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MEDICARE PART D: IS IT WORKING FOR LOW-INCOME SENIORS?

HEARING

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MEDICARE PART D: IS IT WORKING FOR LOW-INCOME SENIORS?

WEDNESDAY, JANUARY 31, 2007

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

The Committee met, pursuant to notice, at 10:35 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Herb Kohl (chairman of the committee) presiding.

Present: Senators Kohl, Smith, Craig, Carper, Lincoln, Nelson, Casey, and Whitehouse.

OPENING STATEMENT OF SENATOR HERB KOHL

The CHAIRMAN. Good morning. This hearing will commence now. We welcome all of our witnesses.

Before we begin, I would like very much to thank Senator Gordon Smith for the great work that he has done as Chairman of this Committee over the past few years.

Senator Smith, this Committee was thoughtful, diligent and very active under your stewardship, and we applaud your leadership and your enthusiasm, and we will try to build on much of the work that you started. As you know, our Committee has a history of bipartisanship, and in that spirit we look forward to working together.

Even though most of us mark the passage of a year with cake and ice cream, I don't know anyone who says growing older is really a piece of cake, and that is why this Committee's work is so important. We are charged with finding solutions to the pressing problems that seniors face, and our agenda for the 110th Congress will tackle many of them.

For example, we must rein in health-care costs, and we ought to start by promoting affordable generic drugs. We also must improve nursing-home oversight to make sure seniors get safe and quality care. With the baby-boom generation set to retire en masse, we have to make sure older Americans can stay in the workforce longer, if they so choose, and we must also help people prepare for their long-term care needs.

Finally, we intend to hold a series of hearings to fix the problems with Medicare's prescription drug program, so that seniors can finally enjoy a simple, affordable benefit. Today, more than 24 million people are receiving their drug coverage through Medicare Part D, and we have a responsibility to make sure that the program works for all seniors.

To start today's hearings, we will explore problems with the low-income subsidy benefit and identify practical solutions. It is worth noting that this extra help for low-income seniors was one of the major selling points cited by supporters of the law when it passed, and, so far, that reality is far from the promise.

Last year got off to a rocky start, as many low-income seniors were denied the drugs they needed at the pharmacy. While some of those problems were resolved, serious challenges remain that are preventing low-income seniors from getting the low-income subsidy.

First, many prescription drug plans have changed their benefit, and not all participate in the low-income subsidy program. Some seniors did not receive the letters notifying them that they need to choose a new plan. So many are showing up at the pharmacy confused and frustrated.

Some seniors did switch plans, but their pharmacy has not been given an up-to-date record, so these seniors are being charged incorrect copays, or leaving without their drugs. Seniors faced many of these same problems last year, and we believe they should have been fixed by now.

So I believe it is time for CMS to put together a comprehensive plan and report back to this Committee on how they intend to fix these problems. Second, I am also concerned about the more than 3 million seniors who are projected to be eligible for the low-income subsidy, but are not receiving it.

In November 2006, Health and Human Services' Inspector General recommended that the Social Security Administration have access to IRS data so that they can better target potentially eligible low-income seniors. I am working on legislation to fix this, and I hope my colleagues on the Committee will join me.

Finally, some 600,000 poor seniors are losing the subsidy altogether. Some may still be able to obtain extra help, but they will need to apply, and since the application process is so onerous, we know that some seniors simply give up. The Administration needs to do everything in its power to find eligible seniors and make the application process a simple one.

We also need to take a serious look at the asset test to make sure that it is fair, easy to navigate and does not exclude seniors who are truly low-income and need extra help with their drug costs. As we enter the second year of the Medicare drug benefit, we have an obligation to make sure it is working for all seniors, but particularly for our poorer seniors, who need the help most.

The recommendations from our witnesses can lead to real solutions, and, of course, we all hope and trust and expect that the Administration is willing to work with us to implement them.

Again, we thank you all for being here.

We turn now to Senator Gordon Smith for his statement.

OPENING STATEMENT OF SENATOR GORDON H. SMITH

Senator SMITH. Thank you, Senator Kohl. It was a pleasure to work with you last Congress, and it will be so in this, as well. Our bipartisan tradition on this Committee will certainly continue on my account. So I appreciate very much your calling this important hearing.

It is the first for the Aging Committee in the 110th Congress, on the issue of low-income subsidy. LIS is one of the best features of Medicare's new prescription drug benefit. Millions of seniors now have access to affordable prescription drug therapies, many for the first time.

Last year, the Committee looked at the difficulties many dual-eligible beneficiaries had in transitioning to the new program. I look forward to revisiting some of the issues that were raised at that hearing.

Since Medicare Part D became effective last year, the Centers for Medicare and Medicaid Services and the Social Security Administration have made a great deal of progress to ensure that the benefit is working well for all beneficiaries. However, there are still a number of improvements that can be made to the program, especially to the LIS benefit.

Ultimately, it is Congress's responsibility to ensure that all low-income seniors who have difficulty paying for prescription drug costs get the help that they need and the help that we intended they have. Last spring, I filed legislation to create a special enrollment period for newly eligible LIS beneficiaries and to waive their late-enrollment penalty.

Fortunately, CMS made changes administratively, but I would like to write the changes they made into law. Giving low-income seniors additional time to enroll in Medicare Part D ensures they are able to choose a plan that best fits their health-care needs.

Despite this progress, I do find it troubling that recent estimates still show that there may be at least 3 million seniors eligible for LIS who have yet to apply for it. It is essential that CMS and SSA and their community partners continue working to capture these seniors through targeted outreach efforts.

I expect we could help many more seniors with their drug costs, if only they knew extra help was available to them. In addition to this, there are a number of things we can do in Congress to help ensure that all seniors who legitimately need help with their drug costs get it.

So, in the coming weeks, I will introduce legislation with my colleague on the Finance Committee, Senator Bingaman, that will reform the asset tests used to determine eligibility for low-income subsidy. Our proposal, which was developed with input from groups like AARP and the National Council on Aging, aims to make it easier for seniors to meet some of the current test's requirements and remove unnecessary administrative burdens.

I believe the existing LIS application is too complex and it is preventing seniors from getting the help that they need. I also plan to reintroduce a bill filed last Congress that creates parity in the cost-sharing charged beneficiaries living in nursing homes and assisted-living facilities.

Our current policy weighs the cost sharing for beneficiaries in nursing homes, but those who live in assisted-living and other community-based facilities illogically have to pay for it. Frankly, I find it unacceptable. I was pleased to be joined by colleagues on the Aging Committee, specifically Senators Nelson, Clinton and Lincoln, as cosponsors of that measure. I am glad they have agreed to work with me again this year.

I look forward to hearing an update from CMS and SSA on how well the LIS benefit is working. While these two agencies have had some difficulty in sharing information in the past, particularly with determining subsidy eligibility and Medicare Part D premium withholding, I am confident they are putting forth all kinds of good faith and their best efforts to make this new benefit work for our seniors.

I thank them for that work and what they did on a rushed basis last year to make a difficult situation easier.

I am hopeful our discussions today will provide the Committee useful insights on how Congress can ensure that all beneficiaries in need, all those who are eligible, get the help they deserve with their drug costs.

So, thank you, Mr. Chairman. Let's carry on.

The CHAIRMAN. Thank you, Senator Smith.

We are pleased to welcome the first panel here today.

Our first witness will be Beatrice Disman of the Social Security Administration. Ms. Disman has served for over a decade as SSA's regional commissioner of the New York region. In 2003, Ms. Disman became chair of SSA's Medicare Planning and Implementation Task Force. This task force is responsible for implementing SSA's role in the Medicare Modernization Act.

She will be followed by Larry Kocot of the Centers for Medicare and Medicaid Services, CMS. Mr. Kocot serves as senior advisor to the administration of CMS. In this capacity, he has worked closely with the administrator in the implementation of the Medicare Part D low-income subsidy benefit.

So we welcome you both, and we look forward to your testimony.

Ms. Disman.

STATEMENT OF BEATRICE DISMAN, NEW YORK REGIONAL COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, NEW YORK, NY

Ms. DISMAN. Thank you so much, Mr. Chairman.

Thank you so much, Senator Smith.

Thanks for inviting Social Security today to discuss our ongoing efforts under the Medicare Prescription Drug Program to sign up Medicare beneficiaries for the low-income subsidy (LIS), or, as we commonly call it, "extra help".

As you indicated, I am Bea Disman. I am the Regional Commissioner of the New York region, and I was really given this incredible opportunity to share the implementation of a very vital program to the American public.

In this role, I have seen the dedicated efforts of so many Social Security employees and partners within and outside of Government, as they have reached out to those individuals who could ben-

efit from the low-income subsidy. I am pleased to be able to share our story.

I am also pleased to be here with our colleagues, who have played an important role in implementing this new program.

In the past year, Social Security has continued its intensive efforts to locate low-income Medicare beneficiaries, and provide them with an opportunity to file for this important benefit. We have used targeted mailings, personal phone calls, computer data matches, community forums, partnerships with State agencies and nonprofit organizations, fact sheets, word of mouth—in short, any and all means at our disposal—to reach those eligible for the "extra help".

Throughout 2005 and 2006, Social Security provided a number of alternatives for beneficiaries who applied for "extra help" assistance. Scanable paper applications, in office applications, community application-taking events, Internet and media telephone applications all have been a part of this effort.

Even though means testing, by its very nature, is complex, Social Security created an application which allows individuals to apply for the "extra help" as quickly and as easily as possible.

During these past 2 years, Social Security held or participated in more than 76,000 Medicare Part D/LIS outreach events. In many of these events, we were joined by Centers for Medicare and Medicaid Services (CMS) and other partners, including my colleagues who will testify later this morning.

We have been in the communities, in senior citizen centers, pharmacies, public housing, churches any place where we thought senior citizens or the disabled were likely to be found.

We worked with State pharmaceutical programs, State Health Insurance Programs, Area Agencies on Aging, local housing authorities, community health clinics, prescription drug providers and others to identify people with limited income and resources who might be eligible for the "extra help".

Throughout these efforts, Social Security's goal has been to reach every potentially eligible Medicare beneficiary multiple times, in a variety of ways. As you know, there are many estimates out there as to the size of the eligible population, but whether there are 300 or 3 million people, Social Security's job is the same—find them. Find them where they live, find them in the communities where they work, and find them any way we can.

Our message is simple: if you could possibly benefit from the program, SSA will help you apply. As you may recall, during the initial launch phase of the "extra help" program in the spring of 2005, we mailed almost 19 million applications. We cast a very wide net.

Such agency mailings continue to be a valuable tool in our efforts to inform the public. For example, the annual cost of living adjustment notices, sent to over 50 million Social Security beneficiaries, as well as our annual notice to individuals potentially eligible for the Medicare Savings Programs, included "extra help" information.

Also, Social Security identified approximately 1.5 million disability beneficiaries who received an "extra help" application, but did not return it. We mailed a special follow-up letter to these beneficiaries in the spring of 2006, explaining that "extra help" will not reduce their disability payments.

In addition, Social Security contracted with a vendor, who made more than 9 million follow-up calls. Subsequently, Social Security personally called 400,000 beneficiaries who the vendor identified as needing assistance. In another outreach, we personally called over 300,000 beneficiaries who had previously received the Medicare $600 assistance under the Medicare drug discount card but had not applied for the "extra help".

Social Security has also reached specific beneficiary communities, those with representative payees, those who speak Spanish, Asian-American and African-American households and those aged 79 and older. Social Security has made special efforts to help the recipients who have lost their deemed status.

In September 2006, Social Security and CMS together mailed more than 600,000 applications, with notices to the Medicare beneficiaries who were no longer automatically eligible. To date, more than 230,000 have reapplied. This is in addition to those who have regained automatic eligibility through the States.

Social Security has started a pilot to personally call 10,000 individuals who have lost their deemed status and have not yet filed for "extra help". The results of the pilot will guide our approach in following up with the rest of the population.

Social Security also sends out between 120,000 and 130,000 "extra help" applications each month to individuals who are newly enrolled in Medicare. As of mid-January 2007, Social Security has found more than 2.3 million individuals eligible for "extra help".

Just as important, we continue to receive between 30,000 and 40,000 applications for "extra help" almost every week, over 600,000 since the beginning of the fiscal year. While SSA employees across the Country continue to promote this valuable benefit, we realize our job is not completed and we continue to look for more ways to reach those eligible for the "extra help" program.

In conclusion, I want to express my personal thanks to this Committee for their continuing support of the agency. As you know, Social Security is operating under a continuing resolution, with funding levels significantly below the President's request.

This means Social Security faces considerable challenges in managing all of our vital workloads. However, I can tell you from my own experience that the dedicated employees of Social Security will continue to do our very best, not only in administering the low-income subsidy, but also in providing our important traditional services.

We look forward to our continuing dialog with organizations, advocacy groups and, of course, the Committee.

Thank you, and I will be glad to answer any questions you have.

[The prepared statement of Ms. Disman follows:]

Statement of Beatrice Disman

Regional Commissioner of Social Security

New York Region

and

Chair of the Social Security Administration

Medicare Planning

and

Implementation Task Force

Mr. Chairman and Members of the Committee:

Thank you for inviting me to discuss the Social Security Administration's (SSA's) ongoing efforts under the Medicare Prescription Drug Program to sign-up eligible Medicare beneficiaries for the low-income subsidy (LIS) program, or "extra help" as it is commonly called. I am Bea Disman, and I have served for over a decade as Regional Commissioner of the New York Region. I have also spent the past 3 years at the helm of SSA's Medicare Planning and Implementation Task Force. In this role I have seen the truly tireless and dedicated efforts of so many SSA employees, and partners within and outside government, as they have reached out to those individuals who could benefit from the low-income subsidy. It has been a remarkable experience for me, and it is with great pride that I am here to share their story with you.

In the past year, SSA has continued its intensive efforts to locate low-income Medicare beneficiaries, and provide them with an opportunity to apply for this important benefit. We have used targeted mailings, phone calls, computer data matches, community forums, partnerships with State agencies and non-profit organizations, public information fact sheets, word-of-mouth – in short, any and all means at our disposal – to reach those eligible to receive assistance with out-of-pocket costs associated with the new Medicare prescription drug coverage. Today's testimony will describe many of these efforts.

Background

To begin, it may be helpful to recap Social Security's role and responsibilities regarding the new Medicare prescription drug coverage. This provides the context to further describe SSA's activities in getting low-income people the "extra help" intended by Congress.

As you know, the Medicare Modernization Act, or MMA, enacted in December 2003, established the new Medicare prescription drug benefit. The new Medicare prescription drug coverage was designed to allow all people with Medicare an opportunity to voluntarily enroll in prescription drug coverage. MMA also provided an additional level of assistance, or "extra help," for people with Medicare who have limited incomes and resources in helping to pay for the monthly premiums and cost-sharing that are required by the new Medicare prescription drug coverage.

The responsibility for enrolling individuals for the prescription drug coverage is a joint effort between the Department of Health and Human Services (HHS) and private insurance companies, which establish Prescription Drug Plans (PDPs) for that purpose. HHS automatically enrolled individuals who were already eligible for Medicare and full Medicaid benefits in a PDP plan and the subsidy in November 2005. This process was intended to ensure a smooth transition for these "full-benefit dual eligibles" from Medicaid drug coverage to the new Part D, and this population also had opportunities to switch to a different PDP provider than the one in which they were automatically enrolled. Additional low-income beneficiaries who also received Supplemental Security Income (SSI) or participated in certain Medicare Savings Programs (MSPs) were automatically eligible for a subsidy and enrolled into a PDP plan (if they had not already selected a plan) during May 2006.

SSA was given the responsibility by Congress to take "extra help" applications and to make eligibility determinations for individuals who were not automatically eligible. In order to be eligible for "extra help," individuals must have incomes below 150 percent of the poverty level applicable to their corresponding household size. In 2007 this is $15,315 for an individual and $20,535 for a couple. Resources must

be less than $11,710 for single individuals or $23,410 for a married couple. It should be noted that both the income and resource limits adjust annually, based on the Federal Poverty Guidelines (for income) and the Consumer Price Index (for resources).

Individuals with incomes between 135 percent and 150 percent of poverty are eligible for a subsidy amount based on a sliding scale depending on their resources. Individuals with incomes below 135 percent would be eligible to receive the highest subsidies.

SSA was given these responsibilities because of its network of nearly 1,300 offices with 35,000 employees across the country, and because of its already existing role in administering some parts of the Medicare program. Over the past 70 years, SSA has gained a reputation for helping citizens in the communities where they live, and Congress realized that SSA's presence "on the ground" would be vital in the launch of the Medicare "extra help" program. Also, the low-income subsidy was designed with many similarities to SSI, a means-tested assistance program for low-income aged, blind and disabled individuals, which SSA has administered for more than 30 years.

Development of "Extra Help" Application

Upon passage of MMA, SSA immediately began planning for the implementation of the limited-income subsidy. We recognized from the onset that development of a simplified application for the "extra help" was essential for successful implementation. Thus, our goals were to develop an application that elderly and disabled Medicare beneficiaries, their caregivers, or other third party assistance providers would be able to understand and easily complete and not have to travel to a Social Security field office. SSA also wanted to maximize the use of automation, not only to process these forms efficiently, but also to process them as quickly as possible.

To accomplish these goals, SSA conducted substantial testing of the "extra help" application form. The paper application went through many drafts before being finalized. Social Security, in collaboration with the Centers for Medicare & Medicaid Services (CMS), conducted focus groups with current Medicare beneficiaries to test potential applicants' understanding of the application, conducted special

cognitive testing of the application and had design engineers review the layout of the applications. We also discussed various draft versions of the application with national and local advocacy groups and with State Medicaid Directors, as well as with Congressional staffs.

Our Office of Systems staff contributed to the design of the application as well to make sure that the information on the form could be electronically scanned into our computers, thereby reducing errors and minimizing the number of employees needed to process incoming applications.

Realizing the need to reach our beneficiaries in new ways, SSA worked to develop alternatives to the traditional paper-based application. In July 2005, we unveiled the Internet version of the application located at www.socialsecurity.gov, allowing people to apply online for help with Medicare Prescription Drug Plan costs. The online application has been a tremendous success, receiving one of the highest scores ever given to a public or private sector organization by the American Customer Satisfaction Index (ACSI).

The percentage of "extra help" applications we receive through Internet filing continues to rise. Over the last 4 months, about 20 percent of new applications are Internet filings. This means that, as a percentage of applications received, the online "extra help" application has even exceeded the success of SSA's online Application for Retirement benefits.

Telephone inquiries were also part of our efforts to make the "extra help" application process as simple as possible. We provided extensive training to assist our teleservice representatives in answering subsidy-related questions. These teleservice representatives can refer callers directly to specialized claims-taking employees who could then take applications by phone. This process allows individuals calling our 1-800 number to immediately file for the "extra help."

Social Security developed a computer matching process with the Internal Revenue Service (IRS) regarding the validation of certain

income and resource information provided by applicants. This process was designed to reduce one of the barriers often cited as to why individuals do not file for means-testing programs. Using this computer match allowed SSA to build an application process that would not require applicants to submit proof of resources and income, as long as the applicant's statement on the application was in substantial agreement with the computer records.

In summary, although subsidy eligibility determinations are by their very nature complex, we believe that we have created a simple application process, which allows individuals to apply for the "extra help" as quickly and easily as possible, while also taking advantage of current technology.

I would also note that efforts to improve the "extra help" application are ongoing. In recent months, for example, we have added fields to the paper application that allow the applicant to enter the amount of his or her Social Security benefit. Of course SSA already knows this information, and the original application instructions stated that the applicant did not need to supply Social Security benefit amounts. But our analysis of applications received showed that applicants were trying to enter the information anyway, and this was frequently leading to inaccurate application entries and inaccurate eligibility determinations. In another update, for example, we simplified the question about filing as a couple and changed the resource amounts to reflect the 2007 resource limits.

Outreach Efforts

I would now like to turn to the efforts SSA has undertaken to inform beneficiaries about the "extra help" available for prescription drugs. Efforts to educate the public about the new, "extra help" program began almost immediately after passage of MMA, and this outreach continues today. SSA has worked with CMS and other Federal agencies, community based organizations, advocacy groups, and State entities in order to spread the word about the available "extra help."

During the past two years, SSA has held more than 76,000 Medicare outreach events. We were in the communities – in senior citizen

centers, pharmacies, public housing, churches – any place in which we thought senior citizens or the disabled were likely to be found. Targeted application-taking events were held in Social Security offices throughout the country, and personal invitations to these events were mailed to beneficiaries who had not yet applied for the "extra help," but had been identified as being potentially eligible for the program.

We also continue to work with States that have their own pharmaceutical assistance programs, State Health Insurance Programs, Area Agencies on Aging, local housing authorities, community health clinics, PDPs, and others to identify people with limited income and resources who may be eligible for the "extra help."

Throughout these efforts, SSA's goal has been to reach every potentially eligible Medicare beneficiary multiple times, in a variety of ways: for example, by targeted mailings and events, and follow-up phone calls. And while we are confident we have taken appropriate steps to reach out to those who may be eligible for the "extra help," our outreach efforts are continuing. Because there is no enrollment period for the "extra help," a Medicare beneficiary can apply at any time. This means there is no inappropriate time to reach out to our lower-income beneficiaries, and there is no wrong time for these individuals to complete an application.

As you know, many estimates have been made as to the size of the eligible population. But whether there are 300 or 3 million people, SSA's job is the same – find them. Find them where they live, find them in the communities where they work, find them in any way we can. Our message is simple: if you could possibly benefit from this program, SSA will help you apply.

Mailing of Subsidy Applications and Targeted Outreach

To further explain how this outreach philosophy has translated into action, I would now like to describe some of the specific routes SSA has taken to reach our lower-income Medicare beneficiaries.

Although the new Medicare prescription drug coverage did not begin until January 2006, SSA began mailing applications to individuals

who were potentially eligible for "extra help" in May 2005. During the following three months, we mailed almost 19 million applications. Our goal was to have as many potentially eligible limited income Medicare beneficiaries as possible file for the "extra help" before the Medicare prescription drug program started in January 2006.

We also intended to cast the widest net possible in our efforts to reach the public. Thus, we sent the 19 million applications to potentially eligible individuals, even though we knew that not all of this group would meet the income and resource requirements. Social Security was only able to use certain data bases to screen the Medicare population to identify potential eligible individuals who had

income below 150% of the Federal poverty level. This initial effort allowed us to begin making eligibility determinations for the "extra help" as early as July 2005.

Just as important as the initial mailing of applications was follow-up contacts with those individuals who did not return them. We contracted with a vendor to remind individuals of the availability of the "extra help" program and to ask if they needed assistance. Of the 9.1 million people who were called by the vendor, 800,000 asked that we resend applications, and nearly 400,000 requested assistance and were referred to SSA. In addition, 5 million follow-up notices were sent because the vendor could not locate a phone number for the individual (for example, an individual who was displaced by Hurricane Katrina).

We continue to use Agency mailings to inform the public. For example, the cost of living adjustment notice sent in November 2005 and again in November 2006 to over 50 million Social Security beneficiaries, each time, contained information about the new drug program and the availability of "extra help." In May 2006, our annual notice to individuals potentially eligible for Medicare Savings Programs provided "extra help" information to 5.7 million beneficiaries.

Also, SSA identified approximately 1.5 million disability beneficiaries who received an "extra help" application mailer, but did not file an application. We mailed a special follow-up notice to these

beneficiaries between March 16 and April 11, 2006, explaining to beneficiaries that they may be eligible for the subsidy, and assuring them that this would not have an adverse effect on their disability benefits.

In addition, we personally called over 300,000 beneficiaries, who did not respond to an "extra help" application mailer, but had previously applied for and received the $600 assistance under the Medicare drug discount card, to offer help in completing the "extra help" application.

Targeted advertising efforts have been coordinated with national organizations, such as AARP, and targeted outreach events have been conducted with state organizations such as the Elderly Pharmaceutical Insurance Coverage (EPIC) program in New York.

In additional efforts to reach specific communities, SSA has undertaken targeted mailings to beneficiaries with representative payees, beneficiaries who speak Spanish, Asian-American and African-American households, and beneficiaries age 79 and older who lived in zip codes with a high percentage of low income households. During the period of June through August, 2006, 2.5 million "extra help" applications were mailed to these individuals.

SSA has also made a special effort to reach and reenroll those "extra help" recipients who have lost "deemed" or automatically eligible status. As I previously described, some individuals received the subsidy automatically, by virtue of Medicaid, SSI or MSP eligibility. In some cases, however, these individuals lose eligibility to these other programs, and thus their deemed status. Working with the CMS, in September 2006, SSA mailed more than 600,000 applications with notices to Medicare beneficiaries who were no longer automatically eligible for "extra help." To date, more than 230,000 of these people have reapplied. This is in addition to a number of individuals who have regained automatic eligibility through reentitlement to certain State programs. Social Security has just started a pilot to personally call 10,000 of these individuals who have lost their deemed status and have not filed for "extra help." The results of the pilot will guide

our approach in following up with the rest of this population.

In addition to the many specific outreach activities SSA has performed in the past year, the agency also provides educational outreach to Medicare attainers – those current Social Security beneficiaries who turn 65 or reach the 25th month of their disability. If our records indicate an attainer may potentially be eligible for "extra help," SSA sends an application. This means between 120,000 – 130,000 beneficiaries receive LIS applications every month. Similarly, many individuals call our 800 number or visit our field offices to conduct traditional Social Security business. We educate these individuals about the "extra help," and we will take the application if it is appropriate.

Continuing Success

As of mid January 2007, SSA has received applications from almost 6.1 million beneficiaries, of which almost 1 million were unnecessary, because either the applicants were automatically eligible or because they had filed more than one application. We have made over 5.9 million determinations on the eligibility for "extra help" and have now found more than 2.3 million of these individuals eligible.

Generally, SSA continues to receive between 30,000 – 40,000 applications for "extra help" every week – almost 600 thousand since the beginning of the fiscal year. This continued level of interest from beneficiaries – this unexpectedly high amount of applications received more than one year beyond the program's launch – tells us our outreach campaign is working.

While SSA has no direct role in assisting individuals in either selecting or enrolling in PDPs, we have provided instructions to the field offices on how to make sure those with questions on the new Medicare prescription drug coverage are directed to the resources they need. In some cases this means our employees will simply refer the questioner to 1-800-MEDICARE, or to the beneficiary's PDP provider, but in other cases it means making a personal call to state coordinators, reprinting and faxing award notices, and even making emergency calls to CMS Regional Offices.

SSA employees across the country are continuing to promote this valuable benefit. Our job is not completed, and we continue to look for more ways to reach those eligible for the "extra help" program.

Conclusion

In conclusion, I want to express my personal thanks, to this Committee for your continuing support for the Agency. As you know, SSA is operating under a continuing resolution, with funding levels significantly below the President's request. Moreover, the separate funding pool that the Congress authorized under MMA during the prescription drug program's start-up period no longer exists.

This situation means that "extra help" outreach has to be handled along with all of SSA's other vital workloads – such as the taking of retirement and disability claims. However, I can tell you from my own experience, that the dedicated employees of SSA will continue to do our very best, not only in administering the low-income subsidy and premium withholding for the Medicare prescription drug program, but also in providing our very important traditional services to the American public.

We look forward to our continued dialogue with organizations, advocacy groups, and of course, this Committee, as we progress with "extra help" program efforts.

Thank you and I will be glad to answer any questions you may have.

The CHAIRMAN. Thank you for your testimony.

Mr. Kocot.

STATEMENT OF LARRY KOCOT, SENIOR ADVISOR TO THE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. KOCOT. Thank you, Chairman Kohl, Senator Smith and distinguished members of the Committee. I am Larry Kocot. I am senior advisor to the Administrator of the Centers for Medicare & Medicaid Services. As you mentioned, Mr. Chairman, I have been deeply involved in policy development and implementation of Medicare Part D.

Yesterday, CMS released the latest enrollment numbers for the Medicare prescription drug benefit. More than 1.4 million beneficiaries have enrolled in Medicare's Part D program since June 2006, bringing the total number of people with comprehensive prescription drug coverage to more than 39 million.

Over 90 percent of all people eligible for the Medicare prescription drug benefit are receiving the prescription drug coverage they need. Five separate surveys have reported independently that more than 75 percent of beneficiaries are satisfied with the program.

Without question, Part D has been a positive change to the lives of Medicare beneficiaries, especially for the people who receive the Medicare low-income subsidy. One of the main objectives, as you mentioned, of the Medicare Modernization Act, was to provide the greatest assistance through access to prescription medication to those with the greatest need. That is what CMS is doing today.

The low-income subsidy provides substantial help to Medicare beneficiaries with limited incomes, including a Federal subsidy ranging from 25 to 100 percent of the monthly premium cost for qualified plans and minimal cost sharing for covered drugs. Recognizing the importance of this benefit to this vulnerable population, CMS began taking steps to reach out to beneficiaries with limited incomes immediately after the bill was signed.

As of today, nearly 10 million low-income beneficiaries are getting comprehensive drug coverage for little or no cost. 6.9 million were enrolled through our automated processes and an additional 2.3 million enrolled beneficiaries submitted applications that were approved by SSA.

In comparison with other means-tested programs, the Medicare low-income subsidy benefit enrollment numbers are impressive. However, we will not rest until we have reached and assisted every beneficiary that qualifies and wants to apply for the low-income subsidy.

With the recently extended special election period that allows low-income subsidy-approved beneficiaries to enroll through the end of 2007 without a penalty, these numbers should continue to grow. Additionally, as Ms. Disman mentioned, of the 632,000 beneficiaries who lost their low-income eligibility status for this year, so far about 35 percent have regained their eligibility and now qualify for the low-income subsidy.

People who are receiving the low-income subsidy are very satisfied with the coverage they received. According to a recent survey,

87 percent of dual eligibles—that is, beneficiaries eligible for both Medicare and Medicaid—who are receiving benefits through Part D feel peace of mind now that they are enrolled in Part D.

More than nine out of 10 dual eligibles are satisfied. Forty-six percent of the people who reported skipping or splitting dosages prior to Medicare's prescription drug coverage say they no longer have to do so because of Part D.

Nevertheless, as I said, we still need to reach people who may be eligible, but have not applied for the low-income subsidy. Our work to identify and enroll these beneficiaries has been a multifaceted, continuous effort that did not stop with the end of the first enrollment period.

Given that many beneficiaries are difficult to reach through traditional means, CMS has ongoing special initiatives targeting beneficiaries in areas which may be isolated from the general community outreach efforts.

We are working closely with over 40,000 partners who have sponsored and participated in the 12,700 events that we have held to date. Some of our strongest partners include the organizations represented here today, the Access to Benefits Coalition, the Health Assistance Partnership, the National Council on Aging and our sister agency, the Social Security Administration.

The one-on-one counseling and personalized attention that these partnerships made possible enabled CMS to reach tens of millions of people, one person at a time. Another critical component of CMS's outreach initiatives has been the direct engagement of the provider community and especially the tens of thousands of pharmacists who did so much to get this program off the ground.

One year ago, with the startup of the most significant change in Medicare since its creation in 1965, CMS faced a number of systems and process issues that, if left unaddressed, would have curtailed some Part D enrollees access to covered drugs.

CMS has worked hard to find and fix the problems and improve this program, and we will continue to do so. As a result, better communications between plans and pharmacies, enhancements to file and data exchange with plans, SSA and the States and other systems and process improvements, have enabled us to take steps early to avoid similar issues in 2007. What a difference a year makes.

Well before the year began, CMS worked with pharmacies and drug plans to closely monitor the program as it entered its second year. Though we continue to look for, and we are ready to solve, any problems that do arise, hundreds of thousands of newly enrolled beneficiaries have gone to pharmacies for the first time without a hitch in January.

We continue to see operations run smoothly. Whether it is pharmacists at the drugstore or beneficiaries filling their prescriptions, very few of the problems that people encountered at the program's implementation have been experienced this year.

Thank you, again, Senator, Mr. Chairman, and thank you for this opportunity to be here with you today. I am happy to take any questions you might have.

[The prepared statement of Mr. Kocot follows:]

TESTIMONY OF

S. LAWRENCE KOCOT

SENIOR ADVISOR TO THE ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

HEARING ON

LOW-INCOME SUBSIDY ISSUES IN THE MEDICARE PRESCRIPTION DRUG BENEFIT

January 31, 2007

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of S. Lawrence Kocot
Senior Advisor to the Administrator
Centers for Medicare & Medicaid Services
Senate Special Committee on Aging Hearing
"Medicare Part D: Is it Working for Low Income Seniors?"

January 31, 2007

Thank you Chairman Kohl, Senator Smith and distinguished members of the Committee, for inviting me to discuss how the Medicare prescription drug benefit is working for Low Income Subsidy (LIS) eligible beneficiaries.

Prescription drugs are key to the delivery of modern medical care and they are essential to preventing and managing illness, and improving peoples' quality of life. In many respects, the new Medicare prescription drug benefit (Part D) is probably the single most important addition to benefits in the history of the Medicare program.

Because of the extraordinary importance of this new benefit, CMS outreach to Medicare beneficiaries has been unprecedented. Beginning in 2005, Medicare embarked on a multi-faceted campaign to reach out to not just the potential LIS-eligibles. but to each of the more than 42 million people with Medicare.

Medicare's partners, including grassroots organizations, local, state and federal agencies, State Health Insurance Assistance Programs (SHIPs), the faith community, and individual volunteers sponsored and attended tens of thousands of Medicare events and opportunities across the country for people to get personalized assistance.

Some of our strongest partners were the organizations represented here today: the Access to Benefits Coalition (ABC), Health Assistance Partnership (HAP) and the Social Security Administration (SSA). The one-on-one counseling and personalized attention these partnerships made possible enabled Medicare to reach tens of millions of people—one person at a time.

Medicare made numerous improvements to the way we reached out to beneficiaries and their families, including harnessing the power of the internet and strengthening call center capability and capacity.

This ongoing outreach effort has been part of the transformation in the way Medicare does business, from a bill-paying agency to a real partner in keeping beneficiaries' health. Moreover, it is working. We are committed to reaching people who may be eligible but have not applied for the Low Income Subsidy, but it is important to note that today more than 90 percent of people with Medicare have coverage for prescription drugs through Part D or another source. Approximately 70 percent of those identified as potentially eligible for LIS in 2006 are enrolled in Part D. Enrollment in Medicare Part D, and in particular, enrollment by LIS beneficiaries, is impressive by any measure for a new public sector benefit program.

CMS has worked equally hard to ensure that once enrolled, people with Medicare are able to take advantage of their prescription drug coverage without difficulty. In the early days of the program issues were identified and resolved, and as a result, millions of people with Medicare have been using their drug coverage effectively, including the roughly 9.9 million LIS beneficiaries with drug coverage in 2006.

Surveys consistently show over 75 percent of Medicare beneficiaries are satisfied with their current coverage and drug plans. This includes low-income people, including beneficiaries eligible for both Medicare and Medicaid, who receive the LIS. According to a recent survey, 87 percent of dual-eligibles feel "peace of mind" now that they are enrolled in Part D. More than 9 out of 10 dual-eligibles are satisfied. Many (46 percent) of the people who reported skipping or splitting dosages prior to Medicare's prescription drug coverage say they no longer have to under Part D.[1]

[1] KRC Research survey for the Medicare Rx Education Network, conducted September 1-7, 2006.

Overview of the Low-Income Subsidy

Prescription drug coverage is absolutely essential for people with limited incomes. One of the main objectives of the Medicare Modernization Act (MMA) was to provide the greatest assistance to those with the greatest need.

The LIS provides substantial help to Medicare beneficiaries with limited incomes: a federal premium subsidy ranging from 25 to 100 percent of the monthly premium cost for qualified plans, and minimal cost-sharing for covered drugs.[2]

Three groups of beneficiaries are automatically eligible for LIS, meaning they do not have to fill out any sort of application to receive the subsidy:

- Beneficiaries who are eligible for and enrolled in both Medicare and Medicaid due to their income level—the "dual-eligibles" referred to earlier.
- Beneficiaries enrolled in the Medicare Savings Program. These are the Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs).
- Beneficiaries receiving Supplemental Security Income (SSI), but not Medicaid.

Beneficiaries not falling into one of these categories must apply for the LIS. This means they must submit an application to their state Medicaid agency or SSA, which is responsible for verifying income and assets to determine eligibility. Upon receipt of

[2] By "qualified plan" we mean a plan with a premium at or below the LIS benchmark. Note that LIS beneficiaries may select any plan in their service area, but will have to pay an additional premium for plans that bid above the LIS benchmark. As required by law, the Low-Income Subsidy is a means-tested public benefit. In order to apply and qualify, Medicare beneficiaries generally must meet both an income and asset test. In 2006, the maximum income to qualify for the LIS was $14,700 for singles with no dependents or $19,245 for married individuals with no dependents. (Individuals with dependents had higher income thresholds, and residents of Alaska and Hawaii had lower thresholds). Assets could not exceed $10,210 for a single person or $20,420 for a couple. As required by statute, these levels were updated for 2007. The maximum income to qualify for the LIS is now $15,315 for singles with no dependents or $20,535 for married individuals with no dependents. (Individuals with dependents have higher income thresholds, and residents of Alaska and Hawaii have lower thresholds). Assets may not exceed $11,710 for a single person or $23,410 for a couple (this includes $1,500 per person for burial expenses).

approval from SSA, beneficiaries may begin receiving subsidized benefits. Of course, these individuals need to be enrolled in a prescription drug plan to get these benefits. CMS automatically enrolls – or facilitates enrollment – into a plan those beneficiaries who have been approved for LIS but have not enrolled in a plan on their own.

CMS was extremely successful in enrolling LIS-eligible individuals into Part D plans in the first year of the program. Of the approximately 13 million beneficiaries CMS estimates were eligible for the LIS in 2006, nearly 10 million now have coverage for prescription drugs. Through ongoing outreach that continues even today, CMS built upon the successes of 2006, with over 300,000 new LIS-beneficiaries enrolled in Part D prior to January 1, 2007. With the recently extended special election period that allows LIS-approved beneficiaries to enroll through the end of 2007 without penalty, these numbers should continue to grow.

Our work to identify and enroll these beneficiaries is a multi-faceted, continuous effort that did not stop with the end of the first enrollment period; rather it has been a sustained and ongoing effort. These potentially eligible LIS individuals continue to be targeted with a multi-pronged education and outreach campaign that leverages existing information intermediaries and resources. Initiatives include direct mailings and targeted telephone calls to beneficiaries, along with local outreach from community groups, intergovernmental partners, and health care providers, including pharmacists. Given that many beneficiaries may be difficult to reach through traditional means, CMS has special initiatives targeting both urban minority beneficiaries, and beneficiaries in rural areas who may be isolated from general community outreach efforts.

Reaching out to People with Medicare: Partnership Is the Key to Success

As noted, CMS began preparation for outreach and education on the low-income subsidy immediately following enactment of the MMA. CMS partners, including grassroots organizations, local, state and federal agencies, SHIPs, the faith community, and individual volunteers sponsored and/or attended more than 12,700 Medicare outreach events providing opportunities for people to get personalized assistance during fall open enrollment. In addition, the Medicare "Mobile Office Tour" logged more than 70,000 miles to 165 cities with more than 200 stops.

CMS' efforts to reach people who might be eligible for extra help have consistently been among our highest priorities. Partnerships continue to play a significant role in reaching the LIS population, and they have been instrumental in providing the one-on-one counseling and personalized assistance that continues to make Part D a success. CMS is committed to maintaining open lines of communication and dialogue with our partners in order to tailor our outreach efforts. One example includes our relationship with SSA, a partnership critical to reaching the LIS population. CMS collaborated with SSA for numerous LIS education and outreach events, as well as direct mailings and follow-up phone calls to potential LIS beneficiaries. We maintain this very close relationship with SSA in working to continue to identify potential LIS eligible beneficiaries.

In addition, the U.S. Administration on Aging (AoA) has been crucial to both the success of LIS beneficiary enrollment, as well as the success of Part D in general. Prior to the open enrollment period, AoA granted a contract to assist with the enrollment of beneficiaries into Part D. A large part of this contract supported grassroots efforts to target hard-to-reach populations, especially in minority and disability communities. Partner organizations included National Adult Day Services Association, Meals on Wheels Association, National Alliance for Hispanic Health, and American Association of Homes and Services for the Aging, just to cite a few.

Also, CMS has worked collaboratively with the USA Freedom Corps and the US Department of Housing and Urban Development to distribute LIS literature and materials

to people living in subsidized housing, and the US Department of Agriculture to identify individuals through the food stamp program who might be eligible for the LIS.

The SHIPs and the Health Assistance Partnership (HAP) that supports them also have been invaluable partners to CMS in helping LIS eligible beneficiaries. SHIPs in each state offer local one-on-one counseling and assistance to people with Medicare and their families. Through CMS funded grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. Although SHIPs have a diverse portfolio of health care issues for which they help beneficiaries, the CMS grant provided to SHIPs directed them to increasingly focus their attention and efforts during enrollment opportunities on hard-to-reach populations, including the LIS eligible population. SHIP directors have reported anecdotally that the number of low-income beneficiaries they serve each year has increased significantly, currently making up 20-25 percent of their total client base.

Further, SHIPs are expanding their Part D targeted outreach initiatives—especially those that provide education and expand enrollment opportunities for dual-eligible, low-income, hard-to-reach beneficiaries, and beneficiaries who lack coverage for their prescription drug expenses. In support of SHIPs, CMS and HAP are discussing how to develop ways to coordinate HAP services so that the SHIP network effectively reaches all populations. Further, HAP convenes monthly informational MMA forums, and has assisted several SHIPs with volunteer recruitment and training. For instance, they are working with the Ohio SHIP on a technology tool to better manage volunteers and to support data entry. They also worked with the Iowa SHIP on a web-based counselor recertification program and they are currently working with the Maine and Kansas SHIPs on strategic action plans.

CMS is also grateful for the assistance of the National Council on Aging (NCOA) and ABC-Rx in supporting our outreach efforts. CMS and AoA worked together to contract with NCOA to develop an on-line Low-Income Subsidy application service from June 2005 to September 2006. In addition, NCOA received a CMS-funded grant to reach and

assist beneficiaries in applying for LIS, and subsequently enroll beneficiaries in a plan. Also, as part of its coalitions – ABC-Rx and Benefits Checkup Rx -- NCOA came up with innovative outreach strategies to find and help people file for the low-income subsidy.

Another critical component of CMS' outreach initiatives was the direct engagement of the provider community, and especially the pharmacy community. In our initial effort that began in May 2005, CMS partnered with chain and independent pharmacies in an education and outreach program for the Low-Income Subsidy. This effort, which preceded the implementation of the drug benefit, was designed to provide information to potential enrollees about the coming Medicare drug benefit and to encourage low-income beneficiaries to take advantage of personalized help in applying for the subsidy. Information and assistance was provided in more than 30,000 chain pharmacy stores across the country. CMS was able to reach and enlist the help of many thousands of additional pharmacists and independent pharmacies through efforts with state and national pharmacy associations and buying groups.

The communications between CMS and pharmacies marked the beginning of an extensive and lasting effort to exchange information and educate the pharmacy community. During open enrollment, pharmacists held thousands of in-store informational days, provided medication reviews, offered community presentations and events, and have helped beneficiaries compare their plan options.

CMS continues to leverage existing relationships with hundreds of community-based organizations around the country. These include schools, senior-centers, community centers, and places of worship. Having a unique relationship with the community, these organizations are able to understand the populations they serve and can best identify their needs. CMS has also conducted over 1,200 "train-the-trainer" events with local and national partners on LIS-specific outreach, including SHIP counselors, physicians, pharmacists, Federal/State/local government partners, and hundreds of community organizations across the country to reach LIS beneficiaries and provide individual

guidance. In addition, as natural partners, CMS works in ongoing efforts with physicians, providers and their staff to provide counseling services and enrollment activities for the low-income population.

What a Difference a Year Makes: CMS Addresses Systems Issues, Anticipates Transition Challenges, and 2007 Moves Forward Smoothly

One year ago, CMS was facing a number of systems and process issues impacting some Part D enrollees' ability to access covered drugs. CMS worked hard to find and fix the problems, and took significant steps early to avoid similar issues in 2007. We worked with plans, pharmacists and States to improve data systems impacting beneficiary access. For example, we facilitated better communications between plans and pharmacies which resulted in upgrades to pharmacy software systems that will improve messaging between pharmacies and plans for better customer service. Also, throughout the year, CMS made a series of systems and process changes and enhancements to improve our file and data exchanges with plans, SSA and the states to improve performance and accuracy in beneficiary enrollment and benefits processing.

In September 2006 CMS published a "Readiness Checklist" for all prescription drug plans, reminding them of their obligations, key dates, and vital tasks to ensure a smooth annual enrollment season and transition to the 2007 benefit year. The Readiness Checklist included elements related to call center requirements, complaint resolution, systems testing and connectivity, data submission and file processing, enrollment procedures, beneficiary marketing and communication strategies, beneficiary and pharmacy customer service, and timely payment to pharmacies.

In early November 2006, CMS asked all plans to report back to CMS on their successes and any problems encountered in accomplishing the tasks on the Readiness Checklist. The results from this exercise served two important functions: First, it reassured CMS that the vast majority of plans were fully prepared for annual enrollment and the new benefit year and that they had successfully interpreted our guidance and requirements. Second, it identified an area where some plans indeed were having problems – for

example, some plans reported that they were not able to issue the Annual Notices of Change (ANOCs) within the timeframe specified by CMS. Using this information from the Readiness Checklist, CMS was able to quickly implement a strategy to ensure that beneficiaries who did not receive an ANOC in a timely manner would be granted a special election period to extend the period of time they had to make a decision about their 2007 plan choice.

Each month CMS auto-enrolls or facilitates the enrollment of dual eligibles and or LIS eligibles into certain prescription drug plans. These plans are sent lists of beneficiaries each month who are not already enrolled in a plan, and the qualified plan accepts those beneficiaries as their enrollees. There are special system requirements and processing needs associated with accepting auto-enrollments and facilitated enrollments. In fall 2006, CMS identified a handful of plans that either would be receiving auto-enrollees and facilitated enrollees for the first time or would receive a significantly higher volume of auto-enrollees and facilitated enrollees in 2007 compared to 2006. To ensure that these beneficiaries would experience a smooth transition to receiving their prescription benefits through a Part D plan, CMS conducted autoenrollment and facilitated enrollment readiness audits. These audits were very thorough and examined all of the systems and other processes plans needed to have in place to successfully process the enrollment records, communicate with beneficiaries, and provide service. Any plan that was not fully prepared to undertake this important task was excluded from receiving autoenrollments and facilitated enrollments.

To ensure a smooth transition for the existing LIS enrolled population specifically, CMS worked with States and SSA to identify dual, MSP and SSI beneficiaries who would again automatically qualify for LIS in 2007. Such beneficiaries were "re-deemed" for the low income subsidy for all of 2007. CMS also anticipated that some beneficiaries deemed eligible for LIS in 2006 would not be automatically eligible in 2007. After working with SSA to identify an initial count of 632,000 individuals no longer automatically eligible for extra help in 2007, CMS and SSA worked together to contact these individuals by mail, explaining their loss of deemed status, and provided an

application for LIS with postage paid envelope to apply and qualify for this help through the SSA application process. It was CMS's goal to ensure that each of these beneficiaries was aware of their change in status and could take action accordingly.

Additionally, CMS provided information to plans about affected beneficiaries, so they too could conduct outreach (by phone or mail) to enrollees who would no longer automatically qualify for extra help in 2007. As states have submitted their monthly data files identifying duals who have regained their Medicaid eligibility, the number of beneficiaries no longer automatically eligible for extra help has decreased. CMS outreach included a September 2006 letter to beneficiaries; guidance to state Medicaid directors with a list of people who lost LIS down to the zip code level; and technical assistance to the prescription drug plans – including providing each drug plan sponsor with a list of affected members in early October. As a result, as of January 2007, roughly 35 percent of people who had lost their deemed status had regained LIS eligibility – including those who regained their deemed status and those who reapplied and qualified for LIS with SSA. We expect these numbers to continue to grow throughout 2007.

CMS also anticipated transition issues related to the requirement that plan sponsors must qualify annually for automatic assignment of dual eligible beneficiaries. Due to the nature of the annual bidding process and the requirement that dual eligible beneficiaries be assigned only to plans that submit bids below the regional low-income benchmark (LIS benchmark), a strong potential existed that many plans qualified to accept auto-assignment of dual eligible beneficiaries in 2006 might not qualify in 2007 resulting in a large-scale shift of this population in the new benefit year. Early estimates were that as many as 3.7 million dual eligibles would be in plans that would no longer have premiums below the LIS benchmark amount in 2007.

To address this issue, as well as to promote effective competition that builds on the savings achieved through beneficiaries' plan choices in 2006, CMS implemented a transitional approach to determining the federal contribution to the drug benefit for low-income Medicare beneficiaries in 2007. This transition policy resulted in greater stability

in zero-premium plan options for LIS beneficiaries, thus minimizing the need for beneficiaries to be reassigned for 2007. In addition, as another key aspect of CMS' efforts to minimize dual eligible beneficiary movement among plans, CMS is conducting a demonstration that permits plans with premium increases of less than $2 above the LIS benchmark for 2007 to qualify to retain their current LIS beneficiaries. In the case of beneficiaries who changed plans in 2006 after being facilitated into a plan by CMS, CMS did not randomly reassign the beneficiaries into a new plan for 2007 if the beneficiary affirmatively elected to stay in their 2006 plan and pay a higher monthly premium (due to the plan's bid above the 2007 LIS benchmark). In effect, if the beneficiary had independently chosen that plan for 2006, CMS honored the decision for 2007, allowing the beneficiary to remain in their 2006 plan. In these cases, plans notified individuals of their prospective premium increase in 2007 and of their right to change plans.

Thanks to these efforts, fewer than 250,000 individuals needed to be re-assigned randomly to different prescription drug plans. CMS mailed color-coded (blue) letters to all LIS beneficiaries who were being reassigned to notify them of the reassignment and their options for selecting an alternative plan. Plans also mailed notifications, indicating the enrollee could be reassigned to a different drug plan sponsor for 2007.

Finally, CMS has made important strides to promote a seamless transition for Medicaid-eligible individuals who are about to attain Medicare eligibility. Beginning in July 2006, we requested that States submit information to us concerning these individuals in advance of their Medicare eligibility so that CMS can deem them eligible for the LIS and assign them to a Medicare Part D plan before the start of their Part D eligibility. This prospective identification and enrollment process has resulted in the seamless transition of more than 10,000 new dual eligible individuals per month into Medicare Part D coverage.

Looking Ahead: Reaching the Remaining LIS-Eligibles

Despite all the progress made to date, CMS is committed to doing much more. Working with our partners, we will continue our outreach and education effort until we are

satisfied that every beneficiary who might want to apply for LIS can learn about the benefits and receive personalized assistance to get the most out of their Medicare benefits at the lowest possible cost.

CMS' partner engagement goals for 2007 strive to make Medicare a permanent grassroots program. CMS is working with its various partners and key stakeholders in this evolution, and is increasing proactive outreach. By connecting partners and sharing resources nationally and in the field, CMS will continue to help people with Medicare make the most of their benefits through personalized assistance and ongoing outreach.

The CHAIRMAN. Thank you very much.

More that 600,000 poor seniors are losing the low-income subsidy that covered nearly all of their drug costs last year. Some may still be able to obtain extra help, but they need to apply, as we know. Of the 600,000, how many have reapplied this year and are continuing to receive a low-income study.

Ms. DISMAN. Within the Social Security Administration, of the 230,000 that have applied at Social Security, at this point in time we have 132,000 that have been found eligible of the 191,000 that we have processed.

The CHAIRMAN. Well, it is my understanding, as you point out, that these seniors receive letters notifying them that they were no longer automatically eligible. The question I ask is wouldn't it have been easier, or simpler, if you had just started the applications for them and asked them to provide the necessary information to determine their true eligibility, instead of automatically removing them from the program?

Ms. DISMAN. I will have to yield to my colleague in the Centers for Medicare and Medicaid Services, since that is within their jurisdiction.

Mr. KOCOT. Well, Senator, as you know, we can only serve beneficiaries who are qualified for the low-income subsidy. Those beneficiaries that did lose some status in MSP or SSI, other than Medicaid, once they do drop off those rolls, we are required to have them apply for the subsidy and qualify for it, so we really have to have them qualified and applied for.

We are required to get them to provide evidence that they do qualify, the burden of proof really shifts to them.

The CHAIRMAN. Well, yes. What I have said is wouldn't it have been better to simply send them the application, along with the notification that they need to reapply?

Mr. KOCOT. Well, Senator, that is exactly what we did. We sent them a letter telling them that they were no longer automatically going to qualify and that they should apply as soon as possible and, in fact, many did.

Ms. DISMAN. The application was with the notice that we wound up jointly drafting and sending.

The CHAIRMAN. So the application went out with the notification that they are no longer eligible.

Mr. KOCOT. That is right. That they are no longer automatically eligible.

The CHAIRMAN. Right.

Mr. KOCOT. It did encourage them. As a matter of fact, many of these people probably are eligible, but they do have to apply.

Senator, if I might add, we also followed up with plans, and CMS itself followed up with a lot of different communication, as did a lot of other outreach groups, pharmacies and plans working cooperatively to reach these people one-on-one. We have really taken on quite a bit of effort to get them to reapply and, as a result, many have. But this, we acknowledge, is the hardest population to reach and the hardest population to spur to action, but we will continue trying.

The CHAIRMAN. Well, with so many who have not been able to regain their admission to the program, what is it that you intend

to do to reach them that we haven't done yet? What are your ideas for improving on your ability to reach these people?

Mr. KOCOT. Well, we are working with many of our partners that we have been working with over the last 2 years, and many are submitting ideas to us and we will be working with them to come up with an action plan to reach the rest of these beneficiaries. As a matter of fact, Senator, many of these beneficiaries—our experience doesn't show a large number, but some are showing up at pharmacies, some are telling us they didn't know.

What we are doing is we are getting them into the process, having them apply and working with the plans to take care of their immediate needs if they are emergency needs. So we are taking these on a one-by-one, case-by-case basis so that no one falls through the cracks.

Ms. DISMAN. Senator, we have had the opportunity on the local level, with the Regional Commissioners, to work with various States, to help identify these people and to have them file. We are also personally now going to start calling these people.

Many of them will not qualify, because they have too much resources, but we are really attempting to reach out on a one-on-one basis, and all of our offices are aware that if anyone comes in and says that they just realized that they don't have the low-income subsidy, that they are to take the application, and we actually have a special procedure between Social Security and CMS to really track that individual.

The CHAIRMAN. Last year, some seniors opted to have their Medicare Part D plan premiums automatically withheld from their Social Security checks. As a result of confusion between drug plans, CMS and SSA, some seniors had too much money withheld and will be receiving refunds next month, while others had too little withheld and are being asked to pay more.

What has been done to ensure that this confusion will not happen again this year?

Ms. DISMAN. Well, Senator, I am pleased to report that, looking at the data exchange between CMS and SSA this year, there has been much improvement. We are looking at new enrollments. It has been more timely and more accurate. We actually have our staffs working very closely together, looking at how we hand off data between each other, looking at all of the various exchanges. We are all focusing on what the issues are and ways that we can make improvements.

We are as concerned with the individuals not having the correct premiums, the impact on their Social Security benefits, and we are very concerned that it be done in a timely and accurate manner. We have had a process of us getting the data back to CMS after they transmit something to us within 2 days, so that we tell them whether or not it has been successful or there has been a problem with the data.

So our staffs are extremely focused on that, and it is our commitment to try to really deal with the issue.

The CHAIRMAN. Senator Smith.

Senator SMITH. Thanks, Senator Kohl.

Beatrice, I have heard a number of reports that some beneficiaries have difficulty accurately reporting in-kind contributions

for the asset test that goes with this benefit. Obviously, given that misrepresenting assets is a Federal offense, I can understand why some might be dissuaded from applying.

I wonder if you have any thoughts about how we can make it easier to report in-kind contributions so this is not an unnecessary deterrent.

Ms. DISMAN. Well, Senator, I think as you know, when the legislation was enacted, it really had reference to the Supplemental Security Income (SSI) program and the various income levels and in-kind support and maintenance is certainly one of the areas. Anything that can be done to simplify the categories certainly simplifies the application and simplifies the understanding and the administrative aspects of it.

We actually try to approach this area of in-kind support and maintenance by having just one question on the application, by having the person estimate, by us not verifying the information and by us setting up a flat amount if it was over a certain amount. But we did that within the structure of what the statute is at this point in time.

Senator SMITH. I doubt that beneficiaries are—maybe some, but many are deliberately trying to misrepresent their assets. But, for example, for anyone who may be interested in what I am talking about, for example, if a senior is getting Meals on Wheels, is that an asset for purposes of the asset test? If so, what kind of value do you put on it in terms of meeting the qualifications?

Ms. DISMAN. Well, Meals on Wheels, Senator, is not an asset.

Senator SMITH. OK.

Ms. DISMAN. But I think what you are talking about with the in-kind support and maintenance is if a relative provides for the telephone bill. Let's say they elect to pay a telephone bill.

Senator SMITH. What I was referring to is in-kind contributions come in under the asset test, as I understand it.

Ms. DISMAN. They come in under the income test.

Senator SMITH. OK, so for purposes of the income test, even that, people don't want to misrepresent it. But what would Meals on Wheels be for purposes of the income test?

Ms. DISMAN. It wouldn't. Meals on Wheels do not count as income.

Senator SMITH. OK.

Ms. DISMAN. There is a whole list of income that doesn't count.

Senator SMITH. I appreciate the clarification.

Larry, current law waives the cost share requirement for certain low-income beneficiaries who receive long-term care services in nursing homes. But, as I stated in my opening statement, those who receive services in community-based settings, like assisted living facilities, don't get that.

My question is, what steps can CMS take to help these beneficiaries with their drug costs until Congress enacts a more permanent solution to the problem?

Mr. KOCOT. Well, as you know, Senator, this is kind of a statutory problem for us in the interpretation of institutionalized beneficiaries. It does not include those facilities that you had talked about.

We are doing everything we can to try to facilitate, as you know, people into the community. For all the right reasons, the reasons that you had stated, we want to actually incentivize people to use the assisted living facilities and so forth rather than having to resort to go to long-term care facilities.

Senator SMITH. It doesn't make much sense, does it, that there is this inherent bias toward one versus the other, when the other may actually save a lot of money.

Mr. KOCOT. We certainly agree with you that the incentives should be aligned for people to have choices that give them alternatives that are other than a long-term care institutionalized setting.

Senator SMITH. But, to be clear, you don't really have a lot of administrative elbow room under the current statute?

Mr. KOCOT. I don't think we do, Senator.

Senator SMITH. So Congress needs to act.

Mr. KOCOT. We can certainly investigate and report back to you on what administrative relief we think that we can provide.

We understand your concerns regarding the imposition of cost sharing on the full benefit dual eligible population enrolled in home and community-based settings. However, we do not believe we have latitude to treat home and community-based recipients as institutionalized for the purpose of the cost sharing exemption.

Senator SMITH. I would appreciate it if you would do that, because obviously the sooner Congress acts, the better, but the sooner the Government acts in a general sense, better still.

If you do have any administrative flexibility to get rid of this distinction, this bias, that is really counterproductive to our own bottom line, I would appreciate knowing what you——

Mr. KOCOT. I am not aware of any, but we will get back to you, Senator.

Senator SMITH. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Craig.

Senator CRAIG. Mr. Chairman, again, I haven't had yet the opportunity to publicly say congratulations on becoming the Chairman of this Committee. I, sometime back, was Chairman and enjoyed it a great deal. It can be an extremely valuable tool to do exactly what you are doing today, and I appreciate that.

Let me ask for unanimous consent that my full opening statement be a part of the record.

The CHAIRMAN. It will be done.

[The prepared statement of Senator Craig follows:]

PREPARED STATEMENT OF SENATOR LARRY CRAIG

Mr. Chairman, I know that others have made their statements and we have several witnesses who we want to hear from, so I will be brief in my comments. First of all, Senator Kohl I want to thank you for calling your first hearing as Chairman about this important issue. There is no question that Medicare Part D has had an enormous impact on the everyday lives of our seniors.

However, I think it is worthwhile to note that this program has had an incredibly positive impact on the lives of our seniors. I have to admit that initially I was skeptical about the prescription drug program. I ultimately supported it because access to affordable prescription drugs is vital for our seniors. Since then, I have been pleasantly surprised at the level of success Medicare Part D has achieved—both in terms of beneficiary satisfaction and in decreased cost to the federal government. Recent reports indicate that Medicare Part D enjoys an 80 percent approval rating

among beneficiaries is saving over $1100 per year in out of pocket costs for medications.

As for the focus of this hearing—low-income beneficiaries—I think Medicare Part D has performed well in this respect as well. In May 2006, the Centers for Medicare and Medicaid Services (CMS) estimated that 3.2 million of 13.2 million persons eligible for low-income subsidies did not have prescription drug coverage through Medicare Part D or another source. This means that approximately 75 percent of low-income beneficiaries are receiving prescription drug coverage. When considering that this population is much more difficult to reach than the general Medicare population, it is impressive that the efforts to enroll these individuals in the program were this successful. CMS and the Social Security Administration (SSA) have taken steps to further encourage enrollment by these individuals.

I wanted to take a moment to recognize the successes of Medicare Part D, but I am not under the illusion that the program is perfect. As our witnesses have discussed in their testimony, there have been problems with implementation, particularly for "dual-eligible" individuals who previously received prescription drugs through Medicaid. Our witnesses have also highlighted that one source of these problems are delays in sharing data among CMS, SSA, and private prescription drug plans.

Unfortunately, these kinds of problems are not unique to CMS and SSA. As Chairman, and now as Ranking Member, of the Veterans Affairs Committee I have examined the issues of data sharing between the Department of Defense (DoD) and the Department of Veterans Affairs (VA). DoD and VA have come a long way in terms of sharing data in order to better serve our veterans but there is still work to be done. This is also true of CMS and SSA. Improved data sharing will go a long way towards resolving many of the difficulties that beneficiaries are currently experiencing. I am hopeful that both agencies recognize the importance of this issue and are working to improve data sharing.

With that said Mr. Chairman, I want to again thank you for holding this important hearing. I want to welcome our witnesses and I look forward to hearing from them.

Senator CRAIG. But I think in that statement I would be remiss if I didn't say that Part D is a roaring success. That is coming from the skeptic that I was thinking, that we could not make it as successful as it has become, and today it has nearly an 80-plus percent favorable rating amongst beneficiaries. For a new Federal stand-up program, in the short time that it has been in existence, that is a pretty darn good record.

I know we struggle with trying to be as inclusive as possible, Mr. Chairman, but there is also a reality, at some point it becomes the personal responsibility of the individual involved here, because enrollment is voluntary. While we can push as much information at them as possible, sometimes you can't force them to do something that is voluntarily their responsibility.

Having said that, let me move in this line of questioning. Some individuals, including both members on the next panel of witnesses, have suggested that SSA be given access to IRS data to target outreach to low-income beneficiaries.

First of all, how helpful would this be in your attempt to reach these low-income individuals? Secondarily, if we are going to start deciding that IRS can now distribute information for purposes of marketing a voluntary program, isn't that a little bit of big brother and a step too far?

Beatrice, do you want to tackle that one?

Ms. DISMAN. I will tackle part of it, Senator.

Certainly, I think when we talk about the "extra help" and the low-income subsidy, I think you know we went to great lengths to identify the population that might be eligible for the "extra help". We cast a very wide net to be able to do that.

Our approach really would be the same, using multiple ways, a variety of ways of contacting people, whether it be the mailings, the personal phone calls, the community events, the telephone, the Internet.

However, having information as to what people's tax information or pensions and things that we don't have available, would have allowed us to more efficiently target this population.

So, for example, our initial launch was 19 million people that we sent low-income subsidy applications to. We knew that this was a very wide net, but because we did not have access to information that could have given us resource information on individuals or other kinds of income, we cast such a wide net, not to exclude anyone.

So it certainly would help to have a more efficient targeting, but there is sensitivity on using——

Senator CRAIG. So you are suggesting that big brother it might be, but it will be at least an efficient big brother?

Ms. DISMAN. Well, I am also suggesting the sensitivity on using tax information for non-tax purposes.

Senator CRAIG. I would hope so.

Ms. DISMAN. I really do think that both the Administration and Congress have to look at it and see what it is. But, certainly from a programmatic point of view and where I am as operationally administrating the program, it would have helped us to be more efficient.

Senator CRAIG. OK. Maybe to both of you, a common problem that I hear from my constituents about Medicare Part D, and one that our second panel has cited, is a delay in data sharing amongst CMS and SSA and private plans. We know that CMS and SSA are both Federal agencies.

Questions would be, what is being done to make it easier for these two entities to share information, and what can be done to improve data sharing between the public and the private?

Mr. KOCOT. Well, Senator, we have come to know quite a bit about data sharing due to some of the problems that we encountered last year, and we have done everything that we can to work with plans to streamline that data sharing. In addition, we have worked with SSA to streamline data sharing.

But one of the things that is a reality that we face, and not only with SSA, but also with plans, is that people are real time, but, unfortunately, benefits administration is not.

It does take time for data to be collected, for example, from a plan, and to be transferred to CMS, as in the case of the withholding from Social Security. It then has to go to Social Security. It has to be checked, it has to be verified. If there are problems, it is sent back and then it is sent back again and then it goes into a Social Security check, done by the Treasury Department.

So, in that process, not only do you have to have every piece of data correct and amounts that are correct, but also you have to have enough lead time so that you can get it into, for example, taking it out of a Social Security check. You have to have lead time to get it all confirmed and verified, so there is a time frame built into any process for benefits administration.

We are doing everything we can. We have been working hand-in-hand with Social Security to look at all of their processes, and all of our processes, to try to streamline and cut out steps along the way. We have been successful in doing that, and we will continue to do that.

We have done the same thing between plans and pharmacies, and we have cut down a lot of that time and we have cut down a lot of the margin of error that can happen in those processes. This is a new program. We are learning and we will continue to learn, streamline and improve.

Senator CRAIG. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Whitehouse.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

I have just come off a very energetic campaign season that lasted about 2 years. I am from Rhode Island. As you may know, Rhode Island has the third-highest population of seniors in the Country, and the only two that are ahead of us are Arizona and Florida, which are destination States for well-off seniors.

So I would submit that we have the highest population of people who are likely to be needing the Part D services of any State in the Country, and I have to tell you that our experience is very different than Senator Craig's in Idaho.

I could not go into a senior center and mention Part D without hearing hisses and boos spontaneously from the crowd. Over and over again, I was approached by people telling me stories that were heartbreaking. A fellow came to one of my community dinners and his 93-year-old grandmother was going to lose her apartment—she had been independent her entire life—because she had fallen into the donut hole and could not afford her medication and her apartment any longer.

Every week we had another heartbreaking story come through the door. I know that there are people for whom life is better as a result of Part D. But, at least in Rhode Island, where many seniors gather together at senior centers, live in senior high rises, there is a lot of concern and sense for those whom the system has failed, who couldn't fight their way through the extraordinary confusion and profusion of options and gave up, who fell into the donut hole.

The seniors talk to each other about that, and we have a very, very contrary experience in Rhode Island. I think "Part D stands for disaster" was a phrase we heard all the time, and "Part D, they gave it the right grade," is a phrase that I heard all the time. So I come at this from a different perspective than, I guess, Idaho projects.

There are a number of issues that concern me about this, but I think I really want to hear from you on two.

One is, in terms of outreach, to help seniors who may or may not have their full faculties with them, fight their way through the complexity, fight their way through the forms, fight their way through the asset tests, fight their way though the multiple burdensome, confusing, often conflicting mail they are getting from the Government and the different programs.

What is the best way you think that we can streamline this so people can make a simple up-down decision, or at least maybe two or three simple up-down decisions to escalate this? That is question one.

Question two is that, in Rhode Island and I think in many other States, we had a pharmaceutical assistance program for the elderly that was State-supported. It is called RIPAE in Rhode Island, R–I–P–A–E. What happened was that, as soon as Part D went into effect, the Administration proposed cutting that benefit in half, because they were being told by the folks involved that the benefit was going to be far less utilized. The reason it was going to be far less utilized was that it was an add-on benefit.

When you have got 17 different programs and 17 different formularies and, at the time, the companies were free to change the formulary midstream and dump people off medications that they had taken the program just to get access to, when you had that fluid an environment in Part D, there was nothing secure enough for RIPAE to attach itself to fill the gap. Consequently, the proposed reduction.

Are you seeing that in other places, where the State additional benefit is being reduced, or its application has been made a lot more difficult, as a result of all the complexity of Part D? Is there a way to recapture the funds from the States and coordinate them better with the Part D benefit?

So, simplicity and better coordination with existing State programs would be the two questions I would have for you.

Mr. KOCOT. Would you like me to start?

I think, Senator, it is important to note that there are two parts to your question, and one is application for the benefit, or enrollment in the benefit, and then application for the low-income subsidy. We will probably want to answer them separately, because I think you are asking two separate questions.

With regard to enrollment in the benefit, which I will take first, we have relied on the outreach, the one-on-one partnership and the help of many in the community to assist people through the application process, understanding their plans and so forth. As a matter of fact, one of our most active partners, and one of the most successful partners, has been one of your constituents, CVS.

They were, early on, an active participant with us in educating seniors and reaching out to them, holding events at senior centers. They actually developed a tool to help beneficiaries understand their choices and define what choice is best for them. They also were with us early in 2005 as one of the primary organizations that sponsored low-income subsidy application fairs and reaching out to all of their applicants, and all of their customers, even prior to the drug benefit even taking place.

So we have a lot of partners in the community who are working with us, many very successfully, touching people like no other people can, for example, like pharmacists do. People rely and trust their pharmacists, and we have been utilizing that asset.

You asked a question about better utilizing and better coordinating with State programs, and I want to answer that, but I wanted to correct one thing you said. You said that people were switching formularies midstream. I can tell you that we have a policy and

no plan can switch a formulary that will have a negative impact on a beneficiary.

So any plan that is switching formularies midstream and a beneficiary is hurt by that, they have to grandfather those people if they are in that plan and relied on that plan's information for that formulary, so we want to hear about it. I don't think that any exist, but I would like to hear about them, if they do.

Senator WHITEHOUSE. OK, I will follow up.

Mr. KOCOT. In terms of better coordination with the States, certainly, we can always coordinate better with the States. I haven't heard, and I don't know the specifics about Rhode Island, but I haven't heard of any benefit coming less from a State.

Indeed, the whole point of the program was to allow the States to add on to the benefit that Part D offers so that they could enhance their seniors' benefits with qualified SPAPs and other programs.

So, again, I don't know the specifics of Rhode Island. I would like to hear more about that, because they should be able to augment what seniors are getting in Rhode Island, not take away from it.

Senator WHITEHOUSE. Although you can understand how it might be hard for a State program to provide a supplement to, in our case, 17 different formularies or even more formularies in other States, and to those that change on an annual basis.

Mr. KOCOT. Well, actually, Senator, we have a process for States to work within so that they can utilize the most and get the most out of the benefit, and we would be happy to work with the folks in Rhode Island to get them to the same place where I believe it is 22 other States are with qualified SPAPs.

Senator WHITEHOUSE. We would love that, because obviously we have got a significant population and a very unhappy one.

Ms. DISMAN. Senator, let me address the question about the "extra help" application and how we can work together to simplify. But, before I do, let me comment that certainly Social Security has worked very closely with Rhode Island. Rhode Island itself has mandatory filing for the "extra help" application, because of their pharmaceutical assistance program.

So, as a result, our colleagues on the ground in Rhode Island have been really instrumental in being in the community, and certainly in being at CVS and we have actually participated in much of this on-the-ground pharmaceutical and outreach kind of effort.

Senator WHITEHOUSE. Yes, there clearly has been an enormous effort to try to overcome the hurdles.

Ms. DISMAN. I think when you look at a program that is very complex and that really has income and resource requirements that are tied to the SSI program, that of its very nature becomes a program that is more difficult for a beneficiary to understand, as well as for administration. No matter how we have tried to simplify the program, certainly there are some difficult concepts in a means-tested program.

I would say to you that there are many proposals that are on the table. We certainly have not had an opportunity to look at it or to look at the cost of the proposals. But, certainly, we would be willing to work with CMS, as well as with the Committee, to take a look at what a number of approaches could be.

Senator WHITEHOUSE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Whitehouse, and we thank you very much. You have been very informative and helpful, and we look forward to working with you.

Senator WHITEHOUSE. Thank you.

The CHAIRMAN. We call now our second panel.

Our first witness on this panel will be Howard Bedlin, who is vice president for public policy and advocacy for the National Council on the Aging. National Council on the Aging chairs the Access to Benefits Coalition, which is comprised of National and community-based organizations who are dedicated to ensuring that low-income Medicare beneficiaries have access to needed prescription drugs at the most affordable cost.

The Access to Benefits Coalition has developed a report on low-income beneficiaries and the obstacles they are facing in Medicare Part D. That report is being released today, and Mr. Bedlin is here to discuss it with us.

The second witness will be Ellen Leitzer. Ms. Leitzer is the executive director of the Health Assistance Partnership. HAP is an advocate for the Nation's State health insurance assistance program and the beneficiaries that they serve. Ms. Leitzer is here to discuss the challenges HAP has seen in assisting Medicare beneficiaries to negotiate Medicare's Part D low-income subsidy benefit. She will also have recommendations on how we can make the benefit run more smoothly, so we welcome you both here today.

We will begin with you, Mr. Bedlin.

STATEMENT OF HOWARD BEDLIN, VICE PRESIDENT FOR PUBLIC POLICY AND ADVOCACY, ACCESS TO BENEFITS COALITION, WASHINGTON, DC

Mr. BEDLIN. Good morning. I appreciate the opportunity to be here before you. I am Howard Bedlin, vice president for public policy and advocacy with the National Council on Aging, the nation's first organization formed to represent America's seniors and those who serve them.

NCOA also chairs the Access to Benefits Coalition, comprised of 104 National members and hundreds of community-based nonprofits and up to 55 coalitions in 34 States. We appreciate the opportunity to testify before you today on improving the Medicare prescription drug low-income subsidy, or LIS.

Many aspects of the Part D program implementation have been quite successful, due to the hard work of CMS and SSA and the Administration on Aging and their private-sector and nonprofit partners. However, there is still much work to be done on behalf of those in greatest need of help.

The LIS makes it possible for those who qualify to receive the most generous prescription drug coverage, with no donut hole, no deductible and low or no premiums and copayments. However, an estimated 75 percent of the Medicare beneficiaries still without any prescription drug coverage are eligible for the LIS. We estimate that between 35 and 42 percent of those who needed to initially file an LIS application successfully did so, and also that 3.4 to 4.4 million beneficiaries eligible for the LIS are still not receiving it.

As you mentioned, an immediate concern is the approximately 400,000 beneficiaries who lost their automatic LIS eligibility and still need to apply. Because this problem will reoccur every year, it is important to minimize potential harm for this population.

As Congress considers improvements in the Medicare Modernization Act and drug program this year, priority should be given to helping those vulnerable beneficiaries in greatest need. We would appreciate this Committee's support and recognition that it will require a robust and sustained effort to assist those remaining low-income beneficiaries.

The promise of MMA will not be fully realized until we invest in cost-effective strategies to find and enroll all of those people who are eligible for, and not receiving, the extra help available.

We have tested and analyzed various approaches for increasing enrollment in the LIS and other needs-based benefits, and four cost-effective strategies have emerged.

First, use comprehensive, person-centered approaches, rather than focusing on a single benefit.

Second, invest in the aging network and trusted community-based organizations that can create broad-based coalitions.

Third, promote the use of online tools that can screen for multiple benefits and directly file applications.

Fourth, encourage States to use cross-matched lists people already enrolled in other public benefits to identify eligible individuals.

We are pleased to issue a new report today titled, "The Next Steps: Strategies to Improve the Medicare Part D Low-Income Subsidy." Copies of the report have been provided to the Committee and can be found on our Web site. We request that the full report be included in the hearing record.

I want to highlight briefly eight specific, largely non-controversial, in my view, relatively inexpensive legislative recommendations from the report that we urge Congress to consider and take action on this year to help our Nation's most vulnerable low-income seniors in greatest need.

I want to thank you, Mr. Chairman and Senator Smith, for the interest and support that you expressed in your opening statements on several of these recommendations. We really look forward to working with you on them.

First, we believe we should eliminate the low-income subsidy asset eligibility test. It is the single most significant barrier to the LIS, as it penalizes retirees who did the right thing, by saving to create a modest nest egg to provide security in their old age. This is also a cost-effective way to fill the donut hole for many of those in greatest need.

Second, Congress should appropriate funds to support the most efficient and effective ways to find and enroll LIS eligibles. First-year funding of $4 million, we believe, is needed to begin the work of a new National Center on Senior Benefits Outreach and Enrollment that was recently reauthorized under the Older Americans Act. The center would apply lessons learned and use cost-effective strategies, create and support State and local benefits enrollment centers, maintain and update Web-based decision support tools, de-

velop an information clearinghouse on best practices and provide training and technical assistance.

Third, permit beneficiaries to apply for LIS at any time, without penalty. More time is needed to find and enroll those still eligible for the extra help. Under Medicare Part B, low-income beneficiaries can enroll any time and are exempt from premium penalties. Medicare Part D rules should be consistent with Part B rules.

Fourth, improve the LIS application form by eliminating questions on the cash surrender value of life insurance and in-kind support and maintenance, which Senator Smith mentioned.

Fifth, index all LIS cost sharing by the Consumer Price Index, not prescription drug costs, so the contributions will not be increasingly unaffordable for those least able to pay.

Sixth, permit SSA to access IRS tax filing data to better target outreach efforts while recognizing privacy concerns. I am sorry Senator Craig is no longer here, because there are some good precedents for this in the Medicare law now.

Seventh, do not count the value of the LIS when determining benefit levels for other needs-based programs.

Finally, do not count savings in 401(k) plans when determining LIS asset eligibility.

In conclusion, now that the first year of the Medicare Part D prescription drug program has ended, we can look back and see what worked and where improvements are needed for low-income beneficiaries. We are grateful for the hard work of CMS and SSA in implementing Part D and their continued dedication to the low-income subsidy.

But to fulfill the promise of the prescription drug benefit for those in greatest need, the public and private sectors should invest in evidence-based, cost-effective outreach and enrollment efforts and Congress should enact legislation this year that includes the recommended changes to the program that we have outlined.

Thank you. I am happy to provide more detail on these recommendations or answer any questions.

[The prepared statement of Mr. Bedlin follows:]

Statement

of

Howard Bedlin
Vice President, Public Policy & Advocacy

National Council on Aging

on

Recommendations for Improving The Medicare Prescription Drug Low-Income Subsidy Program

before the

U.S. Senate Special Committee on Aging

January 31, 2007

I am Howard Bedlin, Vice-President for Public Policy & Advocacy at the National Council on Aging (NCOA) – the nation's first organization formed to represent America's seniors and those who serve them. Founded in 1950, NCOA's mission is to improve the lives of older Americans. Our programs help the nation's seniors improve their health, find jobs and job training, discover meaningful opportunities to contribute to society, enhance their capacity to live at home, and access public and private benefit programs. Our members include senior centers, area agencies on aging, faith-based service agencies, senior housing facilities, employment services, and consumer organizations. NCOA also includes a network of more than 15,000 organizations and leaders from service organizations, academia, business and labor who support our mission and work. On behalf of NCOA and those we represent, I appreciate the opportunity to testify before this Committee today on the Medicare Part D Low-Income Subsidy program (LIS).

NCOA chairs the Access to Benefits Coalition (ABC),[1] comprised of national and community-based organizations dedicated to ensuring that Medicare beneficiaries with limited means know about and make the best use of resources available to access their needed prescription drugs and reduce their prescription drug costs. There are 104 national ABC members, including aging and healthcare organizations such as AARP, the National Alliance for Hispanic Health, and the Catholic Health Association of the U.S.; national charities such as Easter Seals; and groups representing patients and caregivers such as the Alzheimer's Association and the National Alliance for the Mentally Ill. In addition, faith-based and multicultural groups such as the National Council of Churches USA and the National Asian Pacific Center on Aging are committed to finding and enrolling low-income beneficiaries in the LIS. Established in 2004, the Access to Benefits Coalition has involved hundreds of community-based nonprofits through 55 local coalitions in 34 states and the District of Columbia, in educating and enrolling tens of thousands of beneficiaries in the Part D LIS and other prescription savings programs.

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[1] www.accesstobenefits.org

ABC and its network of local organizations use powerful web-based tools such as NCOA's BenefitsCheckUp decision support tool[2] and the Medicare Plan Finder[3] to help beneficiaries—as well as family caregivers and organizations who wish to assist them—to understand, apply for, and enroll in public and private prescription savings programs. BenefitsCheckUp also helps determine if individuals qualify for the Medicare Part D Low-Income Subsidy or other prescription savings programs with application forms available on the site, or enabling users to apply on-line for some of the benefits.

As the Committee is aware, NCOA supported the Medicare Modernization Act in 2003. The primary reason for our support was the generous extra help provided to low-income beneficiaries in greatest need, including coverage through the "doughnut hole". We believe several major aspects of Part D program implementation to date have been quite successful – with approximately 90% of Medicare recipients now having coverage, providing choice to consumers, and containing plan costs. However, there is still much work to be done on behalf of LIS eligibles. HHS has estimated that at least 75 percent of the Medicare beneficiaries **still** without any prescription drug coverage are eligible for the Low-Income Subsidy.[4]

Much of NCOA's focus in promoting successful program implementation has been on the need to improve access to the benefit for low-income beneficiaries. NCOA estimates that **between 3.4 and 4.4 million Medicare beneficiaries eligible for the LIS are still not receiving it.** We also estimate that between 35 and 42 percent of Medicare beneficiaries who needed to voluntarily file an application with SSA in 2005 and 2006 to receive LIS have successfully done so (2.2 million out of 5.2 or 6.2 million). By historical standards, this take-up rate is in line with other means-tested federal benefit programs [See Table below]. On the other hand, it also means that **58 to 65 percent of all Medicare beneficiaries who were eligible for LIS and who had to apply to get LIS are not now receiving the benefit.**

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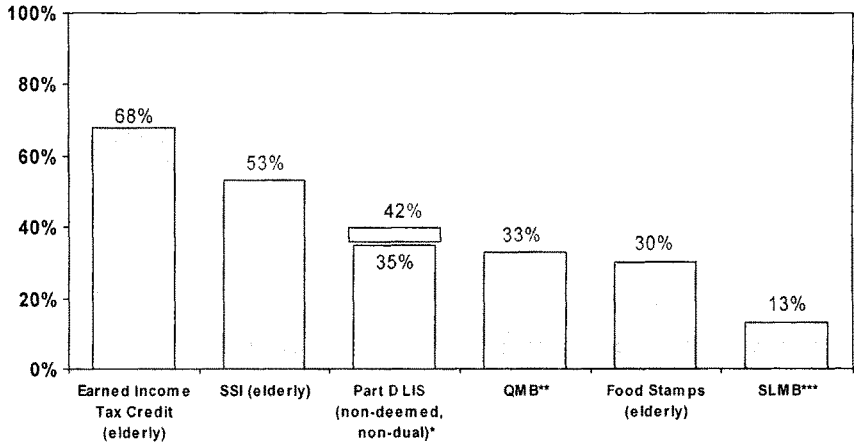
[2] www.benefitscheckup.org
[3] www.Medicare.gov
[4] Statement of Michael Leavitt, Secretary of U.S. Department of Health & Human Services, May 2006.

It is important that Congress not rely on the historically low enrollment rates for other needs-based benefits programs when judging the success of the Medicare Part D program. Congress should raise expectations for both the Part D Low-Income Subsidy and all other needs-based benefits programs to ensure that low-income seniors and people with disabilities receive all the benefits for which they are eligible. Participation in available benefits programs will improve the overall health and quality of life for those in greatest need, allowing them to remain healthy and independent for as long as possible.

Participation Rates in LIS and Other Needs-Based Benefits Programs



*A range of 35 to 42% is included for the Part D LIS because there are different estimates provided by CMS (13.2 million) and CBO (14.2 million) on the total number of Medicare beneficiaries eligible for LIS and, therefore, there are different estimates of the number of non-deemed, non-duals eligible for LIS.
** The Qualified Medicare Beneficiary program is a Medicare Savings Program (MSP) that provides premium and cost sharing assistance for beneficiaries with incomes below 100 percent of the FPL.
*** The Specified Low-Income Medicare program is a MSP that provides premium assistance for beneficiaries with incomes between 100–120% of the FPL.

Another issue of concern involves individuals who have lost their automatic eligibility for LIS. In September 2006, CMS announced that there were approximately 632,000 people who had been automatically receiving the LIS in 2006, but who were at risk of losing their deemed LIS status in 2007. These are people who lost their Medicaid,

MSP, or SSI coverage at some point during the year. In order to continue to be eligible for LIS in 2007, these people would need to voluntarily file an LIS application or regain their eligibility for the Medicaid, MSP or SSI programs. According to the most recent figures available, we understand that roughly one-third of the 632,000 either regained their deemed status or successfully applied for LIS. Therefore, we estimate that approximately 400,000 beneficiaries lost their LIS benefit and still need to apply for LIS this year.

Many of these 400,000 beneficiaries will be spending far more out-of-pocket for their prescription drugs than they did last year. For example, many may be paying a deductible for their drugs for the first time. Anecdotal reports indicate that many plans have granted a 60-day transition period, so a large number of these beneficiaries will not likely find out that they have lost their LIS benefit until March. We urge plans, CMS, and advocates to devote specific, additional resources to working together to contact this vulnerable and help them apply for LIS. Because this problem will reoccur every year, it is especially important to minimize potential harm to this vulnerable population.

NCOA has developed programmatic and legislative recommendations for reaching and enrolling vulnerable, low-income beneficiaries and we would appreciate the Committee's support and recognition that it will require a robust and sustained effort to find the remaining beneficiaries and help them sign up for the LIS. The promise and potential of the Medicare Modernization Act will not be fully realized until we invest in cost effective strategies to find and enroll all of the people who are eligible for and not receiving the Extra Help available to them.

Cost Effective Strategies for Enrolling Beneficiaries in Needs-Based Benefits

Over the past three years, the NCOA, the Access to Benefits Coalition and the Benefits Data Trust (BDT)[5] have been testing a variety of strategies for increasing enrollment in the LIS and other key public benefits. Various pilot projects have been funded primarily by The Commonwealth Fund, The Atlantic Philanthropies, the Center

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[5] Benefits Data Trust (BDT) is a charitable organization established in 2005 by NCOA and the Foundation to Benefit Our Seniors specifically to use sophisticated list strategies and specialty call center response to increase enrollments in public benefits.

for Medicare & Medicaid Services (CMS), and Kaiser Permanente. Key findings and supporting documentation are attached to this testimony in an Appendix.

Over the past year, four evidence-based strategies have emerged that are particularly cost-effective for finding and enrolling Medicare beneficiaries in the LIS:

1. **Use comprehensive, person-centered approaches to outreach and enrollment (rather than focused solely on a single benefit).**

   People who are eligible for one means-tested public benefit are highly likely to also be eligible for, but not receiving other key public benefits. Many people who are applying for LIS are also eligible for other public benefits and vice versa. For example, 71 percent of those found who screened eligible for the LIS through online technology also screened eligible for and are not now receiving MSP benefits [See Appendix – Figure 1].

   A major benchmarking study by The Bridgespan Group and NCOA examining more than 30 different single-benefit outreach and enrollment projects shows that, consistently, about 55% of the total costs per enrollment are related to identifying qualified individuals and persuading them to apply and 45% of the costs relate to actual assistance with applications [See Appendix - Figure 2]. Because most federal agencies are limited by statute and/or practice from conducting outreach for more than a few benefits (e.g., USDA conducts Food Stamps outreach; SSA conducts LIS and SSI outreach; CMS conducts MSP outreach), the government is incurring the same costs of identification and persuasion over and over again.

2. **Invest in the aging network and trusted, non-profit community-based organizations that can create broad-based networks to efficiently connect people who are like eligible for LIS to enrollment specialists who will help them apply for the benefit.**

   The "aging network" and other community-based non-profit organizations are well-suited to find and enroll low-income Medicare beneficiaries but need the resources be able to find the remaining population who is harder-to-reach and in need of application assistance. The per-enrollment costs of community-based efforts range between $30 and $280 depending on the approaches, how they are implemented and

the populations targeted [See Appendix – Figure 3]. A particularly cost-effective approach seems to be to create referral networks in which key organizations (such as drug stores, health plans, health centers, social service agencies, etc.) efficiently refer people seeking assistance and likely eligible for LIS to specialty enrollment centers. Ideally, there will be "warm transfers" (i.e., the "real-time" transfer of a person who has been identified as needing assistance with paying for medications) to the enrollment centers [See Appendix – Figure 4].

3. **Promote the widespread use of person-centered, online screening and enrollment services (such as the BenefitsCheckUp) that enable consumers and organizations to screen for multiple benefits and directly file LIS applications; and,**

The BenefitsCheckUp, which is supported by foundations and corporations, served 232,000 clients in 2006 and its consumer edition (serving people and/or their caregivers directly accessing the site) is currently producing enrollments in major public benefits at a cost of $15 per benefit. If the online service was sponsored and/or promoted by government, it could reach and serve many more people and would likely achieve enrollments for $7 - $10 per major benefit [See Appendix – Figure 5].

4. **Encourage states to work across departments and use cross-matched state lists of people already enrolled in other public benefits to identify individuals eligible for and not receiving LIS.**

Cross-matching state lists of people enrolled in other public benefits has resulted in particularly higher percentages of people who apply for and, ultimately receive, other benefits. The experiences of the State of Pennsylvania Department on Aging are particularly compelling and should be replicated in other states.

Recommended Changes to the Medicare Part D Low-Income Subsidy Program

The following recommendations are highlights from a report titled *The Next Steps: Strategies to Improve the Medicare Part D Low-Income Subsidy* issued today by the Access to Benefits Coalition and NCOA. Copies of the report have been provided to

Committee members. The report is being distributed this morning at the hearing and can also be found on our website at: www.ncoa.org and www.accesstobenefits.org. We request that the full report be included in the hearing record.

Recommended Legislative Changes

- **Eliminate the asset test because it is the single-most significant barrier to the Part D LIS for low-income seniors and people with disabilities.** Of the LIS applications filed with SSA, 41 percent are denied because the person is over the asset limits.[6] According to the Congressional Budget Office, an estimated 1.8 million Medicare beneficiaries with incomes below 150 percent of the Federal Poverty Level (FPL) will not qualify for the additional assistance because their assets exceed the amount currently allowable.[7]

People who manage to save a modest sum for retirement and still have very limited incomes should be encouraged and rewarded, not denied the extra help that they need. Half of the people who fail the asset test have excess assets of $35,000 or less.[8] These people tend to be older, female, widowed, and living alone. Often when the husband dies, the wife's income is significantly reduced, but she still has the modest assets that were accumulated during the marriage.[9]

In addition, the asset test is inherently discriminatory against people who rent their homes, instead of own them. People who own their home—regardless of its value—but have limited incomes can qualify for the Low-Income Subsidy. However, people who rent their home and have $20,000 in the bank to pay future rent or other expenses are disqualified from the program regardless of their low income.

Eliminating or increasing the asset limit amount for the Low-Income Subsidy would make the benefit available to significantly more low-income people who

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[6]Statement of Cheri Arnott, Associate Commissioner for External Affairs, Social Security Administration at the 2007 Families USA Conference on January 25, 2007.
[7] http://www.cbo.gov/ftpdocs/48xx/doc4814/11-20-MedicareLetter2.pdf (Accessed July 6, 2006)
[8] Rice, Thomas and Desmond, Katherine. "Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test." The Henry J. Kaiser Family Foundation, April 2005.
[9] See Rice article at footnote 39.

desperately need additional assistance with paying for their prescription drugs. This is also a cost effective way to fill the "doughnut hole" for many of those in greatest need.

- **Enact legislation to make the LIS Special Enrollment Period (SEP) and waiver of the Late-Enrollment Penalty (LEP) permanent.** We applaud CMS for creating SEPs to permit beneficiaries to apply for the LIS and enroll in a plan without experiencing a premium penalty after the May 15, 2006, deadline until the end of 2007. However, we urge Congress to enact legislation that would make both the LIS SEP and waiver of the LEP permanent.

Under Medicare Part B,[10] low-income beneficiaries eligible for Medicare Savings Programs[11] can enroll any time and are exempt from premium penalties. This is not the case under Medicare Part D. Treatment of the most vulnerable seniors and people with disabilities should not vary so significantly within Medicare programs. The Part D rules should be made to be consistent with the Part B rules.

Finding and enrolling the LIS population will take time, as evidenced by take up rates in other needs-based benefits. Low-income beneficiaries are least able to afford premium penalties, and if they are subject to financial punishment, they will never apply for the prescription drug assistance they need. To meet this continuing challenge, we need to reduce barriers, not impose them. Without both a permanent enrollment period and elimination of the Late-Enrollment Penalty, efforts by government agencies, national organizations, and local nonprofit groups to find and enroll LIS-eligible individuals will be thwarted. Failure to permanently extend the SEP and waive the LEP would effectively ensure that there will be no more progress made in helping low-income seniors and people with disabilities—a result that is wholly unacceptable.

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[10] Medicare Part B is medical insurance that pays for doctor's services and other costs that are not paid under Medicare Part A (hospital insurance).

[11] Medicare Savings Programs (MSPs), include Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualified Individual programs. Each MSP program has specific income eligibility limits and to be eligible, a person's resources cannot be more than twice the SSI resource limit. Individuals eligible for any of these programs are deemed eligible for the full LIS. MSPs are administered by state Medicaid agencies and pay for the Medicare Part B premium; the QMB program covers Medicare cost-sharing, as well.

- **Appropriate funds to support organizations that use a person-centered approach to outreach, which has been shown to be one of the most efficient and effective ways to find and enroll LIS eligibles.** Finding and enrolling seniors and people with disabilities with limited resources in needs-based benefits programs has been a significant challenge for many years. We know that reaching everyone in this special population will take a great deal of time and energy. We strongly recommend that additional financial resources be made available to support national organizations and local community-based organizations, so they may continue the important grassroots, one-on-one work they have been doing during the initial enrollment period.

The Access to Benefits Coalition report *Pathways to Success: Meeting the Challenges of Enrolling Medicare Beneficiaries with Limited Incomes* (2006) states that the most effective projects involved in the study used a one-on-one "person-centered" approach.[12] The study found that the average cost is approximately $100 per enrollment, although it may be somewhat higher as the remaining LIS beneficiaries are the most difficult to find. We strongly encourage SSA and CMS to fund programs that have a person-centered approach to finding and enrolling LIS eligible seniors and people with disabilities.

The Older Americans Act (OAA), which was reauthorized last October, created a new National Center on Senior Benefits Outreach and Enrollment. In §202 of the OAA, the Assistant Secretary of HHS is authorized to establish a National Center that will:

- Maintain and update Web-based decision support and enrollment tools and integrated, person-centered systems designed to inform older individuals about the full range of benefits for which the individuals may be eligible under federal and state programs;
- Utilize cost-effective strategies to find older individuals with greatest economic need and enroll the individuals in the programs;
- Create and support efforts for Aging and Disability Resource Centers and other public and private state and community-based organizations, including faith-

[12] "The most effective projects in this study used a one-to-one 'person centered' approach—one that provides personalized assistance from a trusted source, and takes a 'holistic' approach to the individual being enrolled." The Bridgespan Group, 2005.

based organizations and coalitions, to serve as benefits enrollment centers for the programs;

- Develop and maintain an information clearinghouse on best practices and cost-effective methods for finding and enrolling older individuals with greatest economic need in the programs for which the individuals are eligible;
- Provide, in collaboration with related federal agency partners administering the federal programs, training and technical assistance on effective outreach, screening, enrollment, and follow-up strategies; and
- Play a critical role in finding and enrolling the remaining seniors and people with disabilities who are eligible for, but not yet enrolled in, the Low-Income Subsidy.

Now that the National Center has been authorized, we urge Congress to appropriate $4 million in initial funding so that its work can begin and low-income seniors and people with disabilities across the country can be enrolled in the LIS and other needs-based benefits programs.

- **Do not require information about the cash surrender value of life insurance policies when determining LIS eligibility.** We have received a great deal of support from local ABCs for removal of the cash surrender value question from the LIS application. Beneficiaries often do not have this information and paperwork readily available, and they do not know how to get the information. Seniors and people with disabilities often plan for their families to use their life insurance benefit to pay for their final expenses—and thus they often are not willing to cash in their life insurance now and place an additional burden on their family members upon their death.

- **Do not take the value of in-kind support and maintenance (ISM) into consideration when determining eligibility for the LIS.** ISM can include the market value of food, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection fees given to the recipient by a third party. Our ABCs report that it is difficult for applicants to estimate the amount of in-kind support as it generally changes from month to month. The unrealistic level of detail involved in

calculating the value of in-kind support and maintenance is likely resulting in potentially eligible beneficiaries not filing LIS applications.

- **Do not count funds in retirement savings plans such as 401(k) accounts as assets, but do count distributions from such plans as income.** For the majority of people who are not covered by traditional defined benefit pension plans, the resources in their 401(k) and other retirement savings accounts represent their only retirement savings. Periodic distributions during retirement from 401(k) accounts often constitute the only income people have to supplement their Social Security benefits.

However, Social Security does not consider a person's pension (defined benefit plan) to be an asset when determining LIS eligibility. Pensions are only counted to the extent that a person is actually drawing money from them. Forcing people to cash in their 401(k) plans to become eligible for LIS is a disincentive for people to save for retirement. As with traditional pension plans, distributions from 401(k) plans should be treated as income, but the funds in the account should not be treated as assets. Treating the two retirement vehicles differently is inconsistent and unfair to people whose primary planned retirement source is a 401(k).

- **Index the co-payments and deductibles for people between 100 and 150 percent of the Federal Poverty Level to the Consumer Price Index (CPI—all items, U.S. city average), as it is more reflective of cost increases and, therefore, more closely mirrors beneficiaries' ability to pay.** LIS-eligible people with incomes below 100 percent of the FPL will have their prescription drug cost sharing increased in 2007 according to the CPI (all items, U.S. city average).[13] Social Security implemented a cost-of-living adjustment of 3.3 percent in 2006[14] that corresponded to the CPI increase in that same year.

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[13] See §1860D-14(a)(4)(A)(i) of the Social Security Act. "The dollar amounts applied under paragraph (1)(D)(ii)—(i) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase in the Consumer Price Index (all items; U.S. city average) as of September of such previous year." http://www.ssa.gov/OP_Home/ssact/title18/1860D14.htm (Accessed January 16, 2007)

[14] SSA Cost of Living is generally equivalent to the Consumer Price Index for Urban Wages Earners and Clerical Workers (CPI-W). http://www.ssa.gov/OACT/COLA/colaseries.html (Accessed June 6, 2006)

However, for LIS-eligible beneficiaries with incomes between 100 and 150 percent of poverty, their cost sharing is increased according to the percentage increase in average per capita aggregate expenditures for covered Part D drugs, without regard to the amount of Social Security benefit increases.[15] For example, Part D co-payments for this group increased in 2007 at a rate of more than twice the CPI, from $2.00 to $2.15 for generics and from $5.00 to $5.35 for brand name drugs.[16] Therefore, the value of the benefit for people between 100 and 150 percent of the FPL diminishes significantly over time.

The co-payments and deductibles for people with incomes between 100 and 150 percent of FPL should be indexed to the CPI in the same way it is for people with incomes below 100 percent of FPL, to ensure that people can continue to afford their prescription drugs.

- **Require the Internal Revenue Service (IRS) to assist SSA with tax-filing data, providing SSA with the names of Medicare beneficiaries who are likely eligible for the LIS to better target outreach efforts, while recognizing privacy concerns.** Currently, SSA does not have access to crucial IRS data that would allow it to better target its outreach for the Part D LIS. IRS data are used only for the purpose of verifying income and asset levels after an LIS application has been filed. The Administration should encourage the sharing of information more effectively among federal agencies for the purpose of reaching out to more potential LIS beneficiaries.

The Department of Health and Human Services Office of the Inspector General issued a memo to CMS on November 17, 2006, expressing concern that CMS and SSA need more effective ways to identify potential LIS-eligible people.[17] The memo points out that data sharing among CMS, SSA, and the IRS already occurs under the Medicare

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[15] See §1860D-2(b)(6) of the Social Security Act. "The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." http://www.ssa.gov/OP_Home/ssact/title18/1860D02.htm (Accessed January 16, 2007)

[16] CMS Letter (Center for Medicaid and State Operations, Disabled and Elderly Programs Group) to State Medicaid Directors, December 18, 2006. http://www.cms.hhs.gov/smdl/downloads/SMD121806.pdf (Accessed January 16, 2007)

[17] Department of Health and Human Services, Office of the Inspector General, November 17, 2006. http://www.oig.hhs.gov/oei/reports/oei-03-06-00120.pdf (Accessed November 28, 2006)

Secondary Payer Program pursuant to §1862(b)(5) of the Social Security Act, enacted by the Omnibus Budget Reconciliation Act of 1989.[18] In 2007, SSA will use information on gross income from prior tax filings to implement an income-related system for Part B premiums for individuals earning more than $80,000. Congress should enact legislation that would allow CMS and SSA to access critical income and resource data contained in IRS files, thereby allowing them to more accurately identify potential LIS eligibles. This information would allow these agencies to target their outreach efforts and would result in increased enrollment in the LIS program. It is important that this sharing of data be done in a way that safeguards the privacy of the individual beneficiaries.

- **Mandate that prescription drug LIS assistance should not be counted when determining eligibility for other needs-based programs.** The Part D LIS provides significant financial assistance to low-income Americans in paying for needed prescription drugs. The effect of the Part D LIS is compromised, however, when reductions are made in other needs-based assistance due to receipt of the LIS benefit. Forcing seniors and people with disabilities to choose between the immediate need that they have for their Section 8 housing and food stamp benefits and what they may perceive to be a more long-term need of their prescription drugs undermines the basic tenets of the LIS benefit. Congress should pass legislation to ensure that beneficiaries do not lose other needs-based benefits, such as food stamps, Section 8 housing, and Medicaid Medically Needy coverage on account of receiving LIS benefits.

Recommended Administrative & Regulatory Changes

- **Make all outreach materials, instructions, applications, and subsequent correspondence from SSA available in at least three additional languages: Russian, Chinese, and Vietnamese. If the SSA budget allows, translate the LIS application into other languages frequently requested at SSA.**[19] While we recognize that SSA has

[18] According to the OIG memo, the sharing of information among these agencies is known as the "IRS/SSA/CMS Data Match."

[19] Other commonly requested languages at SSA include, among others: Korean, Arabic, Armenian, Farsi, and Haitian-Creole. http://www.ssa.gov/multilanguage/LEPPlan2.htm (Accessed July 6, 2006)

undertaken tremendous efforts to reach out to non-English speaking populations by making instructions and outreach materials in different languages, we are hopeful that SSA can continue this effort by working to make the application available in at least three additional languages—Chinese, Russian, and Vietnamese. SSA has made the application and instructions available in Spanish, and we are hopeful that it will do this for the other three most-requested languages at SSA for Retirement Claims.

We understand that SSA has gone to great efforts to develop their optical scanning process to ensure an efficient application process. While we acknowledge that during the initial enrollment period, this has expedited the application process and reduced administrative costs, the need to make extra, specialized efforts to find and enroll the remaining, particularly difficult-to-reach population supersedes these concerns. Specifically, the benefit of making the LIS application available in the most frequently requested languages (other than English and Spanish) outweighs the additional time it may take to manually process these LIS applications.

- **Have each SSA field office employ at least one dedicated worker specifically assigned to process LIS applications, benefiting both the applicants and Social Security by streamlining the application process and providing expert assistance.** Because of the complexity of the LIS program, each local SSA office should have a worker who is dedicated solely to the processing of LIS applications and fielding questions pertaining to the program. An individual needs specialized skills and knowledge to efficiently assist people with LIS applications. A single point of contact would be helpful to both SSA and potential LIS beneficiaries.

The SSA office would not have to spend considerable time and resources training all employees on the LIS program if there was one designated LIS worker and one back-up worker available to assist LIS applicants. This would allow for the designated SSA representative to become an expert in LIS and provide clients with prompt and accurate answers to their questions. A dedicated worker also would be useful to local community-based organizations that try to contact SSA to assist their clients.

- **Amend the LIS application to allow applicants to designate a third party to assist them through the LIS application process. A person so designated should be able to obtain information from SSA regarding the LIS application, including status reports, and the designee should have the authority to provide information to SSA on behalf of the applicant.** Since Medicare Part D began in January 2006, many applicants have sought out assistance from family members, friends, or local community-based organizations. Beneficiaries may prefer that this person continue to assist them by speaking with SSA on their behalf and acting as a liaison for them. As such, the LIS application should be amended to include a space for the applicant to designate a third party to assist them through the application process. If an applicant designates a third party, such as a community-based organization, family member, or friend, that party should be able to interact fully with SSA on the applicant's behalf. SSA could amend the LIS application to include a sufficient consent for release of information, which would allow SSA to interact with a third party on behalf of the LIS applicant.

- **Maintain a link from the online LIS application to a Web page that provides seniors and people with disabilities—as well as their family members, friends, or advocates—state-specific information on other public benefits for which they may be eligible.** People applying for LIS assistance are likely eligible for other needs-based benefits programs. A 2006 report by the ABC found that finding and connecting with people likely to be eligible for needs-based benefits were the most costly part of the process, comprising on average 55% of the total project costs. Technology that also links people to the LIS application after completing the application for other needs-based programs, such as food stamps, is also an efficient way to enroll more eligible seniors. The correlation rate between people who are eligible for LIS and other needs-based programs is high.

Conclusion

Now that the first year of the Medicare Part D prescription drug program has recently ended, we are in a unique position to look back and see what worked and what areas can be improved to benefit low-income Medicare beneficiaries. Removal of the

asset test is critical to increasing enrollment in the LIS, as people with very low incomes are being denied desperately needed assistance with their prescription drugs. Other barriers to enrollment should also be addressed, such as permitting LIS eligibles to apply for LIS and choose a plan without penalty at any time. In addition, appropriating funds for cost- effective strategies and a national network of enrollment centers as authorized under §202 of the Older Americans Act will increase participation in the LIS program.

We are grateful for the hard work of CMS and SSA in implementing this new program and their continued dedication to the low-income subsidy. We remain concerned, however, that an estimated 75 percent of Medicare beneficiaries still without any prescription drug coverage are eligible for the LIS and that 3.4 to 4.4 million eligibles are not participating. To be successful, Congress and the Administration should invest in evidence-based, cost effective outreach and enrollment efforts and make the recommended changes to the program to ensure LIS eligibles have access to the program. Continued partnerships between the government and the private and non-profit sectors will ensure that we enroll everyone eligible for this critical assistance.

APPENDIX:

Cost-Effective Strategies for Finding and Enrolling Low-Income Medicare Beneficiaries in the Limited Income Subsidy (LIS) and Other Key Public Benefits

Over the past three years, NCOA, the Access to Benefits Coalition and the Benefits Data Trust (BDT)[20] have been testing a variety of strategies for increasing enrollment in the LIS and other key public benefits. Various pilot projects have been funded primarily by The Commonwealth Fund, The Atlantic Philanthropies, the Center for Medicare & Medicaid Services (CMS), and Kaiser Permanente.

Over the past year, four evidence-based strategies have emerged that are particularly cost-effective for finding and enrolling Medicare beneficiaries in the LIS:

- Use comprehensive, person-centered approaches to outreach and enrollment (rather than focused solely on a single benefit);
- Invest in the aging network and trusted, non-profit community-based organizations that can create broad-based networks to efficiently connect people who are like eligible for LIS to enrollment specialists who will help them apply for the benefit.
- Promote the widespread use of person-centered, online screening and enrollment services (such as the BenefitsCheckUp®) that enable consumers and organizations to screen for multiple benefits and directly file LIS applications; and,
- Encourage states to work across departments and use cross-matched state lists of people already enrolled in other public benefits to identify individuals eligible for and not receiving LIS.

The rationale and some of the supporting data for each of these approaches are presented below. We conclude that these strategies are cost-effective and scalable. However, greater investment in these four strategies is needed by both the government and the private sector to achieve the higher LIS enrollment goals that we desire.

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[20] Benefits Data Trust (BDT) is a charitable organization established in 2005 by NCOA and the Foundation to Benefit Our Seniors specifically to use sophisticated list strategies and specialty call center response to increase enrollments in public benefits.

Strategy #1: Use comprehensive, person-centered approaches to outreach and enrollment (rather than focused solely on a single benefit)

Rationale:

- People who are eligible for one means-tested public benefit are highly likely to also be eligible for, but not receiving other key public benefits. Many people who are applying for LIS are also eligible for other public benefits and vice versa. [Figure 1]

- A major benchmarking study by The Bridgespan Group and NCOA examining more than 30 different single-benefit outreach and enrollment projects shows that, consistently, about 55% of the total costs per enrollment are related to identifying qualified individuals and persuading them to apply and 45% of the costs relate to actual assistance with applications. [Figure 2]

- Most federal agencies are limited by statute and/or practice from conducting outreach for more than a few benefits (e.g., USDA conducts Food Stamps outreach; SSA conducts LIS and SSI outreach; CMS conducts Medicare Part D outreach). As a result, the government is incurring the same costs of identification and persuasion over and over again.

- Much more could/should be done to increase the cost-effectiveness of government-sponsored outreach and enrollment efforts by encouraging/requiring screening for multiple benefits.

Figure 1.
A "person-centered" approach enhances results: *Benefits are highly correlated with one another*

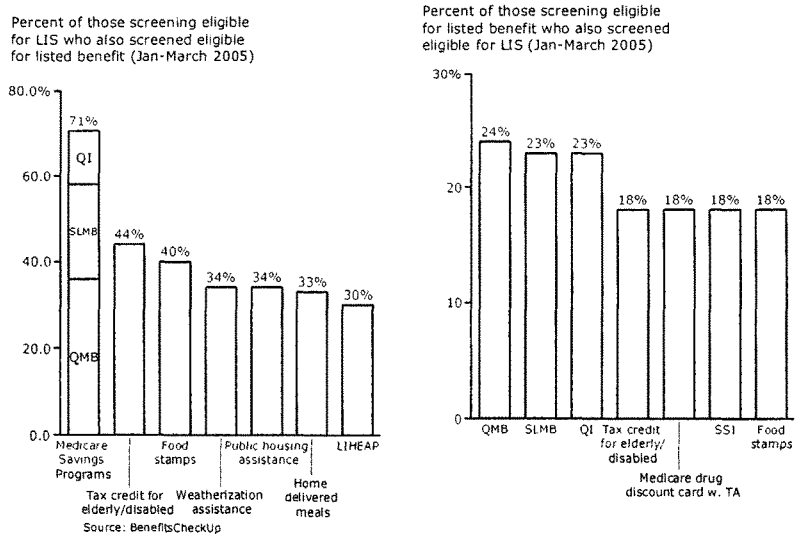
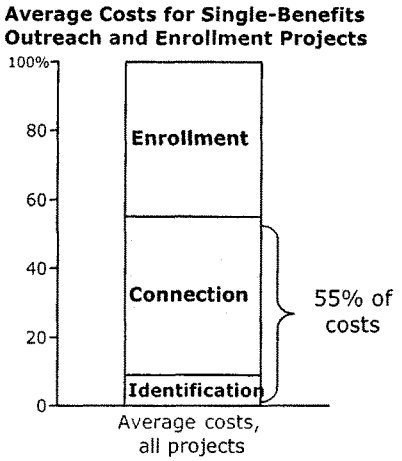


Figure 2.
A "person-centered" approach enhances results because of the high costs of identifying eligible people and persuading them to apply for benefits.



Source: Bridgespan & NCOA outreach & enrollment benchmark study

Strategy #2: Invest in the aging network and trusted, non-profit community-based organizations that can create broad-based networks that efficiently connect people who are likely eligible for LIS to enrollment specialists who will help them apply for the benefit.

Rationale:

- The "aging network" and other community-based non-profit organizations are well-suited to find and enroll low-income Medicare beneficiaries because they:
  a) are client-focused and person-centered;
  b) have trusting relationships with many beneficiaries;
  c) can create community-wide referral systems; and,
  d) are able to leverage funding from multiple sources.

- The per-enrollment costs of community-based efforts range between $30 and $280 depending on the approaches, how they are implemented and the populations targeted. [Figure 3]

- Based on the experiences of local Access to Benefits Coalitions, it appears that the average cost per LIS enrollment was approximately $100 in 2006. However, we expect that the average per-enrollment cost may be somewhat higher in 2007

because the remaining populations are harder-to-reach and may need more assistance to apply.

- The most cost-effective, community-based approach seems to be to create referral networks in which key organizations (such as drug stores, health plans, health centers, social service agencies, etc.) efficiently refer people seeking assistance and likely eligible for LIS to specialty enrollment centers. Ideally, these referrals should be "warm transfers" (i.e., the "real-time" transfer of a caller who has been identified in some way as having a specific need) to a helpline dedicated to assisting them with application for LIS.

    - Referrals through lists or warm transfers to specialty enrollment centers (national or local) are three to six times more likely to result in application submissions than outbound calls.
    - Warm transfers to LIS enrollment centers result in the highest numbers of actual applications and are, on average, almost five times more cost-effective than direct mail and three times more cost-effective than outbound calls. [Figure 4]
    - Efficient warm transfers to enrollment specialists (local or national) can produce LIS enrollments at a cost as low as $25 to $30 each..

- In every community, there is a need for some targeted funding, particularly to focus on enrollment assistance (helping people to fill out the application forms once they been identified).

- Federal investment in the aging network, especially to support the enrollment assistance function, can be very cost-effective, and in many cases, will enable organizations to leverage other resources for outreach and referral.

Figure 3.
Outreach and enrollment costs vary widely.

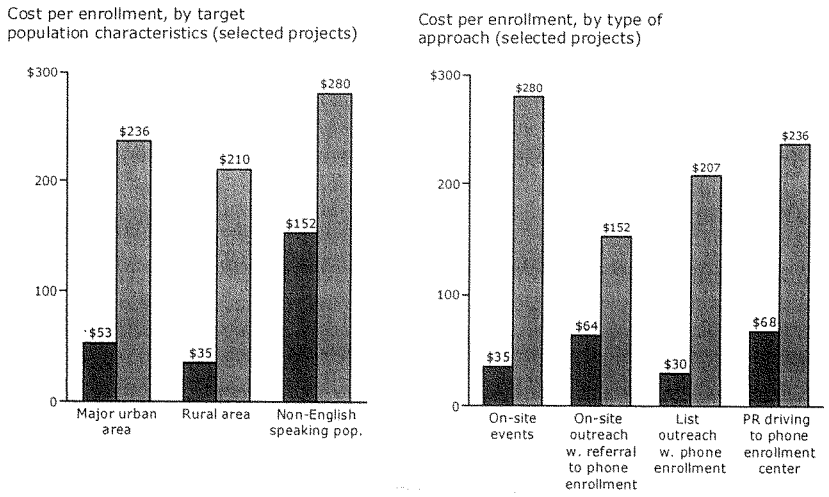
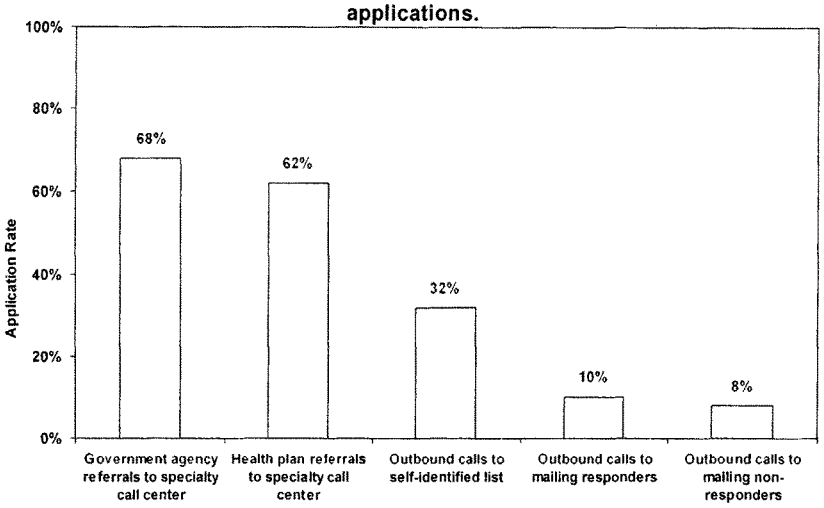


Figure 4.
Referrals of likely-eligible people to specially enrollment centers produces the highest conversion rates of contacts to applications.



Source: BDT data analyses.

Strategy #3: Promote the widespread use of person-centered, online screening and enrollment services (such as the BenefitsCheckUp) that enable consumers and organizations to screen for multiple benefits and directly file LIS applications.

Rationale

- On-line screening and enrollment services have the potential to help two different groups of low-income Medicare beneficiaries:
  - Consumers who can successfully use the Internet to get benefits for themselves or family members; and,
  - Consumers who need the assistance of intermediary organizations to learn about and enroll in benefits.

- There are many advantages to online screening and enrollment tools, including:
  - They can be easily accessed by both consumers and intermediary organizations.
  - They can simultaneously screen for and facilitate enrollment in multiple benefits.
  - Online filing for LIS significantly reduces processing costs for SSA.

- Surprising numbers of low-income seniors and their families are able to successfully use online tools to get benefits for themselves or their family

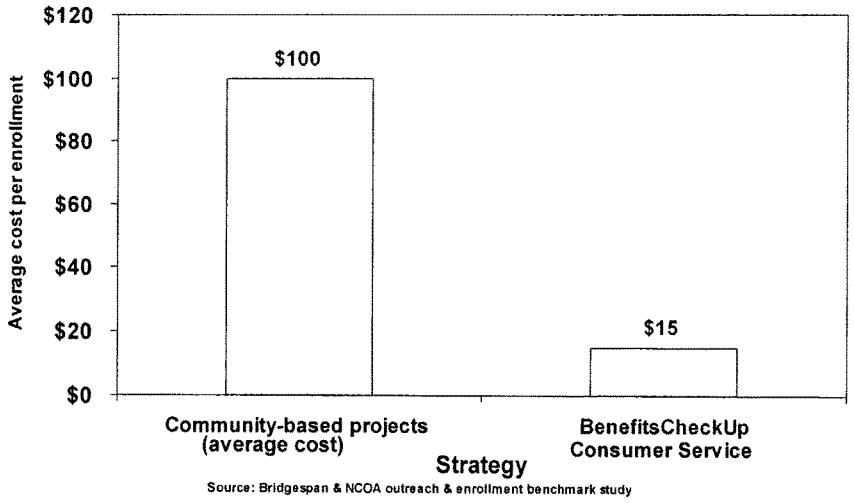
members. More than half (59%) of low-income users of online tools follow through with the application process. This audience has taken the step to screen for benefits and is motivated to apply for them. Additionally, almost one-quarter (23%) of people directly accessing online tools receive application assistance from a friend or family member.

- The BenefitsCheckUp, which is supported by foundations and corporations, served 232,000 clients in 2006 and its consumer edition (serving people and/or their caregivers directly accessing the site) is currently producing enrollments in major public benefits at a cost $15 per benefit. [Figure 5]

- If the online service was sponsored and/or promoted by government, it could reach and serve many more people and would likely achieve enrollments for $7 - $10 per major benefit.

- Online tools also increase the efficiency and effectiveness of community-based organizations.
    - Enrollment centers that assist consumers by filing online for LIS (either directly to SSA or through the BenefitsCheckUp) are more cost-effective than organizations filling out application forms and mailing them in.
    - Online tools make person-centered screening (for multiple benefits) and application filing much easier to do.

Figure 5.
Consumer use of person-centered, on-line screening and enrollment services is very cost-effective.



Source: Bridgespan & NCOA outreach & enrollment benchmark study

Strategy #4: Encourage states to work across departments and use cross-matched state lists of people already enrolled in other public benefits to identify individuals eligible for and not receiving LIS.

Rationale

- State benefit lists are a valuable resource that should be utilized to maximize enrollment in LIS and other benefits. The potential of this approach is being demonstrated in Pennsylvania. For the past three years, the State Department on Aging has been contracting with Benefits Data Trust to locate and apply individuals for the PACE/PACENET program as well as the State of Pennsylvania Property Tax and Rent Rebate Program (PTRR) and the Medicare Savings Program (MSP). This partnership exemplifies how this strategy can work to successfully locate, contact and enroll individuals into benefits they are eligible to receive.

- By cross-matching a list of 300,000 PACE (Pharmaceutical Assistance Contract for the Elderly) enrollees with a list of 250,000 Property Tax and Rent Rebate program enrollees (list came through Department on Aging from Department of Revenue), *the State identified 100,000 Property Tax and Rent Rebate program enrollees that were likely eligible for and not receiving PACE.*

- By cross-matching the 250,000 Property Tax and Rent Rebate program enrollees against the list of 300,000 individuals receiving PACE/PACENET, *the State identified 90,000 PACE/PACENET enrollees who were likely eligible for and not receiving Property Tax and Rent Rebate.*

- By cross-matching the 300,000 PACE file with the Department of Public Welfare (state Medicaid office) file, *the State identified 100,000 PACE enrollees who were likely eligible for and not receiving Medicare Savings Program benefits (MSP).*

- Using state lists of people enrolled in other public benefits has resulted in higher percentages of people who apply for and, ultimately receive, other benefits, as compared to lists that have less accurate income and contact information (i.e., people "believed to be" eligible). Response rates and application conversion rates are higher when outreach efforts are able to use pre-existing benefit lists.

- Accuracy of both the financial and contact information provided by the Property Tax/Rent Rebate program has resulted in response rates for benefits application that are 250% greater than those resulting from efforts using purchased commercial lists. From an economic perspective, this means the cost of getting people into the benefits is also two and a half times less when using a well-targeted list. In other words, for the same fixed cost, more people are being helped at a much lower cost when efforts are much more targeted. Furthermore, the residual effect is that people who were in just one public benefit program in the beginning potentially end up being enrolled into three programs.

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The Next Steps:

Strategies to Improve the Medicare Part D Low-Income Subsidy

Access to Benefits Coalition & National Council on Aging

JANUARY 2007

Acknowledgments

Founded in 1950, the National Council on Aging (NCOA) is dedicated to improving the health and independence of older persons and increasing their continuing contributions to communities, society, and future generations. Our programs help older people to remain healthy, find jobs, discover new ways to continue to contribute to society after retirement, and take advantage of government and private benefits programs that can improve the quality of their lives. For more information on NCOA, please visit us online at *www.ncoa.org*.

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(202) 479-1200 or
Sara Duda, Director Benefits Access Policy, at
sara.duda@ncoa.org or (202) 479-6678

The Access to Benefits Coalition (ABC or the Coalition) is dedicated to ensuring that Medicare beneficiaries with limited incomes know about and make the best use of all available resources for accessing prescription drugs and reducing their costs. The ABC has 104 national partners and is working through local community coalitions across the country to inform beneficiaries and their families, as well as the professionals who serve them, about the new Part D benefit. Coalition members share an interest in helping the millions of people with Medicare who are eligible for this Extra Help (including people aged 65 and over, as well as younger people with disabilities who qualify) secure the prescription coverage they need to maintain their health and improve the quality of their lives. You can learn more about ABC at *www.accesstobenefits.org*.

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2. Have Social Security field offices employ at least one dedicated worker specifically assigned to process LIS applications where practical. If local offices are relatively small, the dedicated worker could work at the state or regional level 20
3. Amend the LIS application to allow applicants to designate a third party to assist them through the LIS application process 20
4. Use both payment records and NUMIDENT records when checking personal information for LIS applicants 21
5. Maintain a link from the online LIS application to a Web page that provides seniors and people with disabilities—as well as their family members, friends, or advocates—state-specific information on other public benefits for which they may be eligible 22
6. Rework the LIS application to provide further instruction and clarity to the applicant and to people who help the applicant on the questions on jointly owned assets and provide space for further explanations 22
7. Have SSA and state Medicaid offices inform people who are denied LIS benefits due to excess resources that they might want to see a community-based organization or legal services group about steps they could take to become eligible for LIS 24
8. Rewrite the paragraph immediately preceding the signature section on the LIS application so that it is less intimidating and threatening 24
9. Shorten and simplify the decision letter SSA sends to LIS applicants to assist beneficiaries who may have difficulty comprehending long documents 25
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I. Executive Summary

The passage of the Medicare Modernization Act (MMA) was the largest expansion of the Medicare program since its inception in 1965 and over 90 percent of Medicare beneficiaries now have prescription drug coverage due to unprecedented efforts by the public and private sectors. However, millions of those in greatest need have still not signed up for the Low-Income Subsidy (LIS or Extra Help) program, which provides generous financial assistance to beneficiaries with limited income and resources, including coverage through the "donut hole." HHS has estimated that at least 75% of the Medicare beneficiaries still without any prescription drug coverage are eligible for the Low-Income Subsidy.[1]

The challenge of finding and enrolling people with limited means in needs-based programs is not new. After forty years, take-up rates remain low for many federal means-tested benefits. As a result of unprecedented efforts by the public, non-profit and private sectors in the first year of the program, NCOA estimates that 35% to 42% of beneficiaries who could have successfully applied for the LIS in 2006 are actually receiving it. While the LIS take-up rate so far is on a par with historic enrollment rates in other federal, needs-based programs (especially after the first year of effort), there are signs that overall enrollment rates are slowing. We estimate that there are between 3.4 and 4.4 million beneficiaries that we still need to find and sign up for the program in 2007.[2]

These are people who would benefit most from the coverage that Part D and the LIS can offer them. With targeted investments and modest policy changes, significantly higher participation rates can be achieved in 2007.

This paper identifies recommended legislative, administrative, and regulatory reforms that should be made to the LIS to improve access to the program for seniors and people with disabilities with limited means.[3] Some of the key legislative reforms recommended include: (1) eliminating the asset test, as it is the single-most significant barrier to Part D LIS eligibility; (2) enacting legislation to make the LIS Special Enrollment Period (SEP) permanent and eliminate the late enrollment premium penalty for this population; and (3) establishing and funding a dedicated, nationwide network of enrollment centers through the new National Center on Senior Benefits Outreach and Enrollment in order to find and enroll remaining LIS eligibles.

There are also significant administrative and regulatory reforms recommended in this paper. Some of the reforms include having the Social Security Administration (SSA): (1) designate at least one dedicated worker in each field office who is assigned specifically to process LIS applications where practical; (2) amend the LIS application to allow applicants to designate a third party to assist them through the LIS application process and interact with SSA on their behalf; and (3) maintain a link from the online LIS application to a webpage that provides seniors and people with disabilities—as well as their family members, friends, or advocates—with state-specific information on other public benefits for which they may be eligible.

In addition to implementing reforms to the Part D LIS program, Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug plans (MA-PDs) should be required to screen their member lists

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[1] Statement of Michael Leavitt, Secretary of U.S. Department of Health & Human Services, May 2006.

[2] 3.4 to 4.4 million (depending on whether you use CMS or CBO projections of the total number of beneficiaries who qualify for LIS) includes the 2.9 to 4.0 million we estimate who were qualified for but did not voluntarily sign up for Extra Help in 2006, and approximately 400,000 people who had been automatically receiving LIS in 2006 on account of their participation in Medicaid or a Medicare Savings Program (MSP), but who lost that deemed eligibility for 2007 and still need to affirmatively apply for the LIS benefit on their own. We are assuming that about 100,000 successfully filed applications with SSA and 100,000 were found to be eligible based on regaining their Medicaid or MSP.

[3] These recommendations were developed as a result of conference calls with local Access to Benefits Coalitions (ABCs) around the country over the last year, comments received from community-based organizations, discussions with national advocacy experts, and a survey sent out to ABC members on the LIS enrollment effort.

for individuals who are potentially eligible for the Low-Income Subsidy. We estimate that up to 1.1 million more people in plans could enroll in the LIS if they knew they were eligible for the program and received application assistance.[4] PDPs and MA-PDs could partner with nonprofit organizations to help screen their members for LIS eligibility.

We commend CMS for its recent decisions to permit low-income beneficiaries to sign up for LIS and enroll in a plan throughout the remainder of 2007 without penalty. This action is necessary, but not sufficient in itself to achieve higher LIS enrollments in 2007. To reach the remaining LIS eligibles, additional investment in proven strategies that work is needed, along with progress on the other recommendations included in this paper.

With the beginning of the second year of this program, the Access to Benefits Coalition and NCOA call on the Administration, foundations, corporations and advocacy groups to renew their commitment to outreach and enrollment efforts and to invest in effective strategies to help seniors and people with disabilities in greatest need to receive the important benefits available to them.

[4] NCOA estimates the number of beneficiaries in MA-PD and PDP plans who are eligible for and not receiving LIS range from 100,000 to 1.1 million. The range is due to differing estimates from the Congressional Budget Office (14.2 million) and CMS (13.2 million) in terms of the number originally thought to be eligible.

II. Background on the Low-Income Subsidy

The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 promised to provide access to subsidized, comprehensive prescription drug coverage to more than 43 million Medicare beneficiaries by establishing a new benefit under Medicare. This new prescription drug benefit is known as Medicare Part D. The Low-Income Subsidy is an integral component of the MMA providing further financial assistance, through even more significant subsidies, to beneficiaries with limited incomes and resources. The inclusion of the LIS is the primary reason that many members of Congress and several senior advocacy groups, including NCOA, eventually agreed to support the MMA.

Over the past three years, the SSA and the Centers for Medicare & Medicaid Services (CMS) have engaged in significant efforts to implement the Part D program. CMS and SSA have done a commendable job working to ensure that the new Part D benefit would be a success. We appreciate their efforts on behalf of low-income seniors and people with disabilities and are hopeful that their continued leadership, in coordination with continued private-public partnerships, will result over time in increased enrollment of the remaining LIS eligible people.

Eligibility for the Part D LIS is divided into four categories, depending on a person's income and resources. The following chart details the various amounts LIS eligibles will pay for Part D premiums, deductibles, cost sharing, and during the catastrophic coverage period. [Table 1, page 4]

The overall success of the Part D program is dependent, in large part, upon the enrollment of those people eligible for the LIS. This group is more likely than higher-income beneficiaries to have chronic health problems requiring prescription drug coverage. Furthermore, the LIS population is least likely to have had drug coverage prior to the implementation of Part D. The Kaiser Family Foundation has estimated that people who are below 150 percent of the Federal Poverty Level (FPL) are twice as likely as higher-income beneficiaries to be in fair or poor health, to have cognitive mental impairments, or to live in a nursing home.[5] Because of these important considerations, including the generous LIS, finding and enrolling LIS eligible beneficiaries should be a national priority.

The history of needs-based benefits outreach and enrollment efforts to date is not very encouraging. Studies show that even after 40 years, large percentages of seniors who are eligible for important public benefits are not receiving them. Only an estimated 30 percent of seniors eligible for food stamps, 33 percent of people eligible for Qualified Medicare Beneficiary (QMB) protections, 13 percent of those eligible for Specified Low-Income Medicare Beneficiary (SLMB) protections, and 53 percent of the elderly eligible for Supplemental Security Income (SSI) actually receive the assistance to which they are entitled.

It is important that Congress not rely on the historically low enrollment rates for other needs-based benefits programs when judging the success of the Medicare Part D program. Congress should raise expectations for both the Part D Low-Income Subsidy and all other needs-based benefits programs to ensure that low-income seniors and people with disabilities receive all the benefits for which they are eligible. Enrollment in available needs-based benefits programs will improve the overall health and quality of life for seniors and people with disabilities, allowing them to remain as independent as possible for as long as possible.

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[5] Kaiser Family Foundation "Low-Income Assistance Under the Medicare Drug Benefit." Fact Sheet, September 2005. *http://medpin.org/medicare/partd-docs/a-KFF-Facts.pdf* (Accessed January 29, 2007)

TABLE 1 **Low-Income Subsidy Groups and Costs (Calendar Year 2007)**[6]

Group Getting Help with Prescription Drug Program Costs	Group 1 *Dual Eligibles*	Group 2 *MSP*[7] *(QMB,*[8] *SLMB,*[9] *QI*[10]*) SSI*[11] *w/o Medicaid*	Group 3 *Income ≤ 135% FPL,*[12] *Resources Below $7,620*[13]*/ $12,190*	Group 4 *Income ≤ 150% FPL Resources Below $11,710 / $23,410*
Premium $27.35/month (2007) [14]	$0 up to "benchmark"	$0 up to "benchmark"	$0 up to "benchmark"	Sliding scale (25 to 100% of regional low-income benchmark) Based on income
Deductible $265 per year	$0	$0	$0	$53
Cost Sharing [15] up to $3850 out-of-pocket	co-pays: $0 if institutionalized $1/$3.10 ≤ 100% FPL $2.15/$5.35 > 100% FPL	$2.15/$5.35 co-pay	$2.15/$5.35 co-pay	15% coinsurance
Catastrophic Coverage 5% or $2.15/$5.35 co-pay	$0	$0	$0	$2.15/$5.35 co-pay

[6] Source: *http://www.medicareadvocacy.org/FAQ_PartD.htm#LIS* Chart has been modified. (Accessed July 13, 2006)

[7] MSP Medicare Savings Programs (MSPs), include Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualified Individual programs. Each MSP program has specific income eligibility limits and to be eligible, a person's resources cannot be more than twice the SSI resource limit. Individuals eligible for any of these programs are deemed eligible for the full LIS. MSPs are administered by state Medicaid agencies and pay for the Medicare Part B premium; the QMB program covers Medicare cost-sharing, as well.

[8] QMB, Qualified Medicare Beneficiary (QMB)—Those with incomes under 100 percent of the Federal Poverty Level.

[9] SLMB Specified Low-Income Medicare Beneficiary (SLMB)—Those with incomes between 100 and 120 percent of FPL.

[10] QI Qualified Individual (QI)—Those with incomes between 120 and 135 percent of FPL

[11] Supplemental Security Income (SSI).

[12] Federal Poverty Level (FPL). See Appendix E for a listing of the 2007 Federal Poverty Guidelines.

[13] Resource information updated by NCOA to reflect the 2007 increases announced by CMS on December 18, 2006. Please note, that the resource limits listed above include the $1,500 burial exclusion. The CMS announcement can be found at: *http://www.cms.hhs.gov/smdl/downloads/SMD121806.pdf* (Accessed December 29, 2006).

[14] This number has been updated to reflect the estimated National Average Part D Benchmark Premium released by CMS. *http://www.medicare.gov/publications/pubs/pdf/10050.pdf* (Accessed January 2, 2007)

[15] Individuals in these four groups do not have the "Donut Hole" gap in coverage. An individual is in the "donut hole" when their total drug costs for drugs on their plan formulary purchased at network pharmacies reaches $3,850. They are in the donut hole until their spending reaches $5,451.

Implementing these recommended reforms would increase enrollment in the Part D LIS for many more seniors and people with disabilities who desperately need help in paying for their prescription drugs. Interested parties need to take a step back and examine the outreach and enrollment process to determine how we can make improvements in reaching this important group. The LIS eligibles remaining to enroll in Part D are difficult to reach and will require special attention; therefore, we should work to eliminate demonstrated barriers—legislative, administrative, regulatory, and other—and make the enrollment process easier to navigate for Low-Income Subsidy eligibles.

III. LIS First-Year Experience

Public and Private Initiatives

Over the past three years, the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS), and the Social Security Administration (SSA) have led federal efforts to implement the Medicare Part D program. These agencies took unprecedented steps to engage a wide variety of other governmental, corporate and non-profit partners in educating and assisting Medicare beneficiaries. As a result, approximately 90 percent, or 38 out of 43 million eligible people have Part D coverage or its equivalent.[16]

In the MMA, SSA was given primary responsibility for administration of the LIS benefit. In response to this charge, SSA undertook major efforts to find those who qualify for LIS and help them apply, including a mailing to 19 million beneficiaries and hosting more than 76,000 outreach events across the country to educate people about the benefit. SSA also held targeted application-taking events at local SSA offices around the country. SSA conducted and continues to conduct significant direct mailing campaigns to potential eligibles.[17] SSA also has formed partnerships with national and community-based organizations in every state in an attempt to reach eligible low-income people. Access to Benefits Coalitions throughout the nation coordinated closely with SSA and CMS staff in the field. SSA has also worked closely with NCOA to enable individuals and organizations to apply on-line for LIS through the BenefitsCheckUp program.[18]

CMS has also demonstrated a very strong commitment to the successful implementation of the Part D program, including the LIS benefit. CMS formed thousands of partnerships with diverse groups across the country to educate and inform beneficiaries and their family members, friends, and caretakers through comprehensive outreach campaigns. During the most recent November – December 2006 enrollment period, CMS held approximately 12,700 local events in communities across the country.[19]

State Health Insurance Assistance Programs (SHIPs)[20] have been very active in the Part D education effort, providing one-on-one counseling to Medicare beneficiaries across the nation. The SHIPs actively utilize volunteers to reach out into communities and have been an essential partner in disseminating information and assisting beneficiaries with their choices. They are a trusted source of health care information and play an integral role educating Medicare beneficiaries about the LIS. Since they have responsibility for providing assistance with all aspects of the Medicare program, and millions of beneficiaries needed help understanding Part D and choosing a Part D plan, most SHIPs were not able to target their limited resources narrowly on LIS efforts from January

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[16] "Prescription Drug Coverage Among Medicare Beneficiaries" Kaiser Family Foundation, publication #7453 June 2006. *http://www.kff.org/medicare/upload/7453.pdf* (Accessed January 29, 2007).

[17] Statement of Beatrice Disman, Chairman of the Medicare Planning and Implementation Task Force, before the House Ways and Means Committee, Subcommittee on Health, May 3, 2006. *http://waysandmeans.house.gov/hearings.asp?formmode=view&id=4910* (Accessed January 29, 2007).

[18] *www.benefitscheckup.org*

[19] *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2068&intNumPerPage=10&checkDate=&checkKey=&srchType=&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.*

[20] Contact information for SHIPs can be found at: *http://www.medicare.gov/contacts/static/allStateContacts.asp* and more information about the SHIPs can be found at: *http://www.shiptalk.org/Public/home.aspx?ReturnUrl=%2fDefault.aspx* (Accessed January 22, 2007).

through May. In 2006, SHIPs were funded at an estimated $31 million dollars, less than $1 per Medicare beneficiary. Many advocacy organizations, including NCOA, are working to increase SHIP funding to enable them to assist more Medicare beneficiaries.

Despite these significant efforts through the end of the initial enrollment period on May 15, 2006, some were critical of the results on LIS applications and urged that more be done. For example, after this initial enrollment period ended, *The New York Times* wrote an editorial in June praising the Part D enrollment effort in general, with one exception: "Most troubling of all, officials estimate that three million of these people are poor enough to qualify for hefty subsidies that would cover the vast majority of their drug bills. This is the most glaring failure in the enrollment drive. It will need to be rectified by a vigorous outreach effort."[21]

CMS and SSA recognized that more needed to be done, and continued outreach and enrollment efforts throughout the remainder of the year, aided by the CMS decision to create a Special Enrollment Period (SEP) through 2007 for LIS applications and waiving the Late Enrollment Penalty (LEP), which would have resulted in higher premiums.

There were also many private sector initiatives designed to complement and supplement federal efforts to find and enroll people in LIS. These initiatives included those by the Access to Benefits Coalition and the Medicare Today Coalition, as well as major efforts by individual national organizations including AARP, the NAACP, the National Alliance for Hispanic Health, Easter Seals, the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

CMS has also been cooperating with and providing support to NCOA for research effort entitled *Cost Effective and Scalable Strategies for Enrolling Medicare Beneficiaries in Medicare.*[22] While support for the actual interventions has been provided to NCOA by The Atlantic Philanthropies, and Kaiser Permanente and others, CMS has provided instrumental assistance by identifying people who are already enrolled in LIS and therefore should not be targeted as well as some financial support for evaluation efforts. CMS also provided funding to NCOA through the Administration on Aging to make available on-line LIS decision support tools that also screened for other needs-based benefits (including SSI, Medicaid, MSP, Food Stamps and state pharmacy programs).

LIS Enrollments To-Date

Estimates vary about precisely how many Medicare beneficiaries are actually eligible for LIS. According to the Congressional Budget Office (CBO), a total of 14.2 million people were estimated to be eligible for the LIS in 2006.[23] According to CMS, however, the total number of LIS eligibles is 13.2 million.[24] We have been unable to reconcile these estimates. It is likely that the differences are in large part due to data limitations regarding beneficiaries' assets.

CMS has also reported that 7.5 million beneficiaries were automatically signed up ("deemed") for the LIS and enrolled in a Prescription Drug Plan (PDP).[25] This includes dual eligibles—those eligible for both Medicare and full Medicaid—and others who were deemed because they participated in the Medicare Savings Programs (MSP) or received both Medicare and SSI. CMS further estimated that 500,000 beneficiaries eligible for the Part D LIS had creditable drug coverage from other sources.[26] Combining these two figures (7.5 million plus 500,000), we estimate that there were 8 million LIS eligible Medicare beneficiaries who did not need to voluntarily sign-up for the program, as they were either placed in the program automatically or had other creditable coverage.

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[21] "The Drug Benefit: A Report Card" The New York Times, June 5, 2006.

[22] CMS provided NCOA with $156,200 for this project in March 2006.

[23] *http://www.cbo.gov/showdoc.cfm?index=5668&sequence=2&from=0#F52* (Accessed December 20, 2006)

[24] Statement of Dr. Mark McClellan, M.D., Ph.D, before the House Ways and Means Committee, June 14, 2006. *http://waysandmeans.house.gov/hearings.asp?formmode=view&id=4992*

[25] Presentation by Abby Block, CMS Director of the Center for Beneficiary Choices, at the National Health Policy Forum, November 17, 2006. *http://www.nhpf.org/handouts/Block.slides_11-12-06.pdf*

[26] This includes Veterans Affairs, Indian Health Services, and wraparound coverage from State Pharmaceutical Assistance Programs (SPAPs). Statement of Dr. Mark McClellan, M.D., Ph.D before the House Ways and Means Committee, June 14, 2006. Testimony of CMS Administrator Dr. Mark McClellan, M.D., Ph.D before House Ways and Means Committee, June 14, 2006. *http://waysandmeans.house.gov/hearings.asp?formmode=view&id=4992* (Accessed December 14, 2006)

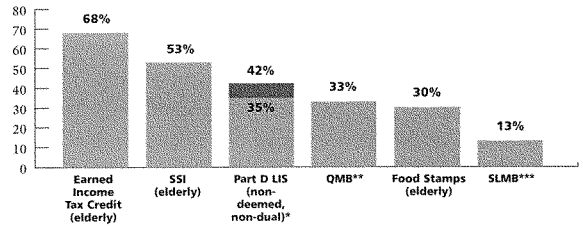
Based on this information, we conclude that there were a total of between 5.2 and 6.2 million low-income beneficiaries who were eligible for LIS, but would not receive it unless they applied for the benefit and SSA formally determined that they were eligible to receive it (13.2 or 14.2 million minus 8 million).

Recent information from SSA indicates that, of those initially able to voluntarily sign up for LIS, 2.2 million people applied for and were found eligible for the LIS in 2006.[27] **This leads us to conclude that between 35 and 42 percent of those eligible to voluntarily apply for the LIS successfully did so (2.2 million out of 5.2 or 6.2 million).** By historical standards, this take-up rate seems to on a par with or better than other means-tested federal benefit programs. [See Table 2 below]. On the other hand, it also means that 58% to 65% of all Medicare beneficiaries who are eligible for LIS and who have to apply to get LIS are not now receiving the benefit.

We also believe that there are two additional population groups that require more attention: LIS-eligibles in PDP and MA-PD plans and people who have lost their deemed status.

In September 2006, CMS announced that there were approximately 632,000 people who had been automatically receiving the LIS in 2006, but who

TABLE 2 **Participation Rates in Other Needs-Based Benefits Programs**



* A range of 35 to 42% is included for the Part D LIS because there are different estimates provided by CMS (13.2 million) and CBO (14.2 million) on the total number of Medicare beneficiaries eligible for LIS.

** QMB is one of the Medicare Savings Programs (MSP) that provides cost sharing assistance to those with incomes under 100 percent of the Federal Poverty Level (FPL).

*** SLMB is one of the MSPs. It provides cost-sharing assistance to those with incomes between 100 and 120 percent of the FPL

[27] Statement of Cheri Arnott, Associate Commissioner for External Affairs, Social Security Administration at the 2007 Families USA Conference on January 25, 2007 was that 2.3 million people have voluntarily filed applications with SSA. Because approximately 200,000 of the 632,000 people have regained eligibility for LIS in 2007 after losing their deemed status at the end of 2006, we are assuming that about 100,000 filed applications with SSA and 100,000 were found to be eligible based on regaining their Medicaid or MSP status.

were at risk of losing their deemed LIS status in 2007.[28] These are people who lost their Medicaid, MSP, or SSI coverage at some point during the year. In order to continue to be eligible for LIS in 2007, these people would need to voluntarily file an LIS application or regain their eligibility for the Medicaid, MSP or SSI programs. SSA sent a mailing to these beneficiaries and CMS has worked with plans to find and help them to regain their LIS benefit. According to the most recent figures available, we understand that roughly one-third of the 632,000 either regained their deemed status or successfully applied for LIS. Therefore, we estimate that approximately 400,000 beneficiaries lost their LIS benefit and still need to apply for LIS this year.

We are quite concerned about this remaining "undeemed" population, as most will be spending far more out-of-pocket for their prescription drugs than they did last year. For example, many may be paying a deductible for their drugs for the first time. Anecdotal reports indicate that many plans have granted a 60- or 90-day transition period, so a large number of these beneficiaries will not likely find out that they have lost their LIS benefit until March or April. We urge plans, CMS, and advocates to devote specific, additional resources to working together to contact this vulnerable and help them apply for LIS. Because this problem will reoccur every year, it is important to identify ways to minimize potential harm. For example, LIS recipients who will be losing deemed status should be screened for every other category of LIS before terminating their benefits.[29]

Based on the most recent government data, it appears there are 2.9 million people who never had any prescription drug coverage in 2006 who are eligible for and still not receiving LIS.[30] However depending on whether one uses the lower CMS or higher CBO projections, on the total number of LIS eligibles, we believe there may be several hundred thousand additional Medicare beneficiaries who are currently enrolled in MA-PD or PDP plans who may be eligible for and not receiving LIS.[31]

CMS's recent decisions to again grant a Special Enrollment Period and waive the Late Enrollment Penalty for the LIS population in 2007 are important steps that help set the stage for renewed LIS outreach and enrollment efforts. Taking into account the remaining "undeemed" population, and recognizing the continuing unresolved question of CMS vs. CBO estimates of the total qualified LIS population, we believe **there are between 3.4 and 4.4 million low-income Medicare beneficiaries who are eligible for, but still not receiving the LIS benefit.**[32] This is the target group for outreach efforts for the remainder of this year.

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[28] Telephone conversation with CMS, January 9, 2007.

[29] National Senior Citizens Law Center, "Medicare Part D for Low-Income Beneficiaries: Flaws and Fixes." Families USA Advocacy Conference, January 25, 2007.

[30] In June 2006, after the initial enrollment period had ended, CMS reported that 3.3 million eligible beneficiaries who had no prescription drug coverage were eligible for and had not signed up for the LIS. At that same time, SSA estimated that 1.8 million beneficiaries had successfully applied. We estimate that an additional 400,000 successfully applied between June and December (not including the 100,000 that signed up who we assume had previously lost their deemed status). Therefore it appears that there are 2.9 million still remaining Medicare beneficiaries with no prescription drug coverage who are eligible for but never signed up for LIS.

[31] Estimates on the number of beneficiaries in MA-PD and PDP plans who are eligible for and not receiving LIS range from 100,000 to 1.1 million.

[32] 2.9 million without any drug coverage, remaining 400,000 people who lost their deemed status for 2007, and between 100,000 and 1.1 million currently enrolled in plans who do not know they are eligible for LIS.

IV. Access to Benefits Coalition

The Access to Benefits Coalition (ABC) is comprised of national and community-based organizations dedicated to making sure that Medicare beneficiaries know about and make the best use of resources available to access their needed prescription drugs and reduce their prescription drug costs.[33] There are 104 national ABC members, including aging and healthcare organizations such as AARP, the National Alliance for Hispanic Health, and the Catholic Health Association of the U.S.; national charities such as Easter Seals; and groups representing patients and caregivers such as the Alzheimer's Association and the National Alliance for the Mentally Ill. In addition, faith-based and multicultural groups such as the National Counsel of Churches USA and the National Asian Pacific Center on Aging are committed to finding and enrolling low-income beneficiaries in the LIS. Established in 2004, the Access to Benefits Coalition has involved hundreds of community-based nonprofits through 42 local coalitions in 33 states and the District of Columbia, in educating and enrolling tens of thousands of beneficiaries in the Part D LIS and other prescription savings programs.[34]

ABC and its network of local organizations use powerful Web-based tools such as NCOA's BenefitsCheckUpRx decision support tool[35] and the Medicare Plan Finder[36] to help beneficiaries—as well as family caregivers and organizations who wish to assist them—to understand, apply, and enroll in public and private prescription savings programs. BenefitsCheckUpRx also helps determine if individuals qualify for the Medicare Part D Low-Income Subsidy or other prescription savings programs and allows them to apply for many of these programs online.

The Access to Benefits Coalition recommends a variety of legislative, administrative, and regulatory changes to the Part D LIS, now that the initial enrollment period is over, and we have an opportunity to look back and see what worked and what did not in the outreach and enrollment efforts for low-income beneficiaries. Making these changes will increase the number of LIS eligibles who enroll in the program and help fulfill the promise of the MMA to provide affordable access to life-saving prescription drugs to America's seniors and people with disabilities. We hope that these recommendations continue to fuel a dialogue among SSA, CMS, and their private-sector partners who all share the same goal of finding and enrolling as many eligible beneficiaries as possible in the LIS benefit.

The 2005 ABC Report "Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes" called on all major sectors of society—public, private, and voluntary—to collaborate to make the LIS program successful.[37] We recognize that reaching the LIS-eligible population continues to be a challenge; however, it is essential that all avenues are open to assuring that eligible beneficiaries are made aware of and are enrolled in this important benefit.

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[33] The ABC Goals are listed in Appendix A. *http://www.accesstobenefits.org/default.aspx.* (Accessed July 13, 2006)

[34] The nationwide ABC Coalitions are listed in Appendix B.

[35] *www.benefitscheckup.org*

[36] *www.Medicare.gov*

[37] "Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes." Access to Benefits Coalition, 2005 in conjunction with The Bridgespan Group. *http://www.accesstobenefits.org/library/pdf/ABC%20Report FNL62305.pdf* (Accessed June 27, 2006)

V. Recommended Legislative Changes

1. Eliminate the asset test because it is the single-most significant barrier to the Part D LIS for low-income seniors and people with disabilities.

Of the LIS applications filed with SSA, 41 percent are denied because the person is over the asset limits.[38] According to a report by the Congressional Budget Office, an estimated 1.8 million Medicare beneficiaries with incomes below 150 percent of FPL will not qualify for the additional assistance because their assets exceed the amount currently allowable.[39]

The asset test penalizes retirees who did the right thing by creating a modest nest egg to provide some security in their old age. People who manage to save a modest sum for retirement and still have very limited incomes should be encouraged and rewarded, not denied the extra help that they need. Half of the people who fail the asset test have excess assets of $35,000 or less.[40] These people tend to be older, female, widowed, and living alone. Often when the husband dies, the wife's income is significantly reduced, but she still has the modest assets that were accumulated during the marriage.[41]

In addition, the asset test is inherently discriminatory against people who rent their homes, instead of own them. People who own their home—regardless of its value—but have limited incomes can qualify for the Low-Income Subsidy. However, people who rent their home and have $20,000 in the bank to pay future rent or other expenses are disqualified from the program regardless of their low income. This policy is discriminatory because the person with the meager amount of cash in savings is automatically disqualified from the LIS benefit, while the person who has significantly more resources tied up in a house of any value is allowed to participate, even though both individuals have limited means and similar difficulty obtaining needed prescription drugs.

Removing the asset test from LIS eligibility requirements also would be beneficial to SSA, as verifying assets is extremely time consuming. According to a report by Marilyn Moon for the Kaiser Family Foundation, "The asset test also poses substantial administrative challenges. People are not routinely asked about this information for income tax or other purposes, for example. As a result, the intensity of effort needed to determine asset eligibility creates burdens for both government agencies and applicants themselves."[42] If the asset test were removed from eligibility requirements, SSA would spend significantly less work time per application determining eligibility.

If the asset test cannot be removed altogether from LIS consideration, the allowable asset amounts should be increased. A 2005 study conducted by Thomas Rice for the Kaiser Family Foundation found that the amount by which people exceed the current allowable asset limits is relatively small. According to the study, 13 percent of people who are over the asset limit exceed the limit by $5,000 or less and another nine percent of people exceed the limit by $5,000 to

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[38] Statement of Cheri Arnott, Associate Commissioner for External Affairs, Social Security Administration at the Families USA Conference January 25, 2007.

[39] *http://www.cbo.gov/ftpdocs/48xx/doc4814/11-20-MedicareLetter2.pdf* (Accessed July 6, 2006)

[40] Rice, Thomas and Desmond, Katherine. "Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test." The Henry J. Kaiser Family Foundation, April 2005.

[41] See Rice article at footnote 40.

[42] Moon, Marilyn, et. al. "Medicare Beneficiaries and their Assets: Implications for Low-Income Programs." The Kaiser Family Foundation, June 2002. *http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14149* (Accessed January 29, 2007).

$10,000. It is important to keep in mind that these people who exceed the asset limit were **income eligible** for the Extra Help.

Increasing the asset limit amount for the Low-Income Subsidy, as a first step, would make the benefit available to significantly more low-income people who desperately need additional assistance with paying for their prescription drugs. Also, enrollment for the LIS would provide low-income Medicare beneficiaries with coverage in the "donut hole."

2. Enact legislation to make the LIS Special Enrollment Period (SEP) and waiver of the Late-Enrollment Penalty (LEP) permanent.

We are grateful to CMS for creating a SEP to permit beneficiaries to apply for the LIS and enroll in a plan without experiencing a premium penalty after the May 15, 2006, deadline until the end of 2006. The SEP allowed advocates to continue to enroll LIS eligibles after the initial enrollment period had ended. We are also pleased that CMS recently announced it is extending the LIS SEP and LEP through 2007. However, we urge Congress to enact legislation that would make both the LIS SEP and waiver of the LEP permanent.

Under Medicare Part B,[43] low-income beneficiaries eligible for Medicare Savings Programs can enroll any time and are exempt from premium penalties. This is not the case under Medicare Part D. Treatment of the most vulnerable seniors and people with a disability should not vary so significantly within Medicare programs. The Part D rules should be made to be consistent with the Part B rules.

Finding and enrolling the LIS population will take time, as evidenced by Table 2, which shows that even after 40 years, large percentages of seniors who are eligible for important public benefits still are not receiving them. Low-income beneficiaries are least able to afford premium penalties, and if they are subject to financial punishment, they will never apply for the prescription drug assistance they need. To meet this continuing challenge, we need to reduce barriers, not impose them. Without a continuing Special Enrollment Period and waiver of the Late-Enrollment Penalty after 2007, efforts by government agencies, national organizations, and local nonprofit groups to find and enroll LIS-eligible individuals will be completely thwarted. Instead of imposing a penalty, we should be encouraging their efforts to reach out to this group, as LIS eligibles stand to gain the most from the prescription drug assistance. Failure to permanently extend the SEP and waive the LEP would effectively ensure that there will be no more progress made in helping low-income seniors and people with disabilities—a result that is wholly unacceptable.

3. Support organizations that use a person-centered approach to outreach, which has been shown to be one of the most efficient and effective ways to find and enroll LIS eligibles.

Finding and enrolling seniors and people with disabilities with limited resources in needs-based benefits programs has been a significant challenge for many years. We know that reaching everyone in this special population will take a great deal of time and energy. We strongly recommend that CMS and SSA provide additional financial resources to support national organizations and local community-based organizations, so they may continue the important grassroots, one-on-one work they have been doing during the initial enrollment period.

The Access to Benefits Coalition report *Pathways to Success: Meeting the Challenges of Enrolling Medicare Beneficiaries with Limited Incomes* states that the most effective projects involved in the study used a one-on-one "person-centered" approach.[44] We strongly encourage SSA and CMS to fund programs that have a person-centered approach to finding and enrolling LIS eligible seniors and people with disabilities. The study found that the average cost is approximately $100 per enrollment, although it may be somewhat higher as the remaining LIS beneficiaries are the most difficult to find. Additional resources also are needed to assist the approximately 400,000 people who were deemed eligible for LIS in 2006,

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[43] Medicare Part B is medical insurance that pays for doctor's services and other costs that are not paid under Medicare Part A (hospital insurance).

[44] "The most effective projects in this study used a one-to-one 'person centered' approach—one that provides personalized assistance from a trusted source, and takes a 'holistic' approach to the individual being enrolled." The Bridgespan Group, 2005.

but will not be automatically eligible for the benefit in 2007 because they are losing their deemed status.[45] These people will need to complete an application to determine their LIS eligibility for the upcoming calendar year. Concerted efforts should be made to reach out and assist this vulnerable group of people, who may not understand they are losing LIS benefits until they go to the pharmacy to refill their prescriptions or start receiving monthly bills in the mail. NCOA also believes there are a significant number of people who have enrolled in plans who do not know that they are eligible for LIS assistance. Both of these populations further illustrate the critical need for additional resources to find and enroll those eligible for, but still not receiving, LIS Extra Help.

The Older Americans Act (OAA) Reauthorization, which was signed into law on October 17, 2006, includes a new authorization for a National Center on Senior Benefits Outreach and Enrollment (NCSBOE). In §202 of the OAA, the Assistant Secretary is authorized to establish a National Center that will:

- Maintain and update Web-based decision support and enrollment tools and integrated, person-centered systems designed to inform older individuals about the full range of benefits for which the individuals may be eligible under federal and state programs;
- Utilize cost-effective strategies to find older individuals with greatest economic need and enroll the individuals in the programs;
- Create and support efforts for Aging and Disability Resource Centers and other public and private state and community-based organizations, including faith-based organizations and coalitions, to serve as benefits enrollment centers for the programs;
- Develop and maintain an information clearinghouse on best practices and cost-effective methods for finding and enrolling older individuals with greatest economic need in the programs for which the individuals are eligible;
- Provide, in collaboration with related federal agency partners administering the federal programs, training and technical assistance on effective outreach, screening, enrollment, and follow-up strategies; and
- Play a critical role in finding and enrolling the remaining seniors and people with disabilities who are eligible for, but not yet enrolled in, the Low-Income Subsidy.

Now that the National Center has been authorized, funding should be appropriated so that its work can begin and seniors across the country can be enrolled in needs-based benefits programs.

4. Do not require information about the cash surrender value of life insurance policies when determining LIS eligibility.

Through our ABC coalitions, we have heard a good deal of support for eliminating the cash surrender value of life insurance policies question from the LIS application. Beneficiaries often do not have this information and paperwork readily available, and they do not know how to get the information. Seniors and people with disabilities often plan for their families to use their life insurance benefit to pay for their final expenses—and thus they often are not willing to cash in their life insurance now and place an additional burden on their family members upon their death. Government programs should not encourage seniors and people with disabilities to liquefy what little assets they have to pay for their prescription drugs. The message seniors and people with disabilities are getting from the current life insurance policy question is that they are being penalized for saving and investing their money. Many seniors and people with disabilities invest in life insurance policies, so they can have a proper burial upon their death and would be unwilling to trade that for prescription drug coverage.

We believe that the Administration already has the authority to remove the cash surrender value from the LIS application. The rules for counting income and resources for LIS eligibility generally follow the rules for the SSI program administered by SSA.[46] An

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[45] Individuals are deemed eligible for LIS if they are a Medicare beneficiary and they receive either SSI or participate in one of the MSP programs (QMB, SLMB or QI-1). As stated previously, CMS has reported that one-third of the 632,000 people who lost their deemed status for 2007 have regained LIS eligibility.

[46] See Social Security POMS HI 03020.001, section C *https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0603020001!opendocument* (Accessed July 6, 2006)

important exception implemented for the LIS subsidy, however, is the elimination of non-liquid resources from consideration.[47] Non-liquid resources include such property as vehicles, farm equipment, and machinery. This significant deviation from the SSI rules strongly suggests that the Administration has the ability to deviate on the cash surrender value of life insurance question. Removing this question also would promote the goal articulated in the MMA of creating a simplified application form and process.[48] If the Administration does not already have the authority to deviate from the SSI rules, then Congress should pass legislation that would allow the Administration to deviate from the rules regarding the cash surrender value of life insurance policies.

5. Do not take the value of in-kind support and maintenance (ISM) into consideration when determining eligibility for the LIS.

Analogous to the cash surrender value of life insurance, we believe the Administration has the authority to disregard the value of in-kind support and maintenance when determining LIS eligibility. Again, if the Administration does not have the authority to deviate from the SSI rules on ISM, then Congress should address this issue in legislation giving the Administration the authority to do so.

We also have received a good deal of support from local ABC members for the removal of the ISM questions from the LIS application, as the questions are quite difficult to estimate due to the fact that the amount of in-kind support generally changes from month to month. The fluctuating amount of ISM makes it extremely difficult for the applicant to track. This difficulty discourages beneficiaries from applying for LIS and, therefore, is a barrier to enrollment. For many seniors and people with disabilities, their dependence on in-kind support would end if they were eligible for assistance with their prescriptions from the LIS. ISM can include the market value of food, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection fees given to the recipient by a third party. It is unreasonable to expect applicants for the Part D LIS to know how to calculate the fair market value of many of these items, particularly sewerage and garbage collection services. The unrealistic level of detail involved in calculating the value of in-kind support and maintenance is likely resulting in potentially eligible beneficiaries not filing LIS applications.

6. Do not count funds in retirement savings plans such as 401(k) accounts as assets, but do count distributions from such plans as income.

For the majority of people who are not covered by traditional defined benefit pension plans, the resources in their 401(k) and other retirement savings accounts represent their only retirement savings. Periodic distributions during retirement from 401(k) accounts often constitute the only income people have to supplement their Social Security benefits.

However, Social Security does not consider a person's pension (defined benefit plan) to be an asset when determining LIS eligibility. Pensions are only counted to the extent a person is actually drawing money from them. Forcing people to cash in their 401(k) plans to become eligible for LIS, therefore, is contrary to basic public policy, which encourages people to save for retirement. A number of advocacy groups have told us that as with traditional pension plans, distributions from 401(k) plans should be treated as income, but the funds in the account should not be treated as assets. Treating the two retirement vehicles differently is inconsistent and unfair to people whose primary planned retirement source is a 401(k).

> "While these retirement savings [401(k) plans] are intended to provide income over a long period of time…they are treated as assets for purposes of establishing eligibility, with interest and dividends treated as income. In contrast, the income from a defined benefit pension is captured in the income test, and the pension does not show up as an asset. In sum, two individuals may effectively have the same

[47] Nemore, Patricia et. al. "Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules." The Kaiser Family Foundation, May 2006. *http://www.kff.org/medicare/upload/7519.pdf* (Accessed July 6, 2006)

[48] See §1860D-14(a)(3)(E)(ii) of the Social Security Act. *http://www.ssa.gov/OP_Home/ssact/title18/1860D14.htm* (Accessed January 16, 2007)

income levels, but the person who controls his own assets will be made ineligible for help."[49]

We believe the Administration currently has the authority to treat funds in 401(k) plans the same as the funds in pension accounts, but if that is not the case, Congress should address the issue in legislation.

7. Index the co-payments and deductibles for people between 100 and 150 percent of the Federal Poverty Level to the Consumer Price Index (CPI—all items, U.S. city average), as it is more reflective of cost increases and, therefore, more closely mirrors beneficiaries' ability to pay.

LIS-eligible people with incomes below 100 percent of the FPL will have their prescription drug costs increased in 2007 according to the CPI (all items, U.S. city average).[50] Social Security implemented a cost-of-living adjustment of 3.3 percent in 2006[51] that corresponded to the CPI increase in that same year. Since the cost-of-living adjustment is in line with the co-payment increase, beneficiaries should continue to be able to afford the co-payments required to get their prescription drugs.

However, for LIS-eligible beneficiaries with incomes between 100 and 150 percent of poverty, their co-payments are increased according to the percentage increase in average per capita aggregate expenditures for covered Part D drugs in the U.S. for Part D eligible individuals, without regard to the amount of Social Security benefit increases.[52] For example, Part D co-payments for this group increased in 2007 at a rate of more than two times the CPI, from $2.00 to $2.15 for generics and from $5.00 to $5.35 for brand name drugs.[53] Therefore, the value of the benefit for people between 100 and 150 percent of the FPL diminishes significantly over time.

According to a study released by AARP, brand name drug prices increased 6.2 percent in the 12-month period ending March 31, 2006.[54] This disproportionate increase in Part D co-payments over the increase in Social Security benefits will become increasingly more burdensome to people living on fixed incomes over the coming years. As the years go on and prescription drug costs continue to rise, the disparity between the rise in drug costs and the increase in Social Security benefits will become even greater. According to the FY 2005 SSA Performance and Accountability Report, "Social Security benefits comprise 90 to 100 percent of the total income for one-third of the elderly beneficiaries; and for almost two-thirds of the elderly beneficiaries, it is their major income source (50 to 100 percent of their income)."[55] The co-payments and deductibles for people with incomes between 100 and 150 percent of FPL should be indexed to the CPI in the same way it is for people with incomes below 100 percent of FPL, to ensure that people can continue to afford their prescription drugs.

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[49] Moon, Marilyn, et. al. "Medicare Beneficiaries and their Assets: Implications for Low-Income Programs." The Kaiser Family Foundation, June 2002. *http://ihcrp.georgetown.edu/agingsociety/pdfs/1000249_MedicareBeneficiaries.pdf* (Accessed July 12, 2006)

[50] See §1860D-14(a)(4)(A)(i) of the Social Security Act. "The dollar amounts applied under paragraph (1)(D)(ii)—(i) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase in the Consumer Price Index (all items; U.S. city average) as of September of such previous year." *http://www.ssa.gov/OP_Home/ssact/title18/1860D14.htm* (Accessed January 16, 2007)

[51] SSA Cost of Living is generally equivalent to the Consumer Price Index for Urban Wages Earners and Clerical Workers (CPI-W). *http://www.ssa.gov/OACT/COLA/colaseries.html* (Accessed June 6, 2006)

[52] See §1860D-2(b)(6) of the Social Security Act. "The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." *http://www.ssa.gov/OP_Home/ssact/title18/1860D02.htm* (Accessed January 16, 2007)

[53] CMS Letter (Center for Medicaid and State Operations, Disabled and Elderly Programs Group) to State Medicaid Directors, December 18, 2006. *http://www.cms.hhs.gov/smdl/downloads/SMD121806.pdf* (Accessed January 16, 2007)

[54] AARP Public Policy Institute "Trends in Manufacturer Prices of Brand Name Prescription Drugs Used By Older Americans—First Quarter 2006 Update." June 2006. *http://assets.aarp.org/rgcenter/health/dd140_drugprices.pdf* (Accessed June 21, 2006)

[55] "Overview of the Social Security Administration" SSA's FY 2005 Performance and Accountability Report, page 9. *http://www.ssa.gov/finance/2005/Overview.pdf* (Accessed July 17, 2006)

8. Have the SSA screen LIS applicants for participation in the Medicare Savings Programs.[56]

State Medicaid offices are required to screen for MSPs when a person applies for the LIS. Unfortunately, the research has shown that most LIS applications are not filed at state Medicaid offices, but instead are processed by SSA.[57] Since SSA processes the vast majority of LIS applications, it should be required to screen for MSP eligibility at the time of the LIS application.

Implementation of this requirement is important for applicants because participation in any of the MSPs automatically qualifies a person to participate in the full LIS.[58] Since many states have income and asset limits for their MSP programs that are more liberal than the LIS limits, more people would be qualified to receive assistance under the LIS. Since SSA already is collecting income and asset information for the LIS application, it would be relatively easy for employees to screen for MSP eligibility at the same time.

We understand that SSA only can perform the tasks that are assigned to it and for which it is allocated resources. If necessary, Congress should enact legislation that would allow SSA to screen for MSP eligibility while it is processing LIS applications and provide corresponding funds to perform the job.

The National Academy of Social Insurance (NASI) released a report in June 2006 titled "Improving the Medicare Savings Programs."[59] This report argues that "Having SSA administer the Medicare Savings Programs would facilitate a national outreach effort, reduce the welfare stigma, and greatly simplify the application process, and may well be the prerequisite for achieving substantial increases in enrollment." Having both state Medicaid offices and SSA offices screen for MSP eligibility at the time of the LIS application will result in many more people becoming enrolled in the LIS.

9. Require the Internal Revenue Service (IRS) to assist SSA with tax-filing data, providing SSA with the names of Medicare beneficiaries who are likely eligible for the LIS to better target outreach efforts, while recognizing privacy concerns.

Currently, SSA does not have access to crucial IRS data that would allow it to better target its outreach for the Part D LIS. IRS data are used only for the purpose of verifying income and asset levels after an LIS application has been filed. The Administration should encourage the sharing of information more effectively among federal agencies for the purpose of reaching out to more potential LIS beneficiaries. This notion also is supported in the ABC "Pathways to Success" Report.[60]

The Health and Human Services Office of Inspector General issued a memo to CMS on November 17, 2006, expressing concern that CMS and SSA need more effective ways to identify potential LIS-eligible people.[61] The memo points out that data sharing among CMS, SSA, and the IRS already occurs under the Medicare Secondary Payer Program pursuant to §1862(b)(5) of the Social Security Act, enacted by the Omnibus Budget Reconciliation Act of 1989.[62] Congress should enact legislation that

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[56] For an explanation of MSPs, see footnotes 7 through 10.

[57] *http://www.kff.org/medicare/upload/7327.pdf* (Accessed June 21, 2006).

[58] The following states do not have any asset test for any of their MSP programs (QMB, SLMB or QI-1): Alabama, Arizona, Delaware, Maine, Mississippi, and Vermont. There is no asset test in Connecticut or New York for the QI-1 program only.

[59] National Academy of Social Insurance "Report of the Study Panel on Medicare/Medicaid Dual Eligibles: Improving the Medicare Savings Programs." June 2006. *http://www.nasi.org/usr_doc/Improving_the_Medicare_Savings_Programs.pdf* (Accessed June 21, 2006)

[60] See the 2005 ABC Report, "Pathways to Success," page 20. "Removing barriers to the sharing of information—including lists of program enrollees in accordance with appropriate policy safeguards—among federal and state agencies and with designated intermediaries to assist enrollment efforts in identifying those most likely eligible for the LIS."

[61] Department of Health and Human Services, Office of the Inspector General, November 17, 2006. *http://www.oig.hhs.gov/oei/reports/oei-03-06-00120.pdf* (Accessed November 28, 2006).

[62] According to the OIG memo, the sharing of information among these agencies is known as the "IRS/SSA/CMS Data Match."

would allow CMS and SSA to access critical income and resource data contained in IRS files, thereby allowing them to more accurately identify potential LIS eligibles. This information would allow these agencies to target their outreach and enrollment efforts and would result in increased enrollment in the LIS program.

In 2007, SSA will use information on gross income from prior tax filings to implement a means-tested system for the Part B premium for individuals earning more than $80,000. This data-sharing arrangement provides an appropriate precedent for using IRS data to better target outreach for LIS. IRS data can be used to identify the individuals most likely to fall below LIS income eligibility levels, including Medicare beneficiaries who have not filed tax returns because their income is below filing thresholds. This information will allow SSA to intensify outreach efforts by targeting the individuals most likely to qualify for the LIS.

The vast majority of people left to enroll in the Part D LIS are seniors and people with disabilities who have limited means. Strategic partnerships among federal agencies, such as SSA, CMS, and IRS, will allow for targeted outreach directly to these people who are most likely eligible for this important benefit. It is important that this sharing of data be done in a way that safeguards the privacy of the individual beneficiaries.

10. Enact a 30-day time limit for a decision to be rendered on all completed LIS applications.

In the interim, Social Security should internally implement a 30-day deadline for rendering a decision on all complete LIS applications. There should be a specific timeframe in place from the time SSA receives a completed LIS application to when a decision has to be made on the application. It is increasingly difficult for applicants, ABCs, and other community-based organizations to help clients and follow up with them, when they have no idea when their application will be processed. It is also difficult to know whether an application is pending, if it has been misplaced in the system, or if the application was ever received at all.

We urge SSA to internally implement a 30-day time limit for a decision to be rendered on all completed LIS applications. Having a time limit would be helpful to applicants and to third parties who assist applicants by allowing them to know when to expect a decision in their case. SSA should attempt to contact applicants via phone within the 30-day timeframe if it needs additional information to process the application before mailing the pre-decisional notice.

11. Mandate that prescription drug LIS assistance should not be counted when determining eligibility for other needs-based programs.

The Part D LIS provides significant financial assistance to low-income Americans in paying for needed prescription drugs. The effect of the Part D LIS is compromised, however, when reductions are made in other needs-based assistance, due to receipt of the LIS benefit. Congress should pass legislation to ensure that beneficiaries do not lose other needs-based benefits, such as food stamps, Section 8 housing, and Temporary Aid to Needy Families (TANF) on account of receiving LIS benefits.

Forcing seniors and people with disabilities to choose between the immediate need of their Section 8 housing and food stamp benefits and what they may perceive to be a more long-term need of their prescription drugs undermines the basic tenets of the LIS benefit. Not allowing the Part D LIS assistance to count against other needs-based benefits also supports the principle that Medicare was designed, in part, to help seniors and people with disabilities in paying for healthcare, so they were not impoverished by the cost. Congress should ensure that the benefits that a senior or a person with a disability gains under the Part D LIS are not offset by losing other needs-based benefits.

12. Create incentives to encourage Prescription Assistance Programs (PAPs) to continue providing free prescription drugs to eligible beneficiaries.

For many years, Medicare beneficiaries without prescription drug coverage have received prescription drugs for free or at a nominal cost through more than

150 Patient Assistance Programs sponsored by pharmaceutical companies. In 2003, those programs helped 6.2 million uninsured or underinsured patients obtain more than 17.8 million prescriptions.[63] It is estimated that in 2004, PAPs provided $4 billion in drugs to low-income beneficiaries.[64] Many of the programs provided free prescription drugs to patients with incomes up to 200 percent of poverty and higher, with no asset restrictions, thus serving a significant number of low-income beneficiaries in need who lacked sufficient drug coverage and were not eligible for the LIS or Medicaid.

Since the Part D program began in January 2006, many PAPs either terminated or significantly scaled back their programs due to fears of violating federal anti-kickback laws. Specifically, federal law prohibits people from offering or receiving remuneration to increase the use of a particular product at the expense of a federal healthcare program.[65] Many PAPs were concerned that providing prescription drugs to low-income people would be construed by the Office of the Inspector General (OIG), as violating these provisions. The OIG issued an opinion to prescription drug company Schering-Plough in April 2006 in which it approved the company's PAP as long as it operated "outside" of Part D and that it had stringent safeguards in place. This opinion was later interpreted to apply to other PAP programs.

Because PAPs provide such valuable service to low-income people, positive incentives should be created for companies to continue to provide this help. PAPs should be permitted to provide assistance within Part D. Specifically, Congress should permit PAPs to provide free drugs in the coverage gap, or "doughnut hole," and count an agreed-upon amount of the free or reduced cost prescription drugs toward the True Out-of-Pocket (TrOOP) limits.

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[63] Statement of NCOA President & CEO James Firman before House Ways and Means Committee on the implementation of the Medicare Drug Benefit, June 14, 2006. *http://waysandmeans.house.gov/hearings.asp?formmode=view&id=4997* (Accessed November 28, 2006)

[64] Wendy Krasner of Manatt, Phelps & Phillips at a presentation for the Novartis "Blue Skies and Brickwork II" Medicare Summit held September 19, 2006.

[65] See *Federal Register,* Volume 70, Number 224, p. 70625 (November 22, 2005).

VI. Recommended Administrative & Regulatory Changes

1. Make all outreach materials, instructions, applications, and subsequent correspondence from SSA available in at least three additional languages: Russian, Chinese, and Vietnamese. If the SSA budget allows, translate the LIS application into other common languages requested at SSA.[66] While we recognize that SSA has undertaken tremendous efforts to reach out to non-English speaking populations by making instructions and outreach materials in different languages, we are hopeful that we can continue this effort by working to make the application available in at least three additional languages—Chinese, Russian, and Vietnamese. SSA has made the application and instructions available in Spanish, and we are hopeful that it will do this for the other three most-requested languages at SSA for Retirement Claims.

The application should have a bold space near the top for individuals to indicate their language preference. All further correspondence and communication from SSA to that person should be in the designated language selected. People who do not speak English as their primary language have an especially difficult time applying for the LIS and enrolling in a Medicare Drug Plan. Social Security has recognized this problem and made the instructions available in a number of languages other than English. The next step is to make the application available in multiple languages. Currently, a person can read the instructions in their native language, but then must complete the actual application in English or Spanish. This disjointed process discourages people who speak languages other than English or Spanish from applying because it is clumsy, confusing, and difficult to use. Moreover, it is likely that this process increases the number of errors that are made on the application, which may result in applications being incorrectly denied and delayed.

To improve access to the LIS by Limited English Proficiency (LEP) applicants, Social Security should work expeditiously to ensure that applications are available in the languages of regularly encountered LEP groups. According to the SSA Web site, after English, the top four most-requested languages for assistance in Retirement Claims are: Spanish, Chinese, Russian, and Vietnamese.[67] Social Security should work, within budgetary constraints, to translate the LIS application and outreach materials into these languages. Having all of the LIS consumer materials available in multiple languages would help to improve access to the subsidy.

TABLE 3 Top Five Language Preferences for Retirement Claims for FY 03[68]

RETIREMENT CLAIMS	
Spanish	71,157
Chinese	7,441
Russian	3,694
Vietnamese	3,006
Other	2,581

[68] Source: *http://www.ssa.gov/multilanguage/LEPPlan2.htm*

Note: This chart does not include the Virgin Islands or Puerto Rico.

[66] Other commonly requested languages at SSA include, among others: Korean, Arabic, Armenian, Farsi, and Haitian-Creole. *http://www.ssa.gov/multilanguage/LEPPlan2.htm* (Accessed July 6, 2006)

[67] *http://www.ssa.gov/multilanguage/LEPPlan2.htm* (Accessed July 6, 2006) This report recommends using the same language groups as requested by Retirement Claims, as retirement claimants are a similar group to LIS applicants.

Making the instructions and applications available in, at a minimum, the languages most requested for Retirement Claims is also consistent with Executive Order 13166, which recognized the need for federal agencies to improve access to federally conducted programs and activities by people with LEP.[69] Subsequent Department of Justice (DOJ) memoranda on EO 13166 specified that "all federal agencies … must create or modify plans…to ensure meaningful access for LEP individuals to the important benefits, services, information, and rights provided by the agencies themselves."[70]

We understand that SSA has gone to great efforts to develop their optical scanning process to ensure an efficient application process. While we acknowledge that during the initial enrollment period, this has expedited the application process and reduced administrative costs, the need to make extra, specialized efforts to find and enroll the remaining, particularly difficult-to-reach population supersedes these concerns. Specifically, the benefit of making the LIS application available in the most frequently requested languages (other than English and Spanish) outweighs the additional time it may take to manually process these LIS applications.

2. Have each SSA field office employ at least one dedicated worker specifically assigned to process LIS applications, benefiting both the applicants and Social Security by streamlining the application process and providing expert assistance.

Because of the complexity of the LIS program, each local SSA office should have a worker who is dedicated solely to the processing of LIS applications and fielding questions pertaining to the program. An individual needs specialized skills and knowledge to efficiently assist people with LIS applications. A single point of contact would be helpful to both SSA and potential LIS beneficiaries. We recommend that, if possible, there also should be a back-up LIS designated worker at each office. The back-up designated worker would step in if the primary designated worker was on vacation, on sick leave, or if he or she left the local office.

Recognizing that some field offices have only limited staff on site, we recommend that in those cases there be a dedicated worker who covers a few offices or a particular region, depending on the circumstances of the area. ABC and NCOA would be happy to discuss potential options to come up with the most efficient and effective plan possible.

The SSA office would not have to spend considerable time and resources training all employees on the LIS program if there was one designated LIS worker and one back-up worker available to assist LIS applicants. This would allow for the designated SSA representative to become an expert in LIS and provide clients with prompt and accurate answers to their questions. A dedicated worker also would be useful to local community-based organizations that try to contact SSA to assist their clients. We have been receiving reports from ABC members that they have had problems getting a person from SSA on the phone in a timely fashion who could answer their questions accurately.

The model of the dedicated worker for a specific SSA program is not unfamiliar to SSA practice. Currently, local SSA offices have representatives who work solely on processing SSI applications and others dedicated to working on HIV/AIDS disability cases. This system is efficient, as the dedicated worker can become an expert in the field and can work directly with applicants to make sure they have all the information they need and that all the information is correct. Given the complexity of the LIS program, it would be very difficult for all SSA field office employees to know the particular details of the program. Having dedicated LIS employees allows SSA employees to become experts on the topic, eliminates confusion for the client, and strengthens trust between both parties.

3. Amend the LIS application to allow applicants to designate a third party to assist them through the LIS application process.

A person so designated should be able to obtain information from SSA regarding the LIS application, including status reports, and the designee should have the authority to provide information to SSA on

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[69] Executive Order 13166, Sec. 2. August 11, 2000. *http://www.usdoj.gov/crt/cor/Pubs/eolep.htm* (Accessed July 6, 2006)

[70] U.S. DOJ Memorandum, "Executive Order 13166 (Improving Access to Services for Persons with Limited English Proficiency) *http://www.usdoj.gov/crt/cor/lep/BoydJul82002.htm* July 8, 2002 (Accessed July 13, 2006)

behalf of the applicant. Since Medicare Part D began in January 2006, many applicants have sought out assistance from family members, friends, or local community-based organizations. These trusted individuals have helped with the LIS application and with the selection of a Prescription Drug Plan. Beneficiaries may prefer that this person continue to assist them by speaking with SSA on their behalf and acting as a liaison for them. As such, the LIS application should be amended to include a space for the applicant to designate a third party to assist them through the application process.

Under the current system, a third party often helps a person complete and file the LIS application, but is then unable to provide that applicant with any other information, assistance, or advocacy regarding the status of the LIS application. Third parties have encountered problems when applicants come back after the application has been filed and say they remembered something that should have been included, removed, or changed. Another problematic situation arises when individuals come back to the advocate who helped them file the application and say they have not heard from SSA for a long period regarding the application. Currently, clients are the only ones able to inquire about their status and communicate with SSA regarding their eligibility.

If an applicant designates a third party, such as a community-based organization, family member, or friend, that party should be able to interact fully with SSA on the applicant's behalf. SSA could amend the LIS application to include a sufficient consent for release of information, which would allow SSA to interact with a third party on behalf of the LIS applicant. For example, SSA currently uses the SSA-3288 to allow a person to consent to the release of information from SSA to a third party. Once this consent is released, SSA can provide personal information to the third party on behalf of the applicant, which would allow them to assist the applicant. We believe that the SSA-3288 can be amended and included on the LIS application to allow SSA to release information to a designated third party.

A designated third party appointed by the applicant also can be a benefit to SSA. Should SSA need more information from an applicant, contacting the third party can expedite the process. Additionally, should SSA need to explain something to the applicant, it can work quickly with the third party to troubleshoot any issue with the application. These issues vary significantly from region to region and from Social Security office to Social Security office. Allowing a person to be designated as a representative would make the LIS application process much more efficient and encouraging for both the applicant and SSA.

Allowing a third party to be designated also would encourage people to apply for LIS who might not otherwise do so. If beneficiaries knew they could get assistance throughout the entire process from a trusted third party, they would view the LIS application process more favorably.

4. Use both payment records and NUMIDENT[73] records when checking personal information for LIS applicants to ensure that assistance is not delayed to otherwise eligible beneficiaries or that they are not denied assistance because of incorrect information in the Social Security database.

Many applicants for the LIS use their Social Security check or statement to obtain information for the LIS application. Applicants often use the Social Security number, spelling of their name, address, etc., as it is printed on these documents, because they assume that the information is correct as listed. Under SSA's current system, when a person files an application for the LIS, his personal information is checked against the Social Security NUMIDENT records. If the person's application does not match these records, they are not able to apply online. If they are working with an informed advocate, the application is forwarded to a field officer who is charged with correcting the mismatch.

A person's information may not match the information in the SSA NUMIDENT records for multiple reasons. Widows may provide their deceased husbands' Social Security number because that is the number they use for Medicare benefits. Often, the error has to do with the spelling of the name on the Social Security check or statement that the applicant relied on. Another common error occurs around the use of middle names and initials that have been left

[73] NUMIDENT is an acronym used by Social Security to mean "Numerical Identification."

out of the application. Some applications with names of Asian descent have been delayed because SSA listed the order of their names incorrectly, entering the last name as the first, on the Social Security check or statement. Another complication has arisen since August 2006 when SSA began requiring information on a person's date of birth. We are finding that many immigrants' date of birth information does not match that on record with SSA. The Medicare Rights Center (MRC) has advised that as many as one in ten electronic applications has been delayed because an applicant's information did not perfectly match the general Social Security payment records and had to be mitigated with the SSA regional office before MRC could submit the application electronically.

Despite significant efforts, it has been shown that locating and filing applications for LIS eligibles have proven extremely difficult for SSA and local community organizations. The determination process should not be made more challenging because of an inability to input an individual's application information due to conflicting information in computer records. Having personal information checked against both SSA sources will ensure that otherwise eligible applicants are not unnecessarily delayed assistance or denied LIS benefits.

Under the current system, when people are unable to apply because of the information in the SSA computer records, they either believe they are not eligible and therefore miss out on the LIS benefit, or they need to challenge the information in the Social Security records. Without the assistance of a personal representative or advocate, however, many potential LIS beneficiaries may not know that they should challenge the information as listed. The current system creates more work for SSA because individuals may re-submit an LIS application and/or may work to have their information changed in the Social Security files. It would be far more efficient and expedient to have a system in place from the beginning that verifies information in all the available SSA databases for a correct match, rather than delaying an applicant the valuable LIS benefit based on faulty information in one database.

5. Maintain a link from the online LIS application to a Web page that provides seniors and people with disabilities—as well as their family members, friends, or advocates—state-specific information on other public benefits for which they may be eligible.

People applying for LIS assistance are likely eligible for other needs-based benefits programs. Having LIS applicants apply for other needs-based programs at the time they are applying for LIS is an effective and cost-efficient way to enroll more seniors in the needs-based benefits for which they are eligible. Technology that also links people to the LIS application after completing the application for other needs-based programs, such as food stamps, is also an efficient way to enroll more eligible seniors. The correlation rate between people who are eligible for LIS and other needs-based programs is high. The following chart illustrates the rate at which people who screened eligible for LIS are also eligible for other needs-based programs. [Table 4, next page]

SSA should create a link from the online application page to a Web page where the applicant, advocate, family member, or friend can learn about other available needs-based benefits programs and how to apply for them. In addition, SSA should provide state-specific information with the LIS decision letter on where applicants can go for other needs-based benefits. ABC and NCOA are looking forward to working with SSA to make this link work with the current SSA technology.

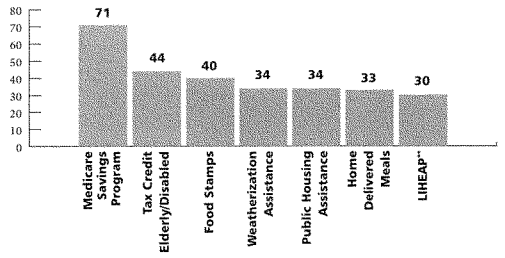
6. Rework the LIS application to provide further instruction and clarity to the applicant and to people who help the applicant on the questions of jointly owned assets and provide space for further explanations.

As currently written, the questions on assets are difficult for applicants and people assisting them to complete with regard to accounts that are owned by multiple people. The application should provide more detailed instructions about what qualifies as a joint

TABLE 4

Benefits Correlations[72]

Percent of those screening eligible for LIS who also screened eligible for listed benefit



[72] "Benefit correlations were calculated based on data obtained in the BenefitsCheckUp database between January 1 and March 31, 2005. Beneficiaries are screened in the BCU system either by themselves, by visiting *www.benefitscheckup.org*, or through a partner organization that uses BCU as its screening tool. This analysis examined the data entered by all BCU users in that time period, determined which ones would be eligible for the LIS, then compared the individual's profile against the eligibility requirements for the various benefits that are listed." Source: Benefits Check-Up at *http://www.accesstobenefits.org/Helpful%20Resources/Reference%20Room/documents/ABCReportFNL62305.pdf*

**LIHEAP is the Low-Income Home Energy Assistance Program

asset for both single and married beneficiaries and how this is to be indicated on the LIS application. The questions on the current application make it very difficult for someone with a limited education to complete accurately. The LIS application also should include space for applicants to add any explanations they feel are needed. For example, jointly owned assets may be exempt if the applicant is unable to dispose of them within the specified time period.

The LIS application should provide space for applicants to explain why certain assets may be exempt. Assets that cannot be converted to cash within 20 days are not counted[73]—it would be much more efficient for the applicant to be able to explain this to SSA from the outset. The current LIS application requires applicants to include the value of these assets, but provides no space to explain the asset and rebut the presumption that the assets should be counted. Not having clear instructions as to what counts as an asset results in many LIS applicants being denied who should not have been. The beneficiary not only experiences a delay in accessing affordable medication, but has the added responsibility to file an appeal in order to justify eligibility. Time and resources can be saved for both applicants and SSA if applicants have the opportunity to provide an explanation at the time of filing their application.

We understand that SSA has been using an LIS application that can be optically scanned in order to make the application process as streamlined and effi-

[73] SSA Programs Operations Manual (POMS) § HI 03030.001

cient as possible. We appreciate SSA's efforts on this front, but believe that now that the initial enrollment period has ended, we need to be increasingly responsive to the special needs of the remaining beneficiaries left to enroll. Providing these individuals with additional incentives to apply—namely an application form that better meets their particular needs—will result in the enrollment of more of the LIS eligible beneficiaries.

7. Have SSA and state Medicaid offices inform people who are denied LIS benefits due to excess resources, but who are income eligible for LIS assistance, that they might want to see a community-based organization or legal services group about steps they could take to become eligible for LIS.

As stated earlier, many people have incomes low enough to qualify for the LIS, but are denied desperately needed assistance with their prescription drugs due to excess resources. When SSA or the state Medicaid office determines that an applicant is not eligible for LIS due to excess resources, the agency should refer the applicant to an outside organization that could advise the applicant of acceptable ways to dispose of the resources to become eligible for LIS. If applicants knew that they could spend their excess assets on certain allowable expenditures to become eligible for LIS or convert their liquid resources into non-liquid resources, many more people may use these suggestions and, in turn, would qualify for the program. As each person's situation would be unique, the community-based counselor or legal services group could counsel individuals as to what would be best for their situation. For example, individuals could be informed that if they needed to renovate their kitchen or repair their roof, they could do so within the Part D LIS eligibility rules without the expenditure affecting their LIS eligibility.

Currently, an applicant can affirmatively request a referral from SSA for a local community-based organization or legal services group for counseling. We believe that many more people would be served if SSA automatically included this referral information with the decision letter—instead of waiting to be asked—so that everyone would benefit from the available referrals.

8. Rewrite the paragraph immediately preceding the signature section on the LIS application so that it is less intimidating and threatening.

The LIS application should be rewritten to remove the language, "I/We understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both." NCOA has received feedback from ABC members that many seniors and people with disabilities are reluctant to sign the application with this harsh statement. LIS applicants feel that if they write something down incorrectly or mistakenly, they may face the possibility of going to prison.

SSA can rewrite the section so that it still achieves its objective—deterring false information—while at the same time not intimidating people away from applying for benefits. The SSA regulations only require an attestation under penalty of perjury regarding the level of assets or resources.[74] There is no language in the regulations that requires the application form to include the threat of imprisonment for providing knowingly false or misleading information. Other government forms have penalty of perjury sections that are not nearly as dense and legalistic as the one on the LIS application. For example, the IRS 1040 form simply states, "Under penalties of perjury, I declare that I have examined this return and its accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete."[75] This statement is a reasonable protection for making sure that people provide accurate information, yet at the same time does not discourage Medicare beneficiaries from applying for LIS benefits for fear of incarceration.

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[74] See §1860D-14(a)(3)(E)(iii) of the Social Security Act. *http://www.ssa.gov/OP_Home/ssact/title18/1860D14.htm* (Accessed January 16, 2007)

[75] IRS 1040 *http://www.irs.gov/pub/irs-pdf/f1040.pdf?portlet=3* (Accessed August 2, 2006)

9. Shorten and simplify the decision letter SSA sends to LIS applicants to assist beneficiaries who may have difficulty comprehending long documents.

The ABC is concerned that the current letter[76] SSA sends to LIS applicants informing them whether they qualify for the LIS is unnecessarily complicated and not user friendly. A good number of the people who receive the current decision letter are unable to read it due to factors such as limited education or mental health problems. The letter should be rewritten so that someone at a fourth-grade reading level can understand it.[77]

For example, the letter should clearly state near the beginning that individuals could reapply for the program at any time if they feel their situation has changed. Without that being clearly stated, many people do not know that they should reapply for the program in the future.

Furthermore, the reasons a person was denied LIS assistance should be clearly listed in the letter SSA sends. Simply stating that a person's income is over 150 percent of the FPL is not helpful to most people. It would be more helpful to explain the applicant's income and resources and why either their income or resource levels have made them ineligible for the Part D LIS. The decision letter should be treated as an opportunity to educate people and serve as a guide for future contact with the program. Providing a clear explanation to beneficiaries eliminates confusion and frustration, enabling them to understand why they are not currently eligible for LIS benefits, but how they may become eligible in the future. The letter currently does not accomplish this because most people have difficulty understanding what it means. ABC and NCOA would appreciate the opportunity to provide detailed comments about how the initial decision letter and the appeals decision letter can be revised to make them more accessible and useful to more people.

10. Amend the LIS application and allow space at the end, but before the signature, for applicants to write any further explanation they feel necessary.

Both the online and paper applications for the LIS should provide space at the end of the application (but before the signature) for an applicant to provide explanations to questions they feel they need further clarification. On other applications and forms, SSA allows space for the person filling out the form to provide additional information. The SSA-632 "Request for a Waiver of Overpayment" has a section at the end entitled "Remarks," allowing individuals to write in any further information they deem necessary. Providing the same opportunity on the LIS application should not prove to be administratively burdensome.

We understand that SSA is concerned with keeping the LIS application in an optically scannable form. However, as stated earlier, the remaining LIS eligibles are a distinct number of people who need additional attention and who would benefit from an application that more closely meets their specific needs. In terms of adding time to SSA employees by requiring them to manually review applications with handwritten notes, we believe this time will be minimal, as not everyone will include explanations. It also will save time by requiring fewer appeals because people can present necessary information at the time of application. If individuals have an opportunity to explain their situation on the original application, there will be less of a chance of them needing to appeal a decision that was not based on their complete circumstances.

Because applicants must sign the application under penalty of perjury, many seniors and people with disabilities are uncomfortable sending in the application without having the opportunity to fully explain their answers. Providing beneficiaries the opportunity to explain their circumstances will help encourage them to apply and will streamline the process for SSA by cutting down on unnecessary appeals.[78]

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[76] An example of the current decision letter issued by SSA is attached as Appendix D.

[77] See *http://www.epic.org/privacy/glba/vtlutz.pdf* Statement of William Lutz, professor of English and expert on language. "To ensure that a mass audience can understand a document, literary experts recommend that a document be written as low as the fourth grade level." (Accessed June 8, 2006)

[78] The LIS application is included in Appendix C.

11. Provide states with asset and income data that allow state Medicaid offices to screen and enroll Medicare beneficiaries in Medicare Savings Programs.

Currently, SSA only plans to provide states with "leads data" on LIS applicants. The leads data include information such as names and mailing addresses, income as a percentage of the Federal Poverty Level, whether the income is for an individual or couple, and whether assets are above or below LIS limits.[79] Because states have varying asset and income criteria for MSPs, the leads data does not provide the states with sufficiently detailed income and asset information to determine MSP eligibility. A 2006 report by the Medicare Rights Center argues that the lack of specificity in the available data limits its value for state outreach efforts for MSPs which, like other needs-based benefits, also remain significantly undersubscribed after many years. Legal analysis shows that privacy concerns should not prevent SSA from sharing income and asset data that is more detailed.[80] If SSA still has privacy concerns, it also could include language on the LIS application informing people that it will share information with the states to assist them in determining eligibility for MSP programs. AARP suggests that the LIS application include language such as, "Information may be shared with your state to see if you are eligible for extra help through state programs that help pay Medicare bills. State officials may contact you if additional information is needed for this."

If SSA were to provide more detailed leads data to states, the states would be able to determine MSP eligibility using the SSA-provided information without receiving an application from a potential beneficiary. This would increase participation in the various MSPs, which historically have been undersubscribed and also increase the number of people eligible for the LIS benefit. Again, information should only be shared between SSA and the states in a manner that ensures its safety and privacy.

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[79] For a discussion of how data from SSA could help states enroll more people in the MSPs, see The State Solutions Report by the Medicare Rights Center section entitled, "Overcoming Privacy Concerns: How Applicant Data for the Part D Low-income Subsidy Can Boost Enrollment in Medicare Savings Programs" State Solutions, May 2006. *http://www.statesolutions.rutgers.edu/Reports/Overcoming%20Privacy%20Concerns.pdf* (Accessed June 19, 2006)

[80] See above report

VII. Conclusion

The Medicare Modernization Act, with the Part D prescription drug coverage and corresponding Low-Income Subsidy, promised to provide improved access to prescription drugs for seniors and people with disabilities. Great strides have been made to provide drug coverage to the 43 million Medicare beneficiaries, yet for millions of beneficiaries with limited income and resources, the promise has not been fully realized.

Despite the commendable efforts by SSA and CMS, a great deal more must be done to reach out to and sign up the 3.4 to 4.4 million people remaining who are eligible for the LIS—comprised of those with no drug coverage, those people who lost and still have not regained their deemed status in 2007, and those LIS eligibles who we believe are enrolled in plans but do not know they are eligible for the subsidy. Finding and helping beneficiaries with limited means apply are essential to the overall success of the program, because they can least afford the prescription drugs they need and as such, stand to gain the most from the benefit.

Removal of the asset test is critical to increasing enrollment in the LIS, as people with very low incomes are being denied desperately needed assistance with their prescription drugs. Other barriers to enrollment should also be eliminated, such as permitting LIS eligibles to apply for LIS and choose a plan without penalty at any time. In addition, funding the nationwide network of enrollment centers as authorized in §202 of the Older Americans Act will lead to significantly more LIS eligibles enrolling in the program.

Needed improvements will only come to the Part D LIS if members of Congress, SSA, CMS, and advocates across the country join together this year in a collective "call to action" to make improvements to the program and invest in proven strategies to find and enroll the remaining LIS eligibles. Greater, more targeted efforts must be focused on this goal. We urge lawmakers and Administration officials to carefully consider the proposals in this paper, which will ensure greater access to this needed assistance for people with limited means. ABC and NCOA encourage CMS and SSA to continue their commitment to improving the LIS and ensuring that concerns of vulnerable, low-income seniors and people with disabilities are a top priority. We urge the corporate and philanthropic sectors to increase their investments in this area. We also challenge our fellow advocates to renew and strengthen their efforts to improving access to benefits for this population in greatest need.

APPENDIX A: Goals of the Access to Benefits Coalition

The goal of the Access to Benefits Coalition is to quickly and measurably educate Medicare beneficiaries with limited incomes, help them make informed choices about Medicare Prescription Drug Coverage, and assist them in applying for Extra Help if they qualify. The Coalition accomplishes its goals through:

- Developing and using the best-available knowledge from the public and private sectors about best practices and cost-effective strategies for reaching and enrolling Medicare beneficiaries with limited incomes and resources;
- Activating and supporting nationwide community education and outreach, focused on reducing confusion and providing beneficiary support in decision-making and enrollment;
- Developing and implementing public information and outreach campaigns;
- Developing a robust decision-support tool to help consumers make optimal choices; and
- Mobilizing widespread support and participation in national, state, and local Access to Benefits Coalitions.

Source: *http://www.accesstobenefits.org/About%20Us/*

APPENDIX B:
List of Nationwide ABC Coalitions

There's still time.

People who qualify for the Extra Help through the Medicare Prescription Drug Coverage can join a Medicare drug plan anytime between now and December 31, 2006.

We Can Help.

Those who qualify for the Extra Help through the Medicare Prescription Drug Coverage (also called Medicare Part D) now can sign up for a Medicare drug plan without penalty before the end of 2006. This Extra Help from Medicare pays for 95 percent of a beneficiary's drug costs on average.

The Access to Benefits Coalition helps seniors and younger people with disabilities get access to the prescription coverage they need, including the Extra Help available from Medicare. The coalition includes more than 100 national members and hundreds more community-based organizations in more than 42 coalitions in 33 states and the District of Columbia.

ABC helps people with Medicare find out if they qualify for the Extra Help and enroll in the prescription coverage that makes sense for them. Using ABC's sophisticated web-based technology, trusted local organizations in communities across the country provide one-on-one counseling and enrollment assistance to tens of thousands of Medicare beneficiaries with limited incomes and resources. (Visit **www.BenefitsCheckUp.org** to see the web-based services ABC provides.)

See reverse for listing of ABC Coalitions.

Join us in finding Extra Help and drug coverage for those who need it most.

www.AccesstoBenefits.org

42 Coalitions Nationwide

Local and state ABC coalitions are working to educate and enroll Medicare beneficiaries with limited incomes in the Extra Help available through the Medicare Prescription Drug Coverage, as well as other public and private prescription savings programs.

CONTACT YOUR LOCAL COALITION.

ALABAMA
TARCOG Area Agency on Aging
Huntsville: (256) 830-0818

ARIZONA
Governor's Office for Children, Youth and Families
Phoenix-Tucson: (520) 628-6582

CALIFORNIA
City of Los Angeles Dept of Aging
Los Angeles County: (213) 252-4043

Council on Aging
Orange County: (714) 560-0424

Consumer Center for Health, Education & Advocacy
San Diego: (619) 471-2612

Senior Action Network
San Francisco/Oakland: (415) 546-2088

COLORADO
Senior Benefits Program St. Anthony Hospitals
Denver: (303) 899-5581

DISTRICT OF COLUMBIA
IONA Senior Services
Washington DC: (202) 966-1055

FLORIDA
Area Agency on Aging of Pasco/Pinellas
St. Petersburg/Clearwater: (727) 570-9696 ext 234

Senior Resource Alliance
Orlando: (407) 228-1836

Area Agency on Aging of Palm Beach/Treasure Coast
Palm Beach/Boca Raton: (888) 688-1211

West Central Florida Area Agency on Aging
Tampa: (813) 740-3888 ext 245

GEORGIA
Atlanta Regional Commission, AAA
Atlanta: (800) 669-8387

IOWA
Heritage Area Agency on Aging
Cedar Rapids: (319) 398-5559

ILLINOIS
Area Agency on Aging of SW Illinois
Belleville & St Louis, MO: (618) 222-2561

Age Options
Oak Park: (708) 383-0258

INDIANA
IAAAA Education Institute
Indianapolis: (317) 598-9300

KENTUCKY
Green River Area Development District
Owensboro: (800) 928-9094

LOUISIANA
The New Orleans Council on Aging/SenioRx
New Orleans: (888) 922-8322

MASSACHUSETTS
Action for Boston Community Development, Inc.
Boston: (617) 357-6000

MARYLAND
Baltimore City Commission on Aging and Retirement Education
Baltimore: (410) 396-4932

MAINE
Legal Services for the Elderly
(Statewide): (207) 621-0087

MICHIGAN
Detroit Area Agency on Aging
Detroit: (313) 446-4444

MINNESOTA
Minnesota Senior Federation
Minneapolis-St. Paul: (651) 783-5005

MISSISSIPPI
Mississippi Department of Human Services
(Statewide): (601) 359-4836

MISSOURI
Area Agency on Aging of SW Illinois
St Louis & Belleville, IL: (618) 222-2561

MONTANA
Missoula Aging Services
Missoula: (406) 728-7682

NEW HAMPSHIRE
New Hampshire Health Insurance, Counseling, Education & Assistance Services
Concord: (800) 852-3388

NEW YORK
Medicare Rights Center
New York: (888) 795-4627

NORTH CAROLINA
Seniors' Health Insurance Information Program
Raleigh: (919) 807-6900

OHIO
Central Ohio Area Agency on Aging
Columbus: (800) 648-1176

Cleveland Dept. of Aging
Cleveland: (216) 421-1350 ext 182

Area Office on Aging of Northwestern Ohio
Toledo: (800) 472-7277

OKLAHOMA
LIFE Senior Services, Inc.
Tulsa: (918) 664-9000

OREGON
Clackamas County Social Services
Oak Grove & Clark County, WA: (503) 653-8427

PENNSYLVANIA
CARIE
Philadelphia: (215) 545-5728 ext. 233

SOUTH CAROLINA
Santee-Lynches Area Agency on Aging
Sumter: (803) 775-7381

TENNESSEE
Knoxville-Knox County Community Action Committee Office on Aging
Knoxville: (865) 524-2786

TEXAS
Bexar Area Agency on Aging
San Antonio: (210) 362-5307

Area Agency on Aging of Harris County
Houston: (713) 794-9069

UTAH
Salt Lake County Aging Services
Salt Lake City: (801) 468-2483

VIRGINIA
Senior Services of Southeastern Virginia
Norfolk: (757) 962-9207

WASHINGTON
Clackamas County Social Services
Clark County & Oak Grove, OR: (503) 653-8427

WEST VIRGINIA
West Virginia Primary Care Association
(Statewide): (304) 346-0032

Detailed contact information can be found at:

www.AccesstoBenefits.org

APPENDIX C:
LIS Application Form

Social Security Administration
Important Information

THIS COVER LETTER IS FOR INFORMATION ONLY.
DO NOT COMPLETE THE FOLLOWING PAGES.
THIS IS NOT AN APPLICATION.

You may be eligible to get extra help paying for your prescription drugs.

The Medicare Prescription Drug program began on January 1, 2006. The program gives you a choice of prescription plans that offer various types of coverage.

You may be able to get extra help to pay for the annual deductible, premiums and co-payments related to the Medicare Prescription Drug program.

But before we can help you, **you must fill out the application, put it in the enclosed envelope and mail it today.** Or you may complete an online application at **www.socialsecurity.gov**. We will review your application and send you a letter to let you know if you qualify for extra help. We also will send you information about the Medicare Prescription Drug program. To use the extra help, you must enroll in a Medicare Prescription Drug plan.

If you need help completing the application, call Social Security at **1-800-772-1213** (TTY **1-800-325-0778**). You can find more information at **www.socialsecurity.gov**.

If you need information about the Medicare Prescription Drug program, call 1-800-MEDICARE (TTY 1-877-486-2048) or visit **www.medicare.gov**.

Mail your application today. We will give you a decision about whether you qualify for the extra help.

Jo Anne B. Barnhart
Commissioner

Form SSA-10208-OCR-SM-INST (12-2006)

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

General Instructions for Completing the Application for Help with Medicare Prescription Drug Plan Costs

To Provide Extra Help in Paying for Your Drug Expenses

Do you (or the person you are helping apply) have Medicare and Supplemental Security Income (SSI) or Medicare and Medicaid or does your state pay your Medicare premiums?

If the answer is **YES, do not complete this application because you automatically will get the extra help**. You will receive another letter about how you will receive the extra help. If the answer is NO or NOT SURE, please complete this application. Please read the following instructions and guidelines before completing this application. Complete all questions unless otherwise noted.

How To Complete This Application

- Use **BLACK INK** or a **#2 pencil**;
- Keep your numbers, letters and Xs inside the boxes; use only **CAPITAL** letters;
- Do not use dollar signs when entering money amounts. The dollar sign is preprinted; and
- Cents can be rounded to the nearest whole dollar.

EXAMPLE

Put an X in the box. DO NOT fill in or use check marks in boxes.

X CORRECT | INCORRECT

EXAMPLE

Use capital letters when entering answers A B C D

If You Are Assisting Someone Else With This Application

Answer the questions as if that person were completing the application. You must know that person's Social Security number and financial information. Also, complete Section B on page 6.

Completing Your Application

You may complete the online application at **www.socialsecurity.gov** or use the enclosed pre-addressed stamped envelope to return your completed and signed application to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1020
Wilkes-Barre, PA 18767-9910

Return the entire package in the enclosed envelope. Do not include any attachments. If we need more information, such as statements from financial institutions, we will contact you.

If You Have Questions Or Need Help Completing This Application

You can call us toll-free at **1-800-772-1213**, or if you are deaf or hard of hearing, you may call our TTY number. **1-800-325-0778**.

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

Form Approved
OMB No. 0960-0696

Application for Help with Medicare Prescription Drug Plan Costs

THIS DOES NOT ENROLL YOU IN THE MEDICARE PRESCRIPTION DRUG PROGRAM.

FOR OFFICIAL USE ONLY

State code: WBDOC Exception:

1. Applicant's Name (Print each letter in a separate box.)

FIRST NAME **MI**

LAST NAME **SUFFIX (Jr., Sr., etc.)**

APPLICANT'S SOCIAL SECURITY NUMBER **APPLICANT'S DATE OF BIRTH (MM-DD-YYYY)**

2. If you are **married and living with your spouse**, please provide the following information for your spouse. If you are not currently married or you do not live with your spouse, skip to question 3.

FIRST NAME **MI**

LAST NAME **SUFFIX (Jr., Sr., etc.)**

SPOUSE'S SOCIAL SECURITY NUMBER **SPOUSE'S DATE OF BIRTH (MM-DD-YYYY)**

If your spouse has Medicare, does he or she also wish to apply for the extra help? **YES** **NO**

3. If you are single, a widow(er) or your spouse does not live with you, are your savings, investments and real estate (other than your home) worth more than $11,710? If you are married and living together, are they worth more than $23,410? Include the things you own by yourself, with your spouse or with someone else. **Do not include your home, vehicles, burial plots or personal possessions.**

YES If you put an X in the **YES** box, **STOP**. You are not eligible for the extra help and you do not need to return this application to us. If you need a letter with this decision, sign the application on page 6 and return it to us.

NO or NOT SURE If you put an X in the **NO** or **NOT SURE** box, complete the rest of this application and return it to us.

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

If you put an X in the NO or NOT SURE box in question 3, answer all of the following questions. If you are married and living with your spouse, you must answer all of the questions for both of you.

4. Please enter the money amounts of bank accounts, investments or cash that either you, your spouse (if married and living together) or both of you own in the boxes below. Include items that either of you own with another person. (Include only the dollar figures, not the account number.) If you or your spouse (if married and living together) do not own an item listed, either separately, jointly or with another person, place an X in the **NONE** box.

• Bank accounts (checking, savings and certificates of deposit)	☐ **NONE**	$ ☐ , ☐ . ☐
• Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	☐ **NONE**	$ ☐ , ☐ . ☐
• Any other cash at home or anywhere else	☐ **NONE**	$ ☐ , ☐ . ☐

5. Do you own life insurance policies with a total face value of more than $1,500? Answer for you and for your spouse if your spouse lives with you. If you answered **NO** for both you and your spouse, go to question 6.

YOU: ☐ **YES** ☐ **NO**

SPOUSE (if living together): ☐ **YES** ☐ **NO**

If you answered **YES** for either of you, how much money would you get if you turned in your policies for cash right now? Enter the amount. If you answered YES for both you and your spouse, enter the combined amount. (This is not the face value of your policies. You may need to call your insurance company to help answer this question.)

$ ☐ , ☐ . ☐

6. Do you expect to use money from any of the sources listed in questions 4 or 5 to pay for funeral or burial expenses?

YOU: ☐ **YES** ☐ **NO**

SPOUSE (if living together): ☐ **YES** ☐ **NO**

7. Other than your home and the property on which it is located, do you (or your spouse, if married and living together) own any real estate?

☐ **YES** ☐ **NO**

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

8. Your household size may affect the amount of help you can get. Therefore, we need to know how many relatives who live with you (and your spouse, if married and living together) depend on you or your spouse to provide at least one-half of their financial support. Relatives may include anyone related to you by blood, marriage or adoption.

How many relatives who live with you and your spouse depend on you or your spouse to provide at least one-half of their financial support? **Do not include yourself or your spouse in this number.** (Place an ☒ in only one box.)

☐ NONE ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 or more

9. If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **total MONTHLY income. If the amount changes from month to month or you do not receive it every month, enter the average monthly income for the past year for each type** in the appropriate boxes. Do not list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you or your spouse do not receive income from any of the sources listed below, place an ☒ in the **NONE** box.

		Monthly Benefit
• Social Security benefits (before deductions)	☐ NONE	$ ☐ , ☐ . ☐
• Railroad Retirement benefits (before deductions)	☐ NONE	$ ☐ , ☐ . ☐
• Veterans benefits (before deductions)	☐ NONE	$ ☐ , ☐ . ☐
• Other pensions or annuities (Do not include money you receive from any item you included in question 4.)	☐ NONE	$ ☐ , ☐ . ☐
• Other income not listed above, including alimony, net rental income, workers' compensation, etc. (Specify): _____	☐ NONE	$ ☐ , ☐ . ☐

10. Have any of the amounts you included in question 9 decreased during the last two years?

☐ YES ☐ NO

11. Does anyone provide or help you (or your spouse, if married and living together) pay for any of the following household expenses — food, mortgage, rent, heating fuel or gas, electricity, water and property taxes? (**Do NOT include** food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels or help with medical treatment and drugs.)

☐ YES ☐ NO

If you put an ☒ in the **YES** box, enter the monthly amount or, if the amount changes from month to month, enter the average monthly amount for the past year. $ ☐ , ☐ . ☐

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

If you have worked in the last two years, you need to answer questions 12-16. If you are married and living with your spouse and either one of you has worked in the last two years, you need to answer questions 12-16. Otherwise, sign the application on page 6 and return it to us.

12. What do you expect to earn in wages before taxes **this year**?

YOU: ☐ **NONE** $ ☐ , ☐ . ☐

SPOUSE (if living together): ☐ **NONE** $ ☐ , ☐ . ☐

13. What do you expect your net earnings or loss from self-employment to be **this year**?

Put an ☒ in **NONE** if you are not self-employed.

YOU: ☐ **NONE** $ ☐ , ☐ . ☐

SPOUSE (if living together): ☐ **NONE** $ ☐ , ☐ . ☐

Put an ☒ here if you or your spouse expect a net loss. **YOU:** ☐ **SPOUSE (if living together):** ☐

14. Have the amounts you included in questions 12 or 13 decreased in the last two years?

☐ **YES** ☐ **NO**

15. If you or your spouse (if married and living together) stopped working in 2006 or 2007, or plan to stop working in 2007 or 2008, enter the month and year.

EXAMPLE

For January – September, put a zero (0) in the first box. May 2007 should read: 0 5 2 0 0 7 (M M Y Y Y Y)

YOU: ☐ ☐ (M M) 2 0 ☐ ☐ (Y Y Y Y)

SPOUSE : (if living together) ☐ ☐ (M M) 2 0 ☐ ☐ (Y Y Y Y)

If you are younger than age 65, answer question 16. If you are married and living with your spouse and either one of you is younger than age 65, answer question 16. Otherwise, sign the application on page 6 and return it to us.

16. Do you or your spouse (if married and living together) have to pay for things that enable you to work? We will count only a part of your earnings toward the income limit if you work and receive Social Security benefits based on a disability or blindness and you have work-related expenses for which you are not reimbursed. Examples of such expenses are: the cost of medical treatment and drugs for AIDS, cancer, depression or epilepsy; a wheelchair; personal attendant services; vehicle modifications, driver assistance or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

YOU: ☐ **YES** ☐ **NO** **SPOUSE (if living together):** ☐ **YES** ☐ **NO**

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

Signatures

I/We understand that by submitting this application I am/we are declaring under penalty of perjury that I/we have examined all the information on this form and it is true and correct to the best of my/our knowledge. I/We understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both. I/We understand that the Social Security Administration (SSA) will check my/our statements and compare its records with records from Federal, State, and local government agencies, including the Internal Revenue Service to make sure the determination is correct. By submitting this application I am/we are authorizing SSA to obtain and disclose information related to my/our income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my/our wages, account balances, investments, insurance policies, benefits, and pensions. **Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.**

SECTION A

Your Signature:	Date:	Phone Number: ( ) –
Spouse's Signature:	Date:	

Your Mailing Address:	Apt. #:

City:	State:	Zip Code:

If you changed your mailing address within the last three months, put an X here: ☐

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

Print First Name:	Print Last Name:	Phone Number: ( ) –

SECTION B

If you are assisting someone else, place an X in the box that describes who you are and provide your daytime phone number and address.

☐ Family Member ☐ Attorney ☐ Other Advocate ☐ Other Specify: _____

☐ Friend ☐ Agency ☐ Social Worker _____

Print First Name:	Print Last Name:	Phone Number: ( ) –

Address:	Apt. #:

City:	State:	Zip Code:

Form SSA-1020B-OCR-SM-INST(12-2006) Page 6

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

Privacy Act / Paperwork Reduction Notice

Section 1860 D-14 of the *Social Security Act* authorizes the collection of information requested on this form. The information you provide will be used to enable the Social Security Administration to determine if you are eligible for help paying your share of the cost of a Medicare Prescription Drug Plan. You do not have to give us the information requested. However, if you do not provide the information, we will be unable to make an accurate and timely decision on your application. We may provide information collected on this form to another Federal, State, or local government agency to assist us in determining your eligibility for the extra help or if a Federal law requires the release of information.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement — This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the *Paperwork Reduction Act of 1995*. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 35 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

SEND THE COMPLETED FORM TO US AT THE ADDRESS SHOWN ON THE ENCLOSED PRE-ADDRESSED ENVELOPE:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1020
Wilkes-Barre, PA 18767-9910

APPENDIX D: Example of SSA Decision Letter

Denial - Notice type = 008

Social Security Administration
Medicare Prescription Drug Assistance

Notice of Denial

Great Lakes Program Service Center
600 West Madison Street
Chicago, Illinois 60661-2474

Date: May 2, 2005
Social Security Number: 123-45-6789

JOHN Q. PUBLIC
123 MAIN ST
SPRINGFIELD OH 45501

We have determined you are not eligible for extra help with Medicare prescription drug plan costs. This determination is based on the letter we previously sent you and any additional information you submitted.

The rest of this notice explains how we determined that you are not eligible, the information we used to make this decision, how to sign up for a Medicare prescription drug plan, what to do if your situation changes, and your appeal rights.

WHY YOU ARE NOT ELIGIBLE FOR HELP WITH YOUR PRESCRIPTION DRUG PLAN COSTS

You are not eligible for extra help to pay your Medicare prescription drug plan costs, also known as subsidy, because your income is above the limit established by law.

INFORMATION USED IN MAKING THE DECISION

When you are married and live with your spouse, we count the resources and income for both of you when we determine your eligibility for this extra help.

You and your spouse have the following resources:

- Bank accounts.
- Stocks, bonds, or other investments.

Your resources we count are less than $10,000. The enclosed worksheet shows you how we counted your resources.

You have 5 persons in your household. When we determine the size of your household, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half support from you or your spouse.

You and your spouse have the following yearly income:

- Other pensions or annuities of $28,000

Your income we count is 150% or more of the Federal Poverty Level. The enclosed worksheet shows you how we counted your income.

HOW TO SIGN UP FOR A MEDICARE PRESCRIPTION DRUG PLAN

You do not need to receive this extra help paying for the costs related to your Medicare prescription drug plan in order to be eligible to enroll in a Medicare prescription drug plan or Medicare Advantage drug plan. You can enroll beginning November 15, 2005. For more information about the prescription drug plans available in your area, go to www.medicare.gov on the Internet or call toll-free 1-800-MEDICARE (1-800-633-4227). If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

WHAT TO DO IF YOUR SITUATION CHANGES

If at any time in the future you think you qualify for this extra help, also known as a subsidy, please contact us immediately about filing a new application.

IF YOU DISAGREE WITH THE DECISION

If you disagree with the decision, you have the right to appeal. We will provide you with a hearing by telephone or a case review. We will look at any new information you have. The person who will conduct the hearing or case review had no prior involvement in the first decision. We will review those parts of the decision which you believe are wrong and will look at any new facts you have. We may also review those parts which you believe are correct and may make them unfavorable or less favorable to you.

If you want this appeal, either by a hearing or a case review, you may request it by calling toll-free 1-800-772-1213.

You have 60 days to ask for an appeal.

The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.

You must have a good reason for waiting more than 60 days.

You can call to request an appeal. You can also obtain a copy of the form SSA-1021, "Request for Appeal of Determination for Help with Medicare Prescription Drug Plan Costs" from www.socialsecurity.gov. Contact us if you need help.

IF YOU WANT HELP WITH YOUR APPEAL

You can have a lawyer, friend, or someone else help you. Your local Social Security office has a list of groups that can help you with your appeal. These groups can find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal.

INFORMATION ABOUT MEDICARE SAVINGS PROGRAMS

You may be able to get more help with your Medicare health care costs through programs run by your State. The additional help from these Medicare Savings Programs can be worth more than $900 a year. To get this help, please call your State's medical assistance (Medicaid) office or your social service office and ask about the Medicare Savings Programs. You can get the local phone number for these offices by calling Medicare toll-free at 1-800-MEDICARE (1-800-633-4227). If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

HOW YOU MAY BE ABLE TO RECEIVE SSI

It does not appear that you are eligible for Supplemental Security Income (SSI) benefits. However, you may still want to file an SSI application if you have not already done so. If you file an SSI application, you will receive a formal decision of your eligibility. If you do not agree with the decision, you may appeal. If you decide to file, it is important that you get in touch with Social Security right away. You may call us toll-free at 1-800-772-1213. If you file an application more than 60 days from the date of this notice, you may lose SSI.

IF YOU HAVE ANY QUESTIONS

For information about Medicare prescription drug plans or other Medicare issues, visit on the Internet or call toll-free 1-800-MEDICARE (1-800-633-4227). If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

For information about the extra help with the costs related to Medicare prescription drug plans or general information about Social Security, visit our website at *www.socialsecurity.gov* on the Internet. You may also call Social Security toll-free at 1-800-772-1213. If you are deaf or hard of hearing, you may call our TTY number toll-free at 1-800-325-0778. We can answer most questions by phone.

You can also write or visit any Social Security office. The office that serves your area is located at:

Social Security
2026 W. Main St.
Springfield OH 45501
Telephone: 937-325-0674

If you do call or visit an office, please have this letter with you. It will help us answer your questions.

Regional Commissioner

Enclosure(s):
Resource Worksheet
Income Worksheet

APPENDIX E: 2007 Federal Poverty Guidelines

APPENDIX E **2007 Federal Poverty Guidelines**

Persons in Family or Household	*48 Contiguous States and D.C.*	*Alaska*	*Hawaii*
1	$ 10,210	$ 12,770	$ 11,750
2	13,690	17,120	15,750
3	17,170	21,470	19,750
4	20,650	25,820	23,750
5	24,130	30,170	27,750
6	27,610	34,520	31,750
7	31,090	38,870	35,750
8	34,570	43,220	39,750
For each additional person add	3,480	4,350	4,000

Source: *Federal Register*, Vol. 72, Number 15, January 24, 2007.

Access to Benefits Coalition &
National Council on Aging
1901 L Street, NW, 4th Floor
Washington, D.C. 20036
Phone: (202) 479-6670

www.AccesstoBenefits.org
www.ncoa.org

The CHAIRMAN. Thank you, Mr. Bedlin.

Ms. Leitzer.

STATEMENT OF ELLEN LEITZER, J.D., EXECUTIVE DIRECTOR, HEALTH ASSISTANCE PARTNERSHIP, WASHINGTON, DC

Ms. LEITZER. (OFF–MIKE) Sorry. Prior to joining the Health Assistance Partnership, or HAP, in June 2005, I provided legal services to senior citizens in Bernalillo County, NM. So on a daily basis for 22 years, my staff and I provided legal services and SHIP services, because we also had the SHIP service contract for the largest county in New Mexico, and, as you know, New Mexico is one of the poorest States in the Country.

In addition to supporting SHIP services, HAP also is supporting the increased funding for the SHIP network. As you all know, in the past few years, with the enactment of Medicare Part D, State and local SHIP's programs have been an extraordinarily valuable resource, but a woefully under-funded resource, to this Nation's Medicare population.

SHIPs were originally created in OBRA of 1990, and there are now 1,400 community-based SHIP programs, with 12,000 staff members and volunteers who counsel Medicare beneficiaries about their Medicare, their Medicaid, private insurance and other coverage options.

Each year, SHIPs provide individual assistance to more than 4 million Medicare beneficiaries. Of this Nation's 43 million Medicare beneficiaries, approximately 27 percent have cognitive impairments. Thirty-one percent have limitations of activities of daily living. Almost one-third have not graduated from high school and 12 percent are over the age of 85.

SHIPs are unique in that they offer one-on-one, in-person counseling to one of the Nation's most vulnerable populations. The Federal Government has depended on this Nationwide SHIP network and their staff of volunteers and paid staff to educate beneficiaries about Medicare drug plan benefits and costs and to assist with enrollment decisions that involve mind-boggling choices between dozens of plans.

Many SHIPs have come to rely on HAP for technical assistance about complex Medicare issues and help with resolving difficult cases. Consequently, my organization is in constant communication with State and local SHIP programs Nationwide. Most of the requests for assistance in the past year involve Medicare Part D and the program's impact on the 14.2 million beneficiaries who are eligible for low-income subsidy, or the LIS program.

Many of these beneficiaries accessed their medications prior to 2006 through State Medicaid programs. As a result, the SHIP network has brought many concerns and problems to HAP's attention. The specific concerns are identified and described in detail in my written testimony.

But, essentially, Medicare Part D is so complex and so arcane that it has overwhelmed the systems that CMS, SSA and hundreds of drugs plans created to implement the program. Those systems cannot, and do not, properly function. Consequently, Medicare beneficiaries are leaving pharmacies empty handed and without their medically necessary medications.

The system failures impact all Medicare beneficiaries, but the impact falls disproportionately on the LIS population, because they are the frailest, the most vulnerable, the least empowered to seek help and the least likely to be able to pay for their system errors.

Now, let's look at some of these failures. First, the system for real-time data sharing among CMS, SSA, plans and pharmacies does not work properly, with data being shared untimely, inefficiently or incorrectly. This flawed system results in beneficiaries being charged the wrong cost-sharing amounts at the pharmacy.

This problem weighs most heavily on LIS beneficiaries who cannot afford to pay standard deductibles and copayments. Another result is that when data is not shared in real time, some beneficiaries find themselves in different plans, or in more than one plan. Usually, they are unaware of this shift.

Two, all of the drug plans, particularly Medicare Advantage Plans, are using aggressive marketing tactics to enroll Medicare beneficiaries, with the LIS population being most vulnerable. These tactics include enroll and migrate, in which plans first enroll beneficiaries in stand alone prescription drug plans and then target the same beneficiaries to later enroll in Medicare Advantage Plan with Part D.

The dually eligible are particularly vulnerable to this tactic because they have ongoing special enrollment periods. SHIPs report that sales representatives are blurring the important difference between original Medicare and private fee-for-service plans by using misleading catchphrases such as, "see any doctor you want," "no network." These sales representatives are failing to explain how PFFS require providers to agree to plans' payment terms for each office visit or hospital stay.

Moreover, many doctors are now deciding not to participate in these PFFS plans, so beneficiaries are all of a sudden having to find new providers.

Three, confusing plan structure leads to problems accessing appropriate medications at the pharmacy counter. Because dozens of plans are available in most parts of the Country, each with different formularies and coverage rules, health-care professionals face a tangled web of prior authorization and formulary exception procedures that lack uniformity.

Rather than take the time to untangle the web and work through the process, busy pharmacists and physicians simply substitute a drug, with few or no procedural restrictions. The result is that beneficiaries not only lose access to the drugs they really need, they also are losing access to their appeal rights.

Fourth, the CMS regional and central offices require specific information about client problems on an individual basis and are inconsistent in addressing State and local SHIP needs. From the first day of the Part D drug program's implementation, CMS has insisted on trying to resolve systemic problems on an individual basis.

This is hugely inefficient and ineffective. Additionally, HAP has received numerous reports about some regional offices of CMS being unable or unwilling to provide technical assistance to State and local SHIP staff, who need help that only CMS can provide to resolve the problems.

Fifth, CMS produces misleading media campaigns and correspondence. This past fall, CMS issued an ad that advised beneficiaries to take no action if they were satisfied with their plans. The ad failed to inform enrollees that plans can make significant changes from year to year.

Furthermore, CMS informational materials are often vague, are not available in languages other than English and do not address the needs of the visually impaired, the socially isolated and homebound and those with low literacy rates.

Finally, customer service representatives, or CSRs, at 1–800–MEDICARE and the Part D plans refer beneficiaries directly to SHIPs in situations that they should be handling themselves. Funding for the SHIP network was $31 million in 2006, and we understand that funding is going to be level in 2007.

In contrast, the Medicare contractor Pearson Government Solutions received $440 million in 2006 for a 2.5-year contract. However, the SHIPs have reported that 1–800–MEDICARE CSRs and the plans refer beneficiaries directly to SHIPs for assistance, even with general and programmatic and enrollment issues.

HAP supports legislation which will address and remedy the above-identified ongoing problems experienced by many beneficiaries, including those with low-income subsidy. We specifically endorse all of the recommendations that Mr. Bedlin talked about, on behalf of the National Council on Aging.

We would also like to emphasize once again the value of the SHIP network to Medicare beneficiaries and, in addition, therefore, to supporting the remedies to existing LIS legislation, we urge this Committee to advocate for increased funding for the SHIP network of at least $1 per beneficiary in 2007 and for all future years.

Again, thank you very much for asking me to testify.

[The prepared statement of Ms. Leitzer follows:]

Testimony
of
Ellen Leitzer
Executive Director, Health Assistance Partnership

Before the Senate Committee on Aging

January 31, 2007

The Health Assistance Partnership (HAP) is an independently supported intermediary for the nation's State Health Insurance Assistance Program (SHIPs). HAP is a project of Families USA, a national, non-profit organization which promotes high-quality and affordable healthcare for all Americans. HAP's mission is to increase the capacity of SHIPs so that they might become more efficient and effective in educating and counseling Medicare beneficiaries (and their caregivers) about the health insurance benefits to which they are entitled. HAP is committed to stabilizing and increasing federal funding for the SHIP network.

State and local SHIP programs are an extraordinarily valuable— though woefully under-funded— resource to this nation's Medicare population. Created through the Omnibus Reconciliation Act (OBRA) of 1990, they promote understanding of the then newly standardized Medicare supplement insurance (or Medigap) policies. The role of SHIPs has expanded to 1,400 community-based SHIP programs operating within the Area Agencies on Aging or State Departments of Insurance, with 12,000 staff members and volunteers who counsel Medicare beneficiaries about their Medicare, Medicaid, private insurance, and other coverage options.

Each year, the SHIPs provide individual assistance to more than four million Medicare beneficiaries, approximately 27 percent of whom have cognitive impairments; 31 percent have limitations in activities of daily living; almost one-third have not graduated from high school; and 12 percent are over 85 years of age. SHIPs are unique in that they offer one-on-one, in-person counseling to one of this nation's most vulnerable populations. The federal government has depended on the nationwide network of SHIP staff and volunteers to educate beneficiaries about the Medicare drug plans' benefits and costs and to assist with enrollment decisions that involve mind-boggling choices between dozens of plans.

Many of the SHIPs have come to rely on HAP for technical assistance about complex Medicare issues and help with resolving difficult cases. Consequently, HAP is in constant communication with state and local SHIP programs nationwide. Most of these requests for assistance in the past year involve Medicare Drug Coverage and the program's impact on those who are eligible for the low-income subsidy program. HAP would like to take this opportunity on behalf of the entire SHIP network to bring to light the overwhelming issues that SHIP counselors face every day alongside beneficiaries. Many of these issues could affect any Medicare Part D enrollee. But the 6.6 million beneficiaries who fall into the lowest income subsidy category and no longer have

Medicaid coverage for their prescription drugs are particularly vulnerable.[1] They often do not have the means or resources to address the problems that arise. As a result the SHIP network has brought the following concerns and problems to HAP's attention most recently:

The system for real-time data sharing among CMS, SSA, and plans does not work properly; as a result data is being shared untimely, inefficiently, or incorrectly.
This flawed system results in a lack of subsidy status and/or plan data in pharmacy computer systems. It leads to incorrect cost-sharing amounts being charged at the pharmacy. This problem is most significant for beneficiaries who also have Medicaid or Medicare Savings Programs and cannot afford standard cost-sharing amounts. In addition, if no plan enrollment is reflected in the system, CMS enrolls the dual eligible population into randomly selected plans. Thus, when data is not shared in real-time, some beneficiaries have found themselves in a different plan or in more than one plan; they are then unaware of the shift. Several SHIPs have also reported that beneficiaries with the Low-Income Subsidy enrolled in "benchmark plans" are receiving erroneous bills for premium payments, despite their full subsidy status. This is costly to taxpayers and state safety net programs, as well as the lives and wallets of vulnerable beneficiaries who leave the pharmacy counter without their medications.

Confusing plan structure leads to problems accessing appropriate medications at the pharmacy counter.
Restrictions on formularies, commonly called utilization management requirements, have led many pharmacies to bypass the exceptions and appeals process. Resolving a prior authorization or step therapy issue for beneficiaries involves a different process for each plan. Because dozens of plans (with dozens of different formularies and restrictions) are available in most areas in the country, these hurdles to accessing drugs are too burdensome for busy health professionals. In many cases pharmacists and physicians simply will change a prescription to a drug with fewer or no restrictions. While this process may not be a problem for some individuals, adverse medication interactions can occur, especially for beneficiaries who fill prescriptions at multiple pharmacies. This type of resolution also results in the plans not accurately reflecting exceptions or appeals with regard to medications that are formulary "inclusive" but not accessible.

CMS Regional & Central Offices require specific information about client problems one-by-one.
Since the inception of Medicare Drug Coverage, myriad problems have occurred with all aspects of the program—from problems with the Medicare Prescription Drug Plan Finder (www.medicare.gov) to beneficiaries unable to get their medications despite their best efforts and those of the SHIPs, the pharmacists, or the physicians. Throughout the first year of the program and even today, CMS insists on attempting to resolve these problems piecemeal, rather than to address them systemically.

CMS produces misleading media campaigns and correspondence.
CMS issued an ad in Parade magazine in November 2006 that advised beneficiaries to "take no action" if they were satisfied with their plans. The ad failed to inform enrollees that the plans may have significant changes from year to year. A beneficiary's satisfaction with a Part D plan

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[1] Medicare Policy Project, Henry J. Kaiser Family Foundation *Medicare Drug Benefit Enrollment Update* (Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2006).

in 2006 is no guaranteed predictor of their satisfaction with a plan in 2007. Furthermore, those beneficiaries who receive the Low-Income Subsidy and accepted CMS's auto-assignment into a Part D plan in 2006 were reassigned to different plans in 2007 if their previous plan would have a monthly premium more than $2.00 above the benchmark for their region.

Customer Service Representatives at 1-800-Medicare and the Part D Plans refer beneficiaries directly to SHIPs.
Throughout the existence of Medicare Part D, the SHIPs have reported consistently that Customer Service Representatives (CSRs) at Medicare and the Part D plans refer beneficiaries to SHIPs for assistance with general programmatic and enrollment issues. This practice led to problems with SHIP hotlines being overwhelmed by questions easily answered by the Medicare hotline. Furthermore, yearly funding for the SHIP network was $31 million in 2006, while the Medicare Contractor, Pearson Government Solutions, received $440 million in 2006 for a two and a half year contract. [2]

Telephone hold times to speak with Part D plan representatives are too long.
Long hold times in many cases have led SHIPs and pharmacies to improvise solutions to problems with Part D rather than wait to address problems with the plan.

CMS Regional Offices are inconsistent when addressing State and Local SHIPs needs.
HAP has received numerous reports about many Regional Offices being unable or unwilling to provide technical assistance to State and Local SHIP staff in dire need of resolution when it comes to specific problems that only CMS is authorized to provide. There is a lack of accountability and/or responsiveness by many Regional Offices; and the SHIPs are left to navigate on their own the differing perspectives of the pharmacies, the Part D plans, and CMS.

There exists a deficiency in considering the specific needs of this vulnerable population.
In many cases CMS materials and correspondence are not available in languages other than English (and sometimes Spanish). Materials often do not address the needs of the visually impaired or the isolated and homebound, among others. Reading levels for many materials is consistently higher than those recommended for this population. Often, the information is vague and does not describe the effects of these changes adequately, yielding more questions than answers after reading CMS publications. It is also well documented that the health literacy levels of this population are also much lower than standard literacy levels.

Explanations of Benefits (EOBs) that are mailed to beneficiaries by the Part D Plans are not clear for Low Income Subsidy recipients.
The EOBs are not tailored to the different needs of the LIS population. Some refer to the coverage gap, while many miscalculate the True Out of Pocket (TrOOP) spending for those with LIS.

All of the plans, particularly Medicare Advantage plans, are employing aggressive marketing tactics to all Medicare beneficiaries, especially the LIS population.
Aggressive marketing tactics are not new when we think back during the summer of 2005 the Medicare Drug Gold Rush event where the brochure read, "Profit from The Biggest New Benefit

[2] http://www.pearson.com/index.cfm?pageid=73&pressid=2035

in the History of Medicare – Part D Drug!!! "[3] SHIPs all across the country are reporting new marketing tactics, particularly when it comes to Private Fee for Service (PFFS) plans. Some of these strategies include the "enroll and migrate" strategy, whereby plans first enroll beneficiaries in stand-alone PDPs, and then target these same beneficiaries later to enroll in a Medicare Advantage plan with Part D (MA-PD). The low-income subsidy population who are also dually eligible (Medicare with either Medicaid or a Medicare Savings Program) are particularly vulnerable to this tactic because of their ongoing special enrollment period.

Furthermore, SHIPs are reporting life-threatening hardship for beneficiaries who find themselves in PFFS plans and whose doctors or hospitals are unwilling to accept plan payments or do not understand what they are. New legislation passed late in 2006 exempts PFFS plans not offering Part D coverage from the enrollment "lock-in" and permits them to continue enrolling beneficiaries throughout the year. SHIPs report that sales representatives use misleading catch phrases to draw parallels between Original Medicare and PFFS plans, including "see any doctor you want" and "no network." While technically not false, these sales representatives do not explain how PFFS plans differ from Original Medicare and that they require each provider to agree to the plan's payment terms per patient and per episode.

SHIPs have reported to HAP other marketing strategies by brokers including uninvited soliciting of plans at beneficiaries' doors. Also, once in residential buildings, the sales representatives find additional Medicare beneficiaries by paying home care workers for referrals; offering $200 drugstore coupons for signing up with a plan; telling beneficiaries they must choose a plan or they will lose their Medicare; enrolling beneficiaries in Medicare Advantage plans through sign-in sheets at senior centers or other venues for prizes and gifts; and downplaying formulary restrictions or making bold claims that their doctor is "in network" without such knowledge.

Pharmacies do not use the WellPoint Point-of-Sale (POS) option; or they are unaware it is available or do not understand how it works.
The POS option is not an effective safety net, as it only exists to serve those dual-eligible beneficiaries who show up in pharmacy systems with no plan whatsoever. However, as data is not being shared in real-time, these computer systems do not necessarily reflect the correct enrollment status of individuals. Additionally, pharmacies do not always use this system even if aware of it, because it is often burdensome and they may be at-risk financially if the data in the system is not accurate.

CMS recommends Patient Assistance Programs (PAPs) as a solution for plans' restrictions on formularies.
PAPs exist as an additional, privately funded safety net for certain low-income individuals to obtain needed medication. Instead of requiring the Part D plans to provide more extensive formularies, CMS recommends for beneficiaries who fulfill the requirements of the PAPs to apply for this coverage drug-by-drug.

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[3] http://www.insurancebroadcasting.com/crg051605-2.pdf

In Summary

HAP supports legislation which will address and remedy the above identified ongoing problems experienced by many beneficiaries, including those with the Low-Income Subsidy. We would like to emphasize the value of the SHIP network to Medicare beneficiaries. SHIPs are the only entities that already offer one-on-one assistance with a great depth of knowledge, an objective viewpoint, and an ability to handle complex cases that may require lengthy follow-up. In addition to supporting remedies to existing LIS legislation, we urge this Committee to advocate for increased funding for the SHIP network of at least $1.00 per beneficiary in 2007 and future years.

Overall Recommendations

Coordinate data sharing between states, plans, SSA and CMS in real-time.
There are no mandatory systems in place that ensure dually eligible do not experience gaps in their drug coverage or subsidy. Real-time data sharing between states, Centers for Medicare & Medicaid Services, the Social Security Administration and the plans would allow for pharmacy counter interactions to run more smoothly and accurately.

Return to the original LIS co-pays of $1 & $3 for full status, and $2 & $5 for partial status until the program is operating more smoothly.
Beneficiaries are left to bear the burden of paying increased co-pays for medications they may not be receiving as prescribed, or have been changed due to utilization measures.

Enact a monthly co-pay cap allowing some reprieve for those who take multiple medications per month.
Beneficiaries, who take more than several medications per month, brand or generic, face incredible hardship when it comes to paying multiple co-pays. Enacting a monthly cap allows them to actually receive all of their medications, rather than choosing between paying their rent or food.

Errors that occur by the plans or CMS at the expense of low-income, needy beneficiaries, who have been charged incorrect co-pays, should have the option of opting out of refunding moneys to the plans due to financial hardship.
Where data is incorrect and beneficiaries are charged higher co-pays or asked to pay plan premiums because their LIS status is not reflected at the pharmacy counter, beneficiaries are asked to layout moneys in order to obtain their medications as a result of error beyond their control. Under these circumstances, neither CMS nor the plans are living up to their end of the bargain.

Remove the barriers to applying for LIS by eliminating the asset test and by not allowing the subsidy to adversely affect any other means tested benefits such as food stamps and rental subsidies.
When reductions are made in other needs-based assistance programs such as Section 8 housing, food stamps or TANF benefits, this only serves to discourage LIS enrollment.

Expand the POS option to make it useable in real-life instances of inaccurate or inadequate data transference issues.
Coverage should be available for all LIS beneficiaries that have drug dispensing problems beyond their control at the pharmacy counter. CMS should also require use of the POS option and hold pharmacies harmless for acting in good faith.

Remove any need for determining life insurance or cash value thereof.
The SSA application currently requires applicants to report the cash value of their life insurance policies, however, many beneficiaries do not have this information and paperwork readily available and they do not know how to get the information. Seniors and persons with disabilities often plan to use their life insurance benefit to pay for their final expenses and not cash in their policy now to place additional burden on family members.

Exclude in-kind support as countable income.
In-kind support and maintenance is difficult to estimate due to its fluctuating nature. This discourages beneficiaries from applying for LIS because it also threatens their in-kind support, and is therefore a barrier to enrollment. The unrealistic level of detail involved in calculating the value of in-kind support and maintenance is likely resulting in potentially eligible beneficiaries not filing LIS applications.

Allow SSA access to IRS data in advance to allow for targeted outreach specifically around the Low Income Subsidy, just as they have done with the new Part B premium legislation.
Given that the Part B premiums are now based on income information released by the IRS, the LIS should follow the same protocol for consistency and accuracy.

Authorize the costs of drugs under Part D to count towards medically needy "spend-down" eligibility for Medicaid, as was allowed for low-income people entitled to the "transitional assistance benefit" in the Medicare Discount Drug Card program.
Beneficiaries with Medicare, who also require the use of Medicaid, often met their spend-down or surplus income through medication costs in order to access their Medicaid benefits. Now that they can no longer do so, they are unable to meet their spend-down or access their Medicaid benefit which also covers their doctors, hospitals and rehabilitative needs.

Cover Part D excluded drugs such as benzodiazepines, barbiturates (anti-anxiety, anti-seizure medications), and allergy medications, especially for this population.
It is particularly risky for the overall health of our fellow citizens not to cover mental health medications that keep beneficiaries functional and stable.

Conclusion

While we realize CMS and SSA have been working diligently to resolve some of these problems, all of them still require substantial attention and systemic consideration to improve the Medicare Part D program, especially for our lower income beneficiaries. HAP urges lawmakers to consider these recommendations carefully and strategically, building upon the existing knowledge of the SHIP network that has strived for excellence against all odds.

The CHAIRMAN. Thank you very much.

Do I take it that both of you would recommend that we do away with the asset test?

Ms. LEITZER. Absolutely, Mr. Kohl.

The CHAIRMAN. Mr. Bedlin.

Mr. BEDLIN. Yes, absolutely.

The CHAIRMAN. That is good to hear from both of you.

In your experience, would more seniors apply for the low-income subsidy if the application process were streamlined, and can it be without doing any damage to that application process?

Mr. BEDLIN. Very much so, and we do have some specific ideas. Take, for example, the question on the cash surrender value of a person's life insurance program, something that I personally would have a real hard time finding somewhere in my house. It is complex, and typically seniors will use that for their burial expenses, to help their kids when they pass. So we don't think that that should be counted against them.

Senator Smith earlier asked about the question regarding in-kind support and maintenance, which penalizes someone if their family is helping them to pay for their grocery bills or their heating bills or for their trash collection bills. We don't think that makes any sense. It changes from month to month. We think that question should be eliminated.

We also have concerns about the application form in that it threatens someone with jail time if they fill it out wrong, which is not the case with a lot of similar application forms. Those mention perjury, but they don't mention jail time. We think that should be eliminated.

Fundamentally, though, we need to move from 20th century applications to 21st century, and that means really providing application forms online that can be submitted online. We file our taxes online. There is no reason why one should not be able to fill out a form for a whole host of benefits that they are eligible for, because there is a lot of correlation.

I am not expecting that most of their seniors are going to do it themselves. They will probably ask their kids, or they will ask a counselor. Fill it out online, submit it online, it reduces the cost, it makes it a lot easier, that is the direction that we really need to go.

The CHAIRMAN. Ms. Leitzer.

Ms. LEITZER. Senator Kohl, I agree with everything that Howard has said.

I would add that I have, in the past, tried to help clients for other Government programs figure out the value of their life insurance. Many of these policies were 20, 30, 40 years old; the companies were no longer in existence. It took advocacy on the part of me and my staff to try and figure out who now owned the company that was issuing this policy.

So it is a time consuming and difficult process, and that includes also the process for figuring out in-kind contribution. It is very, very hard to do that.

I would also like to address the issue that you raised earlier of the IRS data sharing. It is interesting to note that the Medicare Modernization Act already authorizes that for the Medicare Part B

premium, so there is precedent for allowing data sharing by the IRS with SSA.

The CHAIRMAN. That is good.

One more question: In addition to the more than 3 million low-income seniors who may be eligible for the subsidy but haven't applied, more than 600,000 seniors, as you know, lost their automatic eligibility and need to reapply this year. Are our poorest seniors falling through the cracks? What can we do to reach this most vulnerable population?

Mr. BEDLIN. That is a very good question, because, as we understand it, 400,000 of the 630,000 that still have not applied and are remaining out there. These are people who had the LIS last year, but now, when they go to the pharmacy, for example, they may be having to pay a deductible for the first time. So they are going to be in for a real surprise when they go to the pharmacy.

Now, many of the plans have provided for, we understand, a 60- or 90-day transition period, so they may not get hit with this higher cost until March or April and they will be, again, in for a big surprise. There are things that we need to do, because this is going to happen every year. Next year at this time, we are going to be facing the same problem.

A number of things can be done. I think we need to screen them, and before we tell them that they are no longer eligible, to make sure since they may well be eligible. I think we do need to, within the concerns of confidentiality and privacy, try to find these people and screen them for whatever LIS category they may be in.

Second, I think we need to require some kind of a transition period. We shouldn't be cutting them off on January 1. There should be some requirement that we use the months of January, March, and April to find these people after the open enrollment period is over.

Finally, maybe there should be a presumption of some kind, that these people will continue to be eligible unless it can be rebutted that they are not. Why continue to put the burden on them? I think it is an area that we really need to take a close look at.

The CHAIRMAN. That is good.

Ms. Leitzer.

Ms. LEITZER. Senator Kohl, I would just add to that that other benefit programs have a recertification process, so before somebody, a beneficiary, is dropped from a program, they are sent a letter to come in and be recertified, and I would suggest that that system should be followed for this population, as well.

The CHAIRMAN. Thank you very much.

Senator Carper.

Senator CARPER. Thanks, Mr. Chairman.

My thanks to both of you for joining us today, for your testimony and for responding to our questions.

You may have spoken to the question that was raised while I was outside of the room. I think you have already spoken to it in part while I was in the room.

We are going to have a debate, they have already had it in the House of Representatives, about changes in the Medicare Part D program with respect to what role should the Secretary of Health

and Human Services play with respect to negotiating drug prices or not.

The House has taken a position, and they have sent their legislation over to us for our consideration. I want to set aside the question of whether or not the Congress would mandate that the Secretary play a role like the House has suggested, or there would be an option for the Secretary to play that kind of role.

Whether we end up agreeing or not on doing something on that score, what else should we do? I think there are a number of areas where you agree. You have mentioned a couple of them, and one of them was with respect to assets.

Just run through for me again, just to re-emphasize the areas, as we take up legislation this, sort of a to-do list of things that you agree on steps that we should take.

Mr. BEDLIN. Sure, thank you.

I think we really need to prioritize where we want to spend limited resources. We all recognize that we are under PAYGO rules, and when we go to staffers, the first question we get is, how much does it cost, and how are we going to pay for it? So we need to prioritize.

That is very important as we look at improving Part D, and we would argue that we need to start by looking at those who are most vulnerable, lowest income and in greatest need of help.

I would ask that you think about a typical American grandmother; widow in her 80's, living alone, relying on her Social Security check for income, multiple chronic conditions, taking a dozen or so medications. There are millions of women who fit this category. My grandmother was one of them.

Let's look at how current law would affect her eligibility for the low-income subsidy. If she saved during her life, to put away a little nest egg, generally around $30,000 to $40,000, current law counts it against her, to deny her the extra help she needs.

Similarly, if she did the right thing, and during her working years invested in a 401(k) plan, current law counts it against her, to deny her the extra help she needs. If she has a life insurance policy, which, again, might help pay her burial expenses when she passes, current law counts it against her, to deny her the extra help she needs.

If her kids help her with her expenses, be they grocery expenses or her heating expenses or trash collection, current law counts it against her, to deny her the extra help she needs.

Let's say she is getting the extra help and overcomes some of these obstacles, but her income is just above the poverty line. Let's say it is $11,000 a year, which is less than $1,000 a month. That is over the poverty line. Under current law, her drug copayments will increase each year by more than two times her Social Security COLA, making her medications less and less affordable over time.

Finally, again, if she is receiving this extra help, it is going to count against her in terms of how much help she is getting from other programs, so that current law would cut her food stamp benefits and cut her low-income housing subsidy.

These are areas that we think need to be priorities. We think they are relatively non-controversial, relatively inexpensive, and we urge the Congress to take action on them this year.

Senator CARPER. I am going to come back and explain to us what you mean by relatively inexpensive——

Mr. BEDLIN. That is a good question.

Senator CARPER. But, Ms. Leitzer?

Ms. LEITZER. My organization has endorsed and we share the same recommendations with the National Council on Aging.

Senator CARPER. Every one of them?

Ms. LEITZER. I am with the Health Assistance Partnership.

Senator CARPER. I said every one of their recommendations?

Ms. LEITZER. Every one of their—in fact, our organizations worked on the recommendations jointly.

In addition, my organization supports the SHIP network, the State health insurance assistance programs, that have been providing one-on-one counseling to the Medicare population. They are an extremely valuable network, they are woefully under-funded, and we would also urge that Congress allocate $1 per beneficiary for this network in 2007 and in future years, as well.

Mr. BEDLIN. We agree with that. SHIPs definitely need more money, and we also think a wise investment is in the new National Center on Senior Benefits Outreach and Enrollment that was recently authorized under the Older Americans Act. We are trying to get a $4 million appropriation, because that new center would be utilizing all the lessons learned and cost-effective strategies that we think can make a real difference.

Senator CARPER. In the pay-as-you-go world, where we are going to try live once again under the rules that existed about 4 or 5 years ago, what is relatively inexpensive? Any thoughts on how we pay for what is relatively inexpensive?

Mr. BEDLIN. Well, it is really a question of priorities.

Senator CARPER. It always is.

Mr. BEDLIN. There are a lot of things that we are spending a heck of a lot of money on, and this is a population who made America as great as it is, fought in World War II and worked all their lives to help their children. Now many of them are on fixed incomes and have a lot of chronic conditions and need help. So, certainly, they need to be a priority for us, in my view.

We will see how CBO scores a lot of these proposals. We think, for example, back-of-the-envelope estimate on eliminating the asset test, would cost about $1.5 billion per year. That is probably by far the most expensive recommendation that we have from the list. We think the others are far less expensive.

There are a lot of ideas that are being floated about with regard to how to pay for them. People are looking at the stabilization fund dollars that remains and so-called overpayments for Medicare Advantage Plans, so I think those could be potentially part of a package.

Senator CARPER. Thanks very much.

The CHAIRMAN. Thank you very much, Senator Carper.

Senator Casey.

Senator CASEY. Mr. Chairman, thank you very much for convening this hearing.

I want to thank you for focusing our attention on issues of concern not just to families across the Nation, but in particular those families that are struggling with all of the challenges that I have

seen on the campaign trail over the course of 20 months when I was campaigning, all of the problems with Medicare Part D.

As much as people appreciate that benefit, there have been tremendous problems in terms of confusion, in terms of access, but also in terms of whether or not we are going to focus on I think the urgent priority to have a negotiation for lower prices. But I think that this hearing today highlights some of the other problems that maybe don't get as much attention as a negotiation question.

One of the questions I had, I wanted to go first to Ms. Leitzer, about one of your recommendations. The third recommendation you made, and I am looking at your testimony on page five, which was this: enact a monthly copay cap, allowing some reprieve for those who take multiple medications per month.

I wanted to have you elaborate on that. I know you have gone through it once, but some of these issues bear repeating and further emphasis.

I know, for people in Pennsylvania, we have—depending on how it is counted, but I think we are still second in terms of the number of senior citizens, in terms of population—we have just over 1.9 million people over the age of 65. We have got a huge Medicare and Medicaid population, of course, that includes those over 65 and a lot of people under 65 who benefit from those programs.

But you cite in particular the hardship, and I wanted to have you elaborate on the question of that hardship.

Ms. LEITZER. Senator Casey, the hardship is that many clients that are certified SHIPs—and, again, we are a National organization that are assisting SHIPs, but also in my own practice at the Senior Citizens Law Office in New Mexico, I had clients whose incomes were SSI or just above SSI level and they were taking 20 medications. That is not unusual.

The fact that they have to pay these copays for each medication they take, that adds up monthly. When you are talking about a really poor population that have other expenses—housing, heating, food—those expenses really make a difference to them, that added.

So to cap what somebody's monthly copays could be would be very, very helpful to this poorest population.

Senator CASEY. Of the people that you are working with every day and that you see, you said it is not necessarily unusual to see individuals that have to take 20 or more medications per day.

What percent, if you can estimate? I realize it is probably an estimate, but give it a good educated guess. We won't hold you to it in specificity, but what percent of that population that you work with in your experience is in that category of 20 or more medications per day?

Ms. LEITZER. I would say that it is more typical to be eight to 10 to 12 medications, but it is not unusual to have people on 20 medications.

In fact, relating this to the 1–800–MEDICARE, when people would call 1–800–MEDICARE and they did have 20 medications, 1–800–MEDICARE would say, "We can only handle people who are on nine medications or 10 medications or less." So the SHIPs were handling a disproportionate number of Medicare beneficiaries who had large numbers of medications.

So, to answer your question, I would say that maybe 5 percent of the population are on 20 or more, but I would say maybe as high as 50, 60 percent who are on eight to 10 medications.

Senator CASEY. Eight to 10 medications, a significant number.

Mr. BEDLIN. Senator Casey, just a quick follow-up?

Senator CASEY. Yes, sure.

Mr. BEDLIN. Three things that can be done.

One is Senator Smith will shortly be reintroducing a bill that treats dual eligibles getting home- and community-based care similarly to those in nursing homes. We support that bill.

Second, I mentioned earlier how those copayments are indexed. For folks below 100 percent of poverty on LIS, they are indexed by the Consumer Price Index. For those between 100 and 150 percent of poverty, they are indexed by Part D costs, which are twice as high, generally, at least, than the Social Security COLA. There is no reason to treat them differently. They should all be indexed by CPI.

Finally, again for dual eligibles, Medicare and Medicaid eligible, if a State should decide to help pay for that $3 or $5, or $1 or $3 copay, they will not get a Medicaid match. That is 100 percent State dollars. We believe that the Federal Government should match that State contribution to help pay for dual-eligible copays.

Senator CASEY. I know I have limited time, but let me get to one more.

I wanted to focus, Mr. Bedlin, on your testimony, and one of the points that you made, if I can find it here on the right page, was on the question of outreach. On page 10 of your testimony, you talk about—and this, of course, is a list of recommended legislative changes.

This, I guess, is the third on the list: Appropriate funds to support organizations that use a person-centered approach to outreach, which has been shown to be one of the most efficient and effective ways to find and enroll LIS eligibles.

I point to this for a couple of reasons. One is, I know in the State of Pennsylvania, for example, with regard to programs that help very vulnerable populations—I am thinking in particular the Children's Health Insurance Program, which I think has to be one of the priorities of this new Congress in terms of reauthorization—one of the biggest problems is, unless you have a sustained and massive television advertising campaign, no one knows about the program, at least with regard, in my experience, with the Children's Health Insurance Program.

So you flood the airwaves with television and the enrollments go way up. You take the T.V. or the other advertising off the air, eligibility goes down.

Of course, there are some people in Washington and State capitals who say, "Well, if no one is calling to be enrolled, we must be doing a great job." It is a myth and it is really misleading, in some cases intentionally misleading, because they don't want to cover those people. They don't want to have to pay for it, or maybe give up a tax cut to pay for it.

But this question of outreach and the question of how you connect with people to give them the opportunity to access programs which will help them is of central concern to me, because too often

it is overlooked. You can have a great program, great benefits, people can be helped by it, but unless those who don't know about these programs have the opportunity, we are making a big mistake.

But I just wanted to have you reiterate or elaborate or amplify what you said about outreach.

Mr. BEDLIN. Thank you. You are absolutely right. Seniors don't know about the benefits that they are eligible for. It is shocking to me that after 40 years, only 30 percent of seniors eligible for food stamps are receiving it.

Under one of the so-called Medicare Savings Programs, which is pretty confusing, but there is one called the SLMB program that pays premiums for beneficiaries with incomes between 100 and 120 percent of poverty. According to our statistics, only 13 percent of the people that are eligible for that are actually receiving it. There is a great deal that could be done.

You mentioned patient-centered outreach. Part of the problem is that historically what we have done is SSA will do outreach for SSI. CMS will do outreach for the Medicare Savings Program. USDA will do outreach for food stamps. A lot of these people are the same individuals. There is a great deal of correlation.

For example, we have found that 70 percent of the people who are eligible for the Part D low-income subsidy are also eligible for the Medicare Savings Program. The problem is we have been searching for needles in a haystack.

Independently, we need to pull together all the different piles of needles that have already been found. Fifty-five percent of the cost is taken up by just finding these people. Once they have been found, we need to actually use a lot of the technology that is available online to get them enrolled in a whole host of benefits that they are eligible for.

Pennsylvania is actually leading the way. They are doing some very innovative things at the State level with the PACE program. Actually, in our testimony, page 24 is all about the great things that Pennsylvania is doing, and we would love to be able to replicate what Pennsylvania is doing in the rest of the Country.

Senator CASEY. Well, I wish I could take full credit for that, but I can't. But I didn't want to use my time to brag about the State. They do a great job.

I think the problem that we face and the challenge that we face in this Congress is making sure—one of the challenges, I should say—is that someday people will say the same about the Federal Government on a whole host of issues that they perform at that level.

So I don't want to dwell on the negative and the challenges, but I think it is very important to emphasize what you have also brought to this hearing.

I know my time is limited, but maybe we will come back. Senator Whitehouse, I wanted to make sure that he had time, because I like to listen to his questions.

The CHAIRMAN. Thank you, Senator Casey.

Senator Lincoln.

Senator LINCOLN. Thank you so much, Mr. Chairman. I really appreciate your dedication to this Committee and to issues that

come before us. It is one of my most favorite of all. I appreciate you, because I really feel like you, to bring up these issues and to provide us an opportunity—and we appreciate the panel that is here.

I have several questions for the first panel, as well, and I apologize that I wasn't here for that. But I would like to submit them to the Committee for answers in writing, if I might.

The CHAIRMAN. Do it.

Senator LINCOLN. Great, thank you so much.

Mr. Bedlin, I just wanted to say, I have come from the Ag Committee, where we were having a meeting on food stamps and nutrition programs. It is quite interesting that our panelists there expressed the same concern about making sure that those who were signing up for food stamps could also sign up for the Part D.

It seems kind of crazy that, with marketing as it is today and the technology that exists, that the technology exists to recognize my household as one that likes pets, eats ice cream, all these other kind of things that people know about us in order to market us, that we can't figure out that when people are in a certain income level that they qualify for multiple programs that they should be getting that would improve their quality of life.

So I very much appreciate your point on that.

I hope, Mr. Chairman, that we will work with Chairman Harkin and others as we move forward with both the farm bill and some of our other issues—Senator Baucus, Chairman Baucus—in the Medicare arena, that we really encourage on behalf of seniors and the aging population in this Country, that we make it a more seamless process and one that is easier.

It is unfortunate that those seniors that are eligible for food assistance programs don't access it and could do so when they access many other programs. So I encourage us to really look at the opportunity and push the Federal programs and the Federal agencies into the 21st century and get them to where they can actually—the other is veterans.

We tried that out of my office a couple of years ago, encouraging the Veterans Association to couple with the Social Security Administration, to kind of show that same group of individuals what opportunities and what programs were available to them from both of those agencies. It does make a difference, when people do that, because it simplifies their lives. Certainly, as we know in our seniors, that that is an issue.

I just want to make a couple of points from the questions I didn't ask the first panel, and that is just mentioning these issues that are related to the Part D that are big problems in our State of Arkansas. Beneficiaries, especially the low income, they need to receive accurate and available assistance. They need better customer service.

They are calling an 800 number. They wait sometimes a couple of hours, oftentimes finally get a Medicare staff person who can't even resolve the problem. It sometimes give them inaccurate information, or it transfers the caller to someone else so they can wait another hour or couple of hours. Better customer service is going to be critical.

Curbing the aggressive marketing that exists out there is also something in think that is going to be important. I know the CMS folks probably could address that. Then more support for counseling, and I would like to go to that so that I can direct to Ms. Leitzer—is that correct?

Ms. LEITZER. That is correct.

Senator LINCOLN. I just want to publicly thank the Health Assistance Partnerships that exist for us in Arkansas. They were absolutely tremendous. There are thousands of Medicare beneficiaries in our State, and certainly around the Country, that turn to their area agencies on aging, their State health insurance assistance programs—you mentioned SHIPs earlier—the Native American aging programs, for their enrollment assistance and counseling.

I want to publicly thank those in Arkansas. The AAAS deserves such a big thanks for working and helping our seniors sign up. They were lifesavers in our State. We would not have had the success we did without them and the Social Security office, who went at a time which was incredible, because we got 65,000 evacuees from Katrina that came to Arkansas. The Social Security Administration regional office and their dedicated office in Arkansas, we could not have asked for more dedicated workers, worked through holiday weekends. They worked through weekends, both assisting the evacuees and then, in the next go-around, helping with our signup for Medicare Part D.

CareLink is a good example, and I attended several of their counseling sessions. CareLink in central Arkansas, which is an AAA-based in Little Rock, it provided one-on-one Medicare Part D assistance to 5,574 older adults, spending an average of 63 minutes per counseling session.

One-on-one counseling, it provides such an important means for these seniors to get the available information they need and understand it. It is one of the best ways to find people that are eligible for LIS, as we mentioned earlier, and help them fill out that difficult application form.

That was the other thing we talked about with the food stamp and nutrition programs was simplifying applications and making it easier. But without those dedicated resources for outreach and assistance through the AAAs, such as CareLink, we just would have been unable to sustain the Medicare Part D efforts on an ongoing basis.

I guess you probably talked about it here, and one of the questions I had for CMS was do they intend to help in terms of resources and funding for the partnerships that exist out there that have done them a tremendous service in making the Medicare Part D program accessible? I know you have mentioned how important those resources are, and, however, I think we can be helpful in directing that.

I want you to know that I am sold. I am a believer and am enormously grateful for the efforts that were put into that.

Maybe you all could even shed some light to the extent of the number of greater low-income citizens we could serve if we had more resources. I don't know if you have got numbers, or maybe you have already talked about that when I ran over to the Energy Committee. I don't know.

Ms. LEITZER. Well, I would just like to say in response, and thank you so much for your expression of appreciation. The SHIPs and other partners have worked extraordinarily, and they worked through Christmas last year.

Senator LINCOLN. They did.

Ms. LEITZER. Some worked through Christmas this year. They just went above and beyond.

I don't know if you were here for the part of my testimony in which I talked about how the 1–800–MEDICARE contractor, Pearson Government Solutions, received $440 million for 2.5 years to provide services at 1–800–MEDICARE. They routinely refer callers for even the simplest questions to the SHIP programs——

Senator LINCOLN. Absolutely.

Ms. LEITZER. SHIPs only got $31 million last year, and we understand it is going to be something like that, just not sure exactly how much. When you look at that discrepancy or disparity, it is huge.

The SHIPs do one-on-one personal counseling that is invaluable when you look at the demographics of the Medicare population. I don't know if you were here for that, but 27 percent are cognitively impaired. These are people who have a very difficult time dealing with information over the telephone or even with waiting or understanding messages.

This is my experience from working with this population. If you give them voicemail, they start talking because they think they are talking to a human being and they don't understand that this is a voicemail system.

So one-third have not graduated from high school. That is a huge number. Thirty one percent have difficulties with activities of daily living. We are talking about a population that needs lots of help, and relatively few have Internet accessibility.

CMS is all about everything is on the Internet. Well, frankly, this population doesn't access the Internet.

Senator LINCOLN. We complained heavily about that, because, for the seniors in Arkansas, as you said, in terms of the low-income nature, the educational levels, they would call 1–800–MEDICARE and then they would just get referred to go to the Web site. They did not have that kind of access, nor did they have the ability to discern from that what they needed to do.

Because we were so involved with our partnerships and with the different groups, the SHIPs, particularly, we were able to really work with them and get them out there. They actually trained some of our local folks. We had people from the Rotary group or for the Sunday school classes that would kind of take a lesson from the SHIPs and from the Area Agency on Aging, and then they would go back to their Sunday school or their Rotary group and make a presentation from what they had learned.

So they were great not just in doing what they did, but sharing their knowledge, because their ultimate purpose was really to get the information to seniors as best they could. So I am definitely sold, and I do want to publicly thank so much of all of those people that really made this happen.

I would just like to add to Mr. Bedlin, your comments earlier, I tried to get the QMBs and the SLMBs automatically enrolled like we did the dual eligibles, but I lost that fight.

Mr. BEDLIN. Well, you won a few, though. I mean, the reason the LIS is as generous as it is is in large part due to your leadership. We appreciate it.

I did want to mention that we estimate that there are 3.5 to 4.5 million beneficiaries that are eligible for the low-income subsidy and are still not receiving it, and we need to make that a priority and invest in finding and enrolling those folks. We need foundations. We need the private sector, who have stepped up a lot.

The My Medicare Matters campaign has provided some resources to try to find them, and the Congress needs to step up by, as we mentioned, funding the SHIP programs at a higher level, maybe targeting some of those resources that SHIPs get to the low-income subsidy. We have found that it costs approximately $100 per enrollee, so it is not inexpensive, but there are a lot of ways that you could make that more cost effective.

We have done some pretty sophisticated benchmarking analysis, looking back at benefits programs over the last several years, and there is wide variation based on what kind of methods you used. It can be $50, it can be $250. What we really need to do is take those lessons learned and take the best practices and find them in the most cost-effective strategies. As I mentioned in our testimony, we have a benefits—checkup Web site that we think can reduce costs.

Many of those online applications are going to SSA and reducing their per-enrollee costs. We have helped to form this National center under the Older Americans Act that would also utilize a lot of these lessons to find these people in the most cost-effective way possible. So we are hoping the Congress will join in investing to try to help those people who need it the most.

Senator LINCOLN. Mr. Chairman, one of the other topics that came up in our hearing in ag too was the asset tests and how complicated they were and difficult they were for seniors, particularly. That was something that we might think about in terms of the low income that are being denied the LIS because their assets are over the limit, sometimes just over that limit of $11,710 for individuals, which is phenomenal.

But, anyway, those might be some areas we look at, and I just appreciate your patience with me, because I really love being on this Committee and I talk too much sometimes.

The CHAIRMAN. Very good.

Senator LINCOLN. Thank you.

The CHAIRMAN. You are really informative. Just for your information, when you weren't here, both our witnesses said they would favor disposing of the asset test. Thank you so much.

Senator WHITEHOUSE.

Senator WHITEHOUSE. Thank you. I will be very brief, because I am running extremely late for my next meeting at this point, but I did want to let you know, first of all, from my point of view, it should not be this way and it does not have to be this way. So anything that I can do to be helpful, call on me.

Second, in the context of all of the confusion, all of the delay, all of the multiple forms, all the people who never get onto programs that they are eligible for, what is the value that you have seen as you have worked in this system?

What is the value of adding multiple providers into this equation, rather than having their be a CMS-run benefit for folks who are in this LIS category? What does it add to have that extra element of multiplicity, at a minimum, and confusion, perhaps.

Ms. LEITZER. I would think the obvious. It adds a profusion of confusion. It is unnecessary. It is overwhelming individuals. It is overwhelming the system and it should not be this way.

Senator WHITEHOUSE. We deal obviously in cost-benefit balances a lot in Government, and while those are clearly the costs, can you even think of a benefit to having that profusion?

Ms. LEITZER. Speaking individually, because I am not authorized to speak on behalf of Families USA, which is my parent agency, individually, I do not see a benefit.

Senator WHITEHOUSE. Just for the record——

Mr. BEDLIN. The process certainly could be simplified. I think there are far more plans that are participating than most people had ever anticipated. For us, one of the questions is does it pass the kitchen table test, when someone wants to really figure out which plan they want to select, which is very confusing, quite often? Probably the only way to do it in an informed way is using the Internet, and a lot of seniors don't have that kind of access.

One of the ideas that some have discussed is looking at the model of Medigap, when back in 1990 there were a whole variety of different Medigap plans that were very confusing. Congress, in its wisdom, decided to standardize some of those plans so that now there are 10 Medigap plans.

I know this is an issue that Finance Committee Chairman Baucus has talked about it. He was very involved in that 1990 Medigap standardization process.

My guess is that if you look at all the prescription drug plans out there, it would not be difficult for the National Association of Insurance Commissioners, for example, to try to figure out what the most common ones are and even get the industry to agree that there are some standard plans that if we were to say, you can offer this range, that it really would simplify things a lot for folks. We would be supportive of looking into that.

Senator WHITEHOUSE. It would help deal with the call shifting issue that we get right now, where competitive plans have every interest to cost shift out to SHIPs, to senior centers and to everybody else to explain the confusion that they have wrought, rather than tarry the costs themselves and make sure that they are really doing an adequate job of explaining and outreaching. I think it is a giant cost shift you are seeing, when people get driven to the SHIPs to answer their questions, or to senior centers, or to State agencies.

Mr. BEDLIN. It is certainly taxing their resources. They have got a lot of other work they do as well, and this past year has not been easy in terms of trying to provide the help people need and still doing a lot of the other work, such as helping people learn about preventive benefits under Medicare, which are also underutilized.

Senator WHITEHOUSE. Thank you both very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Whitehouse.

We thank you so much for being here today.

This is a very important issue. We need to do everything we can to see to it that our poorest seniors have access to the Medicare Part D benefit program, and we need to do everything we can to make the whole program more efficient and more effective.

This hearing has shed a lot of light on the problems, as well as having come up with a lot of good, common sense, practical suggestions to improve the program. So your presence here has been very valuable, very helpful, and we thank you for taking the time.

This hearing is closed.

[Whereupon, at 12:25 p.m., the Committee was adjourned.]

APPENDIX

QUESTIONS FROM SENATOR LINCOLN FOR BEATRICE DISMAN

Question. There have been far too many problems in getting the right premium amount deducted from people's Social Security checks and sent to the right Part D plan. In Arkansas, we are still getting calls about withholding issues—many of these problems go back to January 2006.

Why is this such a big problem, how many total cases have there been, how many remain to be resolved, and how do you intend to prevent these problems from recurring.

Answer. These premium withholding problems have been of great concern to SSA as well, and we are committed to working closely with CMS to resolve all outstanding withholding issues.

Premium withholding originates with the beneficiary enrolling with the Prescription Drug Plan (PDP). The PDP inputs the information to CMS who in turn transmits it to SSA for premium withholding where appropriate.

This means that in every case where a Medicare beneficiary has elected to have plan premiums withheld from a monthly Social Security benefit, SSA must rely on the successful transmission of correct withholding information across two separate entities. If there is a problem anywhere along this chain, the withholding request is either 1) never received by SSA, or 2) contains inaccurate information.

By "containing inacurrate information," we mean that the transaction does not tell SSA enough to verify the amount of required withholding, the effective dates of withholding, or in some cases, even the correct record to adjust. Historically, a significant number of CMS' transactions have "rejected" because of errors in the transmitted data. SSA cannot correct the errors independently.

However, the quality of transmissions we are receiving from CMS in 2007 has improved. Fewer CMS transactions contain data errors, and the occurrence of some of the more common errors has been reduced. SSA analysts have worked with CMS on an ongoing basis to reconcile data files, ensuring that the transactions flowing from CMS will make accurate premium and enrollment adjustments, per the beneficiary's request. In effect, SSA performs a "trial run" of much of the CMS data, to verify that the final, accepted transaction will reflect the intent of the beneficiary (as relayed through the PDP and CMS).

SSA defers to CMS regarding the total number of premium withholding cases there have been and the number of unresolved cases.

We continue to work with CMS to analyze and simplify the data exchange between our two agencies, recently holding a 2-day process improvement workshop to help address unresolved issues. A primary goal of this effort is to reduce the occurrence of data edits without compromising the quality standards that are a hallmark of SSA's business practice. We also continue to assist CMS in the resolution of outstanding premium issues.

Question. The biggest complaint in Arkansas is that applying for the low-income subsidy is too challenging for seniors. I have been informed that the Social Security Managers in Arkansas have contacted many of the LIS folks from last year who didn't return their redetermination forms. When contacted to inquire why they had not returned the forms, some said that they didn't want to go through the process again, it just wasn't worth it.

The LIS application form is several pages (about 8) and, despite your best efforts to simplify it, is very complicated.

Wouldn't eliminating the asset test make the enrollment process much simpler?

Short of that, aren't there some questions that could be removed, like those about the cash value of life insurance and help from family and friends with groceries and other household expenses?

Answer. SSA does not have the authority to make such changes administratively, as the requirements to consider assets and in-kind contributions are statutory in na-

ture. However, removal of either the asset test or the specific application questions you mention would clearly make the process simpler, but would also increase the costs of the program.

The Medicare Modernization Act (MMA) directed SSA to follow Supplemental Security Income (SSI) methodology for counting resources. The SSI resource standards are in Section 1613 of the Social Security Act. MMA established the resource level significantly higher than the SSI level, which is $2,000 for an individual and $3,000 for a couple. There is a sliding resource level for MMA, which combined with certain income levels determines if a full or partial subsidy is received. In 2007, for MMA purposes, an individual's resource level could be $10,210 and a couple $20,410. As an extension of these MMA-liberalized resource limits, SSA does not consider non-liquid resources for purposes of the LIS program. However, the exclusion of liquid resources (such as cash-surrender value of life insurance and other resources that could be quickly converted into cash) would not be consistent with the SSI methodology intended by MMA.

Likewise, MMA directed SSA to follow SSI methodology regarding income consideration (Section 1612 of the Social Security Act). Under these rules, considered income includes earned income, unearned income, and in-kind support and maintenance (ISM). Assistance from family and friends with groceries and household expenses meets the definition of ISM for SSI purposes, thus its consideration for the LIS is consistent with the intent of MMA.

QUESTIONS FROM SENATOR THOMAS CARPER FOR BEATRICE DISMAN

Question. It is my understanding that over 600,000 low-income beneficiaries lost their "deemed" status, making them no longer dual eligible. Now, this group who were automatically enrolled in the benefit at first will have to proactively sign up. What are CMS and SSA doing to ensure this group does not fall through the cracks?

Answer. We share your concern. To address this situation, SSA and CMS arranged for the SSA low-income subsidy application to be included with the notice that CMS mailed to all affected beneficiaries in September 2006. This means that every beneficiary who lost his or her deemed status received a letter explaining the need to proactively apply for the subsidy and also received the form needed to apply for "extra help."

SSA continues to receive applications based on this mailing. To date, about 230,000 of these beneficiaries have reapplied. This is in addition to a number of individuals who have regained automatic (deemed) eligibility through reentitlement to certain State programs.

In an additional effort to reach out to these beneficiaries, SSA is doing a study to make personal phone calls to 10,000 individuals who have lost deemed status and, to date, have not reapplied. By conducting this study we hope to encourage these individuals to apply, but just as important, we hope to learn about the reasons why some individuals have not returned the application. As we proceed with this study, our next steps will be guided by what we learn from these phone calls.

Question. I believe the automatic enrollment process for dual eligibles performs an important function by guaranteeing that low income beneficiaries get immediate coverage. However, I am concerned that because dual eligibles are randomly assigned to plans that do not necessarily fit their needs, we may be creating more work for ourselves in the long run. How can we more accurately enroll this group to reflect their needs, and cut down on the wasted cost and time exhausted trying to reassign these beneficiaries later?

Answer. We defer to CMS, as SSA is not involved in the auto enrollment process.

Question. We need to ensure that CMS has the proper structures in place to oversee participating health plans. CMS must ensure that plans are doing what they are supposed to be doing and that any lack of compliance is immediately identified and corrected. How has CMS improved their ability to monitor the compliance of these various plans?

Answer. We defer to CMS regarding their plans to monitor health plan compliance.

Question. While is is important to provide plans the flexibility to change their benefits package every year to adapt to changing drug demands, it seems problematic that plans that qualified for Low Income beneficiaries one year may no longer cover them in the next. 1.2 million dual eligibles had to be reassigned to other plans during the latest enrollment period because of terminated plans and fluctuating benefits costs. What can we do to curb this turnover year in and year out?

Answer. We defer to CMS, as SSA has no role in either the structuring of individual prescription drug plans or in the auto-enrollment process.

QUESTIONS FROM SENATOR KOHL FOR LARRY KOCOT

Question. Mr. Kocot, as you know, Congress remains committed to implementing a Medicare Part D program that serves the needs of all of America's seniors, including low-income and minority beneficiaries. It was because of this commitment, in fact, that Congress included a provision in the Medicare Modernization Act that charges CMS with the responsibility of overseeing the Part D plans to "ensure that drug plans provide access to medically necessary treatments for all and do not discriminate against any particular types of beneficiary." As you may know, the FDA recently approved a drug for the treatment of heart failure in self identified blacks, called BiDil. It has come to our committee's attention that, to date, only about half of Part D plans are covering this medication. I am told that this is because plans believe or have been told that it is not necessary to cover this drug if they are covering what is being referred to as "its generic component parts," Isordil and Apresoline, neither of which are approved for the treatment of heart failure.

If you would, Mr. Kocot, could you please inform this committee about, what if anything, CMS has done to be sure that the decisions regarding coverage of this drug are being made based on the best available science and not as part of an effort by plans to discourage African American patients with heart failure from participating?

Answer. Formularies and formulary management practices vary across plans, subject to CMS-published guidelines reflecting two overarching policy objectives. First, Part D plan sponsors must provide access to medically necessary Part D treatments and *must not substantially discourage enrollment by particular types of beneficiaries.* Second, plan sponsors are expected to use approaches to drug benefit management that are proven and in widespread use in prescription drug plans today.

As a condition of participation in Part D, sponsors must submit their plan formularies for CMS review and approval. CMS considers covered drugs as well as utilization management techniques. If CMS reviewers find that a plan's formulary could substantially discourage enrollment by certain types of beneficiaries or otherwise violate Part D program requirements, that formulary will not be accepted and if unchanged, the plan is not eligible for a Part D contract.

CMS is fully committed to ending healthcare disparities in the United States. Consistent with the most recent feedback we have received from the American College of Cardiology (ACC) and American Heart Association (AHA) regarding management of HF in African-Americans, CMS has ensured that all Part D formularies contain either BiDil® or isosorbide dinitrate and hydralazine (the individual generic components which are the active ingredients found in BiDil®). We will continue to evaluate the information on BiDil® and other drug products and update our formulary processes as appropriate when new information becomes available.

QUESTIONS FROM SENATOR BLANCHE LINCOLN FOR LARRY KOCOT

Question. There have been far too many problems in getting the right premium amount deducted from people's Social Security checks and sent to the right Part D plan. In Arkansas, we are still getting calls about withholding issues—many of these problems go back to January 2006.

Why is this such a big problem, how many total cases have there been, how many remains to be resolved, and how do you intend to prevent these problems from recurring?

Answer. Premium withholding continues to work for the vast majority of the 4.7 million beneficiaries who requested withholding in 2006. While many beneficiaries have experienced some issues with their withholding, CMS is committed to addressing and resolving these issues as soon as possible. The majority of issues were caused by CMS and Social Security Administration (SSA) systems having mismatching data on certain beneficiaries.

CMS, working with the Social Security Administration and key stakeholders (plans, pharmacies, etc.), has made tremendous strides to resolve premium withhold issues encountered in the first year of the program and to lay the groundwork for continued improvements in 2007 and beyond. Those steps have clearly paid off, with a 97% acceptance rate for transactions between CMS and SSA in 2007.

Question. I am being told by my constituents that no matter what the Medicare problem is that they are required to call the 800 number. The wait time can be a couple of hours and often the Medicare staff person can't resolve the problem, gives inaccurate information, or transfers the caller to someone else for another wait. This is especially distressing considering many low-income persons are facing enrollment changes and may need assistance.

What steps are being taken to provide quick and accurate information to callers who have problems with their checks or other issues?

Answer. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to establish a centralized, single toll-free number for beneficiary inquiries. Using 1–800–MEDICARE as the focal point for all beneficiary telephone inquiries relating to Part D provides beneficiaries with an opportunity to obtain answers to all types of Medicare questions, receive claims information, and order Medicare publications in a consistent manner.

We do not have any documented reports of callers waiting several hours to reach a 1–800–MEDICARE Customer Service Representative (CSR). However, we would be happy to trace any specific call complaints if provided with the date of the call, the telephone number where the call was made from, and the name of the caller. Further, our 1–800–MEDICARE Contractor, Vangent (formerly Pearson Government Solutions), performs real-time monitoring and makes staffing adjustments based on wait times and call arrival patterns.

Also, note that we implement a "call back" process when the average speed of answer (or wait time) for any 30 minute period reaches 15 minutes. This ensures that beneficiaries do not have exceptionally long wait times. We direct a certain percentage of calls to a dedicated automated voice message system where callers can leave their names and phone numbers and a CSR will call the individual back at a less busy time.

In the event there is a complex issue that cannot be handled at our call center, we have a process in place to refer these issues to a specialized group of CSRs who will research the issue and provide a resolution for the beneficiary. These types of inquiries represent less than 1 percent of the total call volume. We do refer callers with non-related 1–800–MEDICARE issues to the appropriate agency for assistance (such as callers who have contacted 1–800–MEDICARE but their issue must be handled by the Social Security Administration or the Railroad Retirement Board.)

1–800–MEDICARE CSRs receive weekly Refresher Training to update them on new procedures and initiatives. The materials covered for the week are conducted either in a classroom setting, or by individualized desktop training. Once the materials are presented, the CSRs are given a knowledge test which contains questions from the current and prior week's training materials. This approach ensures that CSRs retain information that was covered earlier in the month.

Finally, a minimum of four calls per customer service representative, per month, are monitored for quality using a national Quality Call Monitoring (QCM) scorecard. More calls are monitored for new customer service representatives and for those CSRs with performance concerns. During the review of the QCM scorecards, CSRs listen to their recorded calls with their supervisors and corrective actions are taken where applicable.

Question. Does CMS plan to provide resources, funded under Medicare Part D administration, to the Areas Agencies on Aging and Native American aging programs to support their community-level outreach, assistance and counseling efforts?

Answer. In FY 2007, CMS will provide more than $30 million to the State Health Insurance Assistance Programs (SHIPs) in every state. However, CMS does not have a breakout by state or nationally on the amount of Federal SHIP funding that flows to the Area Agencies on Aging (AAAs) through their contracts and relationships with SHIPs. CMS directs SHIPs to build networks of locally accessible counseling locations, and many States use Federal SHIP funding to contract or otherwise fund AAAs to achieve that goal.

In addition to any SHIP funding provided to the AAAs, CMS has an interagency agreement with the U.S. Administration on Aging (AoA) to target resources to AAAs in geographic areas with high concentrations of beneficiaries who might be eligible for the low-income subsidy. In FY 2007, the total amount allocated under this agreement is $1.4 million.

CMS has developed a collaborative partnership with the AoA to leverage the federal, state, tribal, and local partnerships called the National Aging Services Network. Through this collaborative effort, CMS is providing resources to the AoA and its National Aging Services Network to offer outreach and education, assistance, and counseling to people with Medicare at the local level. This partnership is designed to help beneficiaries make informed decisions about their healthcare and have greater access to affordable medications.

The National Aging Services Network reaches more than 7 million older persons, Medicare beneficiaries, and their caregivers, includes 56 State Units on Aging (SUA), 655 Area Agencies on Aging (AAAs), 243 Tribal organizations, more than 29,000 local community-service organizations, 500,000 volunteers, and a wide variety of national organizations.

Question. In Arkansas, insurance companies are aggressively selling HMOs to seniors who only thought they were getting Part D plans. The seniors later found out their providers weren't part of the plan they signed up for. There was a segment in the news in my state a couple of days ago (on Channel 7—On My Side) about this happening to an elderly woman and she was having trouble getting out of her plan.

What, if anything, is being done to remedy this?

Answer. Medicare Advantage (MA) organizations that directly employ or contract with a person to market a MA plan must ensure that a plan representative or agent complies with applicable MA and Part D laws, federal health care laws, and CMS policies (including CMS' Marketing Guidelines). CMS will hold organizations utilizing agents that violate Medicare program marketing requirements responsible for the conduct of these agents.

CMS has taken a proactive approach to ensure that the marketing activities and outreach of these plans is accurate and complies with all program requirements. For example, CMS has begun utilizing a program audit assistance contractor to conduct "secret shopping" of sales events across the country. This information enables CMS to learn first hand what is happening in the sales marketplace, determine the accuracy of MA sales presentations, and identify organizations for compliance intervention that are not meeting CMS marketing and enrollment requirements.

CMS also is strengthening its relationships with state regulators. Specifically, CMS worked with the National Association of Insurance Commissioners and States to develop a model Compliance and Enforcement Memorandum of Understanding (MOU). This MOU enables CMS and State Departments of Insurance to freely share compliance and enforcement information, to better oversee the operations and market conduct of companies we jointly regulate and enable the sharing of specific information about marketing agent conduct.

Question. There were approximately 13 million beneficiaries eligible for the low-income subsidy in 2006, but 9.9 million enrolled.

How do you plan to reach the rest in 2007? Would it help if the IRS told you in advance which beneficiaries meet the income limits so you can target outreach directly to them? Are there other steps Congress could take to help?

Answer. Since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS has made extensive efforts to implement the law and provide beneficiaries with access to prescription drugs. Because of the extraordinary importance of this new benefit, CMS outreach to Medicare beneficiaries has been unprecedented. We are pleased that over 90 percent of all people eligible for the Medicare prescription drug benefit are receiving prescription drug coverage through the Medicare prescription drug benefit or from another creditable source.

We agree it is critical to ensure low-income beneficiaries are able to access, and take advantage of, the extra help available to them under the new Medicare prescription drug benefit. CMS, in partnership with the Social Security Administration (SSA), was extremely successful in enrolling low-income subsidy (LIS)-eligible individuals into Part D plans in the first year of the program. Of the approximately 13 million beneficiaries CMS estimates were eligible for the LIS in 2006, nearly 10 million now have coverage for prescription drugs. Through ongoing outreach that continues today, CMS has added over 300,000 new LIS-beneficiaries who enrolled in Part D prior to January 1, 2007. With the recently extended Medicare demonstration that allows LIS-approved beneficiaries to enroll through the end of 2007 without any late enrollment penalty, these numbers should continue to grow.

CMS is continuing outreach activities to the remaining individuals who might be eligible for the subsidy. Outreach efforts to this critical population have been data-driven, with our focus on identifying LIS-eligible populations at the State, county, community, and individual level. These individuals have been targeted with a multi-pronged education and outreach campaign that leverages existing information, intermediaries and resources. Initiatives include direct mailings and phone calls to beneficiaries, along with local outreach from community groups, intergovernmental partners, health care providers, and pharmacists. Given that many beneficiaries may be difficult to reach through traditional means, CMS has special initiatives targeting urban minority beneficiaries and beneficiaries in rural areas who may be isolated from general community outreach efforts.

The Office of the Inspector General (OIG) of the Department of Health and Human Services recently issued a report entitled, "Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy, OEI–03–06–00120." In this report the OIG recommended, ". . .legislation is needed to allow CMS and SSA to more effectively identify beneficiaries who are potentially eligible for the subsidy." OIG goes on to say "access to IRS data would help CMS and SSA identify the beneficiaries most likely to be eligible for the subsidy." However, many of those eligible for the

low-income subsidy do not file federal income tax returns because of their limited incomes. As a result, the utility of using IRS data to target low-income beneficiaries would be minimal in comparison to the privacy concerns that would be inherent in making this data available. Given the extreme sensitivity and privacy concerns that revolve around any sharing of personal tax information, along with our existing outreach strategy, we do not believe we need additional legislative authority to appropriately target low-income beneficiaries.

Question. Many people with very low incomes are being denied LIS because their assets are just over the limits ($11,710 for individuals and $23,410 for couples). That's hardly enough of a nest egg to get someone through retirement.

Wouldn't eliminating the asset test get help to millions of additional beneficiaries who need it? Short of eliminating the asset test, shouldn't we at least increase the limits?

Answer. Congress established as asset test as a component of the low-income subsidy of the Medicare prescription drug benefit. Inherently, eliminating the asset test would increase the number of individuals who could qualify for the low-income subsidy. At this time, the Administration does not support eliminating the asset test.

QUESTIONS FROM SENATOR CARPER FOR LARRY KOCOT

Question. It is my understanding that over 600,000 low-income beneficiaries lost their "deemed" status, making them no longer dual eligible. Now, this group who were automatically enrolled in the benefit at first will have to proactively sign up.

What are CMS and SSA doing to ensure this group does not fall through the cracks?

Answer. CMS took great strides to ensure that beneficiaries receiving the low-income subsidy (LIS) who were no longer automatically eligible for extra help in 2007 had uninterrupted drug coverage and as seamless a transition as possible.

Due to a loss of eligibility for Medicaid, including the Medicare Savings Program, or Supplemental Security Income (SSI) benefits, some Medicare beneficiaries no longer automatically qualified for LIS in 2007. In September 2006, CMS reached out to these beneficiaries by notifying them through the mail about this change, and providing information and guidance to help them get drug coverage that meets their needs. The letter advised that if a beneficiary has limited income and resources and thinks s/he may still qualify for extra help, s/he will need to apply and qualify through SSA, via the application that is included with the notice, or their State Medical Assistance (Medicaid) office.

CMS also worked with the Social Security Administration (SSA), State Medical Assistance (Medicaid) Offices, the State Health Insurance and Assistance Programs (SHIPs), physicians and pharmacists, prescription drug plans, and hundreds of partner organizations across the country to reach beneficiaries with these messages and guidance. Our customer service representatives at 1–800–MEDICARE are prepared to answer questions and to guide beneficiaries through the process of losing their LIS status, and relevant information is posted on our consumer website, www.medicare.gov.

As a result, as of January 2007, roughly 35 percent of people who had lost their deemed status had regained LIS eligibility—including those who regained their deemed status and those who reapplied and qualified for LIS with SSA. We expect these numbers to continue to grow throughout 2007.

Question. I believe the automatic enrollment process for dual eligibles performs an important function by guaranteeing that low income beneficiaries get immediate coverage. However, I am concerned that because dual eligibles are randomly assigned to plans that do not necessarily fit their needs, we may be creating more work for ourselves in the long run.

How can we more accurately enroll this group to reflect their needs, and cut down on the wasted cost and time exhausted trying to reassign these beneficiaries later?

Answer. Section 1860D–1(b)(1)(C) requires that any full benefit dual eligible that fails to enroll in a PDP or an MA–PD be auto-enrolled on a random basis among all PDPs in a given PDP region that have premiums at or below the low-income benchmark.

Question. We need to ensure that CMS has the proper structures in place to oversee participating health plans. CMS must ensure that plans are doing what they are supposed to be doing and that any lack of compliance is immediately identified and corrected.

How has CMS improved their ability to monitor the compliance of these various plans?

Answer. CMS has strengthened its oversight of Part D plans by improving its method for identifying companies for compliance audits, making more efficient use of the resources devoted to ensuring compliance, and developing a closer relationship with state regulators.

CMS has developed a contractor risk assessment methodology that identifies organizations and program areas that represent the greatest compliance risks to Medicare beneficiaries and the government. This approach enables the Agency to focus its compliance/enforcement resources on those program areas representing the greatest concern to CMS. Further, CMS uses a contractor to augment the Federal employees conducting Part D compliance audits. Among the steps the contractor is taking is to conduct "secret shopping" of sales events across the country; this information is enabling CMS to learn first-hand what is happening in the sales marketplace and to identify organizations for compliance intervention that are not meeting CMS marketing and enrollment requirements.

CMS also has strengthened its relationships with state regulators that oversee market conduct of plans. Specifically, CMS worked cooperatively with the NAIC and State Departments of Insurance to develop a model Compliance and Enforcement memorandum of Understanding (MOU). This MOU enables CMS and State Departments of Insurance to freely share compliance and enforcement information, to better oversee the operations and market conduct of companies we jointly regulate and enable the sharing of specific information about marketing agent conduct.

To gain entry into the program, Part D plans must submit an application for CMS approval. CMS performs a comprehensive review of a plan's application to determine if the plan meets program requirements. Annually, plans also must submit formulary and benefit information for CMS review prior to being accepted for the following contract year. For each plan sponsor, CMS establishes a single point of contact (Account Manager) for all communications with the plan. The Account Managers work with plans to resolve any plan problems, including compliance issues.

Finally, CMS continually collects and analyzes performance data collected from Part D plans, internal systems, and beneficiaries. CMS has established baseline measures for the performance data. Plans not meeting the baseline measures are contacted and compliance actions initiated.

Question. While it is important to provide plans the flexibility to change their benefits package every year to adapt to changing drug demands, it seems problematic that plans that qualified for Low Income beneficiaries one year may no longer cover them in the next. 1.2 million dual eligibles had to be reassigned to other plans during the latest enrollment period because of terminated plans and fluctuating benefits cost.

What can we do to curb this turnover year in and year out?

Answer. CMS is committed to ensuring that beneficiaries receiving the low-income subsidy have uninterrupted drug coverage and a seamless transition as they move through plan years. Almost all 2006 Part D sponsors either continued their current plans in 2007 or streamlined and consolidated their 2006 plans. Additionally, in 2007 beneficiaries with limited incomes who qualify for the extra help have a range of options available for comprehensive coverage. Nationally, over 95 percent of low income beneficiaries did not need to change plans to continue to receive this coverage for a zero premium. In 2007, CMS had to randomly reassign about 250,000 beneficiaries outside their current organization and took steps to ensure that these beneficiaries were aware of the action and could review their options.

QUESTIONS FROM SENATOR BLANCHE LINCOLN FOR ELLEN LEITZER

Question. Do AAAs/SHIPs have the financial resources needed to continue the task?

Answer. The Health Assistance Partnership works closely with this country's SHIP network and can only speak knowledgeably about SHIP funding. The short answer to Senator Lincoln's question is no—SHIPs do not have adequate funding to meet the needs of the Medicare population that they serve.

The most significant source of unbiased consumer education for the Medicare program has been the national network of State Health Insurance and Assistance Programs (SHIPs). In 1990, Congress established the SHIP network so that counseling assistance, referrals, and accurate information could be made available to Medicare beneficiaries nationwide. The SHIP network is the only entity that offers in-depth, one-on-one assistance to beneficiaries with an objective viewpoint, and an ability to handle complex cases that may require lengthy follow-up. The 1,400 local, community-based SHIP programs have an estimated 12,000 staff members and volunteers; their officers are often housed in area agencies on aging, senior centers, hospitals,

and other organizations that serve the elderly. Due to limits in resources, most SHIP counselors are volunteers.

Question. The SHIP network is under-funded. Funding should be increased from $30 million to $43 million—a total of one dollar per beneficiary—for the following reasons:

Answer. Growing Complexity of Medicare: In addition to helping seniors navigate the confusing Medicare Part D program, SHIPs are needed to help beneficiaries understand a growing array of coverage options that create confusion, including: original fee-for-service Medicare; supplemental insurance; employer-based retiree coverage; regional PPOs; private fee-for-service (PFFS); and Special Needs Plans. The CMS plan comparison tools often lack key information needed to weigh benefits and risks, identify and evaluate variables, and counterbalance incomplete or misleading marketing claims.

Improving Low Income Seniors' Participation in Special Subsidy Programs: SHIPs are uniquely positioned to help low income beneficiaries. Fewer than 1 in 3 of those eligible for Medicare Savings Programs (MSPs) actually receive them. Applying for these programs can be daunting and an estimated two-thirds of enrollees need help completing the forms. SHIPs can help raise awareness of Medicaid and Medicare Savings Programs; help beneficiaries gather documentation; help beneficiaries understand program asset limits and estate recovery rules; help beneficiaries find providers who accept Medicare and Medicaid; and draw attention to Special Needs Plans for dual-eligibles.

Evaluating Changing Benefits: Private plans can change benefit structures and cost-sharing annually and beneficiaries will need to evaluate their coverage every year. SHIPs will be needed to help beneficiaries make sense of annual plan changes and help to evaluate whether it makes sense to switch plans.

Understanding Long-Term Care Options: Medicare does not cover many long-term care and personal care services. SHIPs are needed to help educate Medicare beneficiaries about Medicare's home health benefits, Medicaid's role in funding long-term care services, and provide one-on-one assistance for people denied longterm care benefits. In 2004, out-of-pocket spending for long-term care totaled $36.9 billion nationally. Only 10% of Americans 65 and older had long-term care insurance in 2002 and for those who can afford long-term care insurance, the choices are bewildering.

Statement of the Center for Medicare Advocacy, Inc.
Senate Special Committee on Aging
"Medicare Part D: Is It Working for Low Income Seniors"
Wednesday, January 31, 2007

The Center for Medicare Advocacy thanks the Committee for an opportunity to submit comments on the subject of Medicare Part D's effectiveness in meeting the prescription drug needs of low income Medicare beneficiaries, both older people and people with disabilities.

The Center is a national, non-partisan education and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and other quality health care. In addition to its education and policy advocacy, the Center represents thousand of individuals in appeals of Medicare denials and responds to more than 6,000 calls annually from beneficiaries and their advocates.

Because we understand the Committee's interest in this hearing to be primarily focused on low income beneficiaries who are not dually eligible, we will similarly focus our comments. For a broader view of Part D after one year, including issues for dual eligibles and issues for all Medicare beneficiaries, we direct the Committee's attention to our report, "Medicare Part D After One Year: A Review of Problems, and Recommendations for Change," a copy of which is included with these comments.

At the outset, we state that we continue to believe that many of the problems experienced by beneficiaries, including those specific to low income beneficiaries, would be substantially reduced by the redesign of Part D to create a benefit that is standardized, available throughout the country and administered through the traditional Medicare program.

Issues for low income beneficiaries might be classified into several categories:

- Enrollment in the low income subsidy (LIS)
- Retention of subsidy status
- Availability of subsidy information at the pharmacy
- Ease of access to needed non-formulary drugs.

Enrollment in the low income subsidy

The Department of Health and Human Services (HHS) estimates that more than 3 million beneficiaries eligible for the low income subsidy are not receiving it.[1] One area of attention that could increase enrollment is improvement in the application process. The process needs to be as simple as possible to encourage wide participation.

Steps that could be taken to simplify the enrollment process include:

- **Making applications, both in print and online, available in multiple languages.** Currently, they are available only in English and Spanish, with instruction sheets in 15 additional languages but not the actual application form.
- **Eliminating threatening language in the application about "going to prison" for giving false information.** Applications for public benefits usually require applicants to certify under penalty of perjury that the information in the application is true to the best of their knowledge. Such a statement would be sufficient to achieve its purpose, without the frightening language about prison.
- **Establishing time frames for processing applications.** The Social Security Administration (SSA) has not, in regulations or guidance, identified any time frame in which it promises to process applications. Beneficiaries have no way of knowing when to expect notification or what to do if they have not received same. Typical time frames used by other programs are about 45 days.
- **Eliminating consideration of the value of life insurance in assessing an applicant's assets.** Applicants may not know where policies are located, or how to report their value (which is expressed as both "face value" and "cash surrender value"). The inability to provide this information may result in failure to complete an application even though the information would not disqualify the applicant.
- **Eliminating consideration, as part of income, of in kind support provided to an applicant.** Advocates report that questions about in kind income are confusing to applicants who often answer them with information other than what was being sought. Again, they may find themselves disqualified when, in fact, they have merely answered the question wrong. Inquiring about in kind support makes the application more complicated.
- **Eliminating the asset test completely.** The asset test creates two barriers to enrollment: it disqualifies people with relatively small savings that exceed the limit. It also may disqualify people who are unable to provide documentation of the value of the assets they have and who thus cannot complete the process. This step requires action by the Congress.

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[1]Medicare: The Medicare Drug Benefit. The Henry J. Kaiser Family Foundation, November 2006.

Retention of Subsidy Status

Last fall, 600,000 beneficiaries were informed that their low income subsidy would end because they had lost eligibility for another program under which they were deemed eligible for the subsidy. The letter did not inform them of any opportunity for a hearing to challenge their loss of the subsidy nor of any possible independent determination of their eligibility that would be undertaken by the Centers for Medicare and Medicaid Services. Instead, it included an application for LIS and directed them to apply, although they had not been required to apply for 2006.

Steps to improve the "renewal" process to retain enrollment in subsidies include:

- **Creating a process with CMS to review independently for LIS eligibility all those who lose "deemed" eligibility status because of loss of the benefit that gave them deemed status.**
- **Notifying all beneficiaries losing deemed status of their right to a hearing to appeal their loss of LIS.**

Separate from those who lost deemed status for the LIS benefit, the Social Security Administration undertook a redetermination of eligibility of all who had applied through SSA for the LIS in 2005 or 2006. SSA adopted a "passive" redetermination process, sending a letter to all recipients telling them to respond *only* if something relevant – such as income, resources or household status – had changed since their original application. After the first year of eligibility, SSA is not required to redetermine eligibility except as the Commissioner determines necessary. We encourage SSA to continue using the least intrusive redetermination process possible, and using the process only when it has information about relevant changes for a particular applicant.

Availability of subsidy information at the pharmacy

Perhaps the greatest problem faced by those who are enrolled in the low income subsidy is not having subsidy information available at the pharmacy when they pay for their prescriptions. Reports from advocates tell us that beneficiaries in myriad circumstances experience this problem:

- Those who lost LIS eligibility in 2006 due to losing deemed status but who have either regained deemed status or been found LIS eligible through the application process;
- Beneficiaries whose 2006 benchmark plan was no longer a benchmark plan for 2007 and who were re-assigned to a new benchmark plan;
- Those who were moved merely from one plan to another of the same plan sponsor;
- Beneficiaries who remained in exactly the same plan between 2006 and 2007;
- Beneficiaries newly enrolled in LIS.

CMS has established a Point of Service safety net process that is currently available only in situations where dual eligibles are not enrolled in any Part D plan. The POS process allows the beneficiary to get a small supply of drugs at the subsidized co-payment rate and puts in place a process to get her enrolled in a plan.

Steps to improve the situation of lack of LIS information at the pharmacy:

- **This POS system could be expanded** to cover all situations where any low income beneficiary, by definition someone with little disposable income to pay co-payments, could have subsidy or plan problems resolved at the pharmacy.
- **A dedicated toll free number** could once again (as it was early in 2006) be made available for pharmacists to confirm subsidy status where a discrepancy existed between the computer's information and the beneficiary's assertion of subsidy status.

Easy Access to Needed Non-formulary Drugs

Beneficiaries currently do not receive any specific plan notice at the pharmacy if their drugs are not covered. The pharmacy is required to either post or distribute a generic notice informing the beneficiary to call her plan with any questions. The notice does not have plan-specific information, the reason for the denial of coverage or information about how to appeal the denial. If beneficiaries do not take the first affirmative step to call their plan, they will never even get a coverage determination from which to appeal.

Steps to improve this situation:

- **A simple correction to this process would be a computer generated notice, at the pharmacy,** of the reason for denial and the steps needed to be taken to appeal. The notice could also be given to a beneficiary whose co-payment is higher than it might be, to inform her of the possibility of having the co-payment reduced.

General system improvements benefiting low income beneficiaries.

Additional steps that would improve the Part D benefit for low income beneficiaries are:

- **Creation of real time data sharing among all Part D entities.** Many problems appear to arise because of gaps in availability of information as it passes among the many entities that comprise Part D: CMS, SSA, states, plans, government contractors tracking payments, to name some. While some data are shared in "real time," most are not, resulting in information that is known to one entity not necessarily being known to another.
- **Creation of an ongoing special enrollment period (SEP) for all LIS enrollees.** LIS beneficiaries are unable to pay out of pocket when plans

change their formularies mid-year, or when they discover, too late, that the plan they liked last year is different this year and no longer covers their drugs. They need the same flexibility available to dual eligibles to change plans when the plan they are in no longer serves their needs.

- **Elimination of the late enrollment penalty permanently for LIS beneficiaries.** CMS has eliminated the penalty for this population for 2006 and 2007; we recommend that it be eliminated permanently.

Conclusion

We have presented here a few relatively simple steps that can be taken to ease the difficulties experienced by low income beneficiaries in navigating Part D. Additional issues exist, for this population as well as for dual eligibles and all Medicare beneficiaries. We are pleased that the Committee is interested in and concerned about Medicare Part D and look forward to working with you to provide a strong drug benefit for Medicare beneficiaries.

February 13, 2007
Center for Medicare Advocacy, Inc.

CMA Weekly Alert - January 17, 2007

PART D YEAR ONE: STILL MUCH TO BE DONE

After one year's experience with Medicare Part D, many people remain confused and frustrated by the complexity and limitations of the benefit. Problems are difficult to resolve because of system failures, complicated data-sharing requirements among multiple entities, lack of useful and standardized information about plan benefits and appeal processes, and regulatory limitations that are more stringent than required by law.

The Center for Medicare Advocacy has prepared a Status Report based on the experiences of advocates and beneficiaries over the first year of Part D. The beneficiary stories in the Report are illustrative of the many beneficiaries who are experiencing problems and high costs due, in large part, to the lack of uniformity in Medicare Part D. The stories focus on particular aspects of Part D implementation – the failure of systems to ensure that low-income beneficiaries are enrolled in plans and receive their subsidies, the lack of useful information about benefit limitations to help beneficiaries plan, the failure of the system for withholding plan premiums from beneficiaries' Social Security checks, and the lack of uniform policies and procedures for seeking exceptions to formulary limitations.

Reflection on the issues underlying these problems confirms that beneficiaries would be better off with a redesigned benefit that is standardized, available throughout the country, and administered through the traditional Medicare program. Such a system would be more valuable for more beneficiaries and more cost-effective for taxpayers.

Accordingly, the Center for Medicare Advocacy continues to call for systemic changes to Part D. Our key recommendations include the following:

Recommendations for Congress:

1. Congress should redesign Medicare Part D to create a benefit that is standardized, available throughout the country, and administered through the traditional Medicare program. Such a system would be more valuable for more beneficiaries and more cost-effective for taxpayers.

2. Congress should eliminate the Donut Hole. If the Donut Hole is not eliminated, Congress should, at a minimum, authorize payments by AIDS Drug Assistance Programs (ADAPs) programs and pharmaceutical assistance program (PAPs) to count towards the beneficiary out-of-pocket spending limit.

3. Congress should require Part D plans to give deference to the opinion of the beneficiary's attending physician when making coverage decisions and should require CMS to delete the provision to the contrary in its regulations [42 CFR§ 423.578(f)].

4. Congress should authorize Part D coverage for off-label uses of drugs that are supported by peer-reviewed studies, are proven safe and effective over a substantial period of time, are covered by the beneficiary's state Medicaid program, or are listed in one of the three compendia currently included in the Medicare Act.

5. Congress should hold oversight hearings on the implementation of Part D. The hearings should include an inquiry into the special problems of dually eligible beneficiaries, the withholding of premiums by plans and Social Security, and CMS's role in setting and enforcing standards for plan participation.

6. Congress should require CMS to expeditiously establish a full system of real time data-sharing among all entities involved in Part D. Congress should require CMS to report on its strategies to resolve these problems effectively and within a specific time period, and should require periodic status reports from CMS.

Recommendations for the Centers for Medicare & Medicaid Services (CMS)

1. CMS should create a real time data-sharing system among all entities involved in Part D, and develop mandatory fail-safe systems to ensure that persons who are dually eligible for Medicare and Medicaid do not experience gaps in either their drug coverage or their low-income subsidy.

2. CMS should expand its point of service (POS) system to make its coverage available at the pharmacy for all dually eligible persons who experience plan enrollment and related drug dispensing problems at the pharmacy. Further, CMS should require pharmacies to use the POS system, and hold pharmacies harmless for good faith billings to the POS that turn out to be incorrect.

3. CMS and Part D plans should be required to provide beneficiaries with clear and accurate information about Part D, individual plan offerings, and in particular, about the Donut Hole coverage gap. This information should include the following:

- Materials from CMS and the enrollee's plan that explain how the initial coverage limitation and beneficiary out-of-pocket expenses, including Donut Hole payments, are calculated should be mailed to beneficiaries;

- Monthly statements that clearly indicate the total amount of payments that have been made that count towards the individual's initial coverage limit and beneficiary out-of-pocket responsibilities should be mailed to beneficiaries; and

- Monthly statements that indicate, after the initial coverage limit has been reached, all costs that continue to count towards the out-of-pocket limit in the Donut Hole and how much more is needed to reach catastrophic coverage should be mailed to beneficiaries.

4. CMS should require plans to provide a written coverage determination electronically at the pharmacy whenever a drug is not covered. The written coverage determination must explain why the plan will not pay for a drug, describe beneficiary appeal rights, and explain how to request the next level of review.

5. CMS should ensure that Part D plans comply with required appeals and grievance processes, that plan call centers respond appropriately to beneficiaries, and that Medicare "customer service" representatives provide accurate information and keep track of beneficiary complaints.

6. CMS should exercise its enforcement authority to take actions against Part D plans that do not provide adequate notice, fail to meet the regulatory time frames for deciding a coverage determination or an appeal, or fail to train their call center staff adequately.

Medicare is the most successful social insurance program in our nation's history. The Center for Medicare Advocacy urges our policymakers to continue that success, rather than derail it. Congress should redesign Part D using the real Medicare model rather than allowing it to be scattered to the whims of private plans. Create a single, nationally uniform program equally available to all who qualify; a program like the one which has successfully served older people and those with disabilities for decades.

Click here to print a .pdf of the full report.

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MEDICARE PART D AFTER YEAR ONE: A REVIEW OF PROBLEMS, AND RECOMMENDATIONS FOR CHANGE

January 16, 2007

EXECUTIVE SUMMARY

After one year's experience with Medicare Part D, many people remain confused and frustrated by the complexity and limitations of the benefit. Problems are difficult to resolve because of system failures, complicated data-sharing requirements among multiple entities, lack of useful and standardized information about plan benefits and appeal processes, and regulatory limitations that are more stringent than required by law.

The beneficiary stories in this report are illustrative of the many beneficiaries who are experiencing problems and high costs due, in large part, to the lack of uniformity in Medicare Part D. The stories focus on particular aspects of Part D implementation – the failure of systems to ensure that low-income beneficiaries are enrolled in plans and receive their subsidies, the lack of useful information about benefit limitations to help beneficiaries plan, the failure of the system for withholding plan premiums from beneficiaries' Social Security checks, and the lack of uniform policies and procedures for seeking exceptions to formulary limitations.

Reflection on the issues underlying these problems confirms that beneficiaries would be better off with a redesigned benefit that is standardized, available throughout the country, and administered through the traditional Medicare program. Such a system would be more valuable for more beneficiaries and more cost-effective for taxpayers.

Accordingly, the Center for Medicare Advocacy continues to call for systemic changes to Part D. Our key recommendations include the following:

Recommendations for Congress:

1. Congress should redesign Medicare Part D to create a benefit that is standardized, available throughout the country, and administered through the traditional Medicare program. Such a system would be more valuable for more beneficiaries and more cost-effective for taxpayers.

2. Congress should eliminate the Donut Hole. If the Donut Hole is not eliminated, Congress should, at a minimum, authorize payments by AIDS Drug Assistance Programs (ADAPs) programs and pharmaceutical assistance program (PAPs) to count towards the beneficiary out-of-pocket spending limit.

3. Congress should require Part D plans to give deference to the opinion of the beneficiary's attending physician when making coverage decisions and should require CMS to delete the provision to the contrary in its regulations [42 CFR§ 423.578(f)].

4. Congress should authorize Part D coverage for off-label uses of drugs that are supported by peer-reviewed studies, are proven safe and effective over a substantial period of time, are covered by the beneficiary's state Medicaid program, or are listed in one of the three compendia currently included in the Medicare Act.

5. Congress should hold oversight hearings on the implementation of Part D. The hearings should include an inquiry into the special problems of dually eligible beneficiaries, the withholding of premiums by plans and Social Security, and CMS's role in setting and enforcing standards for plan participation.

6. Congress should require CMS to expeditiously establish a full system of real time data-sharing among all entities involved in Part D. Congress should require CMS to report on its strategies to resolve these problems effectively and within a specific time period, and should require periodic status reports from CMS.

Recommendations for the Centers for Medicare & Medicaid Services (CMS)

1. CMS should create a real time data-sharing system among all entities involved in Part D, and develop mandatory fail-safe systems to ensure that persons who are dually eligible for Medicare and Medicaid do not experience gaps in either their drug coverage or their low-income subsidy.

2. CMS should expand its point of service (POS) system to make its coverage available at the pharmacy for all dually eligible persons who experience plan enrollment and related drug dispensing problems at the pharmacy. Further, CMS should require pharmacies to use the POS system, and hold pharmacies harmless for good faith billings to the POS that turn out to be incorrect.

3. CMS and Part D plans should be required to provide beneficiaries with clear and accurate information about Part D, individual plan offerings, and in particular, about the Donut Hole coverage gap. This information should include the following:

- Materials from CMS and the enrollee's plan that explain how the initial coverage limitation and beneficiary out-of-pocket expenses, including Donut Hole payments, are calculated should be mailed to beneficiaries;

- Monthly statements that clearly indicate the total amount of payments that have been made that count towards the individual's initial coverage limit and beneficiary out-of-pocket responsibilities should be mailed to beneficiaries; and

- Monthly statements that indicate, after the initial coverage limit has been reached, all costs that continue to count towards the out-of-pocket limit in the Donut Hole and how much more is needed to reach catastrophic coverage should be mailed to beneficiaries.

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4. CMS should require plans to provide a written coverage determination electronically at the pharmacy whenever a drug is not covered. The written coverage determination must explain why the plan will not pay for a drug, describe beneficiary appeal rights, and explain how to request the next level of review.

5. CMS should ensure that Part D plans comply with required appeals and grievance processes, that plan call centers respond appropriately to beneficiaries, and that Medicare "customer service" representatives provide accurate information and keep track of beneficiary complaints.

6. CMS should exercise its enforcement authority to take actions against Part D plans that do not provide adequate notice, fail to meet the regulatory time frames for deciding a coverage determination or an appeal, or fail to train their call center staff adequately.

INTRODUCTION

The Center for Medicare Advocacy has assisted thousands of Medicare beneficiaries and their helpers to understand and utilize the Part D system, plan options, and rules. In our conversations with Medicare beneficiaries, their advocates, and policy-makers, we hear repeatedly about beneficiaries having insufficient information to make sound decisions about which plan to choose, to understand what should be covered, and to know how they will fare during Part D's various coverage gaps. They also report difficulty obtaining exceptions for drugs not on a plan's formulary, for drugs with quantity limits, and for the off-label use of certain drugs. Similarly, we hear many complaints that the exceptions process is both complicated and vague. Beneficiaries who are dually eligible for Medicare and Medicaid are too often unable to obtain their medications due in large part to data-sharing problems among states, the Centers for Medicare & Medicaid Services (CMS), and Part D plans.

As we noted in our Six-Month Report (July 19, 2006), CMS, the agency that administers Medicare, continues to tout Part D as a resounding success, while characterizing what are persistent and systemic issues as small glitches in the system. Our experience continues to show otherwise. Systemic problems identified at the beginning of 2006 continued, and new problems developed during the course of the year. This report highlights some of the most glaring continuing problems:

- As currently designed, the Part D program is immensely complicated. The program's complexities affect the ability of beneficiaries to understand the program, choose plans, pay premiums, benefit appropriately from the low-income subsidy, and utilize the exceptions and appeals process.
- CMS's administration of the Low-Income Subsidy (LIS) lacks clarity and uniformity so that the subsidy too often fails to reach eligible beneficiaries.
- Beneficiaries do not have adequate information to allow them to make sound Part D plan choices or to properly prepare for the gap in coverage of necessary drugs during the "Donut Hole."
- The Part D exceptions and appeals process is too complex and too varied from plan to plan to be adequately accessible to Medicare beneficiaries. Further, the standards for appeals are too vague and do not give adequate credence to the opinion of beneficiaries' attending physicians.

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PART D IS IMMENSELY COMPLICATED. THIS COMPLEXITY AFFECTS ALL ASPECTS OF THE PROGRAM.

1. The Complexity Of Part D Causes Special Problems For Low-Income Beneficiaries

One of the major changes made by Part D is the requirement that beneficiaries who are eligible for both Medicare and Medicaid (dually eligible beneficiaries) get their prescription drugs through Medicare Part D. On January 1, 2006, these people lost their eligibility for prescription drug coverage under Medicaid. Further, Medicaid beneficiaries who become newly eligible for Medicare lose their Medicaid drug coverage when their Medicare eligibility begins, even if they are not enrolled in a Medicare prescription drug plan. Such beneficiaries may experience drug coverage gaps when they are first eligible for Medicare due to time lags in the transmission of information about their new dual status, which must flow from the state to CMS. This change in drug coverage for low-income beneficiaries was the source of some of the most serious and significant problems when Part D began in 2006. Problems with Part D drug coverage for dually eligible people persisted throughout the year. For example:

> Mrs. S, an SSI recipient who had been on MassHealth (Massachusetts Medicaid) and had a number of health problems, including bipolar disorder and diabetes, turned 65 on September 17th and became eligible for Medicare effective September 1, 2006. When she went to the pharmacy in early September, nine months after Part D began, she learned, when the pharmacist tried to bill MassHealth, that she no longer had Medicaid prescription drug coverage. The pharmacist was told that Medicare's records showed that the woman was in a Part D plan. However when he tried to bill that plan, he was unable to do so. Plan officials told both the pharmacist and the client's social worker that they had no record of her. The pharmacist then tried to bill Wellpoint/Anthem, the "Point of Service" (POS) option for dual eligibles who do not have a drug plan, but was unable to do so because Medicare records showed that she was already enrolled in a plan. She left the pharmacy without her medications.

Although CMS automatically enrolls dual-eligible beneficiaries into plans, effective the first day of the month in which they become dually eligible for both Medicare and Medicaid if they have not chosen a plan themselves, the enrollment may not, in fact, have been effectuated by the time they lose Medicaid coverage. Although they are entitled to reimbursement for out-of-pocket costs above the level of their subsidized co-payments, their low-income status may make it impossible for them to actually pay out-of-pocket. Those beneficiaries who choose a plan, rather than accept auto-enrollment, must affirmatively request through their plan that their enrollment be retroactive to the date they became dually eligible. The plan must submit the request to CMS.

As Mrs. S's story indicates, CMS has a point of service (POS) system that allows a newly dually eligible beneficiary for whom plan enrollment information is not available to receive drug coverage at the pharmacy (the "point of service") upon a showing of proof of Medicare and Medicaid enrollment. However, this system is not available to other dually eligible persons who experience difficulties at the pharmacy, including those for whom CMS's records show enrollment in a specific plan. Moreover, many pharmacists are unfamiliar with the POS system and, even if they know about the system, they are not obligated to use it. Further, if pharmacists use the POS system in error, the pharmacy is liable for the difference between the billed amount and the full cost-sharing due. Ironically, because Mrs. S was already enrolled in a plan that did

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not acknowledge her enrollment, the POS option did not work for her and she was worse off than if she had not been enrolled in a Part D plan at all.

A. Information About Subsidy Status Is Also Often Delayed In Its Transmission To The Plan And The Pharmacy

Although dually eligible persons are entitled by law to change plans at any time, they do so at their peril. Considerable confusion often occurs when plan changes are made and it may be difficult to understand which plan is responsible to pay for a drug during a plan-change transition. For example:

> Mr. B, a Medicare beneficiary who resides in the dementia unit in a nursing home, was enrolled by his daughter into a Part D drug plan in January 2006. In April 2006 he became eligible for Pennsylvania Medicaid.
>
> It took five months, and 15+ phone calls to Medicare, the regional CMS office, Pennsylvania Department of Welfare, the local Medicaid office, the Part D plan and the nursing home just to get Medicare to update the beneficiary's status to dual-eligible so that he no longer had to pay monthly drug premiums, co-payments, or the full cost of his drugs. The Pennsylvania Department of Welfare had the wrong birth date for the beneficiary in its records, listed him as not being on Medicare at all, and delayed sending the updated information to the Medicare database. The drug plan also could not update its information until Medicare had updated its information. The nursing home kept reminding the daughter that her father's drug bills were going unpaid.

Medicare beneficiaries becoming newly eligible for Medicaid experience delays in getting access to their low-income subsidy. Data are transmitted by the states monthly; a beneficiary whose dual status is determined the day after the monthly transmission will not appear as a dual-eligible until the following month. Mr. B's story illustrates the complexities of the data-sharing that is required to ensure that dual-eligible beneficiaries do not experience coverage gaps or gaps in their entitlement to lower cost-sharing when they become dually eligible. It also illustrates the complexity of resolving such problems, because so many entities are involved and each may be required to take some action that depends on the prior actions of another agency.

B. Re-determinations Of Eligibility For Low-Income Subsidy Are Made Through Multiple Mechanisms, Leading to Confusion and Errors

Low-income beneficiaries must re-qualify for the Part D low-income subsidy (LIS) each year. Since several paths exist for re-qualification, the process is confusing, especially for those whose circumstances fluctuate over the course of a year. Medicare beneficiaries who are also enrolled in Medicaid, a Medicare Savings Program, or SSI are "deemed eligible" for LIS. If individuals were on the rolls in one of these programs in July of 2006, they were to be "re-deemed" eligible for the subsidy for 2007. As Mrs. M's story indicates, however, plans do not always have correct information about beneficiaries' subsidy-eligibility status:

> Mrs. M, a dually eligible resident of Virginia who is deemed eligible for the low-income subsidy (LIS), was told that she needed to meet the Part D $265

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> deductible when she went to get a prescription on January 2, 2007, although people entitled to the LIS do not have a deductible. The woman had no changes in her income, assets, or program eligibility for SSI, Medicaid, or Medicare. Her Medicaid eligibility worker called her drug plan and was told the woman had lost her low-income subsidy eligibility.

In December 2006, CMS sent a memorandum to Part D plans explaining that they must use the best available data to reconcile status when a beneficiary believes he or she is still eligible for the subsidy. The beneficiary may present proof of eligibility, such as a Medicaid card, at the pharmacy and the plan should follow up to collect the evidence. In Mrs. M's situation, however, the plan failed to explain to the pharmacist that the beneficiary could present documentation of her Medicaid eligibility at the pharmacy in order to continue receiving the subsidy, and her medications, until the issue was resolved.

Another example:

> Mr. and Mrs. Y have developmental disabilities and qualified for Missouri Medicaid for a portion of 2005 after they "spent down" their excess income to meet medical expenses. Thus, they were deemed eligible for the full low-income subsidy in 2006. Because they allegedly had not met their "spend-down" amount in the second half of 2006, however, they were not deemed eligible for the low-income subsidy for 2007. The couple qualifies for a partial subsidy based on income, and so, in contrast to their experience in 2006, they will have to pay a deductible and premium for their drug coverage in 2007. They will also have to pay more for each prescription.
>
> An advocate who was assisting the couple in choosing new drug coverage at the end of December 2006 discovered that the couple had hospital and medical bills that should have been sufficient to establish that they had met their "spend-down amount" (payment toward medical expenses, recognized by Medicaid, as reducing the applicant's income for purposes of qualifying for Medicaid) in October 2006. Had they submitted the medical bills to the state Medicaid agency, they would have been eligible for Medicaid and deemed eligible for LIS for all of 2007. Because they did not submit the medical documents on time, they will have to pay premiums and cost-sharing until their Medicaid is established retroactively. They will then be deemed eligible for full LIS retroactively, and they and their advocate will have to take steps to seek reimbursement for the premiums and other expenses they paid until information about their LIS-subsidy level is shared with their drug plan.

Individuals who were not on the Medicaid rolls at the time CMS made deemed status decisions were sent letters telling them that they were losing their subsidy because of the loss of their other benefit. The letter included an application to be mailed to the Social Security Administration. However, if the individual later regains eligibility for the other benefit, he or she will be re-deemed for the LIS, without further consideration of his or her SSA application. While this is a desirable outcome, beneficiaries are too often confused by the array of letters they receive regarding their changing status. Moreover, delays in the transmission of subsidy information between states, SSA, CMS, and plans may result in incorrect LIS status information being available at the pharmacy when a beneficiary arrives in 2007. As described above, this can result

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in low-income people paying more than they should – and sometimes failing to obtain their medications.

When a Medicaid beneficiary loses eligibility for Medicaid benefits, states have an obligation under Medicaid law to determine if that person is eligible under another category of the state's program. For example, someone losing Medicaid eligibility might, nonetheless, still be eligible for a Medicare Savings Program, since these income and resource limits are higher than Medicaid in most states. If states routinely undertook these new determinations of eligibility for other Medicaid benefits before terminating people from the program, fewer LIS recipients would find themselves in the limbo of not knowing about their LIS status. Similarly, even for those individuals no longer eligible for any benefits under the state Medicaid program, the state or the Social Security Administration (SSA), whose income and resource limits are higher than those of most states' Medicaid programs, could undertake independently to determine their eligibility for the LIS.

SSA is required by law to redetermine eligibility of those individuals who applied for LIS through SSA within the first year after their initial enrollment. SSA used a largely "passive" redetermination process for 2007. It sent letters to beneficiaries who qualified for the LIS in 2006 asking them to contact SSA if their circumstances had changed. If the individual's circumstances had not changed, the beneficiary was not required to take any action. If they had, the process continued. Little information is available at this time on the effectiveness of this system.

After the first redetermination, the Commissioner of SSA has discretion to undertake redeterminations as necessary. Since most low-income Medicare beneficiaries do not have significant changes in income and resources, the Commissioner could exercise his discretion to minimize redeterminations.

Recommendations

Congress should hold oversight hearings on the implementation of Part D. The hearings should include an inquiry into the special problems of dually eligible beneficiaries and CMS's role in setting and enforcing standards for plan participation.

Congress should require CMS to create a plan to move expeditiously to a full system of real time data-sharing among all entities involved in Part D. Congress should require CMS to report on its strategies to resolve these problems effectively and within a specific time period, and should require periodic status reports from CMS.

CMS should require states to redetermine the eligibility of *anyone losing Medicaid* to determine if that individual qualifies for the low-income subsidy (LIS, also known as Extra Help) as a result of eligibility for other qualifying benefits. CMS should also require states to redetermine LIS eligibility for *anyone who lost his or her Extra Help due to losing their deemed status.* Further, CMS and SSA should explore which agencies should oversee such redeterminations.

CMS should create a real time data-sharing system among all entities involved in Part D, and develop mandatory fail-safe systems to ensure that persons who are dually eligible for Medicare and Medicaid do not experience gaps in either their drug coverage or their low-income subsidy.

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CMS should expand its point of service (POS) system to make its coverage available at the pharmacy for all dually eligible persons who experience plan enrollment and related drug dispensing problems at the pharmacy. Further, CMS should require pharmacies to use the POS system, and hold pharmacies harmless for good faith billings to the POS that turn out to be incorrect.

2. Beneficiaries Are Confused By The Part D Benefit Structure, And In Particular By The Gap In Part D Coverage Known As The "Donut Hole"

The standard Part D prescription drug benefit includes a deductible and beneficiary cost-sharing up to an initial coverage limit. Once that limit is reached, beneficiaries enter a "coverage gap," known as the "Donut Hole," and are responsible for the full cost of their drugs unless and until they reach a catastrophic threshold. Cost-sharing is reduced for all beneficiaries who get out of the Donut Hole, including those who are eligible for the low-income subsidy (LIS), also known as "Extra Help." Unfortunately, many beneficiaries do not understand the benefit structure and the implications of the Donut Hole. Thus, they were not adequately prepared when they had to pay the full cost for their prescriptions. For example:

> In September 2006, Mrs. L, the wife of a Medicare beneficiary, was charged $73.59 for one of her husband's prescriptions instead of the $28.00 that she had been paying since the beginning of the year. The pharmacy technician had "no idea" why the cost of the drug increased. The wife called the drug plan and was told about the Donut Hole. The woman said that when she signed her husband up for Part D, she did not understand how the Donut Hole might affect her family. Because her husband would not exit the Donut Hole by December 31, he paid the Part D premium as well as the full cost of his drugs for the rest of 2006. Since learning of the Donut Hole and its impact, the woman has been blaming herself. She remarked that she knows she needs to educate herself (her husband is not mentally capable of doing so). She said that she has to work, to take care of her husband, to pay the bills, and to figure out how best to manage all health care options, and she does not have enough time in the day to sort out health insurance issues. She wonders how a program could be designed with such flaws.

Information provided to beneficiaries by both CMS and by drug plans often does not clearly explain the Donut Hole coverage gap. Even beneficiaries who understood that they would experience a gap in coverage did not understand how the initial coverage limit is calculated (full cost of all formulary drugs) and how their out-of-pocket costs to reach the catastrophic limit are calculated (beneficiary cost-sharing for formulary drugs up to the coverage limit, plus full cost of formulary drugs purchased at network pharmacies while in the gap.) Further, because Part D allows the costs of prescriptions to vary throughout the year, beneficiaries who relied on the plan's price for their drugs when they chose a Part D plan may have underestimated what they would spend for prescriptions when they entered the coverage gap.

A. Paying For Drugs In The Donut Hole Creates Problems For Many Beneficiaries

Some beneficiaries who enter the Donut Hole have difficulty figuring out how to pay for their prescriptions. For example:

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> A case worker complained to the Center for Medicare Advocacy that many of her clients cannot afford their medications once they enter the Donut Hole. Some individuals have been assisted through the local Adult Protective Services program and other social services agencies that will pay for at least one month of medications. A few patient assistance programs have provided free medications for individuals who have a statement from their plan that they have reached the gap in coverage. Unfortunately, the case worker had clients who were going without medications or were spending their savings to buy medications.

The Donut Hole problems are exacerbated by the fact that some previous methods of paying for prescription drugs may no longer be available to Medicare beneficiaries. Some pharmaceutical assistance programs (PAPs), sponsored by drug manufacturers, no longer provide assistance to people enrolled in Part D. Even if a PAP will assist a Part D enrollee, neither the PAP's contribution toward the drug nor the beneficiary's cost-sharing counts towards the out-of-pocket amount the beneficiary needs to spend in order to get out of the Donut Hole. Similarly, assistance provided by AIDS Drug Assistance Programs (ADAPs) does not count to get out of the Donut Hole.

CMS encourages beneficiaries to consider using generic drugs and to enroll in plans with enhanced drug coverage that includes coverage through the Donut Hole. However, changing to a generic drug is not always possible. Many people with cardiac problems, cancer, multiple sclerosis, and other ongoing conditions rely on new, brand-name drugs for which there are still no generic equivalents. Most plans that offer Donut Hole coverage only pay for generic drugs in the gap. A few plans provide gap coverage for brand-name drugs, but there are only a few such plans, they are costly, and they are not available in every state. Even fewer such plans are available in 2007 than in 2006. [1] Thus, these plans provide no assistance to beneficiaries for whom a generic drug is either not available or not medically indicated.

B. Lack Of Knowledge About How The Donut Hole Works Often Leaves Beneficiaries Unprepared For This Gap In Coverage

Beneficiaries often do not know when they are approaching the Donut Hole or if and when they will reach the catastrophic coverage amount. Part D plans are supposed to include information in the monthly summary of benefits they send to plan enrollees so that enrollees can calculate when they will reach the Donut Hole. As shown by Mrs. L's story, however, that information may not be provided at all or may not be provided in a manner understood by beneficiaries. Problems also occur when beneficiaries try to predict whether their drug costs are high enough to get them through the coverage gap. For example:

> A Florida-based advocate worked all year with the CMS regional office on behalf of a dual-eligible beneficiary who experienced continuous enrollment and disenrollment problems. Because the beneficiary's drug costs are so high, the advocate believed that the beneficiary should have gotten through the Donut Hole and therefore not been charged any co-payments for her drugs. However, neither the plan nor CMS could tell the advocate when the beneficiary had reached the

[1] In 2006, 2.3% of PDPs offered coverage for generic and brand-name drugs during the coverage gap (Donut Hole). That number falls to 1.4% in 2007. J. Hoadley, E. Hargrave, K. Merrill, J. Cubanski, T. Neumann, "Benefit Design and Formularies of Medicare Drug Plans: A comparison of 2006 and 2007 Offerings – A First Look" (Kaiser Family Foundation, November 2006), at p. 16.

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> catastrophic threshold. The e-mail response from CMS seemed to indicate that the beneficiary would still be charged co-payments after she reached the catastrophic threshold, even though federal law states otherwise.

Beneficiaries cannot calculate their expenses if they do not know when they will have to start paying for their drug costs in full or when they have reached the catastrophic limit. Beneficiaries' plans and CMS must ensure that Part D enrollees have the information they need and that beneficiaries with very high drug costs get the full Part D benefit to which they are entitled.

Recommendations

Congress should eliminate the Donut Hole. If the Donut Hole is not eliminated, Congress should, at a minimum, authorize payments by AIDS Drug Assistance Programs (ADAPs) and pharmaceutical assistance programs (PAPs) to count towards the beneficiary out-of-pocket spending limit.

CMS and Part D plans should be required to provide beneficiaries with clear and accurate information about Part D, individual plan offerings, and in particular, about the Donut Hole coverage gap. This information should include the following:

- Materials from CMS and the enrollee's plan that explain how the initial coverage limitation and beneficiary out-of-pocket expenses, including Donut Hole payments, are calculated should be mailed to beneficiaries;

- Monthly statements that clearly indicate the total amount of payments that have been made that count towards the individual's initial coverage limit and beneficiary out-of-pocket responsibilities should be mailed to beneficiaries; and

- Monthly statements that indicate, after the initial coverage limit has been reached, all costs that continue to count towards the out-of-pocket limit in the Donut Hole and how much more is needed to reach catastrophic coverage should be mailed to beneficiaries.

3. Beneficiaries Cannot Be Guaranteed That Premiums Will Be Withheld From Their Social Security Checks As Requested, Or That The Premiums They Pay Will Reach The Part D Plan In Which They Are Enrolled

Paying premiums for the Part D plans they have chosen is a challenge for many beneficiaries. Many beneficiaries chose to have Part D premiums withheld from their Social Security checks and paid directly to their plans, as they are accustomed to doing with Part B premiums. For some, Social Security withholding was never implemented. For others, Social Security withholding was implemented incorrectly. Some beneficiaries received refunds of their withheld premiums that were not due them, while others who were due premium refunds waited months to receive the money that was owed them. For example:

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> Mrs. X received an incorrect premium refund in August and repaid the money by sending a personal check to her drug plan, rather than to CMS. She then received a bill from her drug plan for a total of three months' premiums, September, October, and November. These premiums had already been deducted from her Social Security benefit, two payments from her October benefit and one from her November benefit. An advocate contacted the drug plan on her behalf, with a representative of the Social Security Administration on the phone, to verify that the premiums had been deducted. The information was to be sent to the drug plan's finance department, but confusion about the three months' payment has not yet been resolved.
>
> At the same time, the advocate learned that Mrs. X's account with her drug plan had been changed from Social Security withholding to direct pay. The advocate asked if this change was made because the beneficiary paid the "refund" with a personal check. The customer service representative could not answer; she did not have access to payment information. The client had not requested to have her payment method changed to direct pay. The drug plan representative could not talk about payment history.
>
> Another example:
>
> An advocate was concerned about finding a safe and effective course of action for Mrs. R, whose Part D premiums throughout 2006 had never been withheld from her Social Security check as she requested. Mrs. R. is understandably concerned about when and how the year's worth of premiums will be deducted from her Social Security check. In particular, she is worried that, with the press of obligations, she will not have the funds to make a lump-sum payment if requested; the payment issues have left her with a lack of confidence whether to use the Part D benefit at all.

These stories illustrate the complex and apparently intractable nature of premium-withholding problems. Whether Mrs. X's issue was resolved was impossible to confirm despite a three-way conversation with SSA, the plan, and the client and her advocate. Mrs. R's problem continued throughout 2006 and had not been resolved by the end of the year.

The Center for Medicare Advocacy hears regularly from advocates who generally advise clients to ask for direct billing from the plan, rather than premium-withholding, because the withholding system is so broken. While this recommendation is an effective short-term solution, it denies beneficiaries their right under the law to use the premium-withholding system so familiar to them from Medicare Part B, a system that, under Part D, has fallen victim to the complexities and inefficiencies of a program dependent on hundreds of private plans.

CMS has admitted that problems exist with its system of withholding the amount of the Part D premium from beneficiaries' Social Security checks and transmitting that amount to beneficiaries' Part D plans. In a hearing before the Senate Finance Committee in early September 2006, CMS acknowledged that the problem of premium-withholding had initially affected more than half a million beneficiaries. It claimed, at that time, that it had resolved most of the problems and that only about 150,000 remained to be addressed. Later in the fall of 2006,

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however, with problems continuing, CMS changed the default setting for payment of premiums on its web-based Plan Finder, from premium-withholding to direct billing from the Social Security check. A beneficiary wishing to have premiums withheld from his or her Social Security check cannot choose that option on-line but "will be contacted" by CMS to make specific arrangements. The number of beneficiaries still experiencing problems with premium-withholding is unknown, but problems still persist for many:

- Premium withholding continues to occur without beneficiary authorization or continues after the beneficiary has disenrolled from the plan or is not stopped when a beneficiary so requests.

- Premiums are not withheld when a beneficiary has so requested. Some beneficiaries have had no withholding throughout 2006 and are understandably anxious that all the premiums will be taken from a single Social Security check, leaving them with little or no income for the month.

- Withheld premiums have been refunded to many beneficiaries, in some cases correctly and in others, incorrectly. When CMS sought to recover the incorrectly-refunded premiums, it failed to notify beneficiaries of their right to be excused from recovery.

- Plans have still not received payment from CMS or SSA of premiums apparently withheld.

Recommendations

Congress should hold oversight hearings to understand the issues that make premium withholding so unreliable and should require CMS to solve these problems.

CMS should notify all beneficiaries who received incorrect premium refunds in 2006, and all beneficiaries for whom premium withholding has been delayed, of their right to seek a waiver of the recovery of these funds.

CMS should ensure that all plans have been paid all premiums owed for beneficiaries who asked for premium withholding in 2006 (so that the burden is not left with individual beneficiaries to work out problems on their own with their plans).

4. The Process For Getting Coverage Of Drugs That Are Not On A Drug Plan's Formulary Is Confusing, Complicated, And Often Not Understood By Beneficiaries

In promoting Part D, CMS assured beneficiaries that they would have access to all of their medically necessary prescription drugs. What CMS failed to explain to beneficiaries is that they might have to file for a "coverage determination" and pursue an appeal if the drug they need is not on their plan's formulary or is subject to certain restrictions, such as a limitation on the number of dispensable pills ("quantity limits") or the need to request the plan's permission before the drug is prescribed and paid for ("prior authorization"). The process for requesting a coverage determination and then an appeal is complicated, and most beneficiaries do not even understand this process, or the fact that they have the right to seek coverage for a drug not on their plan's formulary.

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A. Beneficiaries Are Not Adequately Informed Of Their Right To Request A Coverage Determination And File An Appeal

The Part D appeals process cannot begin unless and until a beneficiary who is denied coverage for a drug at the pharmacy affirmatively requests a formal "coverage determination" from his or her Part D drug plan. A coverage determination can only be issued by the drug plan itself; the denial at the pharmacy counter has no legal effect. The formal coverage determination from the plan should explain why the plan will not pay for the drug and how to start the appeals process.

Most beneficiaries who are denied coverage for their prescribed medications need to request a special type of coverage determination known as an "Exception." An Exception may include a request to cover a drug that is not on the formulary, a request to reduce the cost-sharing for a drug, a request to provide a larger dose of a drug than the formulary limit, or a request to receive the prescribed drug without first trying a less expensive drug ("step therapy"). An Exception may also include a request to provide a drug without first getting prior authorization from the drug plan.

Unfortunately, beneficiaries are not adequately informed of the need to request a coverage determination. As a consequence, they never contact their drug plan for a coverage determination and they never enter the appeals process. For example:

> After waiting two weeks for her refill, Mrs. F, a Maryland Medicare beneficiary, called the mail-order pharmacy used by her plan, only to be told that her prescription could not be refilled without prior authorization from the drug plan. If she had not called the pharmacy, she would not have known that she needed to request prior authorization from the drug plan before it would cover her drug. Even after she called, the mail-order pharmacy never sent her the notice explaining her rights. Thus, she did not know that she had a right to request an Exception to the prior authorization requirement.

Advocates continue to report that pharmacies are not providing beneficiaries with the CMS-approved notice, *"Medicare Prescription Drugs and Your Rights,"* which explains in general the right to contact one's plan to request an Exception or other coverage determination. In December, an advocate who saw that the notice was not posted at a large chain drug store in suburban Washington, DC, was told that the pharmacy tells beneficiaries to call their plan, without giving them anything in writing or posting the notice.

Medicare regulations require Part D plans to arrange with their network pharmacies either to post the generic *"Medicare Prescription Drugs and Your Rights"* or to hand the notice to a beneficiary whose prescription has been denied. Posting of the notice provides very little protection. The notice is often posted in a place that makes it difficult to read. Moreover, because the notice is generic, telling beneficiaries only of their right to request an exception and the need to contact the plan, beneficiaries do not know what information they will need to provide in order to get their prescription covered or exactly how to contact their plan.

Furthermore, neither CMS nor the plans take responsibility when advocates complain that beneficiaries are not being informed of their rights to ask for an Exception and then to appeal. CMS says the plans are required to ensure distribution of the generic notice; plans claim they have done their job in educating pharmacies.

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B. Beneficiaries Lack Plan Information For Evaluating A Prior Authorization Request

Even if, as in the case of Mrs. F, the pharmacy tells a beneficiary that prior authorization from the plan is required before a drug will be covered, the beneficiary still does not have all the information he or she needs in order to take action to get his or her medication. Drug plans do not make available on their web site or through their customer service centers the criteria they use to evaluate a prior authorization request. Thus, beneficiaries, their doctors, and their advocates do not have the information they need to support a request for prior authorization or a request for an Exception to a prior authorization requirement.

C. The Part D Appeals Process Includes Conflicting Directives Concerning The Effect Of The Attending Physician's Opinion On An Exception Request And Appeal

A beneficiary must have the support of the prescribing physician in order to succeed with an exceptions request. Indeed, the Medicare statute makes the opinion of the attending physician concerning his or her patient's need for a non-preferred drug the controlling factor in determining coverage. However, the Part D regulation specifically downgrades the effect of the physician's opinion to such an extent that it is not clear whether any deference is given. Thus while beneficiaries must obtain a supporting document from their physician even to enter the appeals process, Part D plans are not required to respect the physician's opinion.

This is particularly problematic when the beneficiary and physician seek an Exception for approval of an "off-label" use of a drug approved by the Food and Drug Administration (FDA). The use of drugs "off-label" is legal in the United States and is governed by strict rules for marketing. In many situations, physicians and their patients have determined over time that certain drugs approved by the FDA for one purpose also help with a different medical problem. Yet Part D plans do not defer to the opinion of the treating physician, even when the off-label use is supported by scientific literature, proven safe and effective over a substantial amount of time, and covered by the beneficiary's state Medicaid program. For example:

> In 1995 Mrs. B, a dually eligible beneficiary in Florida, was prescribed an off-label drug to treat her multiple sclerosis (MS). As a result of the drug, she remained symptom-free, and she experienced no side effects. As required, Mrs. B looked to Part D to cover this drug in 2006. She chose a Part D plan because the plan representative said the drug was on the formulary. However, in April 2006, the drug plan said it would no longer cover the drug. The woman requested an Exception, and the plan asked her physician and her attorney to provide two national and professional medical journals to show why the use of the drug was medically reasonable to treat MS. Despite the fact that the beneficiary's medical record established that the drug had been effective for 11 years, and despite the fact that four peer-reviewed medical journal articles were submitted, the plan denied coverage of the drug. An Administrative Law Judge ruled in December that the drug was safe and effective and medically necessary for the woman, and ordered the drug plan to cover the drug. However, because the woman stopped taking the drug at the end of March, her symptoms returned.

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D. Part D Complaint Mechanisms Are Not Prompt Or Reliable, Making The Process More Difficult For Beneficiaries

CMS has established a number of mechanisms through which beneficiaries may seek redress of problems with their drug plan. Beneficiaries may seek a coverage determination and appeal if a drug is not covered, file a grievance with the drug plan if they have a complaint that does not involve drug coverage, and/or file a complaint by calling the Medicare hotline, 1(800)MEDICARE. As illustrated below, these mechanisms are ineffective.

> Mr. S, a New York beneficiary, and his doctor requested an expedited (72 hour) appeal after his drug plan said it would no longer cover one of his drugs. When no response was received, the beneficiary called the plan three times. He waited each time for about 45 minutes, trying to speak to a plan call center supervisor, and was disconnected each time before speaking to a supervisor. Finally, the beneficiary was called by the plan and told that the drug in question was not covered. The telephone representative did not provide any further explanation or describe additional appeal rights. The beneficiary did not receive written notice of the denial. The beneficiary subsequently called 1(800)MEDICARE to complain about the process. CMS's customer service representative told the beneficiary that the Medicare Call Center has no control over appeals issues and that he should contact the drug plan.

Recommendations

Congress should redesign Medicare Part D to create a benefit that is standardized, available throughout the country, and administered through the traditional Medicare program. Such a system would be more valuable for more beneficiaries and more cost-effective for taxpayers.

Congress should require Part D plans to give deference to the opinion of the beneficiary's attending physician when making coverage decisions and should require CMS to delete the provision to the contrary in its regulations [42 CFR §423.578(f)].

Congress should authorize Part D coverage for off-label uses of drugs that are supported by peer-reviewed studies, are proven safe and effective over a substantial period of time, are covered by the beneficiary's state Medicaid program, or are listed in one of the three compendia currently included in the Medicare Act.

CMS should require plans to provide a written coverage determination electronically at the pharmacy whenever a drug is not covered. The written coverage determination must explain why the plan will not pay for a drug and describe beneficiary appeal rights and explain how to request the next level of review.

CMS should require Part D plans to include on their web site, through their customer service centers, and in their written materials, information about whether each drug on their formulary requires prior authorization or other utilization management tools, and the criteria used by the plan in determining whether the precondition to Part D coverage has been met.

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CMS should ensure that Part D plans comply with required appeals and grievance processes, that plan call centers respond appropriately to beneficiaries, and that Medicare "customer service" representatives provide accurate information and keep track of beneficiary complaints.

CMS should exercise its enforcement authority to take actions against Part D plans that do not provide adequate notice, fail to meet the regulatory time frames for deciding a coverage determination or an appeal, or fail to train their call center staff adequately.

CONCLUSION AND RECOMMENDATIONS

The stories presented here illustrate a variety of problems that continue to affect Part D beneficiaries at the end of the first year of program implementation. While each of these problems could be remedied by certain changes in program operations, they all derive, in large part, from the lack of uniformity in Medicare Part D and its reliance on hundreds of private plans. Although some people are better off than they were prior to Medicare Part D, too many remain confused and frustrated with the complexities and limitations of the drug program. All beneficiaries would be better off with a redesigned benefit that is standardized, available throughout the country, and administered through the traditional Medicare program.

BASED ON OUR EXPERIENCE WITH MEDICARE BENEFICIARIES AND THEIR HELPERS, THE CENTER FOR MEDICARE ADVOCACY RECOMMENDS THE FOLLOWING.

THESE RECOMMENDATIONS WILL IMPROVE MEDICARE'S PRESCRIPTION DRUG BENEFIT, MAKING IT MORE VALUABLE FOR BENEFICIARIES AND MORE COST-EFFECTIVE FOR TAXPAYERS.

Recommendations for Congress:

1. Congress should redesign Medicare Part D to create a benefit that is standardized, available throughout the country, and administered through the traditional Medicare program. Such a system would be more valuable for more beneficiaries and more cost-effective for taxpayers.

2. Congress should eliminate the Donut Hole. If the Donut Hole is not eliminated, Congress should, at a minimum, authorize payments by AIDS Drug Assistance Programs (ADAPs) and pharmaceutical assistance programs (PAPs) to count towards the beneficiary out-of-pocket spending limit.

3. Congress should require Part D plans to give deference to the opinion of the beneficiary's attending physician when they make coverage decisions.

4. Congress should authorize Part D coverage for off-label uses of drugs that are supported by peer-reviewed studies, are proven safe and effective over a substantial period of time, are covered by the beneficiary's state Medicaid program, or are listed in one of the three compendia currently included in the Medicare Act.

5. Congress should hold oversight hearings on the implementation of Part D. The hearings should include an inquiry into the special problems of dually eligible beneficiaries, the withholding of premiums by plans and Social Security, and CMS's role in setting and enforcing standards for plan participation.

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6. Congress should require CMS to expeditiously establish a full system of real time data-sharing among all entities involved in Part D. Congress should require CMS to report its plans to resolve these problems effectively and within a specific time period, and should require periodic status reports from CMS.

Recommendations for the Centers for Medicare & Medicaid Services (CMS)

1. CMS should require states to redetermine the eligibility of *anyone losing Medicaid* to determine if that individual qualifies for the low-income subsidy (LIS, also known as Extra Help) as a result of eligibility for other qualifying benefits. CMS should also require states to redetermine LIS eligibility for *anyone who lost his or her Extra Help due to losing their deemed status*. Further, CMS and SSA should explore which agencies should oversee such redeterminations.

2. CMS should create a real time data-sharing system among all entities involved in Part D, and develop mandatory fail-safe systems to ensure that persons who are dually eligible for Medicare and Medicaid do not experience gaps in either their drug coverage or their low-income subsidy.

3. CMS should expand its point of service (POS) system to make its coverage available at the pharmacy for all dually eligible persons who experience plan enrollment and related drug dispensing problems at the pharmacy. Further, CMS should require pharmacies to use the POS system, and hold pharmacies harmless for good faith billings to the POS that turn out to be incorrect.

4. CMS and Part D plans should be required to provide beneficiaries with clear and accurate information about Part D, individual plan offerings, and in particular, about the Donut Hole coverage gap. This information should include the following:

- Materials from CMS and the enrollee's plan that explain how the initial coverage limitation and beneficiary out-of-pocket expenses, including Donut Hole payments, are calculated should be mailed to beneficiaries;

- Monthly statements that clearly indicate the total amount of payments that have been made that count towards the individual's initial coverage limit and beneficiary out-of-pocket responsibilities should be mailed to beneficiaries; and

- Monthly statements that indicate, after the initial coverage limit has been reached, all costs that continue to count towards the out-of-pocket limit in the Donut Hole and how much more is needed to reach catastrophic coverage should be mailed to beneficiaries.

5. CMS should notify all beneficiaries who received incorrect premium refunds in 2006, and all beneficiaries for whom premium withholding has been delayed, of their right to seek a waiver of the recovery of these funds.

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6. CMS should ensure that all plans have been paid all premiums owed for beneficiaries who asked for premium withholding in 2006 (so that the burden is not left with individual beneficiaries to work out problems on their own with their plans).

7. CMS should require plans to provide a written coverage determination electronically at the pharmacy whenever a drug is not covered. The written coverage determination must explain why the plan will not pay for a drug, describe beneficiary appeal rights, and explain how to request the next level of review.

8. CMS should require Part D plans to include on their web site, through their customer service centers, and in their written materials, information about whether each drug on their formulary requires prior authorization or other utilization management tools, and the criteria used by the plan in determining whether the precondition to Part D coverage has been met.

9. CMS should ensure that Part D plans comply with required appeals and grievance processes, that plan call centers respond appropriately to beneficiaries, and that Medicare "customer service" representatives provide accurate information and keep track of beneficiary complaints.

10. CMS should exercise its enforcement authority to take actions against Part D plans that do not provide adequate notice, fail to meet the regulatory time frames for deciding a coverage determination or an appeal, or fail to train their call center staff adequately.

THE CENTER FOR MEDICARE ADVOCACY

Founded in 1986, the Center for Medicare Advocacy is a national, non-profit, non-partisan organization that works to ensure fair access to Medicare and quality health care. The organization is headquartered in Connecticut, with offices in Washington, DC and throughout the country.

The Center responds to over 7,000 calls and emails annually from older people, people with disabilities, their families, and support networks. The Center provides in-person and web-based training throughout the United States. The organization is a partner in Connecticut's SHIP (State Health Insurance and Assistance Program, known in Connecticut as CHOICES), providing training, educational materials, and direct assistance with Medicare, Part D, and related programs. Since November 15, 2005, when beneficiaries could first enroll in Part D, through May 15, 2006, when enrollment closed, the Connecticut CHOICES program handled over 38,000 calls, more than two-thirds of which were about Part D. As the CHOICES legal support center, the Center for Medicare Advocacy handled, or provided guidance about, a significant portion of these calls.

As a result of a grant from a national foundation, the Center for Medicare Advocacy also provides advocacy, training, telephone and on-line assistance regarding Part D on behalf of beneficiaries and their advocates throughout the country. The Center hosts two web sites: www.medicareadvocacy.org and www.fairmedicare.org.

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FOR THE RECORD

Statement
on
The Medicare Part D Prescription Drug Program

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Submitted to the
U.S. Senate Special Committee on Aging

January 31, 2007

I. Introduction

America's Health Insurance Plans (AHIP) and our member companies are enthusiastic supporters of the Medicare Part D prescription drug program. This program is providing important benefits and peace of mind to millions of Medicare beneficiaries.

AHIP's membership includes most sponsors of both stand-alone prescription drug plans (PDPs) and Medicare Advantage plans that combine drug benefits with comprehensive health coverage (MA-PDs). These companies have a long track record of participation in Medicare and other public programs. Our members are strongly committed to the long-term success of the Part D program.

As the program begins its second year, more than 39 million Medicare beneficiaries – representing approximately 90 percent of the Medicare population – have prescription drug coverage either through Part D directly, an employer plan that is supported through Part D, or other sources. On a daily basis, these beneficiaries are personally experiencing the early success of the Part D program and the role that competition, choice, and innovation have played in providing them with high quality, affordable prescription drug coverage.

We appreciate the committee's interest in examining the Part D program's role in meeting the prescription drug needs of low-income beneficiaries. This statement offers our perspectives on this important priority and also discusses the program's overall track record during the past 13 months.

II. Savings and Value for Beneficiaries

Part D prescription drug plans are exceeding expectations by offering more comprehensive benefits and lower premiums than were originally anticipated. According to the Centers for Medicare & Medicaid Services (CMS)[1], beneficiaries who previously did not have drug coverage saved an average of $1,200 in 2006 by enrolling in Part D plans. For millions of Medicare beneficiaries – particularly those who have low incomes with no other source of drug

[1] Centers for Medicare & Medicaid Services, *Part D Medicare Prescription Drug Benefit Fact Sheet*, January 2007

coverage – this coverage ensures that they receive the medications they need at an affordable price.

To shed further light on the savings available through Part D, CMS[2] has reported that beneficiaries can save an average of 53 percent on commonly-used drugs tracked by the agency, compared to the amount they would have paid without prescription drug coverage. Beneficiaries who choose the lowest cost plan in their area can save up to 68 percent. Another study, conducted by the Lewin Group[3], found that beneficiaries without previous drug coverage who have one or more of five chronic conditions – arthritis, diabetes, hypertension, osteoporosis, or respiratory illness – are saving 58 percent on their drug costs by enrolling in a Part D plan.

Plan sponsors are offering a range of prescription drug plans with high quality coverage, many of which go well beyond the minimum requirements of the Medicare Modernization Act of 2003 (MMA). Rather than establishing a one-size-fits-all benefits package, the Part D program creates incentives for plan sponsors to design different benefit packages that address beneficiaries' needs in three key areas – cost, coverage, and convenience. As a result, beneficiaries in all 50 states have the option of choosing at least one Part D plan that covers a portion of the costs in the coverage gap. In 41 states, beneficiaries have at least one MA-PD option with coverage in the gap and a zero Part D premium[2].

Presented with these options, the vast majority of beneficiaries have selected benefit packages that differ from the minimum requirements set by the MMA. CMS data show that the standard defined benefit was selected by only 19 percent of beneficiaries in stand-alone prescription drug plans and by only five percent of beneficiaries in Medicare Advantage plans with prescription drug benefits last year[2]. All other beneficiaries are choosing plans that offer enhanced benefits or alternatives to the standard benefit.

While the vast majority of Medicare Part D enrollees have continuous prescription drug coverage throughout the year, a small percentage of enrollees are affected by the "coverage gap." Part D plans provide these beneficiaries who reach the coverage gap with significant discounts off their prescription drug prices. According to one study[4], these savings total more than 35 percent relative to retail prices. This means that beneficiaries are receiving significant savings through

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[2] Centers for Medicare & Medicaid Services, *Part D Medicare Prescription Drug Benefit Fact Sheet*, January 2007
[3] The Lewin Group, *Chronic Health Conditions & the New Medicare Part D Benefit: Savings on Frequently Used Medications*, April 12, 2006
[4] Pharmaceutical Care Management Association, press release, March 15, 2006

their Part D plans even when they have reached the coverage gap (i.e., after exhausting the initial coverage limit and before reaching the catastrophic benefit).

The value offered by Part D plans also can be seen in the lower-than-expected premiums that beneficiaries are paying. CMS data[5] show that the average premium paid by Part D enrollees last year was $23 per month. This figure is 38 percent lower than the $37 monthly premiums that were projected by the Medicare Board of Trustees in their 2005 report. Similarly, CMS has reported that beneficiary premiums in 2007 will average $22 a month if enrollees remain in their current plans. This figure is 46 percent lower than the $41 monthly premiums that the Medicare trustees projected for 2007.

Taxpayers also are benefiting from plans' success in delivering quality prescription drug coverage at an affordable price. The Congressional Budget Office (CBO)[6] recently announced that the projected costs for the Part D program over the next seven years (2007-2013) are now $136 billion lower than the original estimate. CBO reported that a major factor contributing to the lower costs is that bids submitted by plan sponsors for 2007 under the program's competitive structure are about 15 percent lower than the 2006 bids.

III. An Important Safety Net for Low-Income Beneficiaries

While beneficiaries of all income levels can save money by choosing Part D plans, financially vulnerable beneficiaries can expect to receive exceptionally large savings because of the low-income subsidies the MMA provides. More than 9 million Medicare beneficiaries are currently receiving this additional assistance. On average, Medicare will pay more than 95 percent of prescription drug costs for these low-income beneficiaries.

Many beneficiaries automatically qualify for low-income subsidies because they are dually eligible for both Medicare and Medicaid or because they receive Supplemental Security Income (SSI) benefits. However, others need to submit an application to the Social Security Administration (SSA) to determine whether they qualify for low-income subsidies based on their income and resources. AHIP's members have been working pro-actively to reach out to low-income beneficiaries to encourage them to apply for this additional assistance. During the Part D

[5] CMS, *Projected Net Medicare Drug Costs Drop by Another Ten Percent*, January 8, 2007
[6] CBO, *The Budget and Economic Outlook: Fiscal Years 2008-2017*, January 2007

open enrollment period, AHIP members played a leadership role, while working in cooperation with CMS, in assisting beneficiaries who may be eligible for low-income assistance. Plans took the initiative in implementing pro-active steps in several key areas:

- Plan sponsors used a CMS model letter and outbound phone script to contact enrollees who automatically qualified for low-income subsidies in 2006, but who had to apply for the subsidy this year.

- Plan sponsors trained their customer service representatives to assist beneficiaries in completing and submitting the application for low-income subsidies to the SSA.

- Plan sponsors contracted with vendors to provide a "warm transfer" so beneficiaries could receive assistance from trained specialists in completing and submitting the application.

- Taking advantage of an opportunity provided under CMS guidance, plan sponsors have offered up to a three-month grace period for the collection of premiums and cost-sharing to individuals who lost their deemed status for low-income subsidies and are able to demonstrate that they have applied for this extra assistance.

- Plan sponsors are providing links on their websites to the SSA website (www.socialsecurity.gov), which includes general information about low-income subsidies and the application itself.

In addition, plan sponsors are supporting outreach efforts to low-income beneficiaries through partnerships with a variety of national, state, and community groups. Countless other plans have organized community events and health fairs across the nation to raise awareness among beneficiaries about low-income subsidies under Medicare Part D. Through all of these activities, AHIP's members are demonstrating their strong commitment to ensuring that Medicare beneficiaries receive the full range of assistance offered by the Part D program.

Looking forward, AHIP stands ready to work with Congress to explore additional steps – including eliminating the assets test when determining eligibility for low-income subsidies – for further improving the Part D program's effectiveness in serving beneficiaries who have limited financial resources. Additional funding for State Health Insurance Assistance Programs (SHIPs) also would help achieve this goal. Ensuring that low-income beneficiaries do not face

unreasonable barriers in their quest to receive extra assistance with their Part D premiums and cost-sharing should be a top priority in the ongoing debate and oversight of the program.

IV. The Part D Program Is Valued by Beneficiaries

Numerous surveys show that a large percentage of the Medicare population is pleased with the new Part D program and the benefits it is delivering. The positive attitudes of Medicare beneficiaries toward the Part D program are reflected in surveys sponsored by AHIP, the Medicare Rx Education Network, the *Washington Post*/ABC News, AARP, Medicare Today, JD Power and Associates, the *Wall Street Journal*, and the Kaiser Family Foundation.

Each of these surveys confirm that a significant majority of Medicare Part D enrollees are having a positive experience with their new prescription drug benefits. These surveys clearly show that most beneficiaries are satisfied with the program, are saving money on their prescription drugs, are not experiencing problems, and would recommend the program to others.

AHIP's most recent survey, conducted by Ayres, McHenry & Associates in September 2006, found that:

- 70 percent of self-enrolled seniors would recommend that others sign up for the new Medicare prescription drug benefit;
- 58 percent of enrollees said they were saving money with the new benefit;
- Two-thirds of enrolled seniors think passing the Medicare prescription drug plan was a good idea; and
- 88 percent have had no problems using the new benefit.

V. Why the Medicare Part D Program is Succeeding

A major factor contributing to the success of the Part D program is the fact that plan sponsors are working aggressively to negotiate lower prescription drug prices for beneficiaries. A team of CMS economists and actuaries has published research findings[7] estimating that sponsors of Part D plans negotiated discounts and rebates of 27 percent in 2006. These savings represent nearly double the amount that plans were expected to negotiate at the time the MMA was enacted.

The program's success can also be attributed to the various tools and techniques plans have developed to limit out-of-pocket costs for beneficiaries and, at the same time, improve quality by reducing medication errors and promoting clinically sound drug use.

Formularies are an important tool that help control prescription drug costs. Medical professionals play a central role in developing formularies, which must comply with stringent standards to ensure that they include drugs necessary to treat all major diseases. To ensure that formulary decisions are clinically appropriate, health plan Pharmacy & Therapeutics Committees – composed principally of physicians and pharmacists – identify drugs for inclusion on health plan formularies based on documented safety, efficacy, and therapeutic benefit.

Part D sponsors' generic substitution programs encourage beneficiaries to use lower-cost prescription drugs when clinically appropriate. In the first half of 2006, more than 60 percent of prescriptions dispensed through Medicare Part D plans were for generic medications. Part D plan formulary management techniques such as step therapy and prior authorization also are working to reduce out-of-pocket costs for beneficiaries.

A number of studies demonstrate that these tools and techniques are highly effective in making prescription drugs more affordable for consumers. For example:

- CBO has estimated[8] that private sector management techniques employed by Medicare Part D plans would save individuals 20-25 percent off retail prices for prescription drugs.

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[7] *Health Affairs*, Health Spending Projections Through 2015: Changes on the Horizon, February 22, 2006
[8] CBO, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004

- A 2003 study[9], conducted by Associates and Wilson on behalf of AHIP, found that the PACE program in Pennsylvania – the largest state pharmacy assistance program in the nation – could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.

- In addition, the Government Accountability Office (GAO) has reported[10] that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average cash price customers would pay at retail pharmacies.

These findings clearly demonstrate that the private sector has a strong track record of using its experience and capabilities to deliver affordable prescription drug benefits. At a time when federal resources are severely strained, it is important for policymakers to recognize the ability of health insurance plans to implement strategies that are enabling Medicare beneficiaries to receive the greatest possible value for the dollars the Medicare program is spending on their prescription drug coverage.

VI. Conclusion

The Medicare Part D prescription drug program is the most far-reaching expansion of Medicare in its 40-year history. The early data show that this program is delivering significant value to beneficiaries, including millions of low-income seniors who are receiving additional assistance with their premiums and cost-sharing. The availability of high quality choices – spurred by vigorous competition among plan sponsors – has played a pivotal role in generating these savings.

We urge the committee to continue to support the competition, choice, and innovation that have played such an important role in delivering savings and value to our nation's Medicare beneficiaries.

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[9] Associates & Wilson, *Prescription Drug Benefit Management: Improving Quality, Promoting Better Access and Reducing Cost*, October 2003

[10] Government Accountability Office, *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees, and Pharmacies* (GAO-03-196), January 2003

STATEMENT
Of
David Kyllo, Executive Director, National Center for Assisted Living
To
Senate Special Aging Committee Hearing
"Medicare Part D: Is it Working for Low-income Seniors?"
Wednesday, Jan. 31, 10:30 a.m.
562 Dirksen Senate Office Building

Congress Should Waive Medicare Part D Co-Payments for Dual Eligible Beneficiaries Receiving Long Term Care Services in Home and Community-Based Settings, including Assisted Living/Residential Care Facilities

The National Center for Assisted Living (NCAL) is the assisted living voice of the American Health Care Association (AHCA). On behalf of NCAL and AHCA, I would like to thank the Committee for this opportunity to raise an issue of vital importance to America's seniors, and particularly important for frail elderly people with very low incomes. AHCA/NCAL is a non-profit federation of affiliated state health care organizations, together representing nearly 11,000 non-profit and for-profit nursing facilities, assisted living residences, sub-acute centers, and homes for persons with developmental disabilities. NCAL represents more than 2,400 assisted living facilities providing long term care services to about 106,000 residents.

As Medicare Part D enters its second year, it is clear that the program has helped millions of seniors and people with disabilities gain access to needed medications. However, Medicare Part D needs to be modified so that frailest dual eligibles are treated equally. We believe that an existing gap in Medicare Part D coverage may well have been a mistake of omission made as policymakers put together this complex legislation.

Recognizing the vulnerability and special needs of very low-income people living in long term care facilities, the Medicare Modernization Act of 2003 exempted dual eligibles (those covered by both Medicare and Medicaid) living in "long term care facilities" from any cost-sharing for Part D prescription drugs. Technically, under the Part D program, the Centers for Medicare & Medicaid Services defines a long term care facility as a nursing facility, an intermediate care facility for people with mental retardation and developmental disabilities, or an inpatient psychiatric hospital. Unfortunately, the legislation did not extend the waiver of co-payments for prescriptions to dual eligible residents of assisted living/residential care (AL/RC) facilities and others in home and community-based (HCB) settings, despite the fact that this

The American Health Care Association and the National Center for Assisted Living are the nation's leading long term care organizations. AHCA/NCAL and their membership are committed to performance excellence and Quality First, a covenant for healthy, affordable and ethical long term care. AHCA/NCAL represent nearly 11,000 non-profit and proprietary facilities dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 2.5 million of our nation's frail, elderly and disabled citizens who live in nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation and developmental disabilities. For more information on AHCA/NCAL, please visit ***www.ahca.org.***

population may be eligible for nursing home care and has similar needs, vulnerabilities, and income limitations. Under the Part D program, dual eligible assisted living residents and others in HCB settings must make co-payments of $1.00-$5.35 in 2007, with the exact amount depending on a person's income and whether a medication is generic. Because of their very low income (often just a personal needs allowance), these co-payments can present financial hardships for dual eligible residents and can impede them from receiving necessary medications. Requiring these co-payments is also inconsistent with efforts to expand Medicaid-covered long term care options – including HCB settings – for our nation's most vulnerable citizens who had historically only received care in nursing homes. Under current law, these dual eligibles automatically receive reduced Part D benefits by choosing to live at home or in an AL/RC facility rather than in a nursing home.

To provide relief to this group of frail, elderly people, AHCA and NCAL urge Congress to reintroduce bipartisan legislation introduced in the 109th Congress. "The Home and Community Services Copayment Equity Act of 2006 (S. 2409 and H.R. 5907) would eliminate Part D co-payments for more than one million low-income Americans, including dual eligible residents of AL/RC facilities and other licensed facilities such as group homes for people with developmental disabilities, psychiatric health facilities, and mental health rehabilitation centers. Dual eligibles receiving services under HCB waivers in a home setting also would be relieved of Part D co-payments. This legislation is supported by a growing coalition of more than 35 national organizations representing a wide range of interests, including consumers, health care and long-term care providers, geriatric care professionals, pharmacists, and state officials.

Currently, approximately 15% of the nearly one million Americans in assisted living residences are dually eligible for Medicaid and Medicare coverage. Under HCBS waivers, residents placed in AL/RC facilities must be eligible for placement in nursing homes. Like nursing home residents on Medicaid, the more than 120,000 dual eligibles in AL/RC facilities have very limited financial resources, often just a few dollars a month from a personal needs allowance. In some instances, the amount of the combined Part D co-pays of dual eligible AL/RC residents exceeds their monthly personal needs allowances. Residents in nursing homes and assisted living facilities also use a similar number of prescriptions – about 8-10 prescriptions – according to recent studies.

On January 1, 2006, dual eligibles who previously received medications under Medicaid programs were automatically enrolled in Medicare Part D drug plans. Under Part D, pharmacies and plans do not have to dispense medications if a beneficiary does not pay co-payments. Unless the law is changed, dual eligible residents of AL/RC facilities and others receiving services under Medicaid waivers who cannot afford these co-payments may be at risk for not receiving essential medications.

Another reason to eliminate Part D co-payments for this population is to maintain a level playing field between institutional and community-based services under Medicaid. For many years, policymakers and the public have supported expanding options for people to receive long-term care services at home and in community-based settings under the Medicaid program. AHCA/NCAL supports the principle of Medicaid providing services in the setting that best meets each individual's needs and preferences. According to an analysis of the Part D co-payment legislation done for AHCA/NCAL by the Lewin Group, by 2008 the HCB dual eligible population impacted by this legislation will be larger than the number of dual eligible beneficiaries living in nursing homes and other institutions. For a small investment in covering Part D co-pays, Congress would remove an impediment preventing some people

from living at home or in an assisted living facility, and thereby save state and federal dollars, since these care settings may be less expensive than nursing homes. However, the most important reason to pass this legislation is to help frail, elderly seniors afford needed medications.

Finally, the burden placed on these dual eligibles is exacerbated because their Part D co-pays are indexed for inflation while their limited resources grow less rapidly, if at all.

Thank you for this opportunity to bring this issue to the attention of the Committee.

For more information, please contact Karl Polzer, NCAL Senior Policy Director, at 202-898-6320 or kpolzer@ncal.org.

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Written Testimony of Georgia Burke, Project Attorney
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Before the Senate Special Committee on Aging
Hearing on the Low-Income Subsidy for Medicare Part D

January 31, 2007

The National Senior Citizens Law Center (NSCLC) is pleased to submit this written testimony to the Senate Select Committee on Aging on the topic of the Low-Income Subsidy for Medicare Part D beneficiaries. These comments are submitted by the Oakland, California office of NSCLC, which has particular responsibility in the organization for Medicare Part D advocacy and litigation.

NSCLC advocates nationally on behalf of the low-income elderly and persons with disabilities. We have been working with legal services attorneys, State Health Insurance Program (SHIP) counselors, and other lawyers and non-lawyer advocates for the elderly and disabled on Medicare Part D issues since the inception of the program. These contacts with advocates across the country have given us the opportunity to closely monitor the challenges that low income beneficiaries have faced in accessing benefits under Part D.

The Medicare Part D Low-Income Subsidy (LIS) is designed to assist low-income Medicare beneficiaries in paying for their prescription drugs. Currently, 9.5 million Medicare Part D enrollees receive the subsidy, representing forty percent of all enrollees, and CMS and SSA estimate that an additional 3.7 million Medicare beneficiaries have incomes and resources low enough to qualify for the subsidy.

Despite the fact that LIS eligible beneficiaries represent such a high proportion of Part D enrollees, numerous barriers to access exist for this population.

In this submission, we have focused on issues that have immediate impact on access to prescription drugs by LIS eligible beneficiaries and that could be improved by relatively

minor fixes. Although there are broader structural problems with the design of the Part D and its LIS component, they will not be discussed here.

These important issues include:

1. The numbers of individuals receiving the LIS are significantly below projections because SSA's application/eligibility process is needlessly complex and confusing.

Individuals who do not automatically receive the LIS must apply for the LIS through the Social Security Agency (SSA) or their state Medicaid office AND enroll in a Part D plan, which usually entails using either the Medicare website or 1-800-MEDICARE and often includes communication with one or more plans. "One-stop shopping" simply is not available.

Other unnecessary barriers discourage and confuse LIS applicants. For example, for its own administrative convenience, SSA "requires" that a particular scannable form be used or that the application be completed online; it strongly discourages the use of copied forms. Although instructions for the form are available in 15 languages, the form cannot actually be used in most languages; only the English and Spanish scannable forms are accepted.

The LIS application form is not user-friendly in other ways as well. For example, unlike most government forms, it contains an ominous reference to prison penalties for inaccurate information in an application, unnecessarily frightening applicants.

The Medicare Modernization Act requires that both SSA and state Medicaid agencies accept and process LIS applications; however, in practice, states direct individuals to SSA or use the SSA process except in very rare instances. Since SSA does not screen and enroll for eligibility for Medicaid programs, including the Medicare Savings Programs, many opportunities for deemed LIS eligibility are lost.

Furthermore, LIS applications are not always processed in a timely manner by the SSA, and the appeals system is flawed. Individuals who apply for LIS must wait on the Social Security Administration (SSA) for a determination of eligibility. No timelines are required, and SSA determinations can take months, delaying access to the LIS. The SSA is not required to respond to an appeal within any mandatory time frame.

The LIS eligibility processes should be overhauled and redesigned to follow the intent of the statute and provide for the easiest possible application process. Enrollment and subsidy applications should be consolidated. Forms, including copied paper forms and translated forms, should be widely available. States should be required to comply with the law and process LIS applications separately from SSA, and clear timelines should be set for determinations and appeals.

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2. It can be difficult to stay on the LIS.

Eight percent (more than 630,000) of all enrollees who had the LIS in 2006 were not automatically determined eligible again in 2007 because of a change in their Medicaid status. These individuals lost their subsidy effective January 1, 2007 unless they took some further action. CMS did not review their cases to determine whether their income and resources were low enough to remain eligible for the LIS or whether they could qualify for the LIS on some other basis. They simply terminated the benefit because the enrollees were no longer eligible for Medicaid. While CMS asserted that the agency sent a notice to these individuals in September, many beneficiaries report not receiving it. Those who did receive the notice were told to that they must apply with SSA to re-qualify. Beneficiaries were not given an opportunity to appeal the decision. Individuals who were mistakenly determined no longer eligible for Medicaid (i.e. they were in fact still receiving Medicaid, but CMS made a mistake) had no established appeals procedures and, when they complained, were bounced back and forth from plans to CMS to SSA and to their state agencies, with no one taking ownership of the problem.

Adding to the confusion is that fact that SSA has implemented an entirely separate process for redetermining LIS eligibility for individuals who qualify for the LIS through an application with SSA.

No LIS beneficiary should be dropped because of loss of automatic eligibility without first being screened for all possible categories of LIS eligibility. Appropriate notice and appeal rights must be established. CMS and SSA redetermination processes should be streamlined and standardized.

3. Low-Income Subsidy recipients often fail to figure prominently in policy implementation, and their special needs are addressed only as an afterthought.

LIS recipients have often been an afterthought as Part D policies have been designed and implemented. Although they are **forty percent** of current Part D enrollees (and projected to reach at least fifty percent), this special needs group is often ignored. Subsidy recipients represent too great a proportion of enrollees to be treated as an afterthought. CMS and plan materials must be tailored to them. Doing so will cut down on the extra layers of unnecessary confusion that plague this vulnerable population.

For example, in the model Annual Notice of Change (ANOC) developed for stand-alone PDPs, information on costs and rights of subsidized beneficiaries is buried among pages of information relating to costs, benefits and rights of non-subsidized beneficiaries. This despite the fact that LIS recipients represent fifty percent of all stand-alone PDP enrollees.

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Tailored communications to LIS recipients should be the norm. Communications should be clear and not cluttered with information that is inapplicable to the enrollee.

4. Not all LIS recipients have adequate flexibility in plan enrollment.

As LIS recipients are, by definition, "low-income." They do not have personal resources as a fall-back if they need a drug not covered by their plan or otherwise find that a plan they enrolled in no longer fits their needs. LIS recipients, as a group, also are the sickest of Part D beneficiaries and have the most complex medical conditions. For these reasons, all LIS beneficiaries need to have a continuous enrollment period. The MMA recognizes this need for dual eligibles and gives them a continuous enrollment period. However, other LIS enrollees do not have this right.

An ongoing Special Enrollment Period that extends the right to change plans to the entire LIS population will greatly enhance their ability to obtain coverage for the drugs they need.

5. Low-Income Subsidy status does not show up at the pharmacy accurately; individuals eligible for LIS are overcharged or go without needed prescriptions.

Information needed to charge a Part D subsidy recipient often shows up incorrectly or not at all on pharmacy computer systems. This may be because eligibility information for the LIS is incorrect, the Part D plan has the wrong information, or a wide variety of other reasons. For example, when an LIS beneficiary changes plans, the subsidy information is slow to follow, creating problems at the pharmacy counter, usually resulting in the beneficiary having to choose between paying amounts he or she cannot afford, or going without the medication. These "glitches" can create full-blown medical crises for LIS beneficiaries who have no other means of accessing necessary medications.

These problems reflect systemic flaws in the CMS system, the most important of which is that information about LIS eligibility is not available in real time. The data management system established by CMS has built-in delays that virtually ensure that, for some beneficiaries, eligibility information will lag actual eligibility by months.

Medicare Part D is a complicated program requiring transfers of large amounts of data among a wide variety of actors. For LIS eligibles, even more actors are involved. States must transfer data regarding Medicaid eligibility to CMS and SSA must transfer LIS eligibility data to CMS. CMS must transfer data regarding LIS eligibility to plans. Enrollment data must be transferred between CMS and plans, and claims data must be transferred by plans to the TrOOP and Coordination of Benefits contractors.

Instead of creating a single, unified system of data transfers, CMS has created a seemingly infinite web of data that is difficult to decipher. The sheer complexity has

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introduced unacceptable levels of delay and error which impede the rights of LIS eligibles to prescription drug coverage, subsidized co-payments and special enrollment periods to which they are entitled

The delays and errors are particularly extreme in the case of dual eligible LIS beneficiaries but affect all LIS beneficiaries. According to CMS, when the system is working properly it can take up to 76 days to enroll a new dual eligible into a plan and provide information to the pharmacy of the individual's eligibility for the full Low Income Subsidy. It can take 30 days or more for an enrollee's request to change plans to show up on pharmacy computers.

These time estimates are based on CMS' own description of standard time frames. In fact, much longer delays are commonplace. A data entry error or other glitch can cause conflicts that put a beneficiary into electronic limbo.

These data delays and various computer errors and glitches have created gaps in prescription drug coverage for many LIS beneficiaries. Others have been overcharged for medications and forced to either overpay or to go without needed medications. In addition, many dual eligibles who have changed plans during the year have found themselves in the system of more than one plan, creating additional chaos and heightened barriers at the pharmacy.

When data problems come up, CMS tells beneficiaries to contact their plans, though plan representatives often do not have the information to untangle data errors, particularly those involving subsidy eligibility. Beneficiaries end up being sent from plan to agency and back again without resolution to their problems.

CMS should streamline its system to allow real-time transfers of information among plans, states, the Social Security Administration, government contractors and CMS. If there were a single, central data system that all relevant parties could access in real time, errors such as involuntary enrollments and disenrollments would be reduced and beneficiaries would receive fewer confusing mixed messages. Pharmacists would receive reliable information about a customer's plan enrollment and subsidy status.

As an interim measure, CMS should increase the frequency and consistency with which the different Part D entities "talk" to each other. More frequent transfers of information between plans and CMS would shorten existing gaps and delays. More frequent, mandatory cross-checks would help catch discrepancies earlier; for instance, a beneficiary would not get bills from one plan long after choosing to enroll in another.

CMS also should increase transparency to beneficiaries by ensuring that beneficiaries have easy access to the maximum amount of data about their enrollment and subsidy status.[1] CMS should make more detailed information (such as explanations of subsidy

[1] CMS took a step in the right direction for 2007 by increasing the amount of information that the TrOOP coordinator returns to pharmacists who need to check a customer's Part D status. Based on experiences so

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status and reasons for disenrollment) available to pharmacists and 1-800-MEDICARE representatives. More information would make it easier to untangle errors and ensure that Part D beneficiaries leave the pharmacy with the drugs they need.

CMS also should establish an ombudsman or other troubleshooting office to get subsidy and enrollment problems fixed quickly. CMS's current policy of telling beneficiaries to deal with their plan makes little sense when problems arise from government data or computer interface failures.

6. **The threat of a Late Enrollment Penalty deters LIS eligibles from enrolling in Part D plans.**

CMS, recognizing that the imposition of a Late Enrollment Penalty can act as a deterrent to enrollment in Part D by LIS beneficiaries, has waived the penalty through the end of 2007. Unless the waiver is extended or made permanent, LIS recipients who enroll late in the future will pay a Late Enrollment Penalty. Partial subsidy LIS eligibles will pay the full penalty. Full subsidy LIS recipients will pay a reduced penalty, i.e., 20% for five years. Any penalty represents a serious hardship for this group and would function as a huge deterrent to enrollment in Part D.

CMS should permanently waive the Late Enrollment Penalty for all LIS recipients. A permanent waiver of the Late Enrollment Penalty recognizes the special needs of this population.

Thank you for the opportunity to submit this testimony. The National Senior Citizens Law Center would be pleased to work with the Senate Select Committee on Aging to address the problems discussed in this testimony.

Please feel free to contact us.

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far, however, the new "enhanced" query will not provide enough information to enable pharmacists to troubleshoot LIS eligibles' Part D problems effectively.

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AARP Statement for Record

On the

Medicare Part D Low-income Subsidy

Submitted to the

Senate Special Committee on Aging

January 31, 2007

WASHINGTON, D. C.

For further information, contact:
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On behalf of AARP's 38 million members we thank you for holding this hearing on the Medicare Part D prescription drug benefit low-income subsidy (LIS). The extra financial help LIS provides to those least able to afford prescription drug costs is one of the Part D program's most important features and a key factor in our support for the Medicare Modernization Act (MMA) that created Part D.

We are proud that the LIS is now providing essential assistance with premiums and copays to millions of beneficiaries who otherwise might go without lifesaving medicines because of the cost. We commend the Center for Medicare and Medicaid Services (CMS) for providing auto- and facilitated enrollment in the LIS for people deemed eligible because they are in Medicaid, a Medicare Savings Program, or are receiving Supplemental Security Income. We also applaud CMS for establishing a special enrollment period so anyone found eligible for the LIS can enroll in Part D without a late enrollment penalty. We similarly appreciate steps the Social Security Administration (SSA) has taken to minimize the burden of annual LIS eligibility redeterminations.

We have worked diligently with CMS, SSA, the Access to Benefits Coalition, State Health Insurance Assistance Programs, and many other partners on the daunting task of finding and enrolling beneficiaries who are not deemed eligible.

Reaching beneficiaries with limited incomes has always been a challenge, but LIS outreach and enrollment is doubly difficult because the LIS program has a serious flaw – an asset test.

The asset test makes the LIS application process extremely daunting and invasive. It is proving to be a serious barrier in getting extra financial help to people who need it. The asset test also penalizes those who, despite limited incomes, responsibly saved for retirement. AARP believes the asset test must be eliminated.

We believe the barrier created by the asset test is a key reason why millions of beneficiaries who need the LIS are not getting it. CMS projected in its final regulation on Part D that 14.4 million beneficiaries would be eligible for the LIS[1] However, to date, only slightly more than 9 million are enrolled. That means roughly 5 million eligible individuals are not getting the Medicare help they need. CMS has estimated that as many as 3 million of these people have no drug coverage at all.

Penalizing People who Save for Retirement

Many more beneficiaries living on very limited incomes are not getting the help with drug costs that they need because of the asset test. For 2007, no individual with more than $11,710, or couple with more than $23,410 in assets can qualify, no matter how low their income or how high their other living expenses may be. These amounts are hardly enough to get people through retirement.

The Kaiser Family Foundation has estimated that more than 2.3 million Medicare beneficiaries who meet LIS income criteria will not be eligible because of the asset test. Almost half exceed the limit by $25,000 or less. [2]

In fact, the asset test is the leading reason why people who apply for the subsidy are rejected – even if they are only just above the limits. LIS applicants living on very limited incomes are being denied needed assistance because they did the responsible thing of scrimping and saving to have a small nest egg for retirement. The asset test thus directly contradicts efforts to encourage people to save by penalizing those who do in even the most modest ways.

Difficult, Invasive Application

For those who are eligible for the LIS, we believe the difficult application process required by the asset test is a key reason why so many are not enrolled. The application form is lengthy, confusing and invasive, largely because of the asset test. For example, it:

- requires people to report not just savings but such obscure details as the current cash value of any life insurance policies – information people simply do not have on hand;

- asks people whether they expect to use savings for funeral or burial expenses, but does not explain that individuals can have up to $1500 ($3000 for couples) in savings above the asset limits for such expenses;

- asks invasive questions, such as whether applicants get help with meals or other household expenses, which can be difficult to estimate; and

- threatens applicants with prison terms if information they provide is incorrect.

Applying for the LIS thus can seem overwhelming and require many hours, extra help from family members or insurance counselors, and often repeated efforts to find all of the required information.

First Steps

AARP is firmly committed to eliminating the asset test. There are also interim steps Congress can and should take now that will significantly reduce the barrier to LIS enrollment created by the asset test.

Raise the Limits. Congress should raise the asset limits as a first step toward eliminating the asset test. We are finding that there is broad, bipartisan consensus that the current asset limits of $11,710 for individuals and $23,410 for couples are far too low. While raising the limits is clearly inferior to outright elimination, in the short-term it will provide relief to millions of lower-income Medicare beneficiaries who truly need the help the LIS can provide.

Streamline the Application. Congress should require a simpler application process. Specific steps to reduce the LIS application form's complexity and help more eligible people enroll include:

- *Excluding Life Insurance*: Life insurance should not be counted against the asset test. It is not reasonable to expect someone to cash out their life insurance in order to purchase the prescription drugs they need to live. Beyond that, the question on the LIS application asking for the cash value of life insurance itself is a barrier that makes the application process unduly difficult. The cash value of life insurance is information that the average person – regardless of income – simply does not have on hand. Asking the question needlessly lengthens the application form. It complicates the application process by requiring individuals to contact their life insurance companies to obtain the cash value figure. It thus constitutes a red-tape barrier that reduces the odds that eligible individuals will apply at all.

- *Excluding Burial Expense Question*: The application asks if the applicant has set aside money for burial expenses. SSA already assumes that up to $1,500 ($3,000 for couples) of applicants' assets is for burial expenses and has adjusted the asset limits for this amount. This question thus has no value and needlessly lengthens and complicates the form.

- *Excluding Help on Household Expenses*: This question asks if the applicant gets help paying for food, mortgage, rent, utilities or property taxes. Many low income people get food assistance from family, churches, and food banks on a highly irregular, as-needed basis and in very limited amounts. This question, however, requires applicants to enter a specific average monthly amount. Given the often irregular nature of such assistance, this is a figure that many people are unlikely to know with any degree of accuracy. And those who rely on such assistance are the same individuals for who the LIS is needed.

- *Revising the Perjury Warning*: The application threatens people with prison for submitting false or misleading information, and says information submitted will be checked against government and other records. The dire, legalistic language is intimidating and discourages people from applying. This is especially so for people who at best may only be able to make rough estimates on answers to some questions, such as help with household expenses. The threatening language is also prominently placed in a dense paragraph at the top of the "Signatures" page, unlike other government forms that place a more condensed perjury warning next to the signature box. To remedy this, a condensed warning should be placed next to the signature box, as on IRS tax forms.

It should clearly state that minor discrepancies will not result in perjury prosecution, and assure people that they can submit the application with estimates or partial answers. The introduction could read, for example:

> *You can submit this form even if you are not able to provide complete or exact answers to all questions. By signing the form, you are acknowledging that everything you have stated in the application is correct to the best of your knowledge. You authorize us to contact you and review other records – in accordance with all applicable privacy laws -- to get and verify necessary information. Minor differences we may find in reviewing other records will not cause you to be prosecuted for perjury.*

Share Income Data. Congress should also consider authorizing the IRS to confidentially share with CMS and SSA which beneficiaries meet the income criteria for LIS. Currently, the IRS verifies income data submitted by people who apply for the LIS, but believes it is precluded by law from sharing with CMS and SSA in advance which Medicare beneficiaries have incomes that meet LIS eligibility criteria. The HHS Inspector General has said that legislation authorizing IRS to do so would help more effectively and efficiently target outreach efforts.[3]

Coordinate with Medicaid and Medicare Savings Programs (MSP). People enrolled in these programs are deemed eligible for the LIS and enrolled in Part D plans by CMS if they do not choose a plan on their own. These programs help pay Medicare premiums and cost sharing for beneficiaries with incomes below LIS income eligibility levels. However, like the LIS, they have enrollment levels that are far below the number of eligible beneficiaries because of the difficulty in identifying and enrolling low-income individuals.

While MSP enrollees are automatically enrolled in the LIS, currently no effort is made to see if LIS applicants qualify for MSP. MSP eligibility criteria vary by state and sometimes are less stringent than those for the LIS – in fact, several states have no asset test for MSP. Full coordination between the LIS and MSP would mean that many more low-income beneficiaries would get needed help with both traditional Medicare and Part D premiums and cost-sharing obligations. We believe a system should be established to cross-check LIS applications against state MSP criteria and enroll individuals who are eligible for MSP.

Similarly, people who apply and are found to not be eligible for the LIS may be eligible for a state pharmacy assistance program (SPAP). These state-funded programs often provide help with drug bills to people with income and asset levels above the LIS eligibility cut-offs. A system to coordinate enrollment applications between the LIS with these programs also could prove to be very useful. To make sure applicants understand these options, and because the LIS application may not include all information needed to determine MSP or SPAP eligibility in each state, the LIS application should include an additional notice stating that:

> *Information may be shared with your state to determine if you are eligible for extra help through state programs that help pay for prescription drugs or other Medicare bills. State or federal officials may contact you if additional information is needed for this.*

SSA Resource Concerns

Finally, AARP is concerned that administrative funding for SSA has not kept up with the agency's increased work load in conducting outreach and processing applications for the LIS.

This is in addition to its traditional responsibilities of processing retirement and disability claims, as well as the responsibility of income verification for the 5 million Medicare beneficiaries affected by the new Part B income-related premium. Last year, SSA Commissioner Barnhart warned Congress that if SSA funding was insufficient, it would face employee furloughs of approximately 10 days agency-wide. Disruption of services to beneficiaries would be inevitable. The Social Security Administration is presently operating at last year's funding level – a level insufficient to prevent furloughs and service disruptions if its budget is not increased in the appropriations bill due to pass in February.

AARP urges Congress to ensure that SSA can meet its increased responsibilities and avoid any employee furloughs and beneficiary service disruptions by funding its FY 2007 budget at no less than $9.3 billion. Congress also should enact a final, permanent funding level that will allow SSA to prepare for the Boomer retirement wave and meet all of its increased duties due to the Medicare LIS and premium requirements.

Conclusion

The implementation of the Medicare prescription drug benefit represents the most significant change to Medicare since the program began in 1965. The extra financial help provided to people who most need it through the LIS is a key component of this achievement. Its value for the millions of Medicare beneficiaries receiving it and benefiting from the new program cannot be overstated. As we move ahead, there are clearly some changes that can and must be made to ensure that all Medicare beneficiaries who need this extra help receive it. We look forward to working with members of Congress from both sides of the aisle to improve the new Medicare prescription drug benefit and to ensure that all older Americans have access to affordable prescription drugs.

[1] CMS-4068-P, Medicare Program: Medicare Prescription Drug Benefit, 69 Fed. Reg. 46632: August 3, 2004

[2] Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test; Henry J. Kaiser Family Foundation; April 2005

[3] Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy, Daniel R. Levinson Inspector General, November 17, 2006, http://oig.hhs.gov/oei/reports/oei-03-06-00120.pdf

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