are above 135 percent of the poverty line but below 150 pay slightly higher copayments, but relatively small amounts.

Now, a lot of attention has been raised recently about what has been happening with the dual eligibles, those individuals who are eligible for Medicare and Medicaid. Of course they will not be impacted until January 2006, but there is something that is very ironic that is going on with some of the discussion.

Before the legislation was passed, many individuals spoke as though they wanted to have Medicare supersede Medicaid because Medicare has not been typically regarded as a means tested or welfare-related program. Now, it is possible that there are some people with very severe disabilities who happen to live in very generous states that could find themselves somewhat worse off, but, in fact, the states will save money, not as much as they would have if there hadn't been the maintenance of effort provisions, but they will nonetheless save money. So it is hopeful that in the generous states, they will continue providing some extra coverage, but the fact is under the old dual-eligible Medicaid coverage of prescription drugs, because prescription drugs is an optional benefit, there was no guarantee as to what individuals would be covered for.

This was not an entitlement. Many states had preferred drug lists, do have preferred drug lists under Medicaid and a number of states have a lot of restrictions in terms of the amount of drug coverage provided. None of that will now happen with the dual eligible. So that while there may be some issues for some of the most disabled individuals, I think that we ought to understand that dual eligibles in general will be much better off than they had been before.

There is some important information in a recently released study that I see was outside the door by PriceWaterhouseCoopers that shows the substantial amount of help that will be going to people below 150 percent of the poverty line and below 135 percent of the poverty line. They estimate that 98 percent of the spending by dual eligibles will be covered by this new bill. They furthermore estimate that 65 percent of the low-income beneficiaries are expected to pay less than $250.

Just a couple of comments about some lessons that we are already learning. The fact of the matter is reaching low-income populations has always been very difficult. We know that from the qualified Medicare beneficiary outreach attempts at QMB, the so-called SLMB, the selected low-income beneficiaries, from the Children's Health Insurance Program, and that this is not a new problem with regard to the prescription program attached to Medicare.

The cash transition program will help. It will give CMS some time to figure out how to reach out to these low-income populations. As was discussed, automatic enrollment has been requested by some states and that this and other strategies will also be helpful in identifying low-income populations. Outreach is important. The state aging agencies can be helpful. The churches, the advocacy groups are all very important to be involved.

The president's budget assumes 10.9 million people out of 14.5 eligible will actually enroll in 2006. That is an extraordinary number. I do not know whether they will be able to reach it, but the

fact that that is their expectation really is a very important focus point. They will need lots of help.

Let me again end with my plea, do not fix problems legislatively before 2006 when the main benefit has been rolled out unless you do not care if the program starts on time.

There will, of course, be clean-up legislation. There always is. We saw the Balanced Budget Refinement Act and the so-called Beneficiary Improvement Act following the Balanced Budget Act. CMS now has an enormous burden put on it. A new benefit using a new delivery system, a modified private health care plan, lots of changes to Part B drug coverage, lots of provider payment changes, and other areas not even related to Medicare.

Congress has really helped by providing a billion dollars to CMS and $500 million to the Social Security system, something that I believe is unprecedented. It has been helpful that Mark McClellan was confirmed as quickly as he was, but there has been a lot of staff turnover and an enormous amount of work. Some of it was predictable because of the aging of the staff, but even so, when it happens, it is still very difficult.

This means that if there is an attempt to try to change the legislation before January 2006, it is very unlikely that this important benefit will actually exist. Let it go as it is. There will be problems. Fix them legislatively, but after the fact if you care about what happens to these low-income seniors.

Thank you.

[The prepared statement of Ms. Wilensky follows:]

Helping Those Who Need It Most:

Low Income Seniors and the New Medicare Law

Testimony

Presented To

The United States Senate

Special Committee on Aging

By

Gail R. Wilensky, Ph.D.
Senior Fellow, Project HOPE

July 19, 2004

Mr. Chairman and members of the committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation. I am also a former Administrator of the Health Care Financing Administration (1990 to 1992), now called the Centers for Medicare and Medicaid Services or CMS and a former chair of the Medicare Payment Advisory Commission, or MedPAC, from 1997 to 2001. My testimony today reflects my personal views as an economist and health policy analyst and also my experiences as Administrator of HCFA and chair of MedPAC.

The purpose of my testimony is to review the ways in which the new Medicare Modernization Act (MMA) impacts the lowest income and most vulnerable populations, the reasons why these provisions are so important and the lessons that can be learned from the experiences thus far with the prescription drug discount program and previous programs designed to assist the low income Medicare population.

Much has already been written about what's wrong with the new Medicare legislation. While there undoubtedly will be and should be modifications to the Medicare legislation, too little attention is being given to the positive impact the legislation will have on the lowest income populations. It is also important that any changes to the legislation occur after the full benefit has been implemented. As it is, it will take a Herculean effort on the part of CMS to implement the major provisions of the legislation in the time specified.

The Medicare Prescription Drug Discount Card

The Medicare prescription drug discount card began enrolling Medicare beneficiaries into the program in early May and began operations June 1. It is legislated to be in operation until December of 2005 and can best be thought of as a transition to the new Part D drug benefit of Medicare. According to recent CMS estimates, approximately 4 million people have already enrolled in the program, a remarkable number for the first two months of operation, compared to the experience with other new programs.

The prescription drug discount card was established as a way of providing immediate assistance to beneficiaries, available to all but intended for those without other outpatient drug coverage. The main purpose of the drug discount card is to bring the advantages of group purchasing to seniors who previously have had to "buy retail" and thus lower the prices that they have to pay. Purchase of the drug discount card is voluntary and can cost no more than $30 per year. Individuals may purchase only one Medicare-approved discount card.

In addition to the discount card, a cash subsidy of $600 is available to low income seniors who have no other drug coverage. Low income for purposes of the cash subsidy is defined as being below 135% of the Federal poverty line, which is about $12,569 per year for a single person and about $16,862 per year for a couple. These individuals do not have to pay an enrollment fee. An analysis by CMS has found that over a 7-month

period, low-income beneficiaries should be able to save between 32% and 86% over national average retail prices, when both the discounts and the $600 assistance are taken into account.

There are some very important features about the cash subsidy that add to the value of the subsidy and that may also serve as an important precedent for future policy change. The most important feature is that low-income individuals will receive the full $600 for 2004 even though the program only starts mid-year. Second in importance is that individuals who do not spend the full $600 may roll-over any remaining funds to 2005. The roll-over provision of unused funds, if applied elsewhere in current law such as to the flexible spending accounts used by many employees, would fundamentally change the "use-it or lose-it" feature that currently characterize these accounts.

The cash assistance is an important subsidy to the low-income population but it does not provide for 100% coverage even within the first $600 of prescription drug spending. As part of a deliberate policy statement, the Congress decided that low-income seniors should pay something for their drugs, even for the first $600. Individuals with incomes below 100 % of the poverty line pay 5% of the cost, which means a maximum of $30. Individuals who are between 100% and 135% of the poverty line pay 10% of the cost or a maximum of $60.

Because the prescription drug cards and cash subsidies can also be used by beneficiaries who have access to state pharmaceutical assistance program and/or special discounts that

pharmaceutical manufacturers make available to those in need, the potential assistance available to the most vulnerable populations who are not Medicaid-eligible is larger than most realize. In addition, Medicaid coverage remains in place for those who on both programs, the so-called dual-eligibles, until January of 2006.

The Medicare Part D Prescription Drug Benefit

Although a large amount of the media attention has been focusing on the prescription drug discount card, the actual Medicare drug benefit doesn't begin until January 1, 2006. The Part D drug benefit is a voluntary benefit that either will be delivered by private, stand-alone drug plans or as part of a comprehensive Medicare benefit delivered by private health plans. A government fall-back plan is authorized for any area that doesn't have at least two private-sector choices.

The standard coverage, for those above 150% of the poverty-line, involves a $250 deductible, 25% co-insurance for the first $2,250, 100% coinsurance for the next $3,600 (the so-called "doughnut-hole") and catastrophic coverage for any spending above that amount. Catastrophic coverage is defined as a 5% co-insurance or $2 for a generic drug/$5 for a branded drug co-payment per prescription, whichever is greater. In addition, there is a monthly premium, which is estimated to be $35 per month in 2006. The thresholds are indexed to grow according to the growth in per capita Part D drug spending.

The new Medicare law provides substantial additional help paying for prescription drug costs for low-income individuals who also have low assets. The greatest assistance is provided for people on Medicare who also have full Medicaid benefits, the so-called "full-benefit dual eligibles". Institutionalized dual eligibles (i.e. nursing home residents) have no payments. Dual eligibles below 100% of the poverty line pay no premium, no deductible and a small co-payment of $1 per generic or $3 per brand name prescription, up to the catastrophic level of coverage. After that, they pay nothing. Dual eligibles above the poverty line have similar assistance except that their co-payments are $2 per generic and $5 per branded name prescription.

People on Medicare with incomes below 135% of the poverty line and with limited assets ($6,000 per individual or $9,000 per couple) have the same assistance as dual eligibles that are above the poverty line. That means they have full coverage except for the $2/$5 co-payments.

People on Medicare with incomes below 150% of the poverty line and with slightly higher assets ($10,000 per individual or $20,000 per couple) have a more complicated assistance package. They pay a sliding scale premium (the amount depends on the premium cost of the plan they choose), $50 deductible, 15% coinsurance up to the catastrophic coverage and co-payments of $2 per generic and $5 per branded drug thereafter.

The Importance of the Low Income Assistance Provisions

Since the passage of the Medicare Modernization Act, there has been a lot of criticism leveled against the bill because of the gap in coverage after the first $2250 in spending and very little attention paid to enormity of assistance being provided to the low income population. Concern and criticism has also been raised about the dual-eligibles and whether they will get as much coverage after the bill is implemented as they had been getting under Medicaid.

There is at least some irony that prior to the passage of the bill, many of those now raising concerns about the dual eligibiles had been pressing for Medicare to take precedence over Medicaid. The legitimacy of these concerns won't become clear until after the regulations are written that define many of the specifics regarding the behavior of the free-standing drug plans including the required classes of drugs that will be made available to all beneficiaries and also until it becomes clear how state and pharmaceutical assistance programs adapt to the changing environment that follows the implementation of the Part D drug benefit.

What does seem to have been forgotten is that there have been a lot of problems with pharmaceutical coverage for dual eligibles all along. Under the new Medicare legislation, dual eligibles will have an entitlement to drugs and states won't be able to impose arbitrary restrictions on the number of prescriptions, both of which states could and did do under Medicaid. Since prescription drug coverage has been an optional

benefit under Medicaid, there has been no guarantee as to what states would make available. Some states had quite restrictive prescription drug benefits in terms of the allowed numbers of prescriptions per month or refills per year and at least 16 states used preferred drug lists combined with prior authorization provisions.

Although it is true that dual eligibles may not be guaranteed as complete drug coverage as they had in the most generous states under Medicaid, it is certainly possible that these same states will provide additional assistance at their own expense. The states can expect to achieve some savings as a result of the new Medicare law (although not as much as they would have if there hadn't been a maintenance of effort provision in the bill) and may therefore choose to augment the benefits made available to the dual eligibles. In a recently released study by PricewaterhouseCoopers for the Alliance to Improve Medicare, they estimate that the new law will pay for 98% of the spending by dual-eligibles even without supplementary support by the states.

The benefits to the remaining low income beneficiaries are very substantial and will mean that most of their prescription drug expenses will now be covered by Medicare. In the same PricewaterhouseCoopers study, the MMA is estimated to cover 96% of the prescription drug costs for beneficiaries below 135% of the poverty line who meet the relevant asset tests and 85% of the total prescription drug costs for beneficiaries that are below 150% of the poverty line who meet the asset limits for that group.

To put the spending of the MMA into perspective, this means more than 40% of the new Federal spending will be for individuals who are below 150% of the poverty line. Without the legislation, the PWC study estimates that 27% of these low income beneficiaries would have had no prescription drug coverage in 2006. With the new legislation, 65% of the low income beneficiaries (without Medicaid) are expected to spend less than $250 per year, with the median out of pocket spending expected to be about $200 and the mean about $725.

Lessons to be learned

The prescription drug discount card has been in effect for less than two months but there are already some lessons to be learned and more than will become clear as the year continues. Reaching and enrolling low income populations has always been difficult. This was true for the Medicare savings programs, the Medicare Qualified Beneficiary (QMB) and the Selected Low Income Beneficiary (SLMB) programs and also for the state Children's Health Insurance Program (SCHIP). This history actually makes the enrollment of 4 million seniors in two months quite remarkable.

Identifying and enrolling people in the transitional cash assistance program will be helpful for understanding how to reach the potentially-eligible individuals for the low income subsidy in the Part D benefit. States need to work together with the Federal Government to help make this happen better. The automatic enrollment strategy that has

been adopted by Pennsylvania and New York represents one such strategy and can be requested by other states but it raises other issues in its own right.

Out-reach programs conducted by state agencies on aging, the churches, advocacy groups and other means of reaching low income populations have had some effect in the past and should be pursued here. The President's 2005 budget has assumed a very successful rate of low income enrollment: 10.9 million out of a potential 14.5 million enrolled in 2006. I am not aware of any program that has achieved that high a rate of enrollment that quickly. It will represent an extraordinary achievement if it occurs.

CMS has already started modifying how information is presented for the discount cards, the type of information that is available on-line and the amount of time that it takes to connect with the 1-800 number. The Agency's ability to respond to problems as they arise portends well for the future.

The Importance of *Not* Introducing New Legislation Before 2006

There have already been calls for modifying the MMA, because of real or perceived inadequacies in the MMA or other concerns about the legislation. While there are undoubtedly many areas that will need to be modified over time, it is vital that CMS be allowed to proceed with the legislation as it is now written so that the Part D prescription drug benefit can start as of January 2006. To make changes during the next year is to seriously risk the start date. As is shown in this and other testimonies, delaying the

current legislation would have a serious and negative effect on the lowest income beneficiaries.

Many in the public have complained about the January 2006 start-date of the Part D benefit. These complaints are usually made by people who do not understand the large number of operational decisions that need to occur and the implementing regulations that will need to be issued prior to November 15, 2005, the date when Medicare beneficiaries are scheduled to begin their enrollment of the Part D benefit. These decisions relate first, to the provision of a new benefit using a new delivery system housed in a new center in CMS; second to a series of changes to the outpatient drugs already covered in Medicare under Part B; and third, to payment adjustments and other modifications to Medicare providers. Finally, CMS continues to have a number of obligations to fulfill from previous legislation as well as its other program responsibilities.

All of this work needs to occur during a period when there has been an unusually high level of turnover in the senior career staff of CMS, along with all of the uncertainties and change associated with an election period. Fortunately, CMS will not have to go through this activity with interim leadership. The confirmation of Dr. Mark McClellan last March as the CMS Administrator provides an important source of stability and leadership to CMS.

The early results of implementing the MMA have been promising. The appropriation of $1 billion to CMS and $500 million to the Social Security Administration to implement

the legislation is recognition of the daunting challenges associated with the MMA. The Congress would do well to let CMS proceed without further change until the Part D benefit is in place. This will permit CMS to proceed with its implementation strategy, will permit seniors to receive their promised benefits and will still allow the Congress to enact further change as it deems appropriate.

* * *

The CHAIRMAN. Gail, thank you very much. Now, Dr. Thames.

Dr. THAMES. Thames, yes sir.

The CHAIRMAN. Thames. Thank you very much.

STATEMENT OF BYRON THAMES, M.D., TRUSTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS, ORLANDO, FL

Dr. THAMES. Thank you very much, Mr. Chairman, Senator Breaux. We thank you for inviting AARP to discuss the new Medicare drug law and how it helps beneficiaries with limited incomes. These provisions offer meaningful assistance to over 13 million people who need help the most in purchasing prescription drugs. They are among the most important features of this new law, and are the first critical steps toward providing comprehensive and affordable prescription drug coverage that all Medicare beneficiaries need and deserve.

AARP is working to ensure that beneficiaries know about the new benefits and take advantage of the assistance. We are conducting extensive public outreach efforts that to date have reached roughly 300,000 of our members and their families. We have produced three booklets explaining the new law in plain language that the average reader can understand.

AARP is also among the more than 80 groups participating in the Access to Benefits Coalition which is working to find and help those eligible for the extra assistance to understand and enroll in the programs. To meet this challenge, the Coalition is providing grants, education materials and technical assistance to coalitions of local groups that are forming across the country to help people take advantage of the assistance available to them.

The rollout of the new limited income benefits is a massive undertaking and as with many new programs, lessons are learned along the way. Medicare officials are already taking advantage of these lessons to make improvements, such as establishing a standard application form that can be used to enroll individuals in any of the more than 70 different discount card options and allowing state pharmacy assistance programs to auto enroll their members in the drug card program.

AARP believes we can and should make further improvements as we proceed. For example, people in Medicare savings programs also should be auto enrolled in the drug card program. These beneficiaries generally have incomes below 135 percent of the Federal poverty level and are among those who most need help with prescription drugs. Relying on outreach efforts alone virtually guarantees that many of these people will not get the $600 transitional assistance credit to which they are entitled.

Auto enrollment is a proven method to ensure that they do gain access and we believe it can be done in a way that preserves choice and encourages market forces to help drive prices down. For the comprehensive drug program, the most important needed improvement to the low-income provision is elimination of the asset test. The asset test creates a welfare stigma and sends the wrong message because it penalizes individuals who have managed to modestly save for retirement. The asset test also involves complicated rules and massive amounts of documentation which may well dissuade people from applying for extra assistance.

One of Medicare's greatest strengths is that it does not carry such a stigma. Medicare is a social insurance program. An asset test for the drug benefits begins to erode that great strength. With these and other improvements that can be made, the extra assistance provided for people with limited incomes in the new Medicare drug law establishes a foundation and model for providing comprehensive drug coverage to all Medicare beneficiaries.

That is a goal that we all share. We greatly appreciate the efforts of the administration and Congress to reach out to those who are eligible for this extra assistance and to make refinements as the program is implemented.

We look forward to continuing these efforts through full implementation of the new law in 2006 and beyond. Thank you.

[The prepared statement of Dr. Thames follows:]

TESTIMONY BEFORE

THE SENATE SPECIAL COMMITTEE ON AGING

ON

HELPING THOSE WHO NEED IT MOST: LOW-INCOME BENEFICIARIES AND THE NEW MEDICARE LAW

JULY 19, 2004

WASHINGTON, D. C.

WITNESS: THOMAS "BYRON" THAMES, M.D.
AARP BOARD MEMBER

For further information, contact:
Kirsten Sloan/Paul Cotton
Federal Affairs Department
(202) 434-3770

Mr. Chairman and members of the Committee, my name is Byron Thames, and I am a member of the AARP Board of Directors. Thank you for inviting AARP to discuss the provisions in the Medicare Modernization Act (MMA) that provide beneficiaries with limited incomes extra assistance in affording the prescription drugs they need.

The limited-income assistance provisions are among the most important features of the new Medicare drug law. These provisions offer meaningful assistance to over 13 million lower income beneficiaries who need help the most in purchasing prescription drugs. The MMA includes two distinct features to assist those with limited incomes:

- In the short term, a $600 annual transitional assistance credit is available for the next two years through the Medicare-endorsed drug discount card program for those with incomes below 135 percent of the federal poverty level (and no military or group drug coverage).

- Starting in 2006, comprehensive drug coverage with premium subsidies, low cost-sharing, and no coverage gap is available for those with incomes at or below 150 percent of the federal poverty level.

These provisions are the first critical steps toward providing the comprehensive and affordable prescription drug coverage that all Medicare beneficiaries need and deserve. Through extensive public education efforts, AARP is working to ensure that beneficiaries know about the new benefits and take advantage of the assistance. We are also committed to working with the Congress and the Administration to further improve these low-income programs.

My statement focuses on AARP's outreach efforts, the improvements to the low-income provisions to date, and the further refinements we believe are necessary to make the benefits even better for beneficiaries.

AARP Outreach Efforts

To help our members and other Americans understand the benefits of the limited-income assistance provisions, AARP has undertaken extensive public outreach efforts. Roughly 300,000 of our members and their families have participated in AARP sponsored forums and events over the past few months to learn about the new benefits. We have produced three booklets explaining the new law in plain language that the average reader can understand:

- One, *Medicare Drug Discount Card: Helping Those With Limited Incomes*, focuses specifically on assistance available for people with limited incomes through the discount card program;

- A second, *Medicare Drug Discount Card: What You Need to Know*, explains the discount card program overall; and

- A third, *Medicare Changes That Could Affect You*, addresses the comprehensive drug benefit that begins in 2006, as well as other MMA changes that affect Medicare beneficiaries.

These booklets have been very well received by beneficiaries and are available to (and have been extensively used by) other consumer organizations, Members of Congress, as well as others engaged in outreach efforts.

ABC Coalition Outreach Efforts

AARP is also among the more than 80 groups participating in the Access to Benefits Coalition (ABC), which is working to find and help those eligible for the MMA's extra assistance benefits to understand and enroll in the programs. To meet this challenge, the Coalition is providing grants, education materials and

technical assistance to coalitions of local groups that are forming across the country to help people take advantage of the assistance available to them.

The Coalition also has established a website at www.accesstobenefits.org that provides information on not just the MMA limited-income assistance provisions, but also on a host of other programs offered by drug manufacturers, states, and others to help people of limited means pay for the prescription drugs they need.

To further our outreach efforts, AARP is independently providing additional financial support to groups with established networks and expertise in reaching hard-to-reach populations that will benefit from the new law.

Improvements to the Low-Income Benefits

The roll out of the new limited income benefits is a massive undertaking, and as with any new program, lessons are learned along the way. We are very encouraged by the Center for Medicare and Medicaid Services (CMS) response to issues and concerns AARP and others have raised about the discount card program in particular. For example CMS has:

- Established a standard application form that can be used to enroll individuals in any of the more than 70 different discount card options offered by various sponsors around the country;

- Allowed state pharmacy assistance programs to auto-enroll their members in the drug card program, thus maximizing enrollment as well as savings to both states and individual beneficiaries;

- Made several improvements to the medicare.gov prescription drug price comparison website so it is more accurate and easier to use to get individualized information on potential savings from the various cards; and

- Reduced to about two days the time it takes to verify and approve applications for the drug card and its transitional assistance component so people can begin to take advantage of negotiated discounts and the $600 annual credit as quickly as possible.

Further Improvements

AARP believes the Medicare Modernization Act provides a foundation upon which we will build over time. To that end, we will continue to work with the Congress and the Administration to strengthen the discount card program and the broader drug benefit that begins in 2006.

MSP Auto-enrollment

Many of the lower income Medicare beneficiaries eligible for the $600 transitional assistance are the hardest to reach. They are the least likely to know about the drug cards or to be found through traditional outreach efforts.

The auto-enrollment of state pharmacy assistance program enrollees was an effective way of enrolling large numbers of those eligible for the new benefits. We believe auto-enrollment is the most effective way of reaching another important group of beneficiaries – those eligible for the Medicare Savings Programs (MSP). The MMA deems MSP enrollees – Qualified Medicare beneficiaries (QMB), Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Individual (QI) who receive some help with Medicare cost sharing requirements – to meet income criteria for the $600 annual transitional assistance credit.

MSP enrollees generally have incomes below 135 percent of the federal poverty level but do not have comprehensive Medicaid coverage from their state, and thus are among those who most need help with prescription drugs.

Relying on outreach efforts alone to enroll MSP individuals in the transitional assistance program virtually guarantees that many, if not most, of these people will not get the $600 to which they are entitled. MSP experience underscores how difficult this population is to reach, as less than two thirds of those who are eligible for these MSP benefits are enrolled. Enrollment will be even more difficult for this new temporary program. Auto-enrollment is a proven method to ensure that the substantial and needy population of MSP individuals – which include those for whom the $600 transitional assistance would be most important – will gain access to it.

AARP and other groups are engaged in ongoing discussions with the Administration and outside experts on the various issues and challenges raised by MSP auto-enrollment. Based on these discussions, we believe several steps are needed to ensure that it is done effectively, efficiently, and in a way that encourages market forces to help drive prices down.

AARP believes that Medicare, not states, should conduct MSP auto-enrollment. Unlike with auto-enrollment of individuals in state pharmacy assistance programs, states will not directly benefit from MSP enrollment, and some states cannot or would not choose to participate in auto-enrollment. Thus relying on them would yield at best only partial success. While some have raised legal questions, we do not believe that the statute prohibits CMS from acting on behalf of beneficiaries in this manner.

Concerns about other coverage that could potentially disqualify MSP enrollees from eligibility for the transitional assistance program must be put into practical perspective. It is clear that the vast majority of those with incomes low enough to

qualify for MSP generally do not have other drug coverage, since the retiree drug coverage that would disqualify someone almost always go hand-in-hand with good pensions that put incomes well above MSP eligibility levels.

Waiving the requirement for attestation by these individuals would result in, at most, a negligible amount of ineligible enrollments. Concerns about any such enrollment could be allayed by making clear to auto-enrolled individuals that use of the card constitutes attestation that they have no other drug coverage. If concern remains about potential enrollment of ineligibles, MSP auto-enrollees could be required to sign a statement when they first use the card attesting that they do not have other drug coverage.

Concern about choosing the "right" card for auto-enrolled MSP individuals also must be put into practical perspective. For those eligible for the $600 annual transitional assistance, enrollment in any card is better than enrollment in no card, which is the likely outcome for many MSP enrollees if auto-enrollment does not take place.

Finally, concerns about maintaining free choice and a competitive market can be addressed while conducting auto-enrollment. For example, MSP enrollees could be assigned to cards randomly based on voluntary enrollment in each card, thereby reinforcing choices made by other beneficiaries based on price. Auto-enrolled individuals could be told in advance which specific card they will be assigned to and given time to review its features and switch to a different card if they choose.

In addition, the legislation authorizes the HHS Secretary to establish a special election period, which could give auto-enrolled individuals further opportunity to review options and change cards. Auto-enrolled individuals can also be given the opportunity to decline participation altogether, so that the program remains voluntary in nature.

Asset Test Elimination

For the comprehensive drug program, the most important needed improvement to the low-income provisions is elimination of the asset test. Under the MMA, if the total amount of certain types of assets exceeds certain thresholds, $6,000 for singles and $9,000 for couples, beneficiaries receive less help with premiums and cost sharing. If the total amount of assets exceeds $10,000 for singles and $20,000 for couples, they are not eligible for any extra assistance at all.

This asset test sends the wrong message. It penalizes individuals who, despite having very limited incomes, have managed to save a modest sum for retirement. In return for having saved these modest sums, they are denied the comprehensive drug coverage available to those of similar means who have not saved for retirement.

The asset test can also involve massive amounts of documentation. Guidance from Medicare for people applying for limited-income assistance in a demonstration project that mimics the Medicare drug benefit provides a good illustration. Rather than list all the types of assets that have to be reported, the guidance instead includes a list of more than 20 types of assets that do not have to be reported. This is in addition to a two-page list of various types of income that do not have to be reported. The complexity of determining what must be included, along with the threat of sanctions if applications are inaccurate, may well dissuade many people from applying even though they need and would qualify for extra assistance.

Finally, the asset test creates a welfare stigma that could discourage some people who need and are eligible for extra assistance from applying for it. Many Medicare beneficiaries struggling to make ends meet on limited incomes take great pride in their self-sufficiency, and simply would not apply for a benefit they perceived to be part of a welfare program.

One of Medicare's greatest strengths is that it does not carry such a stigma. Medicare is a social insurance program. An asset test for the drug benefit begins to erode that great strength.

Medicaid-to-Medicare Transition

The statute specifically provides for auto-enrollment of Medicare beneficiaries who now get full health care coverage from Medicaid. It also requires states to pay to Medicare a large share of what the states would have paid for these "full dual" eligible individuals' drug costs. As people now receiving drug benefits through state Medicaid programs move to the new Medicare drug benefit, there should be a smooth transition.

In making this transition, it is critical that there be no gap in coverage. The statute calls for auto-enrollment only if a full dual beneficiary "has failed to enroll" in a Medicare drug plan. However, since states will likely discontinue Medicaid drug coverage right away, auto-enrollment of affected individuals should be effective no later than January 1, 2006.

Grandparents Raising Grandchildren

Finally, we want to ensure that there is fair treatment for grandparents raising grandchildren in determining eligibility for limited-income assistance in the full Medicare drug benefit. The statute bases eligibility for limited-income assistance on the federal poverty level, which varies by household size. For example, a married couple raising two grandchildren currently can have an income up to $24,840 and be under 135 percent of poverty, which is substantially greater than the $16,362 income that constitutes 135 percent of poverty for a two-person household. That makes sense because a larger household, such as a couple that is supporting grandchildren or dependent children, has greater economic needs.

However, in the discount card program, Medicare officials have based eligibility solely on whether an individual beneficiary is married or not, and ignored the fact that those with larger households can have larger incomes and still meet the statutory federal poverty level criteria.

We believe it is critical that the entire household size be taken into account when evaluating eligibility for limited income assistance to ensure fair treatment for Medicare beneficiaries who have taken on the added responsibility of raising grandchildren.

Conclusion

The extra assistance provided by the MMA for people with limited incomes results in comprehensive coverage for those who need it most, and is among the most important features in the Medicare drug benefit legislation. The limited-income provisions establish a foundation and model for providing comprehensive drug coverage to all Medicare beneficiaries – a goal that we all share. We greatly appreciate the efforts of the Administration and Congress to reach out to those who are eligible for this extra assistance and to make refinements as the program is implemented. And we look forward to continuing these efforts through full implementation of the new law in 2006 and beyond.

The CHAIRMAN. Doctor, thank you very much. Now, let us turn to Dr. Jane Delgado.

Doctor.

STATEMENT OF JANE DELGADO, PH.D., M.S., PRESIDENT AND CEO, THE NATIONAL ALLIANCE FOR HISPANIC HEALTH, FOUNDING MEMBER, THE ACCESS TO BENEFITS COALITION, WASHINGTON, DC

Ms. DELGADO. Good afternoon, Mr. Chairman, Senator Breaux. I am president and CEO of the National Alliance for Hispanic Health, founded in 1973, and today serving over 12 million persons. I am also a founding organizational member and on the five-person steering committee of the ABC Coalition. My summary statement is going to focus on four things: the importance of MMA to Hispanics; the ABC Coalition; what we are doing at the Alliance; and also some early feedback from communities which is helpful as we move forward.

First of all the importance of MMA to Hispanics. Most people do not know this, but Hispanics live longer than non-Hispanic whites. This is true for both Hispanic men and Hispanic women. So anything that has to do with older adults, we are keenly concerned with.

We are very concerned about individualized care. Our recent report "Genes, Culture and Medicines" points out the differences among people in how they metabolize drugs. So individualized care, which is the wave of the future, with reference to pharmaceutical drugs is very important for us.

The positive impact of MMA on healthy aging especially for low-income seniors. This is important to us as Hispanics.

Now, the ABC Coalition. Many people have mentioned it and I would like to say that our goal is very simple: to enroll 5.5 million beneficiaries by the end of 2005. Our members are very diverse. We are a group of senior organizations, disability organizations, faith-based, minority, provider, consumer and advocacy organizations, and we grow weekly.

Now, our membership is over 82. ABC as an organization is about effective implementation of the new Medicare law to ensure that low-income beneficiaries make optimal use of available public and private benefits to pay for prescription drugs.

I also want to say what ABC is not about. We are not about whether the MMA should or should not have been passed. We are not about how to reform it or whether we should. We are not about who should be elected president or to Congress. We are not about what we should do in other legislative positions. This is an organization people have agreed to be part of to enroll low-income seniors.

Our steering committee is the National Council on Aging, Alzheimer's, ourselves, AARP and Easter Seals, and we work through our working groups.

What we have successfully done has been based on the collective experience of all our members. One is to give grants to local organizations so they can actually enroll people. But the second thing is to give web-based tools to people so once they are at the point of trying to enroll people, they have the best information.

We have heard, that low-income people do not have access to the web. We understand that. But the people who are providing the intermediary service of helping enroll people do. So we have web-based tools that can help people get the best information on what is happening with MMA and the prescription drug benefit.

When we look at what we are doing at the Alliance, we are doing what we know best. We have established networks and funded 25 community-based organizations to actually enroll people, and in that we have to do some creative things—give people laptops, give them money so they could buy laptops so they could actually be part of the enrollment. We have produced videos. We have written and published a bilingual workbook. We have included the information on the Medicare transitional program on our help line.

From the early feedback we get from communities is accurate and timely information is needed. People talk about confusion, but when there are more choices, and choice is a good thing, there is going to be some confusion. So we need to make sure that trusted providers of information are there to help people work through the process.

This is an opportunity not just for the program, but also to talk to people about health. The outreach workers can go out, talk to people, do the kind of work which we want them to do, plus part of it is the MMA prescription benefit.

We find that there is a continuing importance of being able to go to your local pharmacy. People have a relationship with that person. They need to continue that.

The wraparound benefits are very important. If I were going to say what were the key things that are important about MMA, first of all, it is the single-most important opportunity to help lower income beneficiaries in the last 40 years. We think this is a key event for us. We want to make sure to support everything that we can to do it.

Second, the low-income benefit will help even more people in 2005 and further in 2006. We are glad about this, but we also know in order to do this that Medicare really needs to have the legislative language so they can have the full authority to work directly with community-based organizations.

Finally, we understand how very often a national campaign with counting the number of impressions in television and listening to radio is very important but, as we know, from every program in health education, knowledge is not enough. You need knowledge, attitudes, and behaviors. These community-based partners who are out there at the front lines are key to making this program a success.

That is what ABC is about. That is what the Alliance is doing. That is what makes this important, and we are here to work with you to make sure that the new prescription and preventative care benefits ensure a population that has healthy aging.

Thank you.

[The prepared statement of Ms. Delgado follows:]

TESTIMONY OF JANE L. DELGADO, PH.D., M.S.

PRESIDENT AND CEO

NATIONAL ALLIANCE FOR HISPANIC HEALTH

Good afternoon, Mr. Chairman and Members of the Committee.

It is a pleasure to appear before you today to discuss the Medicare Modernization Act (MMA) and its assistance for seniors of modest and low income. My name is Dr. Jane L. Delgado and I am President and CEO of the National Alliance for Hispanic Health (the Alliance), the nation's oldest and largest organization of Hispanic health and human services professionals. Founded in 1973, today Alliance members deliver quality health services to over 12 million persons every year improving health and well being throughout the Americas. The Alliance is also a founding organizational member and serves on the five person steering committee of the Access to Benefits Coalition (ABC) formed this year to ensure that all low-income Medicare beneficiaries, including seniors and younger persons with disabilities, know about and can make the best use of both public and private prescription drug savings programs. Today ABC represents over 80 national organizations and statewide and regional ABC coalitions are currently being established across the nation.

My testimony today focuses on the promise of the Medicare Modernization Act for improved health for seniors with low and modest income. Decades of research have shown that to change behavior you need to address knowledge, attitude, and behavior. **Knowledge is not enough.** The promise of the Medicare Modernization Act will only be achieved by the development of a

community environment that supports and encourages use of new Medicare benefits and which offers local and trusted resources to encourage this change. That is the purpose of the Alliance and ABCs efforts, to go beyond media impressions to the attitude and behavior change needed to achieve signup for Medicare benefits and use of new prescription and preventive care benefits to promote healthy aging.

My testimony will have three parts: (1) the impact of the Medicare Modernization Act for Hispanics, (2) the ABC Coalition, and (3) the Alliance's efforts.

I. The Impact of the Medicare Modernization Act for Hispanics

The Hispanic "Aging Boom"

Like other population groups, Hispanics are experiencing an "aging boom." Today, there are over 2.8 million Hispanic Medicare beneficiaries and that number will continue to grow. Indeed, Census estimates have shown that the proportion of Hispanics who are elderly (65 years of age and older) will increase more than three-fold from 4.0% today to 14.1% in the year 2020. Also, Hispanics will represent an increasing proportion of the senior population overall as the life expectancy for Hispanics is longer than that of other population groups. The most recent projections by the Census Bureau put life expectancy for Hispanic men at 77.2 years compared to 74.7 years for non-Hispanic white and 68.4 years for non-Hispanic black men. Life expectancy for Hispanic women is even longer at 83.7 years which compares to 80.1 years for non-Hispanic white and 75.1 years for non-Hispanic black women. The challenge is ensuring that a longer life expectancy is accompanied by healthy aging.

Supporting Individualized Care

Modern medicines can extend life, enable a better quality of life, and reduce the use of health services. Pharmaceuticals play an important role in the treatment and management of chronic conditions common in Hispanics, including diabetes, depression, and cardiovascular disease. Pharmaceuticals have also contributed substantially to the large reduction in disability and increased ability of seniors to live independently or with home or community-based assistance which has been observed in recent years.

Looking to the future of Medicare and new prescription benefits, one of the most important issues for Medicare will be ensuring that Medicare beneficiaries have access to the best medications for their individual needs. Advances in genetic research have provided scientific insights at a new level of detail. A recently released report by the Alliance, "Genes, Culture, and Medicines," brought together for the first time a growing body of scientific research demonstrating substantial disparities in pharmaceutical therapy for Hispanics. I have attached this important report as part of my testimony.

The report found that about 15% of Hispanics compared to 2.4%-6.7% of non-Hispanic whites have been reported to have a variation in the structure of a gene affecting the metabolism of many common drugs, requiring differences in dosing and access to a broad choice of pharmaceuticals in order to achieve a therapeutic effect. For example, Mexican Americans metabolize drugs regulated by enzymes coded by the CYP2D6 gene faster than whites. This gene mediates the metabolism of at least 30 therapeutically important medications, including

cardiovascular agents and almost all psychotropic drugs. Available research indicates the following variations in genes and drug metabolism for Hispanic populations.

CYP3A4	Slower metabolism/higher blood levels in Mexicans (metabolism in U.S. Hispanics not yet studied)	• nifedipine (cardiovascular) • cyclosporine (immunosuppressive) • midazolam (anesthetic)
CYP2D6	Faster metabolism in Mexican Americans Slower metabolism in Dominicans and Puerto Ricans	• many cardiovascular drugs • many psychotropic drugs
CYP2C9	Slower metabolism in Spaniards (U.S. Hispanic impact not yet studied)	• warfarin (stroke prevention) • phenytoin (epilepsy) • diabetes medications

A key factor in ensuring the benefits of medicines is a thorough understanding, not only of drug therapy, but also of individual response factors that may have an impact on the effectiveness and safety of drug therapy. Failure to recognize an individual who is a fast- or slow-metabolizer, and to adjust the dose accordingly, can potentially result in therapeutic failure or unexpected toxicity, Given the differentials in response to medicines, future Medicare prescription benefit policy must support financing and reimbursement practices that are broad and flexible enough to enable rational choices of drugs, dosages, and formulations for Hispanic patients based on their genetic, medical, and cultural needs. Formularies that restrict choices do not reflect the best science which is finding significant differentials in drug response for racial and ethnic communities and means that "one size fits all" drug policies will not meet the needs of Hispanic seniors. Choice of the best pharmaceutical therapy should be between patient and provider.

MMA and Benefits for Healthy Aging

Passage of the MMA makes more likely the prospect of Hispanics' longer life being a healthy life. More than two-thirds (69%) of Hispanic older adults with a chronic illness or disease do not have prescription drug coverage. At the same time, Hispanics are more likely to suffer from a number of chronic diseases, such as diabetes. The impact is that Hispanic older adults are more likely to go without needed medications created increased emergency room and other health costs from untreated medical conditions. New Medicare prescription and preventive care benefits are a far better use of health resources and the impact on improved quality of life for Hispanic seniors will be significant.

Research has consistently shown that Hispanics are less likely to have access to preventive care services and screenings. The impact on health is significant. Hispanics are less likely to treat conditions early and suffer the consequences of untreated illness. For example, the National Institutes of Health reports that one-third of Hispanics with diabetes are unaware of their condition. Furthermore, Hispanics suffer disproportionately from the complications related to diabetes. Beginning in 2005, Hispanic Medicare beneficiaries will benefit from new benefits for diabetes screening as well as cardiovascular disease in addition to current covered screenings such as mammograms. The Department of Health and Human Services (DHHS) has released new estimates showing Medicare preventive care screenings will be available next year to 2.8 million Hispanics for cardiovascular screening blood tests; 690,000 Hispanics for diabetes screening; and a "welcome to Medicare" initial physical exam for 130,000 new Hispanic Medicare beneficiaries every year. These screenings and the physical examination benefit for new Medicare beneficiaries will make a significant contribution to reducing the burden of

disease for Hispanic seniors. However, offering screenings without the means to treat illness discovered in those screenings would do little to promote healthy aging. Treatment of chronic disease requires access to pharmaceuticals and that is why the new Medicare prescription benefits are so important to healthy aging for Hispanics, particularly low-income seniors.

Medicines and Hispanic Medically Underserved Seniors

Despite the increased rates of chronic illness and disease, Hispanics are less likely than the population as a whole to have access to medicines. Among the specific disparities in pharmaceutical treatment of Hispanics reported in the medical literature are the following:

- Hispanics are undertreated for pain from fractures and receive inadequate management of postoperative pain.
- Hispanics are less likely than non-Hispanics to receive antipsychotic medication.
- Mexican Americans receive fewer cardiovascular drugs following a heart attack than non-Hispanic whites, especially antiarrythmics, anticoagulants, and lipid-lowering therapies.
- Hispanic seniors receive fewer ancillary pharmacy services compared with non-Hispanics, including medication counseling.

Given this profile of less access to medicines, new Medicare prescription benefits represent an important step forward for the health of Hispanic seniors, particularly low-income seniors who have had the least access to the benefits of pharmaceutical therapy.

One of the most important features of new Medicare prescription benefits are the targeting of additional benefits to those most in need. More than one-third (37.5%) of Hispanic seniors live below 135% of the poverty level. It is this group of seniors that will realize the greatest benefits

from transitional prescription benefits this year and next year and the full Medicare prescription benefit in 2006. In addition to the drug discount cards available to all Medicare recipients, those below 135% of poverty now through the end of 2005 will receive a total of $1,200 in additional assistance to purchase their medicines ($600 in 2004 and $600 in 2005) if they sign up for a Medicare-approved drug discount card this year. DHHS estimates that 345,000 Hispanic Medicare recipients are eligible for this transitional assistance translating to over $400 million in prescription transitional assistance available to Hispanic Medicare recipients. The benefit to low income seniors will be even greater in 2006 when the full Medicare prescription benefit comes into place.

However, conflicting information on the benefit, distrust of federal information sources, and a lack of community-based resources to assist in benefit sign-up threaten to limit the number of Hispanic Medicare beneficiaries that will use the new prescription buying power offered by Medicare. Given the history of outreach to underserved communities, without a robust community-based capacity to assist Hispanic consumers many eligible Hispanic Medicare recipients are likely not to take advantage of the transitional assistance or not be reached early when they are eligible for the full $1,200 in transitional assistance.

To address the immediate need for a broad-based effort to inform low-income seniors about the availability of a Medicare prescription assistance transitional benefit and the information they need to select a Medicare-approved prescription discount card, the Alliance has launched the *La Promesa* campaign to reach Hispanic seniors and is proud to be a founding member of the ABC coalition seeking to reach all Medicare beneficiaries eligible for prescription benefits.

II. The ABC Coalition

The Alliance membership is dedicated to ensuring that the communities we serve have the best information about changes in Medicare, because the prescription and preventive care benefits under MMA represent a significant and important expansion of health care access for underserved Hispanic seniors. We are proud to be a founding member and serve on the five persons steering committee of the Access to Benefits Coalition.

Helping to address the need for accurate and timely information provided by trusted sources is central to the efforts of the Access to Benefits Coalition (ABC), particularly for low and modest income seniors. ABC, is a public-private partnership of over 80 diverse organizations that share a commitment to helping lower income Medicare beneficiaries find the public and private prescription savings programs they need to maintain their health and improve the quality of their lives. **ABC's goal is to have enrolled 5.5 million beneficiaries by the end of 2005, 800,000 more than what CMS estimates.** The following are some characteristics of the ABC members.

- Public-private partnership
- National ABC Coalition now includes more than 80 core organizations; 100 expected
- State and local ABC Coalitions will mirror national, and provide broad and deep grassroots support and mobilization
- All share commitment to helping low-income Medicare beneficiaries connect to new Medicare Rx and other Rx benefits, public and private
- All focused on providing decision and enrollment support to low-income beneficiaries
- Needed to supplement federal government's awareness program

ABC members and partners are:

- 82 national nonprofit organizations
- CMS, AoA, CNS and other Federal agencies
- Pharmaceutical and pharmacy companies
- State health insurance counseling programs, state and area agencies on aging and other aging/disability services
- State and local governments
- Health care organizations and systems
- Physician, pharmacist and other health provider groups
- Business community, including, PBMs, employers, media
- Private foundations

What ABC is and is not about defines our work:

ABC IS about:

- Effective implementation of the new Medicare law to ensure that low-income beneficiaries make optimal use of available public and private benefits to pay for prescription drugs.

ABC IS NOT about:

- Whether the Medicare law should or should not have been passed.
- Whether the Medicare law should be reformed or how.
- Who should be elected President or to Congress.

- What beneficiaries who are not low-income should do.

- Taking a position on other legislative issues

The following are key characteristics of the ABC governance.

Steering Committee

- Jim Firman, NCOA, Chair
- Stephen McConnell, Alzheimer's Association
- Jane Delgado, National Alliance for Hispanic Health
- John Rother, AARP
- Randy Rutta, Easter Seals

Steering Committee Responsibilities

- Governance
- Overall Strategy
- Policy
- Decision-making
- Fundraising

Charter

Working Groups

- Outreach and Mobilization
- Research and Policy
- Media and Communications

Small national staff

Every member organization shares a commitment to helping lower income Medicare beneficiaries connect to new Medicare and other prescription drug benefits, both public and private. The national coalition represents a diverse group of senior, disability, faith-based, minority, provider, consumer, and advocacy organizations, and is growing on a weekly basis. The organizations have unique reach and credibility among Medicare beneficiaries.

With support from the pharmaceutical companies, ABC is able to promote the creation of local

Access to Benefits Coalitions in 50 cities and States across the country.

- 30 "catalyst" agencies have signed up to lead local ABC efforts in the largest metropolitan areas in the country where the majority of low income beneficiaries live.
    - Initial catalyst grants of $7500 announced July 13 to form local Coalition and develop implementation plan
    - Implementation Plan due to ABC on August 2; following review and approval, an additional $32,500 will be made available to local Coalitions who provide quality implementation plan; add-on grants will be awarded no later than September 1.
- An additional 20 coalitions will be formed in other States and cities, selected by ABC through a competitive process
    - The ABC RFP was issued on June 23, and proposals are due August 2. Awards up to $40,000 will be made no later than September 1.

Through the national, State and local ABC's, hundreds of non-profit organizations will reach out to the thousands of low income beneficiaries that need help in understanding and enrolling in the combination of programs that will give them the most savings on their prescription drugs.

The Coalition has also recently made available – at www.accesstobenefits.org – a variety of new web-based tools, which are designed primarily to help ABC members and their affiliates to find, educate and help enroll lower income beneficiaries in prescription savings programs. The use of enhanced decision support tools is a key ABC strategy. We know that many lower income people with Medicare who could benefit the most from using web-based decision support tools do not have access to the Internet. Therefore, thousands of Coalition members (staff and

volunteers) will be trained and supported to serve as intermediaries, and help lower income beneficiaries and their families use these new tools, which include:

- **State Prescription Savings Guides** – The Coalition has prepared 51 easy-to-understand State Prescription Drug Savings Guides with state-specific information. This section of the ABC website provides program descriptions, eligibility and enrollment information for the Medicare-approved discount card program, Medicaid and other state drug discount programs, Veterans' Assistance as well as pharmaceutical company discount card and patient assistance programs. A useful bar graph with comparative income eligibility requirements for various programs is also included.
- **Enrollment Center** – Beneficiary education is not enough; people must actually enroll in the benefits they are eligible for. The ABC website includes hundreds of prescription drug savings program enrollment forms. By selecting a state, the user can view enrollment forms for state pharmacy programs, patient assistance programs and Medicare-approved discount drug cards. Some of the forms are fillable online – meaning that they can be filled out while on a computer and printed. Others can only be viewed on-line, printed out and filled out manually.
- **Promising Practices in Outreach and Enrollment** – This section of the website provides links to summaries of case studies that affect outreach and enrollment across various public benefits. Case studies are summarized by category, including: Cross-Program Collaboration; Outreach to Ethnic Populations; Rural Outreach; Provider Enrollment Activities; and Public-Private Partnerships. While not every strategy reported is directly applicable to initiatives related to the Medicare drug benefit, the parallels are significant enough to be of value in the design process of a campaign directed to lower income Medicare beneficiaries. Each case

study includes a link to the longer work from which it was taken; in addition, a fully annotated bibliography of the literature in outreach and enrollment is available.

The www.accesstobenefits.org website also includes a link to the BenefitsCheckUpRx decision support tool, which includes approximately 260 public and private programs to assist seniors in determining what help they can get to pay for prescription drugs. Users can access a questionnaire specifically tailored to promote access to these Rx benefits. The service is also available in Spanish. The coalition is developing an enhanced version of the site, which should be available in late August, to facilitate and simplify decision-making and enrollment in the full range of prescription drug savings programs. The new decision-support tool will help beneficiaries to determine the individualized combination of programs that will save them the most money – not only new Medicare benefits, but state pharmaceutical assistance programs, discount card programs that are not Medicare-endorsed, and over 130 private drug manufacturer patient assistance programs.

III. Efforts of the National Alliance for Hispanic Health

Lessons from the Field

In May of 2004, as Medicare beneficiaries were being informed of the availability of Medicare-approved drug discount cards and transitional assistance, the Alliance launched the *La Promesa* initiative to establish a Hispanic community capacity to support sign-up for new Medicare prescription benefits. Initial activities under the initiative have included:

- Establishment of a network of programs in 25 Hispanic community-based organizations to provide information on Medicare transitional assistance and counseling as part of ongoing

community programs utilized by Hispanic seniors such as community exercise, nutrition, and health education programs;

- Release of a Spanish and English educational video featuring popular Spanish-language television personality Chef Pepín talking about the importance of signing up for new Medicare prescription benefits and the steps for getting a Medicare-approved drug discount card and transitional assistance;
- Distribution of 150,000 copies of a new bilingual workbook for Hispanic Medicare beneficiaries on the steps for getting a Medicare Rx card and space for beneficiaries or their care providers to collect and write down the type of information they need (medications taken, income, local pharmacy address) before calling 1-800-MEDICARE for help in selecting a Medicare-approved drug discount card; and
- Integration of Medicare transitional assistance information as part of the Alliance's National Hispanic Family Health Helpline (1-866-SU-FAMILIA) so that callers can order *La Promesa* information and be referred to 1-800-MEDICARE or *a La Promesa* program in their community offering support in signing up for Medicare prescription transitional assistance.

The Alliance's initial experience with the *La Promesa* initiative has demonstrated several lessons from the field on reaching underserved Hispanic seniors with information on Medicare and new benefits. These include:

- **Accurate and timely information is needed.** There is confusion on what Medicare recipients are eligible to receive. Participants in local programs often report that they have received conflicting information. Indeed, many times the information local program participants report comes from news reports on the ongoing public policy debate on reform of the Medicare Modernization Act rather than information about specific benefits available

today to Medicare beneficiaries. To address this issue, *La Promesa* conducted key informant interviews and based on that process developed a simple "4 steps to getting your Medicare Rx card" message to focus on the new benefits and how to get the full $1,200 transitional assistance benefit by applying before the end of this year.

- **Trusted providers of information are key.** Since Medicare beneficiaries are getting a wide variety of information, sometimes conflicting, it is more important than ever that providers of information be trusted in order to help beneficiaries sort through the information (sometimes misinformation) that they have. For Hispanic underserved communities, this is frequently a source other than the government. One of the most important and trusted sources of information in Hispanic underserved communities is the network of Hispanic-serving community-based organizations (CBOs). Hispanic CBOs are a local presence in the community and have a history of delivering services to their community. They have a level of trust with Hispanic underserved seniors that puts CBOs in a unique position to effectively support seniors apply for Medicare transitional assistance. It is important that as Medicare's plans for outreach evolve, that CBOs serving underserved communities are a central part of those plans. One important effort by CMS is that regional office staff have been "outstationing" to community agencies to provide support to CBO staff and training on Medicare transitional assistance. It is important that the State Health Insurance Counseling and Assistance Programs (SHIPs), that have received the majority of outreach funding under MMA, physically "outstation" themselves at community-based organizations to provide support to CBO staff and direct assistance to Medicare beneficiaries in environments that promote trust.

- **Continuing with local pharmacy provides reassurance.** One of the important decision points for Hispanic seniors on choosing a Medicare-approved drug discount card has been whether or not they can continue to get their medications at their local pharmacy. It is important that CMS continue to work with discount card companies to provide the most accurate information possible on this decision factor for Medicare beneficiaries selecting a Medicare-approved Rx discount card.
- **Wrap-around benefits are important to decisions to select a Medicare Rx discount card.** The decision by many pharmaceutical companies to provide "wrap-around" benefits offering discounted or free medications after Medicare transitional benefits are exhausted has proven an important incentive to many beneficiaries to apply for a Medicare Rx discount card. Furthermore, the effort by many states to more seamlessly integrate state pharmacy assistance programs with Medicare discount cards reduces confusion for seniors and supports the goal of the broadest access possible to prescription benefits for underserved seniors. It is vital that CMS continue in its leadership role with states to support strategies to integrate services. Furthermore, the announcement by CMS last week that medicare.gov would integrate information about pharmaceutical company wrap-around benefits is a significant step to reducing consumer confusion and making it easier for beneficiaries to get the information they need in the easiest way possible.

Conclusion

Enactment of the new Medicare law is the single-most important opportunity to help lower income Medicare beneficiaries to have emerged in the past 40 years. Of immediate significance is the fact that Medicare-approved discount cards include a $600 transitional assistance (TA)

credit this year and next for those with annual incomes below 135 percent of poverty (this year, $12,569 for singles; $16,862 for couples), regardless of assets.

However, Medicare transitional benefits are only one of several important components of the prescription safety net - hundreds of other public and private prescription programs are also available. Most low-income beneficiaries who enroll in the credit program can save a significant amount more than $600 in 2004 and 2005. This is because of the commendable actions by several pharmaceutical manufacturers to offer savings programs for low-income seniors that "wrap around" the Medicare-approved cards. The bottom line is that low-income beneficiaries who take multiple medications and who have incomes below 135% of poverty could save from 40% to 90% on their medications in 2004 and 2005. Low-income beneficiaries will benefit even more from new preventive care benefits in 2005 and when the full Medicare prescription benefit is implemented in 2006.

The importance of ensuring that those in greatest need receive the help they are entitled to is underscored by the significant opportunities and challenges inherent in enrolling low-income beneficiaries in the Medicare discount card $600 credit program. While government efforts will reach beneficiaries who are currently well-served by the current system, years of experience tell us that there also needs to be complementary, coordinated initiatives that go much deeper into the community in order to educate consumers and their families, help them make informed choices and facilitate their actual enrollment in the new Medicare benefits. The National Alliance for Hispanic Health and the Access to Benefits Coalition are dedicated to this goal.

Congress in passage of the Medicare Modernization Act recognized that ensuring all Medicare beneficiaries would benefit from the new law would require robust community-based programs.

Report language to the final legislation called for *special outreach efforts...for disadvantaged and hard-to-reach populations, including targeted efforts in historically underserved populations, and working with...community organizations serving Medicare beneficiaries.* To date, CMS has had limited success in putting community-based organization efforts in the field. Part of the barrier is CMS' limited legislative authority to enter into the types of cooperative agreements with community agencies that most other DHHS agencies make full use of to achieve their Congressionally mandated outreach goals. It is vital that CMS have the full authority it needs to work with community organizations in fulfillment of Congressional report language on reaching underserved communities so that when CMS reports back to Congress as required in three years on outreach efforts to low-income and underserved communities . . . it will report full success.

Success will be achieved if our education approaches look beyond the glitz of a national campaign with the only goal of increasing knowledge and counting impressions made on consumers watching television, listening to the radio, or reading a magazine or newspaper. Decades of research have shown that to change behavior you need to address knowledge, attitude, and behavior. **Knowledge is not enough.** The promise of the Medicare Modernization Act will only be achieved by the development of a community environment that supports and encourages use of new Medicare benefits and which offers local and trusted resources to encourage this change. That is the purpose of ABCs efforts, to go beyond media impressions to the attitude and behavior change needed to achieve signup for Medicare benefits and use of new prescription and preventive care benefits for healthy aging.

The CHAIRMAN. Jane, thank you very much. Now let me get to the last of our panelists on panel two, Patricia Nemore.

Patricia, welcome.

STATEMENT OF PATRICIA B. NEMORE, ATTORNEY, CENTER FOR MEDICARE ADVOCACY, INC., WASHINGTON, DC

Ms. NEMORE. Thank you, Senator Craig and Senator Breaux. Since I understood that the interest of the committee is largely in the implementation of the Medicare drug plan, the testimony that I have submitted for the record as well as my oral comments today focus on those areas where we at the Center for Medicare Advocacy believe the Secretary and the Administrator can act to improve the drug benefit. We have not addressed the many areas of the law that we believe do need to be improved, amended or repealed.

We know that low-income Medicare beneficiaries have disproportionately complex health care needs and that their enrollment in assistance programs is hindered by a lack of information and by complicated and burdensome application and enrollment processes.

The prescription drug program and the low-income subsidy are, as each of you have said today, and everyone who has testified before you, extremely complex and are likely to create a great deal of confusion. I cannot stress enough that these facts argue for the Secretary to exercise all discretion that he has under the law to simplify this program in every way possible to ensure that low-income beneficiaries can, in fact, get some prescription drug coverage.

I would like to make five points.

First, the Secretary must address the unique circumstances of dual eligibles. Dual eligibles will lose their Medicaid drug coverage in January 1, 2006. I differ with some comments I have heard about whether that is good or bad, but we do know that there will no longer be a Medicaid wraparound benefit for these individuals who have great health care needs.

To assure that they have no gap in coverage, dual eligibles will have to choose a Part D plan between November 15 and December 31. They will need to be identified and provided clear information and one-on-one assistance in order to do so.

States and state health insurance counseling programs, what we call the SHIPs, and community-based organizations can be enlisted to help dual-eligibles choose plans. Since the law authorizes the Secretary to automatically enroll dual eligibles in plans, if they do not do so themselves, any automatic enrollment must be followed up by information and assistance to help individuals know how to use their plan or how to choose a different plan if they wish.

Second, the Secretary must act to simplify, streamline and create equity in the eligibility and enrollment processes for the low-income subsidies. A few ways that he could do this are to deem all Medicare savings programs' beneficiaries eligible for the low-income subsidy, eliminating the need for about a million people to apply and enroll to get the subsidy, to permit all the states that use more liberal methodologies in their Medicare savings program process to use those for the low income subsidy, and to require the Social Security Administration in those states that use more liberal methodologies to use those as well, so there would be equity among

residents of a single state, and to require that the simple application form and process that the law requires the Secretary and the Commissioner of Social Security to create is available to all beneficiaries regardless of where they apply. We have heard a lot about the assets test. The assets test will create barriers for people, both because it will make people ineligible but also because it requires enormous documentation. The Secretary must minimize the documentation required.

Third, the Secretary must require that clear detailed information is provided directly to beneficiaries of Part D plans, not merely that they be told about the availability of it, so that beneficiaries have information about a plan's formulary, the formulary design and structure, the structure of any tiered cost sharing and which drugs are included in each tier.

Beneficiaries will need to be directly provided notice when plans add or remove drugs from their formularies or change their tiered copayment system. Such notice must include clear information about how the beneficiary can seek coverage of a drug removed from the formulary or the review of a change in the drug's copayment.

Fourth, the Secretary must clarify the requirements for Part D plans' processes for determinations, reconsiderations and appeals to assure that beneficiaries have access to an expedited review process for the coverage of drugs that are not on the formulary, for drugs that have been removed from the formulary, and for changes in copayment requirements.

Such clarification could include, as under Medicare Advantage, that the physician can seek expedited review.

Fifth, the Secretary must increase substantially resources for outreach, information, counseling and assistance that will assure the availability of the one-on-one assistance that is going to be desperately needed by beneficiaries trying to navigate this extremely complex system that has been created.

This should be done by funding the State Health Insurance Counseling Programs at $41 million per year which is one dollar per beneficiary, and providing resources for groups such as Jane's to do individualized community-based outreach and assistance.

I thank you for the opportunity to testify here today and I am willing to answer any questions. Thank you, Senators.

[The prepared statement of Ms. Nemore follows:]

Testimony of
Patricia B. Nemore, Attorney
Center for Medicare Advocacy, Inc.

before the

United States Senate Special Committee on Aging

"Helping Those Who Need it Most: Low-Income Seniors and the New Medicare Law"

United States Senate
Washington, D.C.
July 2004

National Office: PO Box 350, Willimantic, Connecticut 06226 • (860) 456-7790 Fax (860) 456-2614
Washington, DC Office: 1101 Vermont Ave. NW, Suite 1001, Washington, DC 20005 • (202) 216-0028 Fax (202) 216-0119

Advancing Fair Access to Medicare and Health Care

Testimony of
Patricia B. Nemore

Summary

The Secretary of Health and Human Services (HHS) and the Administrator of the Centers for Medicare and Medicaid Services (CMS) know a great deal about low-income Medicare beneficiaries that should inform their exercise of authority and discretion in implementing the Medicare drug law.

They know, for example, that about 40% of Medicare beneficiaries have incomes under 200% of the federal poverty level, with about 37% under the 150% poverty threshold required for a Part D low-income subsidy.

They know that low-income Medicare beneficiaries are disproportionately over 85 and under 65, and that those under 65 have significant disabilities. Low-income beneficiaries are twice as likely to report their health status as fair or poor but less likely to have supplemental insurance to cover costs of needed health care. Low-income beneficiaries have high out of pocket costs for health care, spending more than a third of their income compared with 10% for wealthier beneficiaries.

They know that those who are the poorest among low-income beneficiaries, the nearly 7 million individuals dually eligible for Medicare and Medicaid are, as a group, probably the highest users of health care in the country. They are 10 times more likely to be in nursing homes than other Medicare beneficiaries and have a higher prevalence of chronic conditions, such as diabetes, stroke and Alzheimer's disease.

They know that these dually eligible individuals are high users of prescription drugs and thus will have great need for the Medicare benefit to work smoothly for them. Prescription drugs account for 14% of state Medicaid expenditures for dual eligibles; of the $21 billion states spent on prescription drugs in 2000 about half was for dual eligibles, although they comprise only about 14% of the total Medicaid population. These high drug users need a broadly defined benefit in a program that works well.

They know that high and complex prescription drug use among low-income Medicare beneficiaries will make it essential that beneficiaries have access to comprehensive

information about what drugs are covered by each plan, how the formulary is designed, what their co-payment requirements are and how they can appeal eligibility and coverage decisions with which they disagree.

National Office: PO Box 350, Willimantic, Connecticut 06226 • (860) 456-7790 Fax (860) 456-2614
Washington, DC Office: 1101 Vermont Ave. NW, Suite 1001, Washington, DC 20005 • (202) 216-0028 Fax (202) 216-0119

The Secretary and the Administrator also know about the significant challenges of providing information, reaching out to and enrolling low-income beneficiaries in assistance programs. They know about the barriers to enrollment that result in participation rates for the Medicare Savings Programs of about 50% overall, after parts of the program have been in effect for fifteen years. Barriers include lack of clear, understandable information, lack of knowledge of programs by agencies charged with their administration, complex enrollment processes that require in-person interviews, lengthy applications, onerous verification processes, difficulties with language and transportation and restrictive assets tests. The Secretary and the Administrator know that the participation rate for Medicare Part B, which has automatic enrollment with the opportunity to decline coverage, is above 95 % while enrollment in programs requiring affirmative action on the part of the beneficiary that includes engaging in a complex enrollment process range from about 40-70%.

With this knowledge of who low income Medicare beneficiaries are, awareness of their complex prescription drug issues and of the challenges of outreach to and enrollment in programs for this population, the Secretary and the Administrator should look for all opportunities under existing law to ensure the fullest coverage possible of needed drugs, to provide information and assistance necessary for accurate decision making and to ensure the most streamlined enrollment processes possible.

The testimony offers specific recommendations for implementation of the law with respect to outreach and enrollment in Part D plans and the low-income subsidy, Secretarial oversight of drug plan design, nursing home issues, information needs of beneficiaries and opportunities to challenge plan determinations.

www.medicareadvocacy.org

Testimony of
Patricia B. Nemore
Attorney
Center for Medicare Advocacy, Inc.
United States Senate Special Committee on Aging
"Helping Those Who Need it Most: Low-Income Seniors and the New Medicare Law"
July 2004

Good morning. My name is Patricia Nemore. I am an attorney with the Center for Medicare Advocacy.

The Center is a national, non-partisan education and advocacy organization that identifies and promotes solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. Staffed by attorneys, paralegals, nurses, and information management experts, the Center represents thousands of individuals in appeals of Medicare denials and responds to over 6,000 calls annually from elders, people with disabilities and their families. Based in Connecticut, with offices around the country, the Center is part of Connecticut's CHOICES program, the statewide program providing health insurance assistance and counseling to Medicare beneficiaries. CHOICES is Connecticut's State Health Insurance Program (SHIP). Through telephone and email contacts, as well as extensive training and speaking engagements, Center staff is in daily contact with both Medicare beneficiaries and those who assist them.

My own work at the Center focuses on Medicare and Medicaid issues affecting low-income older people and people with disabilities; I have spent much time during the last fifteen or so years focusing on this population. I am, therefore, especially grateful to the Committee, and to Senators Craig and Breaux, for this invitation to testify today on what are *potentially* the most helpful aspects of the Medicare Act of 2003 -- its provisions for financial assistance with drug coverage for low income Medicare beneficiaries.

The Center did not support the Medicare Act of 2003. Based on our years of experience representing Medicare beneficiaries, we believe that, on balance, the Act does not serve Medicare beneficiaries well. However, our disagreements with the law were not primarily with the drug benefit and, in any case, are not the subject of this hearing. We serve our clients not only be advocating for the passage of good laws, but also by working hard to assure that the laws we have are implemented and administered to best serve the needs of the Medicare population.

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Today I would like to discuss the areas of the law that need further attention given what we know about low-income Medicare beneficiaries, their prescription drug use and the challenges of providing public benefits to low-income individuals:

* Issues regarding implementation of the Medicare-endorsed discount drug card and transitional assistance, and

* Issues that arise under the 2006 drug benefit and low income subsidy.

While my remarks will focus on those areas where the Secretary has authority and discretion to act pursuant to regulations or other guidance, I will also point to areas of the law itself that will result in hardships to beneficiaries if not amended.

Low-income Medicare beneficiaries: Who are they and what are their drug needs?

The Secretary of Health and Human Services (HHS) and the Administrator of the Centers for Medicare and Medicaid Services (CMS) know a great deal about low-income Medicare beneficiaries that should inform their exercise of authority and discretion in implementing the Medicare drug law.

They know, for example, that about 40% of Medicare beneficiaries have incomes under 200% of the federal poverty level, with about 37% under the 150% poverty threshold required for a Part D low-income subsidy.

They know that low-income Medicare beneficiaries are disproportionately over 85 and under 65, and that those under 65 have significant disabilities. Low-income beneficiaries are twice as likely to report their health status as fair or poor but less likely to have supplemental insurance to cover costs of needed health care. Low-income beneficiaries have high out of pocket costs for health care, spending more than a third of their income compared with 10% for wealthier beneficiaries.

They know that those who are the poorest among low-income beneficiaries, the nearly 7 million individuals dually eligible for Medicare and Medicaid are, as a group, probably the highest users of health care in the country. They are 10 times more likely to be in nursing homes than other Medicare beneficiaries and have a higher prevalence of chronic conditions, such as diabetes, stroke and Alzheimer's disease.

They know that these dually eligible individuals are high users of prescription drugs and thus will have great need for the Medicare benefit to work smoothly for them. Prescription drugs account for 14% of state Medicaid expenditures for dual eligibles; of the $21 billion states spent on prescription drugs in 2000 about half was for dual eligibles, although they comprise only about 14% of the total Medicaid population. These high drug users need a broadly defined benefit in a program that works well.

They know that high and complex prescription drug use among low-income Medicare beneficiaries will make it essential that beneficiaries have access to comprehensive information about what drugs are covered by each plan, how the formulary is designed, what their co-payment requirements are and how they can appeal eligibility and coverage decisions with which they disagree.

Low-income beneficiaries: The challenges of outreach and enrollment

The Secretary and the Administrator also know about the significant challenges of providing information, reaching out to and enrolling low-income beneficiaries in assistance programs. In the late 1990s, for several years, CMS identified as one of its government performance and review goals the increased enrollment of low-income Medicare beneficiaries in the Medicare Savings Programs that pay some or all of Medicare's cost-sharing through state Medicaid programs.

From that effort, CMS learned about the barriers to enrollment that result in participation rates for the Medicare Savings Programs of about 50% overall, after parts of the program have been in effect for fifteen years. Barriers include lack of clear, understandable information, lack of knowledge of programs by agencies charged with their administration, complex enrollment processes that require in-person interviews, lengthy applications, onerous verification processes, difficulties with language and transportation and restrictive assets tests. The Secretary and the Administrator know that the participation rate for Medicare Part B, which has automatic enrollment with the opportunity to decline coverage, is above 95 % while enrollment in programs requiring affirmative action on the part of the beneficiary that includes engaging in a complex enrollment process range from about 40-70%.

With this knowledge of who low income Medicare beneficiaries are, awareness of their complex prescription drug issues and of the challenges of outreach to and enrollment in programs for this population, the Secretary and the Administrator should look for all opportunities under existing law to provide the fullest coverage possible of needed drugs, to provide information and assistance necessary for accurate decision making and to ensure the most streamlined enrollment processes possible.

Transitional Assistance and the Drug Discount Card

Need for individualized assistance to choose a card. The Medicare-endorsed drug discount card program relies on comparative information available via the internet and phone service. Only about 20% of older people are using the internet to get information, and, according to the Kaiser Family Foundation, only about 3% use www.Medicare.gov, the website that includes the prescription drug assistance program for choosing a discount card.[1] Beneficiaries can get some assistance by calling 1-800-

[1] Andy Schneider, "The Medicare Prescription Drug Discount Card Program: Implications for Low-Income Medicare Beneficiaries." Kaiser Commission on Medicaid and the Uninsured. April 2004

Medicare, but the need for individualized help – to understand the distinctions between this program and the drug benefit in 2006, to navigate the comparative data and to enroll for transitional assistance - cannot be overstated. Medicare beneficiaries have traditionally relied on the State Health Insurance Counseling Programs (SHIPs) for assistance in sorting out insurance options. But the labor intensive and time consuming nature of the decision-making process with respect to choosing a drug card, together with a tremendous amount of work SHIPs have to do to get up to speed on other aspects of the new Medicare law put great strain on their budgets. After public outcry, the administration offered additional funding to SHIPS to help beneficiaries understand the discount card. In Connecticut, that additional funding totaled $.17 per beneficiary, increasing overall funding for the program to $.52 per beneficiary.

Recommendation: CMS should provide additional resources to SHIPs to support their work on the drug discount card as well as the additional work they will do with respect to the Part D benefit in 2006.

CMS has just announced a request for proposals for community-based organizations to undertake outreach and enrollment activities related to the discount drug card and transitional assistance. This $3.7 million will provide much needed additional resources at the community level to help beneficiaries enroll, but it remains a drop in the bucket: about $.50 per eligible beneficiary.

Automatic enrollment of Medicare Savings Programs (MSP) beneficiaries in drug discount card and transitional assistance. The Secretary has exercised his discretion to deem individuals who receive MSP benefits as income eligible for Transitional Assistance, but to date has expressed unwillingness to create a process to automatically enroll MSP beneficiaries in a drug card. We know the importance of automatic enrollment, as nearly two thirds of the 3.7 million beneficiaries who have, to date, enrolled in the discount card have been automatically enrolled either by their Medicare Advantage plan or by their State Pharmacy Assistance Program. The Secretary himself authorized states to auto enroll their State Pharmacy Assistance Program beneficiaries, but he declines to offer the same opportunity to MSP beneficiaries not served by a state program. The Administration claims it does not want to interfere with choice, but fails to acknowledge that voluntary Medicare Part B operates as an auto-enrollment, with beneficiaries provided the opportunity to decline coverage.[2] The Secretary could randomly choose a card for individuals, inform them where to get assistance if they want to choose a different card and inform them they can choose not to participate at all. If this were done in the next few months, each person automatically enrolled would still have the opportunity to choose a different card for 2005 during the open enrollment period beginning in November.

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[2] The Secretary's promotion of choice in this situation contrasts with the reality of the situation of Medicare Advantage enrollees, who have no choice with respect to a discount drug card if their MA plan offers a card.

Recommendation: The Secretary should create a process to auto enroll MSP beneficiaries. If he fails to do so, Congress should act quickly on S.2413, the Medicare Assurance of Rx Transitional Assistance Act and its companion, H.R.4437, legislation requiring the Secretary to do so.

Counting of $600 benefit in other federal programs. The law prohibits the counting of either the $600/year Transitional Assistance or the value of the discounted price of drugs purchased with a discount card in determining eligibility for or the amount of assistance under other federal programs. We applaud CMS's decision to reverse its earlier interpretation of the law so that it now requires that the $600 should count toward an individual's spenddown for medically needy Medicaid eligibility. We encourage CMS to advise states that individuals should have freedom to use their $600 when it is most advantageous to them during the year, rather than having to spend it all before receiving Medicaid coverage.

Recommendation: In developing guidance concerning the medically needy spenddown, the Secretary should permit beneficiaries the freedom to use their transitional assistance when it is most advantageous to them. The Secretary should work with HUD and other agencies to assure that they, too, interpret this law so that beneficiaries get the full value of the Transitional Assistance credit, without losing other benefits.

Problems for Medicare Savings Program beneficiaries in several states. We have received reports from advocates and others in the field that in several states, MSP beneficiaries were erroneously told they were ineligible for a discount card because they had Medicaid. As best we are able to determine, this resulted from CMS combining two separate files sent by states, one listing their full Medicaid beneficiaries and one listing their MSP-only population. While staff at CMS is aware of the problem and claim to have resolved it, we remain unaware of how beneficiaries were informed that, indeed, they are eligible and they can use their card. That this problem arose at all raises the importance, to beneficiaries, of smooth data sharing between states and CMS concerning the Medicaid status of individuals. This will continue to be an important issue in 2006 and beyond.

2006 Prescription Drug Benefit and Low-income Subsidies

Loss of Medicaid prescription drug coverage by dual eligibles as of January 1, 2006

The significance of loss of Medicaid drug coverage for dual eligibles in 2006 cannot be overstated. Medicaid, generally, requires some access to all medically necessary drugs, even where the state has implemented a formulary or requirements for prior authorization for certain drugs. The Medicare Act, by contrast, gives plans broad discretion in defining therapeutic classes and categories and in designing their formularies and cost-sharing structures.

Medicaid law limits permissible cost-sharing to nominal amounts, defined as no more than $3. In Connecticut, Medicaid beneficiaries and their advocates were recently successful in getting prescription drug cost-sharing requirements repealed; thus, dually eligible beneficiaries in Connecticut will have heavier cost-sharing burdens under the Medicare Act. This will be true in other states as well.

The Medicare Act's prohibition on Medicaid wrapping around the Medicare drug benefit is a dramatic departure from the Medicare/Medicaid relationship that has existed since the programs' inceptions in 1965. To address the serious and extraordinary health needs of those who are elderly or disabled and are also poor, the programs operate together with Medicaid serving as a Medi-gap policy with respect to Medicare. Medicaid pays for Medicare's cost-sharing and for non-Medicare covered services, such as prescription drugs and non-skilled long-term care. The loss of drug coverage from Medicaid will leave some dual eligibles worse off than they are under Medicaid. It will leave others lacking the extra help they might otherwise get from Medicaid wrap-around coverage for cost-sharing and drugs that their Part D plan does not cover.

Moreover, as noted, the Medicare Act affords great discretion to plans not only in creating their formularies, but also in defining therapeutic classes and categories of drugs they will cover. Therapeutic classes and categories will not be comparable across plans, unless all plans adopt the non-mandatory model guidelines developed by the United States Pharmacopeia. Moreover, plans need not cover all drugs within the classes and categories that they themselves design. While this limitation will affect all Medicare beneficiaries, it will most affect low-income beneficiaries, who do not have the resources to pay for drugs out of pocket. The example of Dan Cusick, an HIV positive dual eligible is instructive:

> Starting in 1995, Dan was on a drug regimen that included 3 anti-HIV drugs: Indinavir, Lamivudine, and Zidovudine, as well as Acyclovir to treat his PML [Progressive Multifocal Leukoencephalopathy]. Under the Medicare prescription drug law, it will be up to individual prescription drug plans to decide whether his three HIV drugs would be considered to be in the same class, and whether to cover only two (or all) of the anti-HIV medications, of which there are currently 20. If there ever comes a time when he cannot take any of the HIV medications and a new drug is approved, he would not be able to count on having access to the drug (security that he currently has through Medicaid), because each prescription drug plan can decide whether or not to cover new drugs.[3]

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[3] Jeffrey S. Crowley, "The New Medicare Prescription Drug Law: Issues for Dual Eligibles with Disabilities and Serious Conditions." Kaiser Commission on Medicaid and the Uninsured, June 2004, 10. 10.

Similar issues will arise for beneficiaries with Multiple Sclerosis (or with many other diseases) who may need one or two specific drugs from four or more different options.

While presumably, states can fill, with state-only money, some coverage gaps that might be experienced by dual eligibles, the law is silent as to how that might work. Moreover, as states continue to feel budget pressures, and since they are required to "pay back" to the federal government most of the savings they realize from not covering drug costs for dual eligibles, they are unlikely to want to undertake new obligations that have no federal matching dollars. Thus, dually eligible individuals in many states face the serious threat of losing rather than gaining prescription drug coverage with the advent of Medicare Part D in 2006.[4]

Automatic enrollment of dual eligibles in Part D plans. The law requires the Secretary to automatically enroll dual eligibles in a Part D plan, on a random basis, if they have not themselves enrolled in a plan. However, it has neither time frames nor a structure for this process. While automatic default enrollment can be helpful to ensure that dual eligibles do not have coverage gaps beginning in January 2006, the Secretary should promote beneficiary involvement in the process to reduce the need for default enrollment as much as possible. Such involvement will reduce the likelihood of an individual being enrolled in a plan that, for example, does not include his pharmacy in its network. States have successfully reduced their default enrollment of families into mandatory Medicaid managed care by using face-to-face bilingual counseling and making multiple outreach efforts in advance of the default enrollment, among other steps.[5]

Recommendation: The Secretary should use part of the $1 billion designated for outreach and education to engage the states and State Health Insurance Counseling Programs (SHIPS) in this effort. The Secretary's default enrollment plan should also include targeted education and outreach following the enrollment so that the beneficiary understands how to use the plan in which she is enrolled and how to choose a different plan, if she wishes.

Enrollment in Low Income Subsidy[6]

Deeming MSP beneficiaries eligible for low-income subsidy. The law requires the Secretary to deem eligible for low income subsidies Medicare Savings Program beneficiaries from states whose eligibility rules are "substantially similar" to those of the

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[4] Despite the myriad methods state Medicaid programs use to control prescription drug costs, states generally are required to provide access to most medically necessary drugs. See Jeffrey S. Crowley and Deb Ashner, "Medicaid Outpatient Prescription drug Benefits: Findings from a National Survey, 2003" Kaiser Commission on Medicaid and the Uninsured, December 2003.

[5] "Medicaid Managed Care: An Advocate's Guide for Protecting Children." National Association of Child Advocates and National Health Law Program.

[6] For a discussion of opportunities for CMS to improve access to the low-income subsidy, see Kim Glaun, "Ways CMS Can Improve Access to the Low-income Medicare Drug Benefit." (forthcoming)

Medicare subsidy and gives him discretion to so deem all other MSP beneficiaries.

Recommendation: The Secretary should exercise this discretion in favor of deeming MSP beneficiaries from all states eligible for the low-income subsidy appropriate to their income range.

Application and enrollment for low-income subsidy. The law requires the Secretary together with the Commissioner of Social Security to develop a model simplified application form and process to provide to the States. States must make eligibility determinations for the low-income subsidy in accordance with this section of the law.

Recommendation: The Secretary should assure that the process does not require face-to-face interviews, that the application form is also made available to community-based organizations that assist low income Medicare beneficiaries, that it is made available on-line in an easy-to-find location, and that states use the process.

Assets test and documentation requirements. The law imposes an asset test for low-income beneficiaries who are not dually eligible. Assets tests create barriers to eligibility in two ways. First, the test itself renders ineligible for benefits low-income people who would otherwise qualify and who have no more income to pay for their prescription drugs than another person with fewer assets. The Kaiser Commission on Medicaid and the Uninsured estimates that 1.8 million people are ineligible for the low-income subsidy only because they would "fail" the asset test.

Second, the disclosure of and documentation required to verify the level of assets may discourage individuals from applying. Research suggests that documentation requirements create barriers to enrollment, and that it is possible to minimize documentation without impairing program integrity.[7]

Recommendation: The Secretary should act to minimize documentation requirements under the law. He can do that by interpreting the law's requirement that the application form being accompanied by copies of recent statements from financial institutions so as to put the least burden on the applicant; one month's bank statement should suffice, with authorization to the entity determining eligibility to inquire further with the bank, as necessary.

Use of more liberal methodologies. The law permits the Secretary to allow states in determining eligibility for the low income subsidy to use more liberal eligibility methodologies used in their MSPs if the Secretary determines that to do so will not result

[7] Kim Glaun, "Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings." Kaiser Commission on Medicaid and the Uninsured. December 2002.

in "significant differences" in the number of subsidy-eligible individuals.

Recommendation: The Secretary should interpret this authority liberally both to allow the low income subsidy to serve the broadest universe of those in need and to ease the burden on states for enrolling individuals in this Medicare benefit.

Use of common eligibility rules regardless of location of application. Individuals may apply for the low-income subsidy either through their state Medicaid program or through the Social Security Administration. The eligibility rules should be the same, regardless of where they apply, and should incorporate a state's more liberal methodologies, if any. SSA has experience in applying state eligibility rules in those states for which it administers a state supplement to the federal Supplemental Security Income program; such a requirement would not, then, be beyond SSA's capability. The law includes an authorization of appropriations for the SSA determination process.

Recommendation: The Secretary should direct the Social Security Administration in states using more liberal methodologies to use those methodologies in SSA's determinations as well.

Family size involved. The law requires that eligibility be measured against the federal poverty level for a family of the size involved. SSA has stated orally that, in its eligibility determinations, it intends to measure against the actual size of the family. We are encouraged by this information and hope it will appear in the regulations; such a standard is essential to take into account the support provided by Medicare beneficiaries with dependent family members other than a spouse.

Recommendation: The Secretary should state, in regulations, that the family size poverty level standard used in determining eligibility should reflect the actual family size of the applicant.

Initial determination. The Medicare law requires the Secretary to determine the initial period of eligibility, up to one year.

Recommendation: The Secretary should exercise this limited discretion to identify one year as the eligibility period so that beneficiaries are not required to reapply before that time.

Redeterminations. In fact, beneficiaries frequently lose benefits at the time of redetermination for failure to complete the process due to cognitive or physical impairments, change of address or hospitalization.[8] The most beneficiary-friendly redetermination process is a passive one that requires the beneficiary to act only if some important piece of information has changed since the last determination, or to sign and return a simple form attesting to the validity of pre-printed information. Unfortunately

[8] Id.

for beneficiaries, the law directs states to use the processes they currently have in place, and few if any states have focused attention on improving their renewal procedures. The law is silent as to the redetermination process to be used by SSA.

Recommendation: The Secretary should direct the Social Security Administration to adopt a passive redetermination process to minimize benefit disruption.

States' duty to screen and enroll eligible MSP beneficiaries. The law explicitly requires states, but not the Social Security Administration, to screen all applicants for the low-income subsidy to determine if they are also eligible for a Medicare Savings Program, and, if so, to offer them the opportunity to enroll.

Recommendation: The Secretary should direct the SSA to screen for MSP eligibility, which would be particularly easy to do if SSA was relying on the state's MSP methodology for determining low-income subsidy eligibility, and to report the results of such screenings to the states.

Drug Plan Design

To the extent Medicare drug plans do **not** have open formularies that cover all medically necessary drugs, low income beneficiaries will be disproportionately harmed. Restrictive formularies, broad class definitions that result in coverage of some but not all drugs an individual is taking, and tiered co-payments that demand a higher amount for a drug that is medically necessary for a particular individual all impose hardship.

Recommendation: The Secretary should exercise vigorous oversight of plan design in carrying out his duties to assure that plans are not likely, through their design, to discourage enrollment of Part D eligible individuals.

Nursing home issues

An estimated 1.6 million nursing home residents are low-income Medicare beneficiaries dually eligible for both Medicare and Medicaid.[9] Additional numbers of residents will qualify for the Part D low-income subsidy for individuals with incomes up to 150% of the federal poverty level. Moreover, nearly all nursing home residents are Medicare beneficiaries and will be eligible to enroll in a Part D plan.[10] Nearly seventy-five percent of nursing home residents have cognitive impairments.[11] Nursing home residents receive,

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[9] Andy Schneider, "Dual Eligibles in Nursing Facilities and Medicare Drug Coverage." Briefing Note: The Kaiser Commission n Medicaid and the Uninsured, November 13, 2003. (Schneider: Dual Eligibles in Nursing Homes)

[10] See, e.g., CMS Compendium 2001, "Characteristics of Nursing Home Residents" at 54. Available at http://www.cms.hhs.gov/medicaid/survey-cert/datacomp.asp (Site visited July 15, 2004)

[11] Id. At 86

on average, more than 6 routine prescription drugs per day.[12]

Issues related to providing prescription drug coverage in nursing homes are distinct from those relating to the community. Nearly 80 percent of all nursing home beds in the country are served by pharmacies that specialize in long-term care services.[13] Such pharmacies specially pack prescription drugs in unit doses, to reduced medication errors. They provide 24 hour service and consultant pharmacists to review monthly each resident's drug regimen.

Residents whose coverage is paid for under a Part A currently have their drug costs paid as part of the prospective payment made to the facility. While they must pay co-insurance for their stay after the 20th day, they have no separate co-payment for prescription drugs.

Residents whose Part A coverage has been exhausted and who are dually eligible then have their stay paid for by Medicaid, including their prescription drug costs which are most commonly paid for separately from the payment to the facility.

Important questions need to be addressed in regulations including:[14]

Will nursing home residents need to enroll in Part D to have their prescription drugs paid for, even if their stay is paid for under Part A?

How will dual-eligibles, whose Medicaid drug coverage will end January 1, 2006, know that they must enroll in Part D in order to have drug coverage? Who will choose the plan, the beneficiary or the facility? If the beneficiary chooses the plan, who will help those many residents with cognitive impairments?

Must all Part D plans cover the special services provided by long-term care pharmacies now? Will they be required to cover unit packaging, 24 hour service and the services of consultant pharmacists?

How will nursing homes fulfill their legal obligation to provide necessary services to residents if a resident requires a drug not covered by her Part D plan?

CMS has recognized the special circumstances of nursing facilities and their pharmacies in its administration of the discount drug card. Unfortunately, by doing so, it has denied nursing home residents the value of any discounts offered, since it waived the law's requirement of negotiated prices and created a special nursing home card that serves only

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[12] Dan Mendelson, Rajeev Ramchand, Richard Abramson and Anne Tumlinson, "Prescription Drugs in Nursing Homes: Managing Costs and Quality in a Complex Environment, " NHPF Issues Brief No. 784 (November 12, 2002), www.nhpf.org, as cited in Schneider: Dual Eligibles in Nursing Homes, *supra* note 9.

[13] Id.

[14] These and other important questions are raised in Schneider: Dual Eligibles in Nursing Homes, *supra* note 9.

as a conduit for the $600 transitional assistance for low-income beneficiaries.

The American Society of Consultant Pharmacists has prepared thoughtful comments on the prescription drug utilization of nursing home residents and what will be needed under Part D to meet their needs. Among their recommendations is that CMS not issue regulations that would affect nursing home residents until after the publication of the Review and Report on Current Standards of Practice for Pharmacy Services provided to Patients in Nursing Facilities.[15]

Recommendation: CMS should immediately convene a work group of nursing home residents' advocates, facilities and consultant pharmacists to further identify the prescription drug issues unique to nursing home residents, including how to ensure coverage for the drug regimens they need, how to inform them of their need to enroll in Part D and assist them in doing so and how to provide coverage for necessary drugs that may not be on their Part D plan. Regulations affecting nursing home residents' use of Part D coverage should be delayed pending the issuance of the mandated long-term care study.

Information needs of beneficiaries

Information prior to enrollment. Since the law gives plans great latitude in design, it will be critical for beneficiaries, and more so for low-income beneficiaries, to have clear comparative information on which to base their decision to join a plan.

Recommendation: The Secretary, pursuant to his mandate to make comparative information available to beneficiaries prior to the initial enrollment period, should require plans to provide information concerning the structure of their formulary, drugs covered by the formulary and which drugs are covered in which tier of co-payment, to the extent the plan uses tiered co-payments.

Information needs of enrollees. Unfortunately, the law is extremely confusing as to the plans' obligation to provide information to enrollees. Generally speaking, the law appears only to require that plans inform enrollees about how and where they can get detailed information about how the formulary works, cost-sharing requirements, drugs covered and how enrollees get access to their covered drugs. The law requires plans to have a toll free number and to post changes in their formulary on the internet. Apparently, they are not even required to notify directly individual plan members when they remove a drug from formulary or make changes in their tiered cost-sharing; they merely must "make available notice." Unless enrollees check the internet or call their plan each time they seek to fill or renew a prescription, they may arrive at their pharmacy and be told their plan no longer covers the drugs they are taking.

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[15] Letter of March 10, 2004 to dennis Smith, Acting Administrator, Centers for Medicare and Medicaid Services from John Feather, Executive Director, American society of Consultant Pharmacists. Available at www.ascp.com (site visited July 15, 2004)

Recommendation: The Secretary has discretion to determine appropriate disclosure concerning benefits the plans must provide; he should exercise this discretion to afford beneficiaries the maximum amount of clear, understandable information about how their plans operate. Plans should be required to mail information to enrollees regarding changes to formularies and prices and should be limited in the number of such changes allowed each year.

Information concerning initial coverage limits and annual out-of-pocket threshold. Although many low income beneficiaries are not affected by the initial coverage limit, some are, and all are affected by the annual out-of-pocket threshold, after which their cost-sharing requirements are reduced or eliminated.

Recommendation: The Secretary must specify how often such notices must be provided to enrollees by plans; he should require them to be sent shortly before the initial coverage limit is reached and shortly before the out-of-pocket threshold is reached.

Determinations, Reconsiderations and Appeals

If drugs are not on formulary, if they are removed from formulary, or if they are subject to tiered cost-sharing at a high tier, beneficiaries must pay the extra costs out of pocket. Low-income beneficiaries have little disposable income from which to pay for uncovered or under-covered drugs.

Moreover, the cost of a drug not covered by the plan does not count toward meeting any of the beneficiary out-of-pocket spending requirements of the benefit. A speedy informal system for challenging coverage determinations is therefore critical for all beneficiaries but especially for those who cannot afford to carry the costs pending a lengthy appeal process. Moreover, even with an expedited review system, beneficiaries need access to a short-term supply of the drug for which they seek coverage.

The law is not clear about requirements for review of various coverage decisions. While there must be a determination and reconsideration process for "covered" benefits, it is not clear that such process must be available to request coverage for drugs not included at all on the plan's formulary. Nor is there any mention at all of a process to seek continued coverage of drugs that have been removed from the plan's formulary. Moreover, there is no mention of how an enrollee would get notice of her right to engage in whatever process the plan has.

Recommendation: The Secretary should clarify the ambiguities in the law to make clear that the internal determination and reconsideration process, including expedited process, apply to questions of non-formulary drugs as well as drugs removed from the formulary. The role of the physician should be as it is in Medicare Advantage; that is, if the physician requests expedited review, it must be granted. The Secretary should also

require that a plan enrollee is entitled to a 72-hour emergency supply of drugs pending the outcome of an expedited process.

Conclusion

The task before us is daunting. The Medicare Act creates an extremely complex set of processes required to be followed for a Medicare beneficiary to enroll in a Part D plan with a low-income subsidy, to ensure that the drugs she needs are covered by her plan and to seek coverage for those drugs that are not. At every step of the way, beneficiaries will need clear, reliable information, counseling and assistance. The Administration must take all steps possible to make systems beneficiary-friendly, to minimize burdens and to maximize participation.

We appreciate the opportunity we have had today to share ideas on these points. The Center for Medicare Advocacy will continue vigorously to advocate for policies that promote the health of all Medicare beneficiaries and especially that recognize the special needs of low-income beneficiaries.

Thank you.

The CHAIRMAN. Patricia, thank you very much, and to all of you again, thank you. My questions will be somewhat general in nature, so as one responds, and the other feels they can add to or need to take from, please feel free to do so as we proceed to do all of this.

During debate on this bill, the biggest focus I think for all of us, both in Congress and in organizations like yours, was on those seniors who did not otherwise have drug coverage and who just could not afford it themselves.

This is a fairly generic question, but does this law substantially when implemented, in your opinion, alleviate that underlying problem and the primary premise behind this legislation.

Gail.

Ms. WILENSKY. It does a lot more than that because it is a much broader coverage bill, but it does focus an enormous amount of assistance on the low-income population which is where more of the individuals without drug coverage lay. So the answer is that it will cover some individuals who had drug coverage already with more extensive coverage, but it will do a very good job in covering those who are both without coverage and who were low income, particularly if it is as successful as the President's budget assumes it will be in terms of reaching out to these individuals.

Again, our experience in past administrations and in other attempts to reach these low income populations, including but not limited to my own efforts as HCFA administrator, is difficult. It is difficult for all income-related programs that I am aware of inside and away from health care, and we should not fool ourselves about the difficulty, but some of the assistance activities that have been mentioned will be helpful in making information clear and available.

The CHAIRMAN. Doctor.

Dr. THAMES. Senator, I would echo those statements. In the debate among the Board of Directors from AARP when this bill was being formed and the decision for us to support this, one of the early overriding factors in looking at what this bill was to do, was that it was going to help meet the needs of those who truly suffered the most particularly those with low income and those who had catastrophic drug bills, and those who have to make terrible decisions about what to spend their money on or whether to take the drugs in the appropriate doses or skip doses or skip days. We believe that this bill will help both those low income and those people with catastrophic drug costs.

Ms. DELGADO. I think this is a very important bill in terms of low-income people, not just because of what we discussed, but in fact it moves CMS from being just a payer to being involved in people's health and more of a public health agency because of some of the other parts of the bill such as, getting your "Welcome to Medicare" physical, getting your diabetes diagnosed early. This changes the whole flavor of what the agency is about, and for low-income seniors, it is a major step forward.

The CHAIRMAN. Patricia.

Ms. NEMORE. Senator, we have provided coverage for low-income people who did not have any coverage before and that will be tremendously important if the potential of the legislation is actually

realized. The complexity of the eligibility process for the low-income subsidy is substantial; you have two different places that you might apply, there might be different rules that would be applied to you in those two different places, you would be subject to two different appeal systems. There is a lot of complexity in getting the subsidy, the low-income subsidy, and then on top of that we have the issue of choosing a plan and having the information you need to choose one plan over another and assure that that plan will be able, in fact, to meet your drug needs.

So there is potential here to help low-income people who have no coverage. We have made it extremely difficult for them to do it, and for the dual eligibles, they will lose the wraparound. Whether or not the benefit is better or not better than what is in their state now, they will lose the wraparound benefit that is applicable to all other Medicare coverage for dual eligibles where Medicaid picks up, fills in the gaps of what Medicare does not pay, and that is not permitted under this law. So I think it is a mixed answer.

The CHAIRMAN. OK. Patricia, you had mentioned and were suggesting some changes. At the same time, Gail has basically cautioned us in saying you better let CMS do its work before you start proposing changes and get it on the ground and get it running, and look at or you are going to be considerably further down the road before anybody receives benefits.

Also, both of you have talked about dual wraparound, uniformity, benefits back to the states, I would like to have both of you discuss that a little bit, both the question of making changes now versus getting done what we have gotten done, if you will, get it on the ground and get it running, and also I watched this year, and the past several years, as states that became increasingly generous in their benefits in Medicaid having substantial withdrawal pains, if you will, because of a reduction in revenues based on the economy and shifts backwards.

In other words, what was not an entitlement, it was simply added benefits pulled back, and the value of stabilizing that benefit, if you will, from a national standpoint, benefits to the states, and the understanding that I have, while some states may have been more generous, the value of a very small copay, if you will, or a very small payment on a prescription by a prescription basis to receive relatively uniformity in coverage.

Discussion about both of those I think would be valuable to the committee in understanding it. Gail, let me start with you, we will go to you, Patricia, and see if we cannot gain from both of your knowledge in this area.

Ms. WILENSKY. In the late 1990's, states acted in ways that many of us would regard as positive but set themselves up for a lot of revenue obligations. They expanded the populations that they made Medicaid available to, they increased the benefits, and they increased the payments to providers, nothing that is bad in and of itself, but potentially much more costly than they had been exposed to.

There was a sharp decline in revenue, as you know, for many states, and that has caused them to cut back, particularly in terms of payments to providers, sometimes to the benefits as well. It is unclear what will happen as the country is coming out of its reces-

sion in terms of state revenues. We know what is happening at the national level, but whether that translates immediately to the states is less clear.

I say that because it is important to understand that while the Federal Government is not going to share in whether states choose to offer additional benefits to their dual-eligible populations or other populations, states are permitted with their own money, of course, to augment benefits in any way that they see fit, and they will save money, although primarily not early on in the legislation over what they would have been spending without the passage of the Medicare Modernization Act, about 15 percent of what they would have spent.

The other 85 percent comes back to the Federal Government through the maintenance of effort sometimes called the claw back provision. So precisely what will happen to individuals in some of the states will depend on how both the state responds and how the pharmacy assistance programs that exist in many of the states and how the manufacturers' programs go on.

But they will lose this wraparound largely, more than the majority, financed by the Federal Government in terms of adding on to what already has existed. So we will have to wait to see.

Let me explain more carefully about why I feel so strongly about not modifying the legislation before the legislation has primarily rolled out which will mean the first or second quarter of 2006. People think that that means that CMS has until 2005, but they do not. If the information is going to be mailed out in October 2005, in order to get enrollment in November so that the benefit can start in January 2006, an enormous number of decisions have to be made by CMS and the Secretary. Rules have to be promulgated in time so that people can have comments come back and then respond to all of those. Many people in Congress do not understand the timeliness that that involves in order to have the decisions and then the rules put out and then the comments reacted to from those proposed rules.

Both of you seem quite sympathetic with that problem, but let me give you some numbers to illustrate what happens if you come up with a very controversial regulation which could well happen at some point in implementing the Medicare Modernization Act.

My two experiences with controversial regulations were the Clinical Lab Improvement Act, CLIA, which had 35 or 40,000 comments only to be outdone by the proposed rule for the relative value scale which produced 100,000 comments led largely by the nation's physicians, but joined in by other groups as well.

While the administrator does not have to respond to each comment specifically, all of the issues that are raised in comments need to be dealt with when the final decisions are made. That is why I feel so strongly that whatever errors are in this legislation and all of us would have written the legislation somewhat differently if we could have, I think it is important to allow the major parts of the legislation to roll out and then fix it.

There will be clean-up legislation. There always is. I am sure it will be needed here, but the benefit is not going to happen if there is legislative change before the rollout.

The CHAIRMAN. Patricia.

Ms. NEMORE. Senator, my organization did not support the Medicare Act of 2003 and I intentionally today, in preparing my comments, did not address the issue of changes in the law that we believe need to be made.

The suggestions I made in my oral testimony, and there are more in the written testimony, are all suggestions that we believe can be done, that the Secretary and the Administrator have the authority to do under the law.

The CHAIRMAN. Under the law. OK.

Ms. NEMORE. We believe because this is such a needy population and such a hard to reach population and the law is so complex, that it is essential that those decisions always be exercised to the advantage of the beneficiary and to streamline and simplify the process wherever possible.

The CHAIRMAN. OK. That is fair.

Ms. NEMORE. So on the matter of the Medicaid issue, I would just like to make a couple of points. Medicaid does require that all medically necessary drugs be covered, be available in the state Medicaid program. That will not be true with any individual Part D plan. Part D plans can choose what to cover and what not to cover. It is true that states have limitations of one sort or another and many states do, but they need, they have to have an override process, so there is in virtually every state the opportunity to seek coverage of any medically necessary drug.

But I think the real point is that there is no wraparound. It is not whether Medicaid was better than Medicare. In the dually eligible context—these are the neediest people we have in the entire population in terms of health care needs—there has always been the model that Medicare coverage is first and Medicaid fills in the gaps, and that has been a very important way for dual eligibles to get the complement of services they need because each program has its own gaps, and together they provide fairly substantial coverage.

One other point on the Medicaid issue, Medicaid as Dr. Wilensky said, Medicaid is more generous or less generous depending on individual state budgets, but it is subject to the political process, and in the state of Connecticut where my program has its main office, Connecticut advocates and citizens were able to persuade the legislature to remove copayments this year, so they were able to exercise their advocacy in the political realm to shape the program to work best for beneficiaries.

This will not be true with Part D. Each plan will create its own formulary, its own cost-sharing systems, and there will not be the opportunity for political advocacy toward any individual plan.

But I think the issue of the wrap is really the most important thing for us to keep in mind, the wraparound benefit.

Ms. WILENSKY. Senator Craig, may I add one more comment?

The CHAIRMAN. Surely.

Ms. WILENSKY. This is a very important issue and a number of points have been raised that I think are important particularly for this committee to understand. I do not disagree with some of the concerns raised outside of the prescription drug area in terms of the loss of a wraparound. But I think having Medicare and Medicaid as two separate programs was a bad way to have these extra

benefits provided. The dual eligibles have long been regarded as not only being by far the most expensive population by virtue of their low-income and their medical needs, but not particularly well treated because these two programs did not integrate with themselves very well.

To the extent that we think that the low-income assistance that is being provided to individuals on Medicare is not adequate for some of the Medicare low-income population because of their additional disabilities. It is important to augment the Medicare program and not have these two programs attempting to interact with each other. It has been an extremely expensive program that is not generally regarded as having functioned well. So while I appreciate that there may be some benefits that have fallen off, I think we will be far better off to try to augment them in a very selective basis for low income disabled Medicare beneficiaries than to think about the two programs lying on top of each other. That just is not a model we should try to replicate.

The CHAIRMAN. I have taken way more than my time. Let me turn to my colleague, John Breaux.

Senator BREAUX. Thank you very much. Ms. Nemore, I had supported the Medicare-Medicaid wraparound. But we did not have the votes to do that, and, of course, for my state of Louisiana, being in a Medicare program which was a guarantee and an entitlement is far superior to being in a Louisiana Medicaid program where you never know what you are going to get from year to year.

It is already a program that is severely limited. I think they can only get six prescriptions filled and that is it. They never know whether it is going to be there the next year or not. So the concept of putting it all under the Medicare program was what we ultimately came up with, and I think Ms. Wilensky's suggestion is we want to do more for seniors, we can increase it, which I am sure the pressure will be there to do.

But there is nothing that prohibits states from using their own state money to continue to do a wraparound if the state is fortunate enough financially—maybe Connecticut would be one of those; Louisiana certainly is not—to be able to do it. If they think it is in their state's interest and they can afford it and it is a proper use of funds, the state is not prohibited either under the discount card or under the Part D when it comes into effect to provide additional assistance. Does that not address some of your concerns?

Ms. NEMORE. Senator, as you noted, your state of Louisiana would be hard-pressed to provide that kind of assistance because——

Senator BREAUX. No, no, they would not be hard-pressed. They would not do it, period. Hard-pressed is being generous. [Laughter.]

Ms. NEMORE. It, as many states in the country that have substantial need, has a very high Federal match for Medicaid, so for those States to undertake this with their state dollars is very difficult.

Senator BREAUX. I was on your side. I argued for it, but we just did not end up with it. Ms. Delgado, is your organization using all of these senior groups to help them and pointing seniors to senior centers and other type of organizations out there to help them educate the members? I mean this is a real tough problem. I think

that if you are 65, and as I get closer to that number, I think I am going to be still smart and intelligent and can use my computer, but certainly my father's generation does not even have a computer. I mean he would not know how to turn it on and would not want to learn, and it is very difficult for them to find where the information is on these new programs.

I really think that these senior organizations can be particularly helpful in providing that type of information to seniors. I mean is that part of what you are attempting to do?

Ms. DELGADO. Most definitely. But it is not just the senior groups. It is also the community health centers.

Senator BREAUX. Sure.

Ms. DELGADO. It is the Meals on Wheels people.

Senator BREAUX. Good.

Ms. DELGADO. It is everyone who may touch someone's life or the life of a child who may have a parent that they can influence or help through the process. So really through ABC and through our own organization the Alliance, it is reaching out to people in whatever ways we can to get them the best information.

I have to tell you that one of our earliest concerns was that people were concerned about the program because they kept being told it is confusing and complicated.

Senator BREAUX. There were some who were intentionally arguing that point vociferously.

Ms. DELGADO. Of course, but what we did is we took the people and told them, well, let us take a step back and see what you have to do, which is why we came out with a workbook for people to use, and once they worked through that workbook, they see, well, this is just listing all my medicines, this is knowing if my pharmacy accepts this card, this is calling this number, so it is making it simpler.

You know government programs are not known for their simplicity. But at the same time, the access to the low-income senior that this provides for their medicine is stupendous.

Senator BREAUX. I like what Dr. McClellan said when he talked about the 1–800–MEDICARE number that seniors or anyone could on behalf of a senior dial up and say, "Here is what I am taking, here are my five prescriptions or even more." Then say which card best fits what my needs are. Have you all ever taken a look at that? I mean is that something that is working, has the potential to work better, can you give me some kind of a feeling from the user's side?

Ms. DELGADO. Actually when the program first started, we had regular contact with CMS asking them to make things simpler, some of the Spanish language. At ABC, we have our own web site that we started. It gives a lot of information, also works seniors through it. We also give them access to another web site that really gets seniors involved in any senior program that they are eligible for. So it's really giving people tools. We have worked with CMS to get them to train local community-based groups on what they need to know and do.

So, yes, it is working, but I have to say this is an—and I have been in Washington 25 years working with DHHS all this time—and the CMS staff are working with the community-based organi-

zations, and that is a new relationship. Sure, it has its bumps, but I think they are moving in the right direction.

Senator BREAUX. Thank you. Dr. Thames, there is no means testing for the drug program.

Dr. THAMES. Correct, sir. You mean the assets?

Senator BREAUX. I mean means test, assets test. I mean you are eligible for the discount card. You are eligible after 2006 for the Medicare insurance program that will cover prescription drugs whether you are making $25,000 of income or whether you are clipping coupons fortunately for $3 million a year. So there is no means test there.

There is a means test for the first time for Part B for medical services. I guess that is what AARP is objecting to?

Dr. THAMES. Well, what we are concerned about is the Congressional Budget Office says that there will be 15.2 million people who are below 150 percent of the poverty level in 2006. Of that number, 13.4 million of those people will be eligible for Part D. That 1.8 million of those people because they have assets will not be eligible under Part D. Is that incorrect?

Ms. NEMORE. For the low-income subsidy.

Senator BREAUX. I do not think that is correct.

Ms. NEMORE. Would not be eligible for the low-income subsidy.

Senator BREAUX. Oh, yeah, sure, for the low-income assistance, yeah.

Dr. THAMES. For the low-income.

Senator BREAUX. Are you objecting to——

Dr. THAMES. We feel that these people are low-income people and that it is wrong with their low incomes to deny them a needed subsidy because they have managed to put aside a small amount of savings for their retirement, which was what we were trying to encourage our people to do.

Senator BREAUX. OK. So AARP's objection is to the asset test?

Dr. THAMES. Yes, sir, the asset test. I am sorry if I did not make that clear.

Senator BREAUX. To become eligible for the subsidy?

Dr. THAMES. Yes, sir, that is our problem because we feel that it is wrong to penalize these people with very low incomes who have worked hard and put aside money that we encouraged them to do for their own retirement and then those assets, particularly at such a low level of assets, for them not to be eligible then for the low-income provisions.

Senator BREAUX. You would not argue against any asset test or would you?

Dr. THAMES. Well, we have said we are against the asset testing, but we have also said if we are going to have asset testing, we think the present levels are too low, Senator. That is in our own discussions.

Senator BREAUX. OK. Thank you, Doctor. Ms. Wilensky, I guess what you are saying, "If it ain't broke, don't fix it yet"?

Ms. WILENSKY. Well, even if you think it is not working as well as you would like it, hold off, let it start, we will discover problems for sure, fix it after it starts.

Senator BREAUX. Yeah, I think that anything as monumental as this bill is to start trying to change it 2 months after it is imple-

mented is something we do not have the capacity to do nor should we. Let us see how it is going to work, give it some time. Obviously, it was written by humans. It is not perfect, and as always, there will be opportunities to improve upon it, but do not try and do it before the ink is dry on the program. Let us get it set up. It is not completely implemented yet; we have made great progress. If you get four million people, I guess, Mr. Chairman, enrolled in the drug discount card after only a couple of months, that really is very significant, and I think it is going to improve, and it is going to get better with people like yourselves helping people to understand it.

So I think all of you have been helpful and provided some good information and thoughts and we thank you for it. Thank you.

The CHAIRMAN. John, thank you very much. This will be my last question of the panel. I think it goes without saying that assistance in paying for drug benefits helps low-income seniors economically. We do not really argue that. But what effect do you expect greater access to drugs to have to the health status of seniors in low-income populations, especially considering that serious health problems are often more prevalent among low-income seniors.

Dr. Delgado, I am especially interested in hearing from you in regard to your experience with the health status and the needs, let us say, of the Hispanic community. We are interested in helping people stay healthy or get healthier, and we now know, of course, that prescription drugs is the same argument but in a different context that we made 30-plus years ago as it related to access to hospitals. Would you respond to that and then any of you who wish to do follow-up on your own comments in relation to health versus economics? We think clearly we are helping them economically. Are we helping them from a health status? Yes.

Ms. DELGADO. Let me just make three points. First, in terms of health, the fact that people will now be able to take their medicines, for example, for diabetes means they will not have to wait to go to the hospital to have an amputation, that they will be able to have better health.

The second thing is that as part of the change in the mind-set of CMS, the "Welcome to Medicare" physical starts talking about health promotion, disease prevention, very important for people's health because before people only went when they were sick to use their benefits. Now, there is an opportunity to say these are the things that you can do to prevent illness and to prevent the consequences of illness.

The third thing is that people need to have access to the full range of medicines. We know, for example, that for Hispanics, for Mexicans in particular, there is data showing that the absorption rates of some medicines are three times the amount than it is for non-Hispanics, meaning people would take their medicines and become ill, and they would go to their doctor, I do not want my medicine, the doctor would say,"Oh, my patient is non-compliant", but really it was not the right thing. By having a system that will cover both generics and brands, we let the physician and the patient decide which is the best medicine for that patient to live a better life.

So it improves the economics, but the health of the person is critical. That means a person can stay home and live the kind of life that we want all our seniors to have.

The CHAIRMAN. Patricia.

Ms. NEMORE. To the extent that the drug plans are able to actually, are covering the drugs that any individual needs, the low-income assistance provided by this legislation will allow people to not have to choose between taking medicine or buying food. That is often a choice that is made by people living on very limited incomes and this benefit can provide some relief for that. We are very concerned about the formulary rules and what can or cannot be covered. The plans have enormous discretion in designing their formularies and may, in fact, not cover a number of drugs. Even if a person found a plan that covered some of their drugs, it might not cover all of their drugs. So there may well be gaps that would still require people to be paying large amounts of money for their drug coverage.

But to the extent that people do not have to choose between food and medicine, that would be a good thing.

The CHAIRMAN. So you can conclude from this also that in the general sense, fully implemented, while you dislike certain portions of it and would have done it differently, it should in the end produce a healthier senior population?

Ms. NEMORE. If we have formularies that allow people to get access to the drugs they need, yes.

The CHAIRMAN. OK. Dr. Thames.

Dr. THAMES. As a family physician who practiced for over 40 years, I am very much impressed with a number of things about the bill, and I will just mention again the physical examination you can get, the fact that we are going to have chronic disease management, we are going to be able to discover disease sooner and treatment is going to be more cost-effective. We are going to be able to keep more people out of the emergency rooms where costs go up, but we are also going to pay for comparable studies for efficacy of drugs, so we are going to decide in the same class of drugs which ones are the most cost-effective to do the same job, and that should make it a benefit, and poor people who have been unable to get the drugs that they need should be able to get not only the drug they need, but we are going to have scientific studies to determine what is the most cost-effective drug that they need for their diabetes or their cardiovascular disease.

So I definitely feel that it would be very beneficial to those folks to identify their disease problems earlier and give them medications that keep them out of the emergency rooms and hospitals and begin to improve their life expectancy to come closer to what it is for more middle income Americans, where it is markedly below that now.

Ms. WILENSKY. Dr. Thames mentioned a number of points that is important for the aging community in particular to be mindful of, that in this bill, it is primarily a prescription drug bill. But there are a number of very important other provisions like the studies for chronic care, which is dominating the ill health of Americans, like the disease management focus, the important preventive health care benefits that were included, and that when you think

about how anachronistic Medicare has been, up until the passage of this bill, focusing on inpatient drug coverage and physician and hospital, home care and nursing care, but excluding outpatient drug coverage, something that is hard to imagine any other type of insurance plan doing for the last 15 years, this bill really moves forward in terms of allowing people to have better health because they have fuller health care coverage and because we are pushing forward on trying to organize how that care can be provided for chronic care and disease management purposes.

The CHAIRMAN. Well, as each one of you have said, you would have done it a bit differently. I think that is probably true of 100 senators and 435 House members. The reality is we did tackle a very large problem and try to resolve it.

Now, of course, the detail of it being brought through regulation is critical and that is why we are here today, and that is why we will probably ask you or your colleagues to be back again and again as we watch in progress this effort taking shape. I do agree that I think we should be tremendously cautious as public policy people about suggesting changes before the fact.

If it is clear within the context of the law, as Patricia has pointed out, maybe that is a nudging of CMS in the right direction or in a slightly different direction than they may be taking, but I think Congress will be cautious in that. We are very anxious to see it on the ground in a timely fashion so that seniors can begin to receive the benefits as was directed by this, as has been directed by this legislation.

So we thank you for your presence today and your diligence. As I say, we will have you back again. I think it is important that we build a record, a record that CMS can look at knowing that we are watching them closely, as we move toward full implementation of what is in my opinion landmark legislation. We thank you all for your time here today. The committee will stand adjourned.

[Whereupon, at 3:58 p.m., the committee was adjourned.]

APPENDIX

MAY 2004

Issue Brief

How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits

LAURA SUMMER AND LEE THOMPSON
CENTER ON AN AGING SOCIETY
GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

For more information about this study, please contact:

Laura Summer, M.P.H.
Senior Research
Health Policy Institute
Georgetown University
Tel 202-687-3595
Fax 202-687-3110
E-mail lbs6@georgetown.edu

or

Barbara S. Cooper
Senior Program Director
The Commonwealth Fund
Tel 212.606-3862
Fax 212.606-3500
E-mail bsc@cmwf.org

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ABSTRACT: The Medicare Savings Programs and Medicaid help elderly Medicare beneficiaries with their cost-sharing responsibilities and provide much-needed additional benefits. But 40 to 50 percent of eligible low-income Medicare beneficiaries are not enrolled in the Medicare Savings Programs. One persistent barrier is the use of asset tests, which greatly complicate the application process for applicants and program staff. Older people with low incomes generally have few assets and the income and assets of older people who qualify for public programs do not change substantially over time. Findings suggest that use of asset tests should be eliminated or asset limits should be increased; at a minimum, cost-of-living adjustments should be made. Findings also indicate that the renewal process should be simplified, and use of verification documents should be reduced or eliminated.

* * * * *

OVERVIEW

The cost of health care can be a significant financial burden for older Americans with low incomes. The Medicare program is an important source of health care coverage for about 35 million people age 65 and older and close to 6 million adults with disabilities under age 65, but costs can be steep even with Medicare coverage. The Medicare Savings Programs and Medicaid provide important benefits to some of the neediest seniors and disabled. They fill in Medicare cost-sharing responsibilities and, in the case of Medicaid, provide much-needed additional benefits (Table 1). But 40 percent to 50 percent of eligible low-income Medicare beneficiaries are not enrolled in the Medicare Savings Programs.[1]

A number of factors contribute to the low enrollment rate. One persistent barrier is the use of asset tests, which greatly complicate the application

Table 1. Financial Eligibility Criteria and Benefits for Medicaid and the Medicare Savings Programs*

Program	Countable Income Limits	Countable Asset Limits	Benefits
Full Medicaid Coverage**	At or below 75 percent of the federal poverty level***	$2,000 for an individual $3,000 for a couple	Coverage for a broad range of health care services
Qualified Medicare Beneficiary (QMB) Program	At or below 100 percent of the federal poverty level	$4,000 for an individual $6,000 for a couple	Medicaid pays all Medicare Part B premiums ($66.60 per month in 2003) and cost-sharing charges****
Specified Low-Income Medicare Beneficiary (SLMB) Program	Between 100–120 percent of the federal poverty level	$4,000 for an individual $6,000 for a couple	Medicaid pays Medicare Part B premiums ($66.60 per month in 2003)
Qualifying Individuals I (QI-I) Programs*****	Between 120–135 percent of the federal poverty level	$4,000 for an individual $6,000 for a couple	Medicaid pays Medicare Part B premiums ($66.60 per month in 2003)

* This chart shows standard income and asset eligibility criteria. In counting income or resources, however, states may also use methods that are less restrictive than those specified for the Medicaid, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individuals (QI) programs. In those instances, income and asset limits are higher than those listed in the chart.

** The primary eligibility pathway for elderly individuals receiving full Medicaid coverage is through the Supplemental Security Income (SSI) program, which has income eligibility limits of approximately 75 percent of the federal poverty level. States have the option, however, of extending full Medicaid coverage to people age 65 and older at higher poverty levels. Specifically, they may cover elderly people whose incomes do not exceed 100 percent of the federal poverty level and whose resources do not exceed $2,000 for an individual or $3,000 for a couple. States may also use less restrictive methods to adjust income and asset limits. In 2001, 16 states and the District of Columbia had income eligibility limits at 100 percent of the federal poverty level or higher.

*** In 2003, the federal poverty level was $9,310 for individuals and $12,490 for couples.

**** States are not required to pay for cost sharing if the Medicaid payment rates for a given service are substantially lower than the Medicare payment rates.

***** The QMB and SLMB programs are entitlement programs, but the QI program is not. Federal QI funding is capped each year and is due to expire September 30, 2004, unless Congress passes new legislation.

Sources: Andy Schneider, Risa Elias, Rachel Garfield, David Rousseau, and Victoria Wachino (2002). *The Medicaid Resource Book*. The Kaiser Commission on Medicaid and the Uninsured; Henry J. Kaiser Family Foundation. *State Health Facts Online. 50 State Comparisons: Medicaid Coverage Expansions for Medicare Beneficiaries* (available at http://www.statehealthfacts.org).

process. Most applicants are required to provide documents verifying their assets. In focus groups, older Americans note that the number of verification documents required presents difficulties, particularly if they cannot locate the documents or must copy them.[2] Older applicants also have misperceptions about eligibility rules regarding assets.[3] Some people do not know that certain assets, such as the home, are not counted in determining eligibility. As a result, they may not apply for benefits even though they are eligible. Others are reluctant to apply because they incorrectly believe that they may have to give up their homes or other assets to receive benefits.[4]

The use of asset tests also complicates program administration. Reviewing asset information is the most time-consuming task in the enrollment process. Eligibility workers often have to help applicants identify and obtain the needed documents, and then must copy, review, and return the papers. Difficulties related to producing and reviewing asset verification documents occur both upon the initial application and later when beneficiaries must reenroll in the programs. Most states require annual reenrollment.

This issue brief presents findings from an analysis of data on the income and assets of low-income older Americans. Data were drawn from the 1998 and 2000 Health and Retirement Study (HRS) and from the 1993 and 1995 Study of Assets and Health Dynamics Among the Oldest Old (a companion study to the HRS). The authors examine the kinds and amounts of assets that low-income Medicare beneficiaries possess, the extent to

which the financial circumstances of beneficiaries change from year to year, and the implications of these findings for Medicare Savings Programs' enrollment and renewal processes.

MORE THAN 7 MILLION QUALIFY FOR BENEFITS BASED ON INCOME

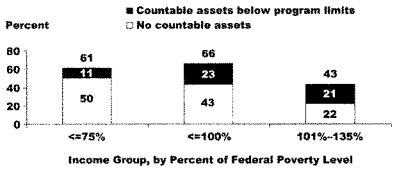
Some 2.3 million elderly individuals have incomes at or below the minimum eligibility limits for full Medicaid benefits. A total of 4 million seniors are eligible for the Qualified Medicare Beneficiary (QMB) program. This group includes the 2.3 million people who qualify for full Medicaid coverage and an additional 1.7 million with incomes between 75 and 100 percent of the federal poverty level. About 3.1 million people qualify for the Specified Low-Income Medicare Beneficiary (SLMB) or Qualifying Individuals (QI) programs (Table 2).

Older People with Low Incomes Generally Have Few Assets

In determining eligibility for Medicaid and the Medicare Savings Programs, countable assets include items such as money in checking or savings accounts, bonds, stocks, or mutual funds. Part of the value of assets such as vehicles and life insurance is also counted, as is the value of any real estate other than the applicant's home.

The median value of countable assets is just $300 for persons with incomes at 75 percent of poverty or less, and only $8,000 for persons with incomes between 100–135 percent of poverty. Not surprisingly, many people who qualify for programs based on income also qualify based on assets. A substantial proportion of people age 65 and older who meet program income limits have no countable assets. Many others have assets valued at or below the program limits. For example, 66 percent of people with incomes below the poverty level also have assets below the limits for the QMB program, and about two-thirds of these people have no assets at all (Figure 1).

Figure 1. Proportion of People in Each Income Group with Countable Assets Below Program Limits, by Income Group



Note: Asset limits for people with incomes less than or equal to 75 percent of the federal poverty level are $2,000 for individuals and $3,000 for couples. Asset limits for the other income groups are $4,000 for individuals and $6,000 for couples

Source: Calculations by the Center on an Aging Society based on data from the 2000 Health and Retirement Study

Table 2. Number of People Age 65 and Older Who Meet the Income Criteria for Medicaid or the Medicare Savings Programs

	Full Medicaid (Income at or below 75 percent of the federal poverty level)	QMB (Income at or below 100 percent of the federal poverty level)*	SLMB or QI (Income from 101–135 percent of the federal poverty level)
All 65 and older	2,323,372	4,047,276	3,054,879
65–74	1,134,156	1,853,272	1,274,321
75–84	798,536	1,449,603	1,254,516
85 and older	390,680	744,401	526,042

* Includes individuals in the first category (≤ 75 percent).

Source: Calculations by the Center on an Aging Society based on data from the 2000 Health and Retirement Study.

Older people who qualify for programs based on income but fail the asset test are not wealthy. Among people age 65 and older who meet income but not asset eligibility limits, the median amount by which they exceed asset limits is $6,500. Almost one-third—30 percent—of people with incomes at or below the poverty level do not qualify for QMB program benefits solely because they have life insurance policies. In other words, the only countable asset they have is a life insurance policy valued higher than $1,500. Seventy-two percent of the people in this group have life insurance policies that exceed the allowable limit by $8,500 or less.

The asset test provides a deduction of $4,500 for a vehicle's value. About half of the people who qualify for Medicaid and the Medicare Savings Program based on income but not assets have vehicles that exceed the limit by $5,500 or less (Table 3).

Table 3. Median Value of Selected Assets for People Age 65 and Older Who Are Eligible for Programs Based on Income, But Not Assets

	Full Medicaid (Income at or below 75 percent of the federal poverty level)	QMB (Income at or below 100 percent of the federal poverty level)*	SLMB or QI (Income from 101–135 percent of the federal poverty level)
Median amount by which life insurance policies exceed the $1,500 limit	$6,000	$8,500	$8,500
Median value of funds in checking or savings accounts	$5,500	$7,000	$7,500
Median amount by which vehicles exceed the $4,500 limit	$5,500	$5,500	$7,500

* Includes individuals in the first category (≤ 75 percent).

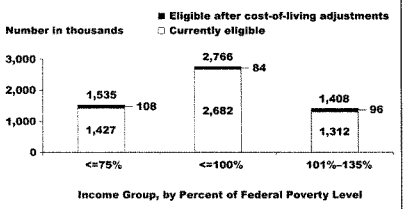
Source: Calculations by the Center on an Aging Society based on data from the 2000 Health and Retirement Study.

Asset Tests and the New Medicare Prescription Drug Benefit

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will subsidize drug benefit premiums and related costs for some low-income Medicare beneficiaries when it takes effect in 2006. Beneficiaries will have to apply for this assistance, however, and eligibility will be determined based on evaluations of income and assets. The income and asset limits for drug benefit subsidies will be somewhat higher than those for the Medicare Savings Programs, and the asset limits will be indexed for inflation. The asset limits for applicants with incomes less than 135 percent of the federal poverty level (FPL) are $6,000 for individuals and $9,000 for couples who receive the largest subsidies. Other applicants in that income group who have assets valued somewhat higher—from $6,000 to $10,000 for individuals and from $9,000 to $20,000 for couples—qualify for smaller subsidies. Applicants with incomes from 135 percent FPL to 150 percent FPL also may qualify for the smaller subsidies if they have assets valued at less than $10,000 for an individual and $20,000 for a couple. An estimated 5.6 million people living in the community will be eligible for drug benefit subsidies. This represents just over two-thirds—67 percent—of those who would qualify based on income alone. Currently, Medicare beneficiaries with incomes less than 135 percent FPL qualify for subsidies for the Medicare drug discount card. There is no asset test for the drug discount card.

Only a small number of people who exceed asset limits have deferred compensation retirement plans in the form of "defined contribution" plans such as Individual Retirement Accounts (IRAs), Keoghs, or 401K-type plans. These people are at a disadvantage, however, compared to those whose deferred compensation is in the form of a "defined benefit" plan. The total value of savings in defined contribution plans is considered to be a financial asset. By contrast, payments from defined benefit plans are considered a source of countable income. These rules favor people with defined benefit plans for two reasons: 1) program income limits are higher relative to asset limits, and 2) income limits, but not asset limits, are adjusted for economic growth.[5] The proportion of people who have defined contribution rather than defined benefit plans is growing for the population overall.

Figure 2. People Age 65 and Older Currently and Potentially Eligible for Benefits, by Income Group



Source: Calculations by the Center on an Aging Society based on data from the 2000 Health and Retirement Study.

ASSET LIMITS HAVE NOT CHANGED

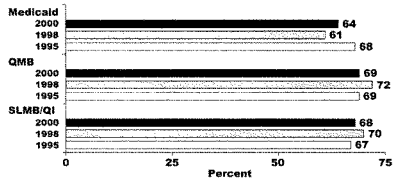
More people would qualify for benefits from the Medicaid and Medicare Savings Programs if asset limits were adjusted for economic growth. Asset limits for the programs have not changed since 1989, despite the fact that the cost of living has increased. If cost-of-living adjustments had occurred, about 100,000 additional people age 65 and older would be eligible to receive Medicaid benefits and another 180,000 would be eligible for the Medicare Savings Programs. This represents a very small increase in the number of people eligible for benefits based on both income and assets (Figure 2).

The deductions allowed in counting the value of specific assets also are unchanged since 1989. If they were adjusted for inflation, the deduction allowed for life insurance would have been $1,926 in 2000 and $2,030 in 2003. After adjustments for inflation, the deduction for vehicles would have been $5,777 in 2000 and $6,089 in 2003.[7]

A large proportion of beneficiaries are eligible year after year. Nearly 70 percent of people age 70 and older who were eligible for the QMB, SLMB, or QI benefits in 1993 were still eligible seven years later, and 64 percent still qualified for Medicaid (Figure 3).[8]

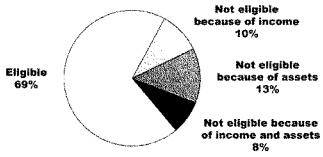
More than 90 percent of beneficiaries who exceed limits in subsequent years acquire either

Figure 3. Proportion of People Age 70 and Older in 1993 Who Remained Eligible for Program Benefits in Subsequent Years



Note: Only people who were alive in all four waves and participated in each wave of data collection were included.
Source: Calculations by the Center on an Aging Society based on data from the 1993 and 1995 Study of Asset and Health Dynamics Among the Oldest Old and the 1998 and 2000 Health and Retirement Study.

Figure 4. Reasons That People Age 70 and Older Who Financially Qualified for QMB Benefits in 1993 Were Not Eligible in 2000



Note: Only people who were alive in all four waves and participated in each wave of data collection were included.
Source: Calculations by the Center on an Aging Society based on data from the 1993 Study of Asset and Health Dynamics Among the Oldest Old and the 2000 Health and Retirement Study.

assets or incomes above the limits—but not both. Among people who qualified for the QMB program in 1993 but not in subsequent years, a small proportion—8 percent—had both income and assets above the limits (Figure 4). The pattern is similar for Medicaid and the other Medicare Savings Programs.

For beneficiaries who in subsequent years exceed the limits, the amounts of "extra" countable income and assets are small (Table 4).

RECOMMENDATIONS

The findings suggest that four aspects of the enrollment process can be simplified for the older low-income population:

1. The use of asset tests can be eliminated.
2. Rules regarding asset tests can be changed.
3. The renewal process can be simplified.
4. The use of verification documents can be reduced or eliminated.

Policy changes in these areas have the potential not only to reduce enrollment barriers when people apply for program benefits, but also to reduce administrative costs. Enrollment simplification strategies that reduce administrative costs may be particularly attractive to state Medicaid programs, which administer the Medicaid and Medicare Savings Programs for older Americans.

Eliminating Asset Tests

To qualify for program benefits, applicants must not exceed separate limits on their incomes and assets. Income and asset tests are used to help target program benefits so that limited resources assist those most in need. Yet the data show that among the older low-income population, income and assets are closely related for a substantial number of people. This suggests that income tests alone would identify those people who most need benefits.

Table 4. Median Value of "Extra" Annual Income and Assets for People Age 70 and Older Who Were Eligible for Benefits in 1993 But Not in 2000

	Income at or below 75 percent of the federal poverty level	Income at or below 100 percent of the federal poverty level*	Income at or below 135 percent of the federal poverty level**
Median value of "extra" income	$2,220	$2,812	$1,800
Median amount of "extra" assets	$3,500	$6,000	$9,500

* Includes individuals in the first category (≤ 75 percent).

** Includes individuals in the first two categories (≤ 75 percent and ≤ 100 percent). The sample was too small to examine values for the population between 101–135 percent of the federal poverty level.

Source: Calculations by the Center on an Aging Society based on data from the 1993 AHEAD and the 2000 Health and Retirement Survey.

For example, two-thirds of older people who qualify for the QMB program based on income also qualify based on assets—some 2.7 million people. And even people who would qualify for Medicare Savings Programs based on incomes but not assets typically have minimal assets. The value of those assets could easily drop below program limits if the potential applicants had to use their modest savings to pay for home repairs, unexpected medical expenses, or similar items. One-third of people who would qualify for the QMB program based on incomes but not assets have "extra" countable assets valued at or below $4,700. In 2000, elderly Medicare beneficiaries spent an average of just over $3,000 on out-of-pocket medical expenses.[10]

Despite the potential for increased program enrollment if asset tests were eliminated, four states—Alabama, Arizona, Delaware, and Mississippi—have modified the tests to effectively eliminate them for Medicare Savings Programs. Connecticut and New York disregard all assets for the QI program.[11] Arizona eliminated the asset test for Medicare Savings Programs in 2001 after conducting a fiscal impact study. The study found that savings on administrative costs related to documenting assets roughly equaled the costs of benefits for additional persons who would enroll in the programs.[12]

Nineteen states that offer Medicaid benefits for parents in low-income families do not use asset tests. Medicaid officials in those states report that asset tests require significant staff time and that few denials occur because of excess assets. They said that eliminating asset tests raises the productivity of eligibility workers, makes it easier to use automated eligibility determination systems, and reduces administrative costs.[13] For example, before Oklahoma eliminated the Medicaid asset test for families, officials concluded that doing so would save about $1 million. The savings would come from the difference between the $3.5 million spent on administrative activities related to verifying assets and the $2.5 million spent on benefits for additional persons who would qualify.[14] Most states do not use asset tests as part of the Medicaid enrollment process for children.[15]

Reducing costs is especially crucial now because the new drug benefit subsidy program will most likely result in additional administrative costs and complexity for state Medicaid programs, which will be responsible for administering it in addition to the Medicare Savings programs. The Social Security Administration is also slated to play a role in administering the drug benefit program. There is likely to be some confusion among older low-income Medicare beneficiaries regarding availability of the two types of benefits, the need in some cases to apply separately for each one, and the different eligibility rules for the benefits. Plans for implementing the drug benefit subsidy program should include efforts to simplify the enrollment and renewal processes. It may be beneficial to consider aligning eligibility rules for the new drug benefit subsidy with those for the Medicare Savings Programs to facilitate enrollment in both.

Changing Asset Rules

If asset limits are retained to determine benefit eligibility, they should be raised. The data show that if asset limits were adjusted to account for economic growth, a relatively small number of people would be newly eligible for program benefits. They are among the people originally targeted to receive benefits.

Limits on deductions for certain assets that have remained unchanged since 1989 also should be updated. For example, asset rules allow a deduction of $1,500 for life insurance policies. Older people typically have life insurance so that money will be available to pay for funeral and burial costs. In 1999, a basic adult funeral cost an average of $5,020. Burial costs an additional $2,000 or more.[16] The $4,500 deduction allowed for vehicles is also outdated.

The treatment of deferred compensation retirement savings also should be examined. Current rules favor defined benefit rather than defined contribution plans. Only a small proportion of people

with low incomes have retirement plans, but for those who do the difference in how the types of plans are treated may affect whether they qualify for program benefits. The bias toward defined benefit plans could be eliminated if the savings in defined contribution plans were not counted as assets. Such a change would respond to changes in the broader market and could encourage modest saving for retirement.

A number of states have adjusted the asset test for their Medicare Savings Programs. Some states exclude a certain amount of assets when determining eligibility, effectively increasing the asset limits. For example, Florida excludes the first $1,000 for each person. Maine excludes the first $8,000 for an individual and $12,000 for couples. Minnesota excludes the first $10,000 for individuals and $18,000 for couples. Some states disregard the value of one or more vehicles. These include Florida, Georgia, Kansas, Maine, Missouri, South Carolina, and Vermont. Higher values for life insurance are excluded in Florida ($2,500), Georgia ($5,000), and South Carolina ($5,000). Louisiana officials note that a new policy which allows a $10,000 exclusion for life insurance policies has simplified the application process for applicants and eligibility workers, thereby reducing the time required to process applications.

Simplifying Renewals

Periodic reviews are conducted for many public programs to ensure that participants continue to meet financial eligibility requirements. In most instances reviews are conducted annually for the Medicare Savings Programs. However, the data indicate that income and asset levels are unlikely to change among the low-income elderly population. The data also show that people who qualify for program benefits in one year, but not in subsequent years, do not have increased income or assets that exceed financial eligibility limits by large amounts. People whose benefits are discontinued may become eligible again and reapply within a short period of time if they face unexpected medical expenses or other costs.

Given these findings, it may be prudent to simplify the renewal process for the older low-income population. For example, instead of requiring participants to reapply for benefits, states can ask participants to sign a postcard or form stating that their financial circumstances have not changed and they wish to continue receiving benefits.

States are currently required to use Income and Eligibility Verification Systems (IEVS) to confirm information about applicants' incomes. Thus, a method already exists to ensure that enrollment errors do not occur at renewal. A few states use an "ex parte" renewal process in which Medicaid program staff use electronic data systems to verify that renewal should occur. For example, data regarding Food Stamp program participation can provide current information about income and assets.

Automatic renewals help program participants by eliminating some of the barriers often associated with the renewal process, such as the need to complete application forms, provide supporting documents, or visit the Medicaid office. In addition, automatic renewal—which is associated with continuous enrollment—may increase the likelihood that participants will receive uninterrupted health care services.

Given that so many participants remain eligible from year to year, longer eligibility periods also may be warranted. Some state-funded pharmacy assistance programs already use longer time frames. Participants in South Carolina's SilverCard Program must reapply for benefits every two years. Pennsylvania's Pharmaceutical Contract for the Elderly (PACE) Program and New Jersey's Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program require that higher-income enrollees reapply every year, but lower-income enrollees have a two-year eligibility period.[7]

Finally, a simpler renewal process can reduce administrative costs. If eligibility workers do not have to review documents or contact enrollees to obtain missing information, they will spend considerably less time on each renewal. And regardless of the type of renewal process used, the cost of

conducting renewals will be cut in half if they occur every two years instead of every year.

Reducing or Eliminating the Use of Verification Documents

Reviews of documents to verify income and assets are common during the enrollment and renewal processes for Medicaid and the Medicare Savings Programs. However, the findings regarding the financial circumstances of the low-income elderly indicate that these reviews may not be necessary.

Applicants sign documents, under penalty of perjury, stating that the information they provide is correct. States are required to use Income and Eligibility Verification Systems to confirm that income information provided by applicants is correct. This verification occurs regardless of whether applicants are asked to provide documents or whether they make self-declarations about their assets or incomes. Case studies of Medicare Savings Programs in five states indicate that states that use collateral verification systems do not report increases in errors or fraud.[18] And a letter from the Centers for Medicare and Medicaid Services reports a direct link in one state between extensive renewal requirements and a significant number of denials and terminations of applicants who did not return verification information but were otherwise eligible.[19] Under federal law, applicants for Medicaid must only show documents verifying immigration status.

Some states have already reduced requirements for verification documents. Income verification documents are not required for the Medicare Savings Programs upon initial application in 12 states and at renewal in 11 states. There are no requirements for documents to verify assets at the initial application in 17 states and renewal in 16 states.[20]

Requiring fewer or no verification documents also may reduce administrative costs. There is some evidence of this from changes to Medicaid programs for children and families. Officials in Michigan report that after they eliminated verification documents in favor of self-declaration of income for the children's Medicaid program and the State Children's Health Insurance Program (CHIP), each caseworker processed an average of four more applications daily. At the same time, audits of reported income showed that self-declaration did not lead to higher error rates.[21] A study of options to simplify the enrollment process for families receiving benefits from California's Medi-Cal program indicates that allowing self-certification could result in savings because the administrative savings would be greater than the costs of new enrollments.[22]

SUMMARY AND CONCLUSIONS

Income is generally a good predictor of the value of assets for older people with low incomes. Most people with incomes that meet eligibility standards for Medicaid and the Medicare Savings Programs also meet eligibility standards for assets. These findings suggest that it may be unnecessary to use asset tests to determine financial eligibility for these programs.

If asset tests are used, they should be adjusted to ensure that people who need benefits receive them. In particular, the limits and the allowable deductions for particular assets should be adjusted to reflect economic growth. Rules regarding retirement plans also should be revised so that all types of deferred compensation retirement plans are treated similarly.

The incomes and assets of older people with low incomes do not change substantially over time. This suggests that the benefits renewal process can be simplified and that longer eligibility periods can be used. In addition, the close relationship between income and assets and the fact that financial circumstances are unlikely to change significantly over time for this population suggests that requirements for documents verifying financial information can be reduced or eliminated.

A number of states have already simplified the enrollment and renewal processes for Medicaid and the Medicare Savings Programs. Such policies have the potential to ease the enrollment process for applicants, ensure that beneficiaries stay enrolled, and reduce administrative costs for Medicaid programs.

Notes

[1] Mark Nadel, Lisa Alecxih, Rene Parent, and James Sears (2000). *Medicare Premium Buy-in Programs: Results of SSA Demonstration Projects. Social Security Bulletin*, vol. 63, no. 3.

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[3] Jennifer Stuber, Kathleen Maloy, Sara Rosenbaum, and Karen Jones (2000). *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* Center for Health Services Research and Policy, George Washington University.

[4] Perry, Kannel, and Dulio (2002).

[5] It should be noted that estimates of the number of people who qualify for programs are conservative because they are based on standard income and asset eligibility rules. Substantial numbers of beneficiaries live in states that use more liberal income and asset rules. For example, calculations by the Center on an Aging Society based on data from the Henry J. Kaiser Family Foundation found that about 42 percent of Medicare beneficiaries live in states that have increased the income limits for full Medicaid coverage for individuals age 65 and older to at least 100 percent of the federal poverty level. Also, a number of states provide QMB, SLMB, and QI benefits to people with assets above the standard limits. See Laura Summer and Robert Friedland (2002). *The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs*. The Commonwealth Fund.

[6] Marilyn Moon, Robert Friedland, and Lee Shirey (2002). *Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs*. Henry J. Kaiser Family Foundation.

[7] Calculations by the Center on an Aging Society based on 2003 GDP in the third quarter.

[8] As noted earlier, changes in survey methods over time may affect the number of people who appear to be eligible each year, with increases in numbers and values for particular assets reported in subsequent years. Thus, the proportion of people who remained eligible in 2000 may be somewhat higher than is reported here.

[9] Under current law, states may opt to disregard all assets, effectively eliminating asset tests.

[10] Stephanie Maxwell, Marilyn Moon, and Misha Segal (2001). *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*. The Commonwealth Fund.

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Data and Methods

Analyses of the Number of People Eligible for Programs

A nationally representative survey was used to examine the incomes and asset holdings of elderly Medicare beneficiaries. The Health and Retirement Study (HRS) contains detailed information on incomes and assets for 19,580 people representing the population over age 50 in 2000. It also includes information about the spouses of respondents, regardless of the spouses' age. HRS data were used to calculate countable income and assets for individuals age 65 and older and their spouses. Program rules about counting spousal assets are complex. For this analysis, the assumption is that all assets are jointly held.

Countable income was calculated using both earned and unearned income. Sources of income included in countable income are earnings, veterans benefits, Social Security benefits, pensions, unemployment compensation, workers compensation, annuity income, IRA withdrawals, alimony, lump sum payments, and income from assets such as rental property, a business or farm, stocks, and bank accounts, among others. Adjustments were made for sources of income that are excluded when determining eligibility. These include the first $20 of any monthly income, the first $65 of monthly earned income, and half of the remaining earnings.

Countable assets include real estate other than the main home, vehicles, life insurance, IRAs or Keoghs, stocks or mutual funds, bonds, amounts in checking or savings accounts or money market funds, CDs or treasury bills, trusts, and other assets. Exclusions from countable assets include the value of one automobile up to $4,500, household goods and property, burial funds up to $1,500, and the cash surrender value of a life insurance policy up to $1,500.

Longitudinal Analyses

Two nationally representative surveys were used to conduct the longitudinal analyses. The Study of Assets and Health Dynamics Among the Oldest Old (AHEAD) contains detailed information on incomes and assets for 8,222 people representing the population age 70 and older in 1993. Information about the same population was collected for the 1995 AHEAD survey. The AHEAD and HRS surveys were combined in 1998. Income and asset information for the population included in the 1993 AHEAD survey is available from the 1998 and 2000 HRS surveys.

Examining longitudinal data on older persons raises the issue of attrition, particularly due to death. Data from four years or waves—1993, 1995, 1998, and 2000—were used in the analyses. Only people who were alive in all four waves and participated in each wave of data collection were included in the population studied. Data were first collected from a representative sample of people age 70 and older in 1993, also known as the baseline year. This cohort of older persons was then re-interviewed in 1995, 1998, and 2000.

Differences in data collection methods over the study's period may affect the number of people who appear to be eligible each year. Specifically, the later surveys asked more detailed questions about the types and amounts of assets people possessed. Thus, there may be some under-reporting regarding countable assets in 1993 relative to subsequent years.

ABOUT THE AUTHORS

Laura Summer, M.P.H., is a senior researcher at Georgetown University's Health Policy Institute, where she conducts research on the design and operation of publicly-financed health care programs and on access to health and long-term care services. Ms. Summer also serves as the deputy director for the Institute's Center on an Aging Society, an organization that studies the impact of demographic changes on public and private institutions and families of all ages. She earned her master of public health degree from the University of Michigan. Ms. Summer can be reached at lls6@georgetown.edu.

Lee Thompson, M.S., is a research analyst at the Health Assistance Partnership, part of Families USA. At the time this brief was prepared, she was a research associate at the Center on an Aging Society, located at the Health Policy Institute at Georgetown University. While at the Center, her research focused primarily on issues related to chronic conditions and long-term care financing. Thompson received a master of science in community development and applied economics from the University of Vermont in 1998.

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