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SENIORS AT RISK: IMPROVING MEDICARE FOR OUR MOST VULNERABLE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

WASHINGTON, DC

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SENIORS AT RISK: IMPROVING MEDICARE FOR OUR MOST VULNERABLE

Thursday, May 22, 2008

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

The committee met, pursuant to notice, at 10:33 a.m. in Room SH–216, Hart Senate Office Building, Hon. Gordon H. Smith, presiding.

Present: Senators Smith [presiding], Salazar, and Whitehouse.

OPENING STATEMENT OF SENATOR GORDON H. SMITH, RANKING MEMBER

Senator SMITH. Good morning. With the blessing of Senator Kohl, we will begin the hearing. With respect to our witnesses, we want to be mindful of your time and take advantage of what you have to contribute today to the U.S. Senate Special Committee on Aging.

We have an impressive list of witnesses, all of whom will share with us their perspective on the improvements that are needed to ensure the Medicare program provides help to America's most vulnerable seniors.

I want to extend a personal welcome to Judy Korynasz and Lisa Emerson, both of whom have flown all the way from Oregon, a trek I know all too well. Thank you for being here this morning despite the jet lag you no doubt feel. I always enjoy having Oregonians testify before Senate committees, and we truly appreciate your efforts to better our understanding of this important issue to America's seniors.

All too often, seniors and their needs get lost in the flurry of debate over spending priorities and the race to finish legislation. I want everyone to know that I will not let that happen. I intend to fight for seniors and will work to ensure that the Medicare package includes policies that make healthcare more affordable to our most vulnerable.

It was just 2 years ago that the Medicare program began offering seniors the option of receiving coverage for their prescription drugs. Since that time, the program has been highly successful, with 85 percent of eligible seniors receiving some form of coverage for their medication.

Every good program, however, always has room for improvement. In fact, as I think back on my 12 years here, I have never voted on a perfect bill yet. There is always a new chapter in democracy and a chance to improve on success.

As of January 2008, the Centers for Medicare and Medicaid Services estimated that of the 12.5 million beneficiaries eligible for the low-income subsidy, 2.6 million still have not enrolled. In addition, the Social Security Administration has reported a significant percentage of those applying for the subsidy who qualified based on their income were determined ineligible because their assets exceeded the eligibility requirement.

We also must look at other Medicare assistance programs that like the Part D low-income subsidy, are intended to help our poorest and most vulnerable seniors afford their healthcare. Sadly, low utilization, overly restrictive asset limits, and poor coordination among our agencies are just a few of the reasons these programs also aren't being utilized by those who need help.

Congress must consider creating parity between Medicare's different programs. Right now, the low-income assistance programs under Part B are significantly more restrictive than the help offered under Part D. Even the congressional advisory panel, MedPAC, recommends that the program's eligibility criteria should be the same.

We also need to look at policies that ensure the agencies are doing a better job of sharing information and coordinating application processes. We can and should do better to ensure that seniors with the greatest need are eligible and receiving assistance.

Last year, Senator Bingaman and I introduced a package of bills to improve Medicare Part D for most of our vulnerable seniors. One important aspect of our legislation would help us to target beneficiaries who might be eligible for LIS by allowing the Internal Revenue Service to share tax-filing information with the Social Security Administration. Our legislation also raises the asset test limits to allow seniors like Mrs. Korynasz, her mother, to qualify for the low-income subsidy.

As Congress continues to develop the Medicare package needed to stave off the 10 percent physician payment cut, I hope my colleagues will remember that the most vulnerable of our seniors also need help. I hope today's discussion will provide some valuable information to guide us as we make Medicare successful and beneficial for all seniors.

With that, we have been joined by two of my colleagues. We will go to Senator Whitehouse first, then Senator Salazar for any opening statement you may have.

STATEMENT OF SENATOR SHELDON WHITEHOUSE

Senator WHITEHOUSE. Thank you, Chairman.

I just wanted to express my appreciation to you for holding this hearing. I particularly want to welcome Ms. Korynasz, who wins the prize for most miles traveled to get here today, and I am glad you did because I think it is an important issue.

I think that in the discussion, particularly about Part D, the powerful vested interests in Washington hold far too much sway, and individual seniors are far too often overlooked.

I am from Rhode Island. Rhode Island has the eighth- highest senior population of any State. States that have a higher senior population include Florida and Arizona, which are destination

States for seniors, very often well-off seniors who go there to retire and enjoy the benefits of the weather and so forth.

Which leaves Rhode Island as a State that has a uniquely high profile of seniors who need the kind of assistance that Part D provides. Over and over and over again, we have witnessed the tragedy of seniors falling into what is benignly and falsely called the "donut hole" and what should probably be called the Bush senior trap for unforeseen expenses.

Yes, clearly, if they had looked through all of the fine print, they could have seen that this was waiting for them, and they would ultimately fall into it. But a lot of the seniors who are highly dependent on multiple medications—heck, I will confess, I don't read through the complex medical forms that I get myself. I think it is a lot to expect elderly seniors who are very dependent on multiple medications to do the same. So it often comes as a surprise.

There was a woman from Woonsocket, who had been independent her entire life. She lived in a tenement, which is Rhode Island for a three-decker, and walked wherever she went. She discovered that she had fallen into the trap when she went to her pharmacist, and they said, "Well, you will have to pay for these. I am sorry. Your coverage is not good."

She had no idea that was going to happen, and she didn't have the money. So she had to walk away from the pharmacy window empty-handed. It was a terrible and frightening thing for her, and she had to face the prospect of losing her independence, losing her apartment. I mean, this was a woman who had fought for her independence for 90 years, and she did not want to give it up lightly.

But she was really presented with no choice, except for the fact that she had a grandson who was willing to come and look after her and take care of it. But stories like that play out over and over and over and over again. They are all completely avoidable, completely avoidable.

If this organization, the U.S. Congress, would simply have the courage to stand up to the pharmaceutical industry and say you have to behave like every other business and negotiate over the price of pharmaceuticals with buyers, instead of doing what we did, which is to disable CMS from negotiating with the pharmaceutical industry and allow this industry to dictate pricing to our Government and for our seniors.

I understand that if we had made that simple correction, there would be enough savings from the lower prices that we would be able to fill this trap into which so many seniors unwittingly fall. So, to me, it is really a terrible exercise in public policy and shows the power of organized lobbyists, surrounded special interests up against folks like Ms. Korynasz and her family and like the lady in Woonsocket, who have nobody looking out for them other than us. If we are not doing our jobs, they are the ones who pay the price.

Thank you very much, Senator.

Senator SMITH. Thank you, Senator Whitehouse.

Senator Salazar.

STATEMENT OF SENATOR KEN SALAZAR

Senator SALAZAR. Thank you very much, Senator Smith, as Ranking Member, for keeping a focus on the vulnerable.

I thank Chairman Kohl also for scheduling this hearing today.

Listening to my friend and colleague, Senator Whitehouse, I remember our days as fellow attorneys general, when he was attorney general of Rhode Island and I was attorney general of Colorado, and one of the things that we had a focus on was the protection of the elderly, the protection of the most vulnerable. In my own State, we had many different summits where we brought our senior citizens together and other interested stakeholders to make sure that we were protecting them.

Today's hearing really is about how we make sure that the programs that we have created are, in fact, programs that are made available and that seniors know how to take advantage of those opportunities that we have created. This is an excellent opportunity to discuss the state of Medicare low-income assistance programs and how to reform these programs to meet the needs of seniors and to increase enrollment.

In my State of Colorado and across this country, many families are feeling the serious financial pressures as a result of the rising cost of energy, gas prices, and medical care. Seniors with limited incomes are those who I think are particularly most vulnerable. Government programs, such as the low-income subsidy, are critical for helping millions of seniors cover the cost of care, including 91,000 seniors in my home State of Colorado.

Most Medicare experts, including MedPAC, believe the low-income programs for Medicare beneficiaries are broken. The Congressional Budget Office estimates the participation rates of beneficiaries are very low in the various programs. Only 33 percent of eligible beneficiaries are participating in some of those programs, while 13 percent in the SLMB program.

When you exclude dual-eligibles that were auto-enrolled in 2006, almost two thirds—that is almost two thirds—of low-income Medicare beneficiaries qualified for the drug benefit low-income subsidy but did not receive the benefit. That is two thirds who qualified did not receive the benefit. Reasons cited for this include lack of awareness that the program exists and an inability to complete the application to receive the benefit.

Compared to other Federal benefit programs, participation in Medicare low-income programs falls far, far behind. Participation rates are estimated to be 75 percent for the earned-income tax credit, 66 percent for supplemental security income, and 66 percent for Medicaid. Experts are all in agreement that to fix these programs we must align the eligibility requirements and significantly improve outreach and enrollment.

It is critical that we have similar, if not better, participation rates in our Medicare low-income programs so that elderly patients have access to the care they need at the time that they need it. Using these programs to increase access to care helps us prevent costly and unnecessary treatments for advanced disease, which is critical to reducing our healthcare spending and improving patients' quality of life.

We have been working with Senator Smith and my colleagues in the Finance Committee on some of these same issues, and I am delighted that the Aging Committee is also putting a focus on this issue here in this Committee.

When I consider the programs we are discussing here today, I am confident, I am convinced that we can reform our system so that low-income seniors are receiving the care they deserve. The fundamental principles of the programs are sound, but we need to make necessary adjustments to include everyone who should be included.

Thank you, Ranking Member Smith.

Senator SMITH. Thank you, Senator Salazar.

To introduce our panel for the record, we will first hear from an Oregonian, Judy Korynasz. She will be sharing her experience with us as a caretaker of her mother, Charlotte Wachdorf. I am inspired and appreciative of her time and dedication to ensuring her mother continues to receive proper quality care and look forward to her testimony.

Barbara Bovbjerg is no stranger to this Committee. We appreciate, Barbara, your being here again. She is the director of GAO's Education, Workforce, and Income Security team. She will discuss GAO's work regarding the Social Security Administration's enrollment of beneficiaries into the LIS program and give an update on these efforts.

Joyce Payne is a member of the AARP Board of Directors. She will discuss what AARP is hearing from its members in regards to Medicare's low-income assistance programs and elaborate on recommendations for reform to these programs to ensure that the poorest and most vulnerable seniors receive the help they need with their healthcare costs.

Laura Summer is a senior research scholar at Georgetown University Health and Policy Institute. Ms. Summer is a senior research scholar at Georgetown University with over 20 years of experience in Federal, State government, independent policy organizations, and academic institutions. We look forward to hearing her testimony and recommendations on the obstacles faced by beneficiaries and how we can improve enrollment in Medicare's low-income assistance programs.

Lisa Emerson is also from Oregon, and is the director for Oregon's Senior Health Insurance Benefits Assistance Program. Ms. Emerson will testify on her experience in this capacity. She, her colleagues, and volunteers deserve our gratitude for their hard work in helping Oregon seniors navigate the Medicare program. I am very interested in her thoughts on what improvements can be made to make her difficult job easier.

So, with that, Judy, why don't we begin with you?

STATEMENT OF JUDY KORYNASZ, BENEFICIARY WITNESS, CAREGIVER FOR HER MOTHER, HILLSBORO, OR

Ms. KORYNASZ. OK. Good morning, Mr. Chairman, Ranking Member Smith, and members of the Committee.

Thank you for inviting me to testify today. My name is Judy Korynasz. I am 66 years old, and I live in Hillsboro, OR. I have Medicare, as does my husband, John, and my mother, Charlotte Wachdorf, who lives with us.

I am here today to tell you about my family's experience with Medicare. In particular, I am going to focus on my family's experiences with the Medicare prescription drug benefits and its effect on people like us who have modest incomes and savings.

My mother's name is Charlotte Wachdorf. She is 87 years old, soon to be 88, and will turn 88 on June 2. She has lived with my husband and I since last November. Before that, she lived with my brother, a retired Air Force colonel, and his wife for 5 years after my father died. When my sister-in-law developed serious back ailments, my mother moved in with us.

My mother's health has been declining for several years. She currently has chronic obstructive pulmonary disease, better known as COPD, diabetes, neuropathy, which causes nerve damage in her feet and up through her legs. As a result of the diabetes, she has congestive heart failure, chronic anemia, and an aneurysm and a blood clot in her heart.

She takes more than 15 medications. She takes Procrit once a month, and the following medications at least daily. She has Synthroid, Detrol, Hydroco, which is a form of Vicodin, Gemfibrozil, Folbic, Actos, Lisinopril, Spironolactone, Advair Diskus, Combivent, Fluticasone, SennaGen, Mirtazapine, and Singulair. Claritin and an iron supplement and a multi-vitamin. She also uses a walker and is on oxygen full time.

The good news is that, thanks to her doctors and these many medications, her health has been stabilizing recently. Unfortunately, paying for these medications takes up a good portion of her financial resources.

Even with help from Medicare Part D, my mother's only income is $1,027 per month in Social Security, an annual income of $12,324. She also has, as of this month, $15,213 left in her savings. This means she meets the income requirements for the Part D extra help program, but she has $3,223 too much in savings.

As a result, every year since Part D started in 2006 she has fallen into the coverage gap and has spent over $3,000 of her own money on prescription drugs. She has only reached catastrophic coverage in December, if at all. Because she has been on hospice care during this time as well, she has paid for only about half through Part D. If she were not on hospice, she would have even higher costs.

This year, she entered the coverage gap in April, and this month, she paid for her Procrit and five other prescriptions, which amounted to $585.13 even with a discount that she obtained from the Oregon prescription discount program.

If her health continues to stabilize, she will leave hospice care. We are grateful for that, but she will then have to pay for the rest of her drugs. I don't know for sure how much that will cost, but

I expect it would consume most of all of her Social Security check while she is in the coverage gap.

My husband and I will help her as best we can. However, our resources are limited as well. Our only incomes are Social Security because our former employer went bankrupt, and our 401(k)s were lost as a result of that bankruptcy. Although my health is fairly good, my husband is a colon cancer survivor and has glaucoma. He takes several expensive eye drops to preserve his sight——Cosopt, Alphagan, and Lumigan.

This month, due to the amount that he had to pay out before he met his—I forget the name of what they call that. Anyway, he had to lay out $273.50 just for two medications, and then the rest was covered by his Part D and his health insurance. So we were grateful for that.

Unfortunately, my husband has also recently been diagnosed with the early stages of Alzheimer's disease. His doctor has told us his prescription drugs are likely to increase significantly soon. He, too, will probably fall into the coverage gap this year.

If the limits on financial assets for the extra help program were increased, my mother would qualify for the program. She would not have a gap in her coverage, and she would not have to spend most of her income and the little savings she does have left on prescription drugs. It would also provide my husband and me with considerable peace of mind to know that my mother's prescription drugs would be affordable.

Finally, I would like to let the Committee know about some of the difficulty we have had figuring out Medicare Advantage and the Medicare drug benefit. Last fall, when my mother moved in with us, I called 1–800–MEDICARE to help us choose a Medicare plan for her. I tried every day for 2 weeks several times a day. The line would ring, and then I would get cutoff. I never did get an answer.

As you know, the Part D program is exceptionally complicated. I could not get reliable information for my mother's Medicare Advantage plan or the mail-order pharmacies either because they would give me different information every time I called. I spent hours wading through information to figure out the best coverage for my mother, my husband, and myself.

Finally, I received invaluable help from the counselors at SHIBA, the Senior Health Insurance Benefits Assistance Program. You may know it as Oregon's SHIP program. The staff at SHIBA has created an excellent booklet that guides people through Medicare, Medicare Advantage, Medigap, and Part D plans.

The SHIBA counselors were wonderful in helping me understand my options and sorting out the information that could otherwise be overwhelming. The staff and volunteers at SHIBA do a terrific job, and I would like to take this opportunity to thank them publicly.

I want to thank the Committee, and especially Senator Smith, for taking an interest in this issue and for inviting me to testify about my family's experience with Medicare.

I hope that the rules can be changed to allow people like my mother to get the healthcare she needs without spending the last penny she has. It seems to me that in a country as wealthy as this

one, there should not be people who cannot take their medications just because they cannot afford them.

Thank you.

[The prepared statement of Ms. Korynasz follows:]

Statement of Judy Korynasz

before the
United States Senate
Special Committee on Aging

May 22, 2008

Good morning, Mr. Chairman, Ranking Member Smith, and Members of the Committee. Thank you for the invitation to testify today. My name is Judy Korynasz. I am 66 years old and live in Hillsboro, Oregon. I have Medicare, as does my husband John, and my mother, who lives with us. I am here today to tell you about my family's experience with Medicare. In particular, I am going to focus on my family's experiences with the Medicare prescription drug benefit and its effect on people like us who have modest incomes and savings.

My mother's name is Charlotte Wachdorf. She is 87 years old, and will turn 88 on June 2nd. She has lived with my husband and me since last November. Before that, she lived with my brother, a retired Air Force colonel, and his wife for five years after my father died. When my sister-in-law developed serious back ailments, my mother moved in with us. My mother's health has been declining for several years. She currently has chronic obstructive pulmonary disease (COPD), diabetes, neuropathy (nerve damage) as a result of the diabetes, congestive heart failure, chronic anemia, and an aneurism and clot in her heart. She takes more than 15 medications. She takes Procrit once a month, and the following medications at least daily: Synthroid, Detrol, Hydroco (a form of Vicodin), gemfibrozil, Folbic, Actos, lisinopril, spironolactone, Advair Diskus, Combivent, fluticasone, SennaGen, mirtazapine, Singulair, Claritin, an iron supplement, and a multi-vitamin. She also uses a walker and is on oxygen.

The good news is that, thanks to her doctors and these many medications, her health has been stabilizing recently. Unfortunately, paying for these medications takes up a good portion of her financial resources, even with help from Medicare Part D. My mother's only income is $1,027 per month in Social Security – an annual income of $12,324. She also has (as of this month) $15,213 left in savings. This means she meets the income requirements for the Part D Extra Help program, but she has $3,223 too much in savings. As a result, every year since Part D started in 2006, she has fallen into the coverage gap, and has spent over $3,000 of her own money on prescription drugs. She has only reached catastrophic coverage in December, if at all. Because she has been on hospice care during this time as well, she has paid for only about half through Part D and

hospice has covered the rest. If she were not on hospice care, she would have had even higher costs.

This year, she entered the coverage gap in April. This month she paid for her Procrit and five other prescriptions, which amounted to $585.13, even with a discount she obtained from the Oregon Prescription Discount Program. If her health continues to stabilize, she will leave hospice care. We are grateful for that, but she will then have to pay for the rest of her drugs. I do not know for sure how much that will cost, but I expect it would consume most or all of her Social Security check while she is in the coverage gap.

My husband and I will help her as best we can. However, our resources are limited as well. Our only incomes are Social Security. Our former employer went bankrupt and our 401(k) was lost as a result of that bankruptcy. Although my health is fairly good, my husband is a colon cancer survivor and has glaucoma. He takes several expensive eye drops to preserve his sight (Cosopt, Alphagan, and Lumigan). His Medicare Part D coverage has covered most of the cost of these medications, and his doctor has also given us samples. Unfortunately, my husband has also recently been diagnosed with the early stages of Alzheimer's disease. His doctor has told us his prescription drug costs are likely to increase significantly soon. This month we spent $273.50 a month on his medications, and we expect his costs to increase further. He too will probably fall into the coverage gap this year.

If the limits on financial assets for the Extra Help program were increased, my mother could qualify for the program. She would not have a gap in her coverage, and she would not have to spend most of her income and the little savings she has on prescription drugs. It would also provide my husband and me with considerable peace of mind to know that my mother's prescription drugs would be affordable.

Finally, I would like to let the committee know about some of the difficulty we have had figuring out Medicare Advantage and the Medicare drug benefit. Last fall when my mother moved in with us, I called 1-800-MEDICARE to help us choose a Medicare plan for her. I tried every day for two weeks, several times a day. The line would ring and then I would get cut off. I never got an answer. As you know, the Part D program is exceptionally complicated. I could not get reliable information from my mother's Medicare Advantage plan or the mail-order pharmacies, either, because they would give me different information each time I called.

I spent hours wading through information to figure out the best coverage for my mother, my husband, and myself. Finally, I received invaluable help from the counselors at SHIBA (the Senior Health Insurance Benefits Assistance program). You many know it as Oregon's SHIP program. The staff at SHIBA have created an excellent booklet that guides people through Medicare, Medicare Advantage,

Medigap, and Part D plans. The SHIBA counselors were wonderful in helping me understand my options and sorting out the information that could otherwise be overwhelming. The staff and volunteers at SHIBA do a terrific job, and I would like to take this opportunity to thank them publicly.

I want to thank the committee, and especially Senator Smith, for taking an interest in this issue and for inviting me to testify about my family's experience with Medicare. I hope that the rules can be changed to allow people like my mother to get the health care she needs without spending the last penny she has. It seems to me that in a country as wealthy as this one, there should not be people who cannot take medications just because they cannot afford them. Thank you.

Senator SMITH. Thank you, Judy.

Barbara, welcome back.

STATEMENT OF BARBARA BOVBJERG, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES, U.S. GENERAL ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. BOVBJERG. Thank you, Mr. Chairman.

Mr. Chairman, Senators, I was originally really pleased to be here to talk about Social Security Administration and the low-income subsidy of the Medicare Part D program, though I am very sobered by the story we just heard. As someone who worries a lot about retirement income, I was particularly horrified to hear about your 401(k)s, but that is a topic for another day.

SSA is charged with publicizing the subsidy, with taking and evaluating applications, and with determining participants' continuing eligibility. My testimony today is going to focus on the numbers of applicants that have been approved and denied so far for the subsidy and the status of SSA's outreach efforts. My statement is drawn from a report that we issued last year about this time on this topic and we have updated a little for progress since then.

First, SSA's progress on processing. Since the beginning of the program, 7.2 million individuals have applied for the subsidy, and SSA has approved about 2.8 million of these. SSA received 1.3 million applications in Fiscal 2007, of which they approved 43 percent and denied 32 percent. The rest required no decision for a variety of reasons, including duplicate applications or applications that were withdrawn.

SSA's goal is to process 75 percent of the subsidy applications within 60 days. And in the first 6 months of Fiscal 2008, SSA reports they processed 93 percent of applications within that timeframe, which is well exceeding its service goal.

Also, we now have more detailed information on income and asset levels for those denied the subsidy than we had previously. According to SSA data for 2007, over 60 percent earned income above the subsidy program's limits. About 17 percent were denied because their assets exceeded program limits, and another 10 percent exceeded both asset and income limits. The rest were denied, again, for other reasons, such as not being eligible for Medicare to begin with.

The extent to which denials exceeded the limit varied, but a significant percentage were barely disqualified. For income-related denials, although the median excess income was $4,500, 10 percent of this group had income that was no more than $500 over the limit. So they just were barely cutoff. As for assets, although the median excess was $13,700, meaning that half were above and half were below that amount, about 6 percent of these denials were only $500 over the threshold.

I will turn now to SSA's outreach efforts. When we began this outreach campaign in May 2005, SSA sent targeted mailings, which included an application form, to almost 19 million individuals identified as potentially eligible, and had contractors call more than 9 million of those individuals who didn't respond to the initial mailing. SSA also conducted other specific follow-up efforts, includ-

ing sending notices to individuals they couldn't contact by phone and more than 76,000 events at senior centers, churches, and other community centers.

Today, however, that focused campaign is more muted. Although some subsidy-specific initiatives remain, including a new campaign of automated phone calls to those potentially subsidy-eligible, SSA has largely incorporated the subsidy outreach into its overall outreach activities for the entire Social Security program. This is understandable, SSA resources are stretched thin, particularly in field offices where much of the outreach is carried out, but is likely less effective than a more concentrated approach.

Of course, as we noted last year, it is difficult to know whether the outreach measures have been effective or not because no one really knows how many people are eligible for the subsidy. Reliable data are simply not available to help SSA with its task of reaching the eligible population.

SSA believes that tax data held by the IRS could help. They feel that even if many lower-income individuals do not file tax returns, they could at least use asset information from the Form 1099 and 1098 to eliminate some ineligibles from their list.

However, by law, IRS cannot provide such information without specific authorization from the Congress, and IRS staff have expressed doubts that tax information would provide meaningful help anyway. This is why last year we recommended that SSA and IRS work together to assess whether tax data could, indeed, help. The two agencies are working together today to answer this question and anticipate results next month.

In conclusion, reaching the millions of people who are foregoing the subsidy remains a significant challenge. While SSA continues to approve applications, its efforts to attract new recipients have slowed and been folded into the overall SSA outreach. This approach, while likely less effective than a subsidy-focused campaign, should not be surprising given SSA's workload in its field offices and its likely inability to devote more time and attention to this program.

Better information to narrow the list of who may be eligible could help, and we are encouraged that IRS and SSA are working together to assess the utility of tax data in this role because a better understanding of who is eligible could help SSA make more efficient use of its limited staff resources by targeting outreach more narrowly to the population who is more likely to be eligible.

That concludes my statement, Mr. Chairman. Thank you for the extra time.

[The prepared statement of Ms. Bovbjerg follows:]

United States Government Accountability Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
Expected at 10:30 a.m. EDT
Thursday, May 22, 2008

MEDICARE PART D LOW-INCOME SUBSIDY

SSA Continues to Approve Applicants, but Millions of Individuals Have Not Yet Applied

Statement of Barbara D. Bovbjerg, Director
Education, Workforce, and Income Security Issues

GAO-08-812T

May 22, 2008

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Highlights

Highlights of GAO-08-812T, a report to the Special Committee on Aging, U.S. Senate

MEDICARE PART D LOW-INCOME SUBSIDY

SSA Continues to Approve Applicants, but Millions of Individuals Have Not Yet Applied

Why GAO Did This Study

To help the elderly and disabled with prescription drug costs, the Congress passed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which created a voluntary outpatient prescription drug benefit (Medicare Part D). A key element of the prescription drug benefit is the low-income subsidy, or "extra help," available to Medicare beneficiaries with limited income and resources to assist them in paying their premiums and other out-of-pocket costs.

To assess the Social Security Administration's (SSA) implementation of the subsidy, GAO is providing information on (1) the number of applicants approved for or denied the low-income subsidy and (2) challenges of identifying individuals eligible for the subsidy and targeting outreach efforts.

This statement is based on a prior GAO report on the subsidy and associated spending issued in May 2007, selected aspects of which we updated in May 2008.

What GAO Found

Of the approximately 7.2 million applicants for the low-income subsidy, SSA approved approximately 2.8 million as of March 2008, and SSA has improved some key measures for its subsidy application processes. SSA approved about 570,000 applicants, denied about 403,000 applicants, and determined that no decision was required for about 281,000 applicants in fiscal year 2007. The table below shows that excess income was the primary reason applicants were denied benefits, while many other applicants were denied benefits because their resources exceeded program limits. Further, SSA has collected data and established some goals to monitor its progress in implementing and administering the subsidy benefit.

Reasons for Denials for Individuals Who Applied in 2007, in Percentages

Application	Income	Resources	Income and resources	Other	Total
Individual	62.2%	20.2	8.7	8.9	**100%**
Couple	61.5%	8.0	10.9	19.7	**100%**
All denied applicants	62.0%	16.6	9.4	12.1	**100%**

Source: SSA data

No reliable data are available to help SSA identify the eligible population for its outreach efforts, and millions who may be eligible have not yet applied. SSA maintains that it would not be able to establish specific goals and measures for its outreach activities, as we recommended in our May 2007 report because, of the lack of reliable data on the total eligible population. Responding to another of our recommendations, SSA is working with the Internal Revenue Service to determine if tax data can help target individuals eligible for the subsidy. The Centers for Medicare & Medicaid Services and the Congressional Budget Office have estimated, respectively, that about 2.6 million to over 4 million individuals who may qualify for the subsidy are not receiving it. Various barriers, such as reluctance to disclose personal financial information or lack of knowledge of the subsidy, may prevent potentially eligible Medicare beneficiaries from applying for the subsidy. To solicit applications from individuals potentially eligible for the subsidy, SSA conducted an extensive outreach campaign from May 2005 to August 2006, but has decreased its outreach activities since then. Staffing constraints in SSA field offices may also limit SSA's ability to assist individuals with the subsidy and conduct local outreach to inform the public about the subsidy.

To view the full product, including the scope and methodology, click on GAO-08-812T. For more information, contact Barbara Bovbjerg at 202-512-7215 or bovbjergb@gao.gov.

May 22, 2007

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to participate in today's hearing to discuss the Social Security Administration's (SSA) progress in enrolling individuals in the Medicare Part D Low-Income Subsidy. High prescription drug costs can have a detrimental effect on low-income seniors and the disabled, who are more likely than others to suffer from chronic medical problems requiring prescription drugs. Such high costs may cause some elderly patients to forgo or restrict their use of prescription drugs. To help the elderly and disabled with these costs, the Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[1] MMA enabled Medicare beneficiaries to enroll voluntarily in drug plans sponsored by private health insurance companies. The benefit includes a low-income subsidy, or "extra help," to assist Medicare beneficiaries with limited income and resources (also called assets) in paying their premiums and other out-of-pockets costs.

The Department of Health and Human Services and its Centers for Medicare & Medicaid Services (CMS) are largely responsible for implementing the new drug plan, called Medicare Part D, and SSA administers the low-income subsidy. SSA is responsible for conducting outreach efforts to identify and notify individuals of the subsidy's availability, taking applications, making subsidy eligibility determinations, resolving appeals, and ensuring continued subsidy eligibility. SSA also withholds Part D premiums from Social Security benefits for beneficiaries who select this option. My testimony will address (1) the number of applicants approved for or denied the low-income subsidy and (2) the challenges of identifying individuals eligible for the subsidy and targeting outreach efforts.

My comments are based largely on a prior GAO report issued in May 2007 addressing SSA's implementation of the low-income subsidy and associated spending.[2] We updated selected aspects of the work during May 2008. We conducted our work in accordance with generally accepted

[1]Pub. L. No. 108-173.

[2]GAO, *Medicare Part D Low-Income Subsidy: Additional Efforts Would Help Social Security Improve Outreach and Measure Program Effects*, GAO-07-555 (Washington, D.C.: May 31, 2007).

government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Summary

Of the 7.2 million applicants for the low-income subsidy, SSA approved 2.8 million of them, and SSA has improved some key measures for its subsidy application processes. SSA approved about 570,000 applicants, denied about 403,000 applicants, and determined that no decision was required for about 281,000 applicants in fiscal year 2007. In a 2007 SSA study of low-income subsidy denials, SSA found that excess income was the primary reason for 62 percent of applicant denials and about 24 percent of these denied applicants were within $1,500 of the income limit. Excess resources were the primary reason for 16 percent of applicant denials and nearly 30 percent of these denied applicants were within $5,000 of the resource limit. Approximately 9 percent had both excess income and resources. Further, SSA has collected key data and established some goals to monitor its progress in implementing and administering the subsidy benefit.

No reliable data are available to help SSA target its outreach efforts, and millions who may be eligible for the subsidy have not yet applied. SSA maintains that it is not able to establish specific goals and measures for its outreach activities, as we recommended in our May 2007 report, because of the lack of reliable data on the total eligible population. However, responding to another of our recommendations, SSA is working with the Internal Revenue Service to determine whether tax data can help to target individuals eligible for the subsidy. According to CMS and Congressional Budget Office estimates, respectively, about 2.6 million to over 4 million individuals who may qualify for the subsidy are not receiving it. Various barriers, such as a reluctance to disclose personal financial information, and inadequate availability of one-on-one assistance for completing the application, may prevent potentially eligible Medicare beneficiaries from applying for the subsidy. To solicit applications from individuals potentially eligible for the subsidy, SSA conducted an extensive outreach campaign, from May 2005 to August 2006, but has decreased its outreach activities since then due to limited funding. Staffing constraints in SSA field offices may also limit SSA's ability to assist individuals with the subsidy and conduct local outreach to inform the public about the subsidy

Background

All Medicare beneficiaries entitled to benefits under Medicare Part A or enrolled in Part B are eligible to enroll in Medicare Part D.[3] Medicare beneficiaries who qualify for full coverage under their state's Medicaid program,[4] as well as Medicare beneficiaries who qualify for more limited Medicaid coverage, Supplemental Security Income (SSI), or state Medicare Savings Programs are automatically enrolled in a Part D prescription drug plan by CMS,[5] automatically qualify for the full subsidy of their premium and deductible, and do not need to file an application. They are referred to as "deemed."

Other Medicare beneficiaries who do not automatically qualify for the subsidy (i.e., who are not deemed) must apply and meet the income and resource requirements. These beneficiaries generally qualify if they have incomes below 150 percent of the federal poverty level and have limited resources. Generally, in 2008, individuals qualify if they have an income up to $15,600 for an individual and $21,000 for a couple and if they have resources up to $11,990 for an individual or $23,970 for a couple.[6] The amount of the subsidy for premiums, deductibles, copayments, and catastrophic coverage varies depending on income and resources.

Individuals generally apply for the benefit directly through SSA, although they may also apply through their state Medicaid office. The agency that receives an application, whether SSA or a state Medicaid agency, is

[3]Individuals who are eligible for Medicare automatically receive Hospital Insurance, known as Part A, which helps pay for hospital stays, related post-hospital care, home health services, and hospice care, and typically does not require a monthly premium. Medicare also offers optional insurance under Supplementary Medical Insurance (Part B) to cover doctor's services and outpatient care, and requires a premium.

[4]Medicaid is a federal and state program that helps pay medical costs for certain low-income people, such as those who are 65 and older, the blind, the disabled, and members of families with dependent children or qualified pregnant women or children. Prior to the effective date of Part D, Medicaid provided coverage for outpatient prescription drug costs for persons eligible for that program.

[5]Medicare Savings Programs are offered by state Medicaid agencies to assist people with limited income and resources with their Medicare premiums and, in some cases, may also pay Medicare Part A and Part B deductibles and coinsurance.

[6]For 2006, the asset limits were based on three times the resource limit of the SSI program for subsidy beneficiaries. For subsequent years, the limits are to be updated based on the Consumer Price Index. Countable resources include such things as savings, investments, and real estate (other than an individual's primary residence). Countable resources do not include such things as a car, a burial plot or limited funds set aside for burial expenses, or certain other personal possessions.

responsible for making initial subsidy determinations and deciding appeals and redeterminations. Those who apply through SSA may submit their subsidy application using SSA's paper application or an Internet application form. Applicants may also have their information entered electronically by visiting an SSA field office or by calling SSA's toll-free phone line. According to state Medicaid officials we spoke with, they encouraged beneficiaries to apply for the subsidy through SSA whenever possible. As of March 2007, only the Colorado and Kansas state Medicaid agencies had made Part D subsidy determinations.

Under the MMA, the Congress provided SSA with a special $500 million appropriation from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to assist SSA in implementing its Part D responsibilities for fiscal years 2004 and 2005, but later extended the appropriation to fiscal year 2006. Since January 2006, SSA officials told us that the agency has had to draw on its overall administrative appropriation to support its Part D activities. SSA informed us that the agency now has a mechanism to track costs for low-income subsidy applications, and estimates that it cost the agency $175 million to administer the subsidy in fiscal year 2007, and that it expects similar costs in fiscal year 2008.

SSA Continues to Approve Applications and Improve Processing Efforts and Has Improved Some Measures for Processing Benefits

SSA continues to approve low-income subsidy applications; of the applicants who were denied benefits, most exceeded income limits and others exceeded resource limits. To monitor its progress in implementing and administering the subsidy benefit, SSA has collected key data and established some goals.

Excess Income Was the Predominant Reason That Applicants Were Denied the Subsidy in Fiscal Year 2007

Of the approximately 7.2 million applicants filing for the subsidy as of March 2008, SSA approved 2.8 million.[7] SSA received 1.3 million new applications in fiscal year 2007, approving approximately 570,000 (43 percent), denying approximately 403,000 (31 percent), and made no decision for approximately 281,000 (22 percent) because applicants had submitted duplicate applications among other reasons.[8]

According to a recent SSA study of individuals who applied for the subsidy in 2007 and where SSA made a decision by January 2008, SSA denied approximately 416,000 applicants. The most common reasons for denials were excessive income and resources.[9] As Table 1 shows, excess income was the primary reason for denials, and excess resources were the reason in approximately 17 percent of the denials.

Table 1: Reason for Denials for Individuals Who Applied in 2007, in Percentages

Application	Income	Resources	Both income and resources	Other reason[a]	Total	Number of persons
Individual	62.2%	20.2	8.7	8.9	**100%**	295,559
Couple	61.5%	8.0	10.9	19.7	**100%**	120,934
All denied applicants	62.0%	16.6	9.4	12.1	**100%**	416,493

Source: Social Security Administration's analysis of Medicare Database, February 1, 2008.

Totals may be greater than 100 percent due to rounding.

[a]This included applicants that were denied because they were not Medicare beneficiaries, were not a U.S. resident, or because they failed to provide SSA with documentation to complete its subsidy determination.

For denials based on excess income, about 10 percent of applicants were within $500 of the income limit. About 98 percent of applicants with

[7]The number of applications, applicants, approvals and denials differs from the number of individuals involved. This is because the same individual may submit multiple applications as a result of changes to their automatic eligibility status or as a result of losing their eligibility for the subsidy based on SSA's redetermination. On the other hand, one application can involve multiple applicants within the same household.

[8]In some instances, SSA canceled applications, including when such applications were withdrawn by the applicant.

[9]The study was based on the Social Security Administration's Medicare Database, and included the full universe of people who applied for the low-income subsidy during calendar year 2007 and whose applications had been denied by the end of January 2008.

excess income received Social Security benefits, and 35 percent received pensions from sources other than veterans' or Social Security benefits. Table 2 shows the extent to which applicants were denied subsidy eligibility because their income was too high. For those denied, the median excess income was $4,572.

Table 2: Amount by Which Income Exceeded the Subsidy Limits when Income Was a Reason for Denial, in Percentages of Persons Denied

Excess annual income of denied applicants in 2007	Single applicant	Couple	All
$20,000 or more	7.5%	7.2%	7.3%
$15,000 to <$20,000	4.8	4.5	4.7
$10,000 to <$15,000	10.8	9.3	10.4
$7,500 to <$10,000	10.1	9.2	9.8
$5,000 to <$7,500	15.7	14.7	15.4
$3,000 to <$5,000	11.3	16.7	12.9
$1,500 to <$3,000	14.4	16.8	15.1
$1,000 to <$1,500	6.6	6.5	6.6
$500 to <$1,000	8.2	7.2	7.9
< $500	10.8	7.9	9.9
Total	**100%**	**100%**	**100%**
Median excess income	$4,751	$4,335	$4,572
Mean excess income	$9,136	$8,753	$9,023
Number of persons	209,539	87,594	297,133

Source: Social Security Administration's analysis of Medicare Database, February 1, 2008.

Totals may be greater than 100 percent due to rounding.

Note: The mean is calculated excluding about 130 outliers over $1,000,000.

For denials based solely on excess resources, nearly 6 percent of applicants were within $500 of the resource limit. Table 3 shows the extent to which applicants were denied subsidy eligibility because their resources were too great. For those denied, the median excess resources were $13,690. Bank accounts and investments, which included stocks, bonds, and individual retirement account balances were responsible for about 57 percent of the excess resource denials.

Table 3: Amount by Which Resources Exceeded Subsidy Limits when Itemized Resources Were the Only Reason for Denial, in Percentages of Persons Denied

Excess Resources of Denied Applicants in 2007	Single Applicant	Couple	All
$20,000 or more	39.2%	48.9%	40.2%
$15,000 to <$20,000	7.1	6.9	7.1
$10,000 to <$15,000	10.5	7.8	10.2
$7,500 to <$10,000	6.6	6.1	6.5
$5,000 to <$7,500	6.5	7.0	6.5
$3,000 to <$5,000	8.3	6.6	8.1
$1,500 to <$3,000	7.1	8.5	7.3
$1,000 to <$1,500	4.0	2.0	3.7
$500 to <$1,000	4.8	3.1	4.6
< $500	6.0	3.3	5.7
Total	**100%**	**100%**	**100%**
Median excess resources	$13,290	$18,934	$13,690
Mean excess resources	$40,904	$57,754	$42,962
Number of persons	37,731	5,267	42,998

Source: Social Security Administration's analysis of Medicare Database, February 1, 2008.

Totals may be greater than 100 percent due to rounding.

Note: This table excludes people who were denied because they checked the box on the application stating that their resources exceeded the established limits. The mean is calculated excluding about 200 outliers over $1,000,000.

SSA Has Made Some Improvements for Measuring Subsidy Processes, but Lacks Measures in Certain Areas

We reported, in May 2007,[10] that SSA had established application processes for determining low-income subsidy eligibility, reviewing appeals, and conducting redeterminations; however, it had not established some key management tools to monitor progress of all of its efforts. To enable agencies to identify areas in need of improvement, GAO internal control standards state that agencies should establish and monitor performance measures and indicators.[11] Accordingly, agencies should compare actual performance data against expected goals and analyze the differences.

[10] GAO, GAO-07-555.

[11] GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool,* GAO-01-1008G (Washington, D.C.: August 2001).

While SSA had tracked the progress of subsidy determinations since it began processing applications in July 2005, it did not have goals for measuring the processing time for these applications until March 2007. SSA's goal is to process 75 percent of the subsidy applications in 60 days and reported that it processed 93 percent of determinations within 60 days during the first 6 months of fiscal year 2008. SSA had also been tracking the amount of time for resolving appeals of subsidy denials, but also did not have a performance goal to assess the timeliness of appeals decisions. In response to our recommendation, SSA established a goal of processing 75 percent of appeals within 60 days—similar to its goal for processing subsidy applications. SSA reported that 74.5 percent of appeals were processed in 60 days during the first 6 months of fiscal year 2008.

SSA tracks various results from the redeterminations process, such as the number of decisions made, and the number and level of continued subsidies. According to the MMA and SSA regulations, all recipients of the subsidy are required to have their eligibility redetermined within one year after SSA first determines their eligibility.[12] Future redeterminations are required to be conducted at intervals determined by the Commissioner. SSA's regulations provide that these periodic redeterminations be based on the likelihood that an individual's situation may change in a way that affects subsidy eligibility. Additionally, SSA's regulations provide that unscheduled redeterminations may take place at any time for individuals who report a change in their circumstances, such as marriage or divorce. In May 2007, we recommended that SSA collect data on the processing time for individual redetermination decisions, and establish performance standards for such processing time. SSA disagreed with our recommendation, stating that the agency monitors the time for completing the overall redetermination cycle, providing adequate management controls. While SSA still does not collect processing time data for individual redetermination decisions, an SSA official recently told us that it is now the agency's goal to complete redetermination decisions before the end of each year, except for people who do not respond to SSA's inquiries.

[12]This does not include individuals who continue to be deemed or automatically eligible for the subsidy. Individuals who report changes to SSA regarding their benefit status are also excluded from the initial redetermination process since they are redetermined as a result the change.

No Reliable Data Are Available to Identify Eligible Population for Outreach Efforts, and Millions May Have Not Yet Applied

No reliable data are available to help SSA identify the eligible population for its outreach efforts, and millions who may be eligible have not yet applied, in part due to privacy concerns and application complexity. SSA is working with the Internal Revenue Service (IRS) to determine whether tax data can help target individuals eligible for the subsidy. According to available estimates, millions of individuals who may qualify for the subsidy have not yet applied. Various barriers, such as a reluctance to share personal financial information, may discourage some individuals from applying. Furthermore, SSA initially conducted a focused outreach campaign, but now incorporates such efforts into its overall Social Security outreach including work with third parties to publicize the subsidy and targeted outreach events on Mother's Day and Father's Day.

SSA Does Not Have Data to Narrowly Target Eligible Population

SSA does not have access to data that might help it to narrowly target the eligible population. In the absence of reliable data for identifying the eligible population, in 2006 SSA broadly targeted 18.6 million individuals who might be eligible for the subsidy, which was an overestimate. SSA identified the target population by using income data from various government sources to screen out Medicare beneficiaries whose income made them ineligible for the Part D subsidy.[13] SSA realized that using these data sources would result in an overestimate of the number of individuals who might qualify for the subsidy, because the data provided limited information on individuals' resources or nonwage income. SSA officials said they took this approach to ensure that all Medicare beneficiaries who were potentially eligible for the subsidy were made aware of the benefit and had an opportunity to apply for it.

SSA officials said that they would have preferred to specifically target Medicare beneficiaries who were more likely to be eligible for the subsidy by using tax data from IRS on individuals' wage, interest, and pension income. Current law permits SSA to obtain income and asset data from

[13]SSA obtained income data from its earnings records, as well as data from the Office of Personnel Management, the Department of Veterans Affairs, the Railroad Retirement Board, and the Office of Child Support Enforcement of the Department of Health and Human Services.

IRS to assist in verifying information provided on subsidy applications.[14] The law, however, prohibits IRS from sharing such data with SSA in the absence of a submitted application. According to SSA officials, such data would allow SSA to identify individuals to target outreach more directly and to estimate how many individuals may qualify for the subsidy. However, IRS officials told us that its data have many limitations that could affect their usefulness. For example, IRS officials said that they have limited data on assets for individuals whose income is less than $20,000 because these individuals do not typically have interest income, private pensions, or dividend income from stocks that could help SSA in estimating an individual's potential asset level. Given these limitation, IRS officials stated that their tax data was more likely to identify individuals who would not quality for the subsidy, rather than those who would. In November 2006, the HHS Office of Inspector General reported that legislation is needed to provide SSA and CMS access to income tax data to help the agencies more effectively identify beneficiaries potentially eligible for the subsidy.[15]

In our May 2007 report, we recommended that SSA develop a comprehensive plan, with specific performance goals and measures, to detail the agency's outreach strategy for enrolling additional individuals who qualify for the subsidy. While SSA agreed with the recommendation in theory, it maintains that it would be unable to implement specific goals and measures due to the lack of reliable data on the eligible population. SSA recently informed us that is still the agency's position. We also recommended that SSA and IRS work together to assess the extent to which IRS tax data would help SSA to identify individuals who might qualify for the subsidy, possibly aiding SSA in better targeting outreach efforts. In implementing our recommendation, SSA provided IRS with a random sample of 200,000 individuals (of approximately 19 million potentially eligible) who might qualify for the subsidy. IRS then provided SSA Form 1098 and 1099 data for these individuals, with identifying

[14]Under 26 U.S.C. § 6103(l)(7)(D), IRS may only provide tax return information to SSA for purposes of, and to the extent necessary in, determining the eligibility for or the correct amount of benefits provided through the subsidy program. In signing the application form, individuals acknowledge that SSA will compare the information reported by them on the form to information supplied by federal, state, and local government agencies, including IRS.

[15]Department of Health and Human Services, Office of Inspector General, *Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy,* OEI-03-06-00120 (Washington, D.C.: Nov. 17, 2006).

information removed. SSA could then use its methodology for IRS to estimate potential subsidy eligibility. The Form 1098 and 1099 information will help SSA determine if individuals have pensions and resources that exceed the subsidy threshold. IRS is expecting to complete its preliminary analysis and share the information with SSA by the end of June 2008.

Millions of Eligible Individuals May Not Be Taking Advantage of the Subsidy

Millions of individuals potentially eligible for the low-income subsidy are still not receiving it. Although no reliable data exist on the total eligible population, CMS estimated that about 2.6 million individuals may be eligible but not receiving the subsidy. Based on a 2004 Congressional Budget Office (CBO) estimate, 4.4 million individuals may be eligible and not receiving the subsidy.[16]

Several barriers may prevent potentially eligible Medicare beneficiaries from applying for the subsidy. In our May 2007 report, we stated that some individuals were reluctant to apply because they did not want to share their personal financial information for fear that an inadvertent error on the application could subject them to prosecution under the application's perjury clause. However, in December 2007 SSA revised the clause removing the threat of imprisonment for false statements. A 2007 Mathematica study conducted for AARP, also found that reluctance to share personal financial information, the stigma associated with applying for public benefits, and inadequate availability of one-on-one assistance for completing the subsidy application, and resource limits affected individuals' decision not to apply for the subsidy.[17] A CMS study also found that individuals do not apply if they are currently not taking prescription

[16]Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, table 8 (Washington, D.C.: July 2004). The data were projected for calendar year 2006. CBO estimated that an overall total of 14.2 million beneficiaries would be eligible for the subsidy in 2006.We derived the CBO estimate by subtracting 8.4 million beneficiaries that CMS estimated in January 2008 were deemed for the subsidy, or had comparable coverage from other federal programs, from the sources' original estimates of all eligible beneficiaries.

[17]Mathematica Policy Research, Inc., *Doors to Extra Help: Boosting Enrollment in the Medicare Part D Low-Income Subsidy*, #2007-15 (AARP, Washington, D.C.: September 2007).

medications because they do not believe that they need the benefit and are discouraged by the assumed high Part D drug costs.[18]

SSA Initially Conducted Focused Outreach Efforts, But Now Incorporates Such Efforts into Overall Social Security Outreach

From the outset of the low-income subsidy program, SSA conducted a broad outreach campaign to inform as many potentially eligible people as possible about the subsidy and how to apply for it. SSA conducted its initial outreach campaign from May 2005 to August 2006. To solicit subsidy applications, SSA sent targeted mailings, which included an application for the subsidy and instructions on how to apply, to 18.6 million individuals identified as potentially eligible. SSA also conducted over 76,000 outreach events in collaboration with federal, state, and local partners, such as CMS, state Medicaid agencies, state health insurance programs, and advocacy groups for Medicare beneficiaries, among other efforts. The number of outreach events has declined, from a high of 12,150 in July 2005 to 230 at the completion of the campaign in August 2006.

Today, SSA continues to solicit applications, but through the agency's ongoing general outreach activities, working with third parties and special targeted events around Mother's Day and Father's Day, though not through a dedicated campaign. Current activities include

- mailing notices annually that include information about the low-income subsidy to low-income Medicare beneficiaries.
- mailing approximately 100,000 applications each month to beneficiaries attaining initial Medicare eligibility after screening them to determine that their income may be below 150 percent of the federal poverty level.
- including information on the subsidy in its Cost-of-Living Adjustment letter sent each December to over 50 million Medicare beneficiaries.
- developing new outreach material for capturing the attention of Medicare beneficiaries regarding the subsidy.
- conducting a "Show Someone You Love How Much You Care" campaign to inform relatives and caregivers about the low-income

[18]CMS, Office of External Affairs, Strategic Research & Campaign Management Group, Division of Research, *Formative Research on the Low Income Not Enrolled Population* (n date).

subsidy. This campaign has focused on Mother's Day and Father's Day in 2007 and 2008.

- using automated phone call technology to call potentially eligible individuals to inform them about the subsidy. SSA field office staff will call individuals who do not respond. This initiative will begin in June 2008.
- using a new special pamphlet, designed with a mailer insert that is placed at pharmacies, hospitals, and medical practices, to enable Medicare beneficiaries to request a low-income subsidy application without calling or visiting SSA.

Recent staffing reductions in field offices may have left SSA with limited resources to assist individuals with the subsidy and conduct local outreach efforts.[19] With staffing reductions, much of SSA's work is focused on its core workload, which includes processing applications for Social Security benefits and for Social Security numbers. Between 2005 and 2007, field office staffing declined by 7.1 percent. We recently testified that this staffing reduction may have increased customer waiting time in field offices. Further, during the course of our recent study, several staff reported that they often did not have adequate time to spend with customers to explain information. Although SSA hired 2,200 new field office staff to assist with the implementation of Medicare Part D, these staff are now focused on the full range of field office workloads and are therefore not available to specifically serve the needs of individuals seeking assistance with the low-income subsidy.

Individuals responding to Mathematica's 2007 study stated that the availability of local SSA staff to help low-income subsidy applicants is important because SSA staff may provide more personalized assistance than staff in SSA's Teleservice Centers, which operate the agency's toll-free telephone service. However, many of the study respondents reported long lines at crowded SSA field offices or difficulty getting through on local field office telephone lines. Mathematica reported that several respondents reported that SSA field offices were overwhelmed by people seeking services other than the low-income subsidy. In our May 2008 testimony on SSA field offices, we also reported that staffing reductions have adversely affected field offices' ability to serve customers. In

[19]GAO, *Social Security Administration Field Offices: Reduced Workforce Faces Challenges as Baby Boomers Retire,* GAO-08-737T (Washington, D.C.: May 8, 2008).

particular, we reported that between 2002 and 2006, the average waiting time for field office service increased by 40 percent from 15 minutes to 21 minutes, and in fiscal year 2007, more than 3 million customers waited for over an hour to be served, according to SSA data. We also reported that SSA's 2007 Field Office Caller Survey found that 51 percent of customer calls to 48 randomly selected field offices went unanswered.

Conclusions

Reaching the millions of people who are forgoing the government's help in paying for their prescription drug benefit remains a significant challenge. While SSA continues to approve applications for the subsidy, the agency's efforts to attract new subsidy applicants have slowed significantly since 2006. CMS and CBO estimate, respectively, that about 2.6 million to over 4 million individuals who may be eligible for the subsidy are still not receiving the benefit. It is not clear how to reach the remaining eligible people, and the barriers to identifying them and convincing them to sign up remain. While advocacy groups encourage a more personalized outreach approach, it may be unrealistic to expect SSA to conduct such efforts, given its resource limitations. The IRS and SSA study may help determine if tax data could help identify individuals who may qualify for the subsidy and target outreach efforts. A better understanding of who is eligible could help SSA make more efficient use of limited staff resources by targeting outreach more narrowly to the eligible population.

Mr. Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other members of the committee may have at this time.

GAO Contacts and Staff Acknowledgments

For further information regarding this testimony, please contact Barbara D. Bovbjerg, Director, Education, Workforce, and Income Security Issues, on (202) 512-7215. Blake Ainsworth, Susannah Compton, Mary Crenshaw, Matthew Lee, Lise Levie, Sheila McCoy, and Paul Wright also contributed to this statement.

Related GAO Products

Social Security Administration Field Offices: Reduced Workforce Faces Challenges as Baby Boomers Retire. GAO-08-737T. Washington, D.C.: May 8, 2008.

Social Security Administration: Policies and Procedures Were in Place over MMA Spending, but Some Instances of Noncompliance Occurred. GAO-07-986. Washington, D.C.: August 31, 2007.

Medicare Part D Low-Income Subsidy: Additional Efforts Would Help Social Security Improve Outreach and Measure Program Effects. GAO-07-555. Washington, D.C.: May 31, 2007.

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Senator SMITH. Thank you, Barbara.

Joyce Payne.

STATEMENT OF JOYCE PAYNE, MEMBER, AARP BOARD OF DIRECTORS, WASHINGTON, DC

Ms. PAYNE. I am Joyce Payne of AARP's Board of Directors. We want to thank you for inviting us to testify on the need to strengthen Part D low-income subsidy and Medicare savings programs.

One in four people on Medicare live on incomes of 150 percent or less of the poverty level. That is just $15,600 for individuals and $21,000 for couples. They desperately need the help these programs provide.

The low-income subsidy covers up to 95 percent of drug costs and closes the Part D donut hole. The Medicare savings programs pay Part B premiums and for those below the poverty level all Medicare cost sharing. However, millions of older Americans who need the help LIS and MSPs provide are not getting it because these programs have a serious flaw, an asset test.

For LIS, beneficiaries can have no more than $11,990 in savings, $23,970 for a couple, no matter how low their income or how high their living expenses. For MSPs, the asset test or the asset limits are even more unreasonable—$4,000 for individuals and $6,000 for couples in most States, a limit that has not changed for the last 20 years. These amounts are hardly enough to get people through retirement. But anyone who has saved even one dollar over these limits is not eligible for help.

Asset tests contradict efforts to encourage people to save by penalizing those who, despite limited incomes, put away a small nest egg for retirement. We should encourage people to save for retirement, not penalize those who do. Asset tests are also a barrier to enrollment, even for those who meet the limits because they make the application process so very daunting and invasive. The result is that millions of people are not getting the needed assistance.

AARP believes there should be no asset test in Medicare. Again, we should encourage people to save for retirement. As a first step, AARP supports the Part D Equity for Low-Income Seniors Act introduced by Senators Jeff Bingaman of New Mexico and the Ranking Member of this Committee, of course, Senator Gordon Smith of Oregon.

This legislation would increase the asset test limits, simplify the LIS application, and help target efforts to identify and enroll people. It takes an additional important step of allowing Social Security to screen LIS applicants for MSPs.

We are committed to seeing enactment of first steps toward that goal this year as part of the Medicare package currently being considered by the Senate, and we look forward to working with Members of the Congress from both sides of the aisle to improve the Medicare prescription drug benefit and to ensure that all older Americans have access to affordable prescription drugs and healthcare.

Again, we thank the Committee for this opportunity to speak on behalf of our 40 million members who want the Congress to strengthen Medicare low-income programs.

We thank you.

[The prepared statement of Ms. Payne follows:]

Testimony Before the

Senate Special Committee on Aging

On

Medicare Programs for Low-Income Beneficiaries

May 22, 2008

WASHINGTON, D. C.

N. Joyce Payne, Ed.D,

Member, AARP Board of Directors

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Chairman Kohl, Ranking Member Smith, distinguished Committee members, I am N. Joyce Payne, a member of AARP's Board of Directors. On behalf of AARP's nearly 40 million members, I thank you for inviting us to testify on the need to strengthen Medicare's low income programs – the Part D Low-income Subsidy (LIS) and Medicare Savings Programs (MSPs).

One in four people in Medicare live on incomes of 150 percent or less of the poverty level ($15,600 for individuals, $21,000 for couples). They desperately need the help these programs provide in order to afford the care they need.

The LIS covers up to 95 percent of drug costs, according to the Center for Medicare & Medicaid Services, and closes the Part D coverage gap ("doughnut hole") for people with incomes below 150 percent of poverty. This assistance to those least able to pay for drugs is one of Part D's most important features and one of the key components of the Medicare Modernization Act.

The Medicare Savings Programs (MSPs), administered by state Medicaid programs, pay Part B premiums for people below 135 percent of poverty, and all Medicare cost sharing for those below the poverty level. MSPs include:

- The Qualified Medicare Beneficiary (QMB) program, which pays all Medicare premiums, deductibles, and copays for individuals with income below 100% poverty (annual income below $10,400);

- The Specified Low-income Medicare Beneficiary (SLMB) program that pays Medicare premiums for individuals with income between 100 and 120 percent of poverty (annual income below $12,480); and

- The Qualified Individual (QI) program that gives states limited annual allotments to pay Medicare premiums for individuals with income between 120 and 135 percent of poverty (annual income below $14,040).

Part B premiums are now $96.40 per month, so the programs save enrollees more than $1,156 each year, and much more for those below poverty.

However, millions of older Americans who need the help LIS and MSPs provide are not getting it because these programs have a serious flaw – an asset test. To be eligible for LIS, beneficiaries can have no more than $11,990 in savings, or $23,970 for a couple, no matter how low their income or how high their other living expenses. These amounts are hardly enough to get people through retirement, and anyone who has saved even one dollar over these limits is not eligible for LIS. That is why AARP has consistently opposed the asset test.

For MSPs the asset limits are even more unreasonable -- $4000 for individuals and $6000 for couples in most states – a limit that has not changed in 20 years.

Penalizing Savers

Asset tests directly contradict efforts to encourage people to save by penalizing those who, despite very limited incomes, manage to put away a small nest egg for retirement. We should encourage people to save for retirement, not penalize those who do.

The Kaiser Family Foundation has estimated that more than 2.37 million beneficiaries who meet LIS income criteria do not meet the asset test. Almost half exceed the asset limit by $25,000 or less. And almost half were widows whose income typically plummets when their husbands die, but whose assets are above the lower threshold set for single people.[1]

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[1] Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test, Thomas Rice, Ph.D,.UCLA School of Public Health and Katherine A. Desmond, M.S.Consultant, Henry J. Kaiser Family Foundation April 2005

Creating Red-tape Barriers

Asset tests are also a serious barrier to enrollment, even for those who meet its limits, because it makes the application process daunting and invasive. The LIS form is eight pages of questions that are difficult for many people to answer, including:

- requiring 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;

- asking people whether they expect to use savings for funeral or burial expenses, but not explaining that individuals can only have up to $1,500 ($3,000 for couples) in savings above the asset limits for such expenses; and

- asking invasive questions -- such as whether applicants get help with meals or other household expenses from family members or charities -- which can be difficult to estimate and embarrassing.

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.

The red tape barrier created by the asset test is a key reason why millions of people who should qualify for the LIS are not getting it. CMS initially projected that 14.4 million beneficiaries would be eligible for the LIS.[2] However, to date, fewer than 10 million have enrolled.

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[2] CMS-4068-P, Medicare Program: Medicare Prescription Drug Benefit, 69 Fed. Reg. 46632: August 3, 2004

That means roughly 4 million or more people who are eligible for LIS are not getting the help they need.

The same kind of barrier to enrollment seen with the LIS exists in the majority of states that still impose an MSP asset test requirement. The result, not surprisingly, is that the vast majority of people eligible for MSPs are not getting needed assistance. Research has estimated that only one third of beneficiaries who are eligible for QMB, and only 13 percent who are eligible for SLMB, are actually enrolled in these programs.[3]

Inadequate LIS and MSP Coordination

In addition, there is limited coordination between LIS and MSP, even though they serve primarily the same populations. Beneficiaries enrolled in MSPs are automatically enrolled in the LIS. However, the Social Security Administration (SSA) does not screen LIS applicants to see if they are also eligible for MSPs in their state. This is a serious missed opportunity for two reasons. First, many LIS enrollees need and are eligible for the assistance MSP provides, but are not getting it.

Second, MSP eligibility criteria in several states are less restrictive than LIS criteria, and some states have eliminated the asset test altogether. Since people enrolled in MSP automatically receive the LIS, this means that many individuals eligible for the LIS under their state's MSP rules are improperly rejected when they apply for the LIS because LIS applications are not cross-checked for MSP eligibility.

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[3] Dorn, S. and Kenny, G.M., *Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers* (New York, NY: The Commonwealth Fund, June 2006).

The Medicare Payment Advisory Commission recently recommended alignment of LIS and MSP income and asset rules, as well as having the SSA screen LIS applicants for MSP eligibility.

Improving the LIS and MSPs helps not only eligible beneficiaries, it also helps Medicare's overall financing -- people who need assistance but do not receive it are more likely to postpone needed care when they cannot afford the cost sharing. Beneficiaries' health declines as preventable complications arise, driving up total Medicare costs in the long term. Strengthening the LIS and MSPs can help prevent these higher long-term costs.

Improving the LIS and MSPs also is particularly important in rural areas. More than one in four people in Medicare live in rural areas and are more likely to be poor – 14.7% vs. 11.8% in urban areas. In fact, almost half of rural Medicare beneficiaries have incomes below 150% of poverty ($15,600 per year for individuals/ $21,000 for couples).

AARP Position

AARP believes there should be no asset tests in Medicare – including both the LIS and MSPs. As a matter of public policy, we should encourage people to save for retirement, not penalize those who do with an asset test.

AARP also believes that there should be full coordination between the LIS and MSP programs. Applicants for either the LIS or MSP should be screened for both programs. Eligibility criteria should be simplified and standardized to reduce confusion and unnecessary barriers. In addition, the QI program should be made permanent by folding it into the SLMB program so eligible people can rely on this assistance without worrying that their state may run out of its limited allotment.

First Steps

AARP is firmly committed to eventually eliminating asset tests in Medicare. However, there are interim steps Congress should take now to reduce the asset test barrier for LIS and MSP. AARP supports the Part D Equity for Low-Income Seniors Act (S. 1102) introduced by Senators Jeff Bingaman of New Mexico and the ranking member of this Committee, Senator Gordon Smith of Oregon. Key provisions of this bill should be included in any Medicare legislation enacted this year, including:

Raising the Limits: Most importantly, this legislation would increase the asset test limits for the LIS to $27,500 for individuals and $55,000 for couples. This will provide relief to millions of beneficiaries who truly need the help the LIS provides. Even those who did not oppose an asset test in Medicare's drug plan agree that current limits – $11,990 for individuals, $23,970 for couples – are far too low.

Streamlining the Application: The legislation would simplify the LIS application in two important ways. First, it would eliminate the question about cash value of life insurance. This is information that people – regardless of income – simply do not have on hand. Asking for this data needlessly lengthens the application form and often requires individuals to make multiple calls to obtain the cash value figure. Life insurance also is something responsible people purchase to protect their families after they have died; it is not something the government should require people to cash in to purchase drugs they need to stay alive.

Second, it would delete the confusing and embarrassing question about occasional help from family or charities with expenses like groceries. People often get assistance from family, churches, and food banks on a highly irregular, as-needed basis in very limited amounts.

This question, however, requires applicants to enter a specific average monthly amount – 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 who are most in need of the LIS.

Targeting Outreach: The bill would also help target efforts to find and enroll people eligible for the LIS by letting SSA officials use Internal Revenue Service (IRS) data – information SSA already uses to determine income-related Part B premiums -- to also determine who meets LIS income criteria. This would much more efficiently and effectively target outreach efforts to these individuals. Currently, the IRS verifies income data submitted by LIS applicants, but SSA does not have authority to use the IRS data it already has to determine who meets LIS income criteria for outreach purposes. The HHS Inspector General has already stated that legislation authorizing this limited use of income data would help target LIS outreach.[4]

Coordinating the LIS and MSP: The Bingaman-Smith legislation takes an additional important step of allowing the Social Security Administration to screen LIS applicants for MSPs. This is important for two reasons. First, people eligible for LIS also need the assistance provided by MSPs. Second, MSPs provide an additional avenue for entry into the LIS in states that have adopted higher MSP income and asset limits, since eligibility for MSP automatically triggers LIS enrollment. Improved coordination between the LIS and MSP would provide needed help with both Part D and traditional Medicare premiums and cost-sharing obligations to many more low-income beneficiaries.

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[4] 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

Maintaining LIS Affordability: Finally, the legislation would keep LIS cost sharing more affordable by indexing it to general inflation. Now cost sharing rises based on increases in overall Part D costs that are rising much faster than general inflation, requiring low-income seniors' to pay increasingly higher rates.

AARP also supports legislation to:

- increase funding for State Health Insurance Programs, which provide the one-on-one counseling that is most helpful to beneficiaries applying for the LIS and MSPs;

- make the QI program a permanent and reliable source of assistance by no longer subjecting this program to annual capped allotments and increasing the income eligibility level to 150 percent of poverty so there is parity between the LIS and MSPs;

- eliminate co-pays for Medicaid beneficiaries who get long term care services in Home and Community Based Service (HCBS) programs, as is done now for beneficiaries receiving these services in nursing homes; and

- count payments by federally qualified health clinics, AIDS drug assistance programs, the Indian Health Service and drug company Patient Assistance Programs (PAP) toward the Part D "doughnut hole" coverage gap.

Conclusion

The Medicare drug benefit represents the most significant change to Medicare since the program began in 1965. The extra help provided to people who most need it through the LIS is a key component, but its success is far from complete.

Similarly, MSPs provide vital assistance necessary to ensure that people with limited incomes can afford access to care, but far too many who need this help are not getting it. It is critical that we eliminate the LIS and MSP asset tests that penalize people who save for retirement and impose barriers to assistance.

We are committed to seeing enactment of first steps towards that goal this year, and we look forward to working with members of Congress from both sides of the aisle to improve the Medicare prescription drug benefit and to ensure that all older Americans have access to affordable prescription drugs and health care.

Senator SMITH. Thank you very much, Joyce.

Laura Summer.

STATEMENT OF LAURA SUMMER, SENIOR RESEARCH SCHOLAR, GEORGETOWN UNIVERSITY, HEALTH POLICY INSTITUTE, WASHINGTON, DC

Ms. SUMMER. Mr. Chairman and members of the Committee, I appreciate the opportunity to testify today.

Much of my work at Georgetown has involved examining the impact of Federal and State policies on enrollment for public benefit programs and particularly recently for the low-income subsidy for Part D as well as the Medicare Savings Programs.

Today, I would like to discuss some program changes to initiate a shift from the current enrollment process, which requires that individuals learn about and seek benefits, to one that relies on the use of available data to identify and inform low-income individuals about their eligibility and to help them enroll.

First, I would like to make an important distinction. We often hear that 80 percent approximately of those who are eligible for the low-income subsidy are receiving it. But there are two groups of people who qualify for the subsidy, those who are deemed eligible by virtue of their participation in other programs and those who have to file a separate application for the subsidy.

Of that group, the 4.2 million who have to file that separate application, it appears from CMS data that only about 38 percent are receiving the subsidy, and that is obviously a very low enrollment rate.

There is a tendency in thinking about how to improve enrollment in a program to want to publicize it more. But as Mr. Salazar noted before, low enrollment occurs not only because people don't know about the program, but also because they find the program difficult to apply for. They aren't familiar with the financial eligibility requirements or the financial benefits, and they simply don't know how to apply. This is what we generally hear when we ask beneficiaries and their counselors about the reasons that people don't apply for the subsidy.

So some administrative simplification could really help increase enrollment. The elimination of the resource test is a key program change to simplify enrollment for beneficiaries and for those who process applications. As we have heard already this morning, that step would allow us to be able to identify the people who really qualify for the subsidy and also to target outreach more effectively because we have good data from national surveys about the income of these folks. But we don't have good information about the resources of low-income seniors.

If the resource test is not eliminated, some steps certainly should be taken to increase the resource limit and also to simplify the way that resources are counted and verified. But simply eliminating a resource test or raising the resource limits will not ensure increased enrollment. We have an example from the State of Maine, which last year decided that they would do without a resource test for the Medicare Savings Program.

Following that decision, they saw very little increase in enrollment in that State for the Medicare Savings Programs. But then

a subsequent decision to deem eligible all of those people who were participating in the State Pharmacy Assistance Program for the Medicare Savings Programs brought a very dramatic increase in enrollment.

As you have heard from others today, the idea of having the Social Security Administration and the IRS work together to determine—to use information on hand to determine who might be eligible for the subsidy is certainly one that has a great deal of merit. Without a resource test, it would be even easier to identify those individuals who are eligible for the subsidy.

At the current time, SSA enrolls Medicare beneficiaries when they become eligible in both Parts A and Part B of the Medicare program, and there is an option to opt out of Part B. Thinking about a streamlined way to promote enrollment, the Social Security Administration could also enroll people eligible for the subsidy and give them an opt-out provision.

We have also heard this morning about the fact that LIS and MSP benefits are available for a similar, but not exactly the same population, and two program changes could achieve administrative efficiency and increase enrollment in both programs.

First, a mandate that no matter where a person applies for a subsidy or for MSP benefits, they be screened and enrolled for the other program, regardless of whether they apply at the Medicaid office or through the Social Security Administration, and a similar mandate that information be shared between those two programs would be very helpful. Of course, aligning the eligibility rules for the two programs would foster dual program enrollment.

I also want to mention that ensuring that benefits continue uninterrupted from year to year is another very important factor in achieving high enrollment rates. Some of the people who are counted in those not participating in the program this year are people who participated last year, but lost their eligibility when they lost their deemed status through Medicaid or when they failed to respond to notices from SSA to redetermine eligibility.

Barbara did mention some of the new data that are available from SSA, but there are other data that would be very helpful to have. It would be good to know about the relative value of resources to income for the folks who apply and who receive and who don't qualify for the subsidy. It would also be helpful to know whether resources change from year to year for this particular population. Even if the resource test is not eliminated at the time of application, I would suggest it certainly should be eliminated at the time of redetermination because in our research, we found that generally assets do not change for this population over time.

Finally, I would just say that even with a simpler enrollment process, there will still be a need for materials and all kinds of materials, not only publicity and applications, but also notices, all correspondence to be available in a variety of languages so that we have linguistically and culturally appropriate information available for those people who may qualify for the subsidy.

We know that beneficiaries tend to seek help from trusted sources and that one-on-one counseling is particularly effective. Over the past few years, the Federal Government really has played an important role in ensuring that there is support for that kind

of activity. But as the program is more established, it is very important to continue to provide that sort of support so that one-on-one assistance can continue to be available on a community level.

Thank you.

[The prepared statement of Ms. Summer follows:]

Testimony
For the Hearing Entitled,
"Seniors at Risk: Improving Medicare for Our Most Vulnerable"

Laura Summer
Senior Research Scholar
Georgetown University Health Policy Institute

Before the

Special Committee on Aging
United States Senate

May 22, 2008

Chairman Kohl, Senator Smith, and distinguished Members of the Committee, I appreciate the opportunity to testify on the topic of improving Medicare for the most vulnerable beneficiaries.

I am Laura Summer, a senior research scholar at Georgetown University's Health Policy Institute. One of my principal research activities is to analyze how federal and state policies and practices affect enrollment in and use of public benefit programs for seniors and others. Most recently I have been studying these issues with regard to the Medicare Part D drug benefit as well as the Medicare Savings Programs (the QMB, SLMB, and QI programs, known collectively as MSPs).[i] The Medicare Savings Programs help low-income beneficiaries with Part B premiums and co-payments.

The addition of a Medicare prescription drug benefit has broadened health insurance coverage for Medicare beneficiaries considerably. The Part D Low-Income Subsidy, also called "Extra Help" or the LIS, offers great potential for low-income beneficiaries to receive substantial help with Part D premiums and cost-sharing. Although they are entitled to this financial assistance, however, millions of beneficiaries do not receive it. In this testimony, I will discuss the reasons for persistent low enrollment in the Low-Income Subsidy, and suggest some program changes that could increase enrollment.

LIS ENROLLMENT

The Low-Income Subsidy is available to Medicare beneficiaries with incomes below 150 percent of the federal poverty line and limited resources. The great majority of the 12.5 million beneficiaries estimated to be eligible for the Low-Income Subsidy are deemed eligible because of their participation in other programs. Low LIS participation rates are occurring among the 4.1 million beneficiaries who must apply separately for the subsidy. According to CMS, almost two-thirds of them (63 percent) were not receiving the subsidy as of January 2008.[ii]

PROGRAM CHANGES TO INCREASE LIS ENROLLMENT

Simplify the enrollment process

Three of the reasons cited most commonly by beneficiaries and their counselors for low enrollment in the Low-Income Subsidy are that beneficiaries do not know how to apply for the subsidy; they do not understand the financial eligibility rules and therefore think they are not eligible for the subsidy; or they do not complete the application because the process is too complicated.[iii]

These survey results suggest that confusion persists despite considerable effort on the part of the Social Security Administration, the Centers for Medicare and Medicaid Services, state Medicaid programs, and community organizations to reach beneficiaries and provide program information and assistance. The Part D program can be confusing for low-income beneficiaries who are not automatically deemed eligible for the subsidy; they must complete a two-part process, first submitting an application for the LIS and then enrolling in or being assigned to a prescription drug plan. Changes to simplify the application process could reduce the need for explanation and assistance while improving enrollment rates for the subsidy.

Eliminate the resource test

The elimination of the asset or resource test is a key program change that would make the application process simpler and less time consuming for beneficiaries, those who assist them, and those who process applications. Studies of other programs show that administrative costs decrease when the application process becomes easier.[iv] There are other administrative advantages. Data currently available from national surveys provide reliable information on income, but limited information on resources for seniors. If income were the sole financial eligibility criterion for the subsidy, government officials could estimate the number of beneficiaries eligible for the LIS with much more specificity. Indeed, CMS estimated in 2007 that 13.2 million were eligible for the Low-Income Subsidy, but the estimate for 2008 was lower by 700,000.[v] CMS could also use survey data to more accurately identify areas of the country that could benefit from targeted outreach. Finally, CMS research indicates that beneficiaries who are eligible for the Low-Income Subsidy may be reluctant to apply because they do not want to provide personal information about resources.

If the resource test is not eliminated, some steps could still be taken to increase the limit and to simplify the way assets are counted and documented. For example, the requirement that applicants provide information about the cash surrender value of life insurance policies has posed problems since beneficiaries often do not have this information on hand. Recognizing this, at least ten states have established exclusions higher than the standard $1,500 for life insurance or burial funds to determine program eligibility for the Medicare Savings Programs and some do not require documentation for this resource.[vi]

Adopt a proactive approach to identifying and enrolling low-income beneficiaries

Eliminating the resource test will help achieve the goal of simplification, but alone, it will not ensure that enrollment increases. In the state of Maine, for example, a policy change early in 2007 to disregard all resources for the Medicare Savings Programs had little effect on program enrollment, but the decision later that year to deem State Pharmacy Assistance Program enrollees eligible for the Medicare Savings Programs caused a dramatic increase in enrollment.[vii]

Without the resource test, the Social Security Administration could take a more proactive role to identify, inform, and – with their permission – enroll Medicare beneficiaries for the subsidy. Presumably, the tax return data that the Social Security Administration uses to determine the Part B premium amount for higher-income beneficiaries could also be used to identify beneficiaries who are eligible for the LIS.

Currently, SSA automatically enrolls individuals receiving Social Security benefits in Medicare on the first day of the month they turn 65; others may apply for Medicare three months before they are eligible. Almost all are enrolled in Parts A and B, but may opt out of Part B. The Social Security Administration could identify and enroll eligible beneficiaries for the subsidy at the same time, also with an opt-out provision. This approach, which informs beneficiaries of their eligibility rather than requiring that they know about the benefit and apply, would not only be simpler, but would also address the problem that substantial proportions of low-income beneficiaries are not aware that a subsidy is available.[viii]

Align rules and procedures for the Low-Income Subsidy and the Medicare Savings Programs

The LIS and MSP benefits target similar groups of vulnerable Medicare beneficiaries. Generally, the income and resource limits are somewhat higher for the subsidy than for the Medicare Savings Programs, though a number of states have expanded MSP eligibility by eliminating or amending resource tests.[ix] All beneficiaries who receive MSP benefits are deemed eligible for the LIS. Many who qualify for the LIS are financially eligible for the Medicare Savings Programs, but even those eligible for both must apply separately for the two programs.

Beneficiaries can apply for the LIS through state Medicaid programs, which handle eligibility determinations for the Medicare Savings Programs. Currently, the Social Security Administration handles the great majority of LIS applications, however. A requirement that specific eligibility information from the subsidy application be forwarded from SSA to the state

Medicaid office for review and processing would likely help increase enrollment in the Medicare Savings Programs.

Two program changes could achieve administrative efficiency and increase enrollment for both benefits. First, mandates that all applicants be screened and – with their permission – enrolled, if eligible, for both LIS and MSP benefits, regardless of where they apply would help. (It is important to note that unlike the LIS, MSP eligibility rules differ from state to state, but the Social Security Administration already has experience enrolling Supplemental Security Income beneficiaries in Medicaid programs for 32 states and the District of Columbia). Second, if the eligibility rules for the two programs were aligned, the task of making eligibility determinations would be easier and beneficiaries eligible for the subsidy could be deemed eligible for MSP benefits.

Reduce coverage loss from year to year

Ensuring that the subsidy continues uninterrupted for eligible individuals is another important factor in achieving high enrollment rates for the LIS. Enrollment may decline at the end of the calendar year as low-income beneficiaries lose their deemed status because they have lost their eligibility for SSI or Medicaid and therefore are no longer automatically eligible for the LIS, though, based on their income and resources, many likely would still qualify for the Low-Income Subsidy. This was the case for more than 447,000 beneficiaries in 2008 who received letters advising them that they had lost their deemed status and that they should apply separately for the LIS.[x] The likelihood that individuals deemed eligible initially will "churn" off and on the subsidy program – that is, lose and regain coverage within a short period of time – could be reduced if Medicaid programs were required to re-evaluate subsidy eligibility for those who lose deemed status, either by using information on hand or requesting information from beneficiaries.

In 2008, an additional 500,000 beneficiaries were required to submit information about changes in income, resources, or household size so that their eligibility for the subsidy could be re-determined by the Social Security Administration. This is done to ensure that these individuals have not experienced a change in status that would make them ineligible. Some 76,000 beneficiaries failed to respond and therefore lost their subsidies. SSA conducts passive renewals, which rely on data available to SSA for most beneficiaries. Overall, the re-determination process would be easier if just income, rather than income and resources, were used as the financial criterion for renewal. Data show that there is little change in the value of resources over time for low-income seniors.[xi]

The goal of achieving consistent or stable subsidy coverage for eligible beneficiaries is an important one. If they lose their subsidies they will lose their drug coverage as well unless they pay the premiums for the plans in which they are enrolled. Beneficiaries can apply again after the loss of a subsidy, but will likely face new challenges when the subsidy is restored if they are randomly reassigned to a plan; they may be subject to formulary and utilization management procedures in their new plans that differ from their previous coverage.

Do not count the Low-Income Subsidy as income

Beneficiary counselors report that fear of losing other means-tested benefits is a common reason that beneficiaries do not apply for the LIS.[xii] Thus, a legislative change to ensure that LIS assistance is not counted as income when determining eligibility for other needs-based programs would address an enrollment barrier. Many precedents for this exist in federal public benefits; the most recent is the Prescription Drug Discount Program that preceded Medicare Part D.

Make administrative data more readily available

With the Part D program is in its third year of operation, a substantial amount of program data exists and should be made more widely available to further policymakers' understanding of how well the program is working and what types of changes may be warranted. To accurately measure progress in enrolling those eligible for the Low-Income Subsidy, it would be useful to have more information about the methods CMS uses to estimate the number of beneficiaries eligible for the LIS. In addition, data from the Social Security Administration could provide important information about the financial circumstances of those who apply for, receive, or do not qualify for the subsidy. Data on the reasons, both administrative and financial, that subsidy applications are not approved could be instructive. SSA data could be used to show the value of resources relative to income for applicants and the extent to which resources change from year to year for those receiving the subsidy. Finally, to better understand if and why eligible beneficiaries have gaps in their subsidy coverage, it would be helpful to know how many of those whose subsidy was terminated (because they lost deemed status or because they did not respond to requests for information to re-determine eligibility) reapplied and received the subsidy again, and how long this took.

Provide more targeted publicity and enrollment assistance

Much of the emphasis in this testimony is on simplifying the application and enrollment process for the Part D Low-Income Subsidy and the Medicare Savings Programs. It is important to

recognize, however, that no matter how simple an application process is some beneficiaries will need more information to better understand the program and may need assistance.

More culturally and linguistically appropriate messages and materials are needed to help inform beneficiaries about the availability of the subsidy. Medicare beneficiaries, like other segments of the U.S. population, are extremely diverse representing a wide spectrum of cultural backgrounds and languages. The low-income population is especially diverse.[xiii] A key consideration here is that appropriate materials and assistance are needed for every aspect of the enrollment process. All materials pertaining to the benefit – information, instructions, applications, and correspondence – should be available in numerous languages in order to increase the likelihood of reaching and assisting all eligible beneficiaries. Currently, SSA makes sample subsidy applications available in 15 languages for information purposes, but only has the capacity to accept scannable English and Spanish versions for processing. CMS has an online outreach tool kit, but materials are available only in English and Spanish; much of the information on the MEDICARE.gov website is available only in English and occasionally in Spanish.

Beneficiaries are most likely to seek help from familiar organizations or individuals they trust. One-on-one counseling such as that provided by State Health Assistance Insurance Programs (SHIPs) and other community-based organizations is mentioned consistently as being particularly helpful and necessary in interviews, and surveys pertaining to the Part D program.[xiv] The federal government has played an important role in providing support for this type of activity. Particularly in the early stages of the Part D program, funds were available to sponsor enrollment assistance by telephone, through the media, and at community events. In case studies of efforts to provide information and assistance effectively to low-income beneficiaries, the individuals who conduct outreach and counseling activities routinely said that without a consistent source of adequate federal support, this type of assistance cannot be sustained.[xv]

CONCLUSION

Government and private entities have conducted extensive outreach efforts for both the Part D Low-Income Subsidy and the Medicare Savings Programs, yet enrollment remains low. Program changes aimed at simplifying the application and enrollment processes are needed to help boost enrollment. In addition, a shift from the current process, which requires that beneficiaries learn about and seek benefits, to one that relies on programs' use of available data to identify and inform low-income individuals about their eligibility could have a significant positive effect on enrollment.

[i] The Qualified Medicare Beneficiary (QMB), the Specified Low-Income Medicare Beneficiary (SLMB), and the Qualifying Individuals (QI) comprise the Medicare Savings Programs (MSP). All cover Medicare Part B premiums and the QMB program also covers some cost-sharing. The QMB and SLMB programs are entitlement programs, financed with Federal and State funds, but the QI program is not. Federal QI funding is capped each year and is due to expire June 30, 2008, unless Congress passes new legislation.

[ii] Centers for Medicare and Medicaid Services, "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop," Press Release January 31, 2008.

[iii] Laura Summer, Patricia Nemore, and Jeanne Finberg, *Medicare Part D: How Do Vulnerable Beneficiaries Fare?* The Commonwealth Fund, April 2008.

[iv] Laura Summer, *Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs*, Rutgers Center for State Health Policy, 2004.

[v] Centers for Medicare and Medicaid Services, "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop," January 31, 2008 Press Release. Centers for Medicare and Medicaid Services, "Medicare Drug Plans Strong and Growing," January 30, 2007 Press Release.

[vi] Patricia Nemore, Jacqueline Bender, and Wey-Wey Kwok, *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,* Kaiser Family Foundation, May 2006.

[vii] Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy, March 2008

[viii] Patricia Neuman, Michelle Kitchman Strollo, Stuart Guterman, William Rogers, Angela Le, Angie Mae Rodday, and Dana Gelb Safran, "Medicare Prescription Drug Benefit Progress Report: Findings From a 2006 National Survey of Seniors," *Health Affairs* Web Exclusive, August 2007.

[ix] Patricia Nemore, Jacqueline Bender, and Wey-Wey Kwok, *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*, Kaiser Family Foundation, May 2006.

[x] Centers for Medicare and Medicaid Services, *Year 2007 Re-Deeming Data-Losing Deemed Status*, available at: http://www.cms.hhs.gov/limitedincomeandresources/

[xi] Laura Summer and Lee Thompson, *How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits*, The Commonwealth Fund, May 2004.

[xii] Laura Summer, Patricia Nemore, and Jeanne Finberg, *Medicare Part D: How Do Vulnerable Beneficiaries Fare?* The Commonwealth Fund, April 2008.

[xiii] Laura Summer, Ellen O'Brien, Patricia Nemore, and Katharine Hsiao, *State and Local Efforts to Assist Vulnerable Beneficiaries*, The Commonwealth Fund, May 2008.

[xiv] Laura Summer, Patricia Nemore, and Jeanne Finberg, *Medicare Part D: How Do Vulnerable Beneficiaries Fare?* The Commonwealth Fund, April 2008. Laura Summer, Ellen O'Brien, Patricia Nemore, and Katharine Hsiao, *State and Local Efforts to Assist Vulnerable Beneficiaries*, The Commonwealth Fund, May 2008.

[xv] Laura Summer, Ellen O'Brien, Patricia Nemore, and Katharine Hsiao, *State and Local Efforts to Assist Vulnerable Beneficiaries*, The Commonwealth Fund, May 2008.

Senator SMITH. Thank you, Laura.

Lisa Emerson.

STATEMENT OF LISA EMERSON, PROGRAM MANAGER, THE SENIOR HEALTH INSURANCE BENEFITS ASSISTANCE (SHIBA)/DIRECTOR, OREGON STATE HEALTH INSURANCE COUNSELING AND ASSISTANCE PROGRAMS (SHIPS), SALEM, OR

Ms. EMERSON. Good morning, Ranking Member Smith and Senator Whitehouse and guests. I am definitely honored and I very much appreciate being here as well to provide testimony today.

As you know, I am the program manager of the Oregon Senior Health Insurance Benefits Assistance Program, also known as the State Health Insurance Assistance Program, funded by a Federal grant from the Centers for Medicare and Medicaid Services as well as some State general fund.

I would like to take this opportunity to thank Congress at this time on behalf of my State and other national partners for approving additional funding for SHIPs this year.

My primary reason for being here today is to provide testimony about the low-income subsidy in Oregon and alert you to the critical role SHIBA plays with people eligible for Part D coverage. Oregon SHIBA is a State-wide free Medicare counseling service based in Salem, Oregon's capital. SHIBA has a certified volunteer base of approximately 200 volunteers that provide one-on-one counseling assistance to many of Oregon's over 571,000 Medicare beneficiaries, which makes up 15 percent of our total State population.

The overriding goal of SHIBA volunteers is to help people understand and make informed decisions about their Medicare benefits, particularly the Part D options because they are complex.

Since January 1 of 2007, the SHIBA counseling network has provided one-on-one counseling assistance to over 20,000 Oregon beneficiaries based on the data that we collect. The average time spent with each beneficiary has been approximately 38 minutes. The estimated in-kind value to the program for over 14,740 volunteer work hours during this period translates to approximately $250,000. These estimates illustrate the public reach and impact of Oregon's SHIP.

SHIBA cannot recruit and maintain a volunteer workforce without the assistance of vital local, county SHIBA partners. We currently contract with 22 local SHIBA sponsoring organizations throughout Oregon to provide local SHIBA counseling services to beneficiaries.

During today's hearing, you did hear directly from Judy and her family's need for the LIS, and she is one of many beneficiaries that we speak to in Oregon. These kinds of stories illustrate a very small sample of the widespread need for more low-income beneficiaries to be eligible for the assistance LIS can provide. I have included in the attachment some additional anecdotal stories from beneficiaries, and again, it is just a sample.

Oregon SHIBA's experience with Part D prescription coverage. Beneficiaries repeatedly have expressed the following concerns to SHIBA about the Part D low-income subsidy program. The income and asset requirements for LIS are restrictive and do not make the

benefit available to enough low-income people who need additional assistance with paying for their prescription drugs.

They report that the income and asset eligibility guidelines for patient assistance programs, also known as PAPs, offered by pharmaceutical companies are more generous than those for the LIS. And they also report concerns with the eligibility criteria of using cash surrender value of life insurance policies, in-kind support and maintenance, and undistributed funds in retirement savings plans such as 401(k) accounts as assets.

They often receive conflicting information about the LIS program from representatives from their Medicare Advantage company, private fee-for-service plan, Medicare, and Social Security Administration, and even insurance producers or agents. There has been a lag in coordination of the reduction in prescription co-pay for LIS beneficiaries when they join new Part D plans, and it has put the burden of proof that they are eligible for the LIS onto the beneficiary.

Many LIS beneficiaries with 100 percent subsidy report they did not realize their subsidy amounts were determined by Social Security Administration rather than by the particular plan that they had selected. Letters from the Social Security Administration can be confusing, and beneficiaries often do not realize that they must apply or reapply in order to receive LIS.

I would also like to take this opportunity to address the Federal grant for SHIBA and other SHIP programs. But in Oregon, the current Federal grant level has—while it has been increased slightly, has been insufficient to support the local level of resources and the volunteer base needed to meet the CMS/SHIP performance measures and standards and manage the growing number of calls from retiring baby boomers.

The creation of Part D increased the complexity of the coverage under Medicare and magnified the confusion among Oregonians about their choices and the impacts on their out-of-pocket costs. This, in turn, has increased considerably both the volume of calls to SHIBA and the amount of time volunteers spend providing assistance to each caller.

Because the drug benefits offered by individual plans can change dramatically from year to year, beneficiaries still require annual assistance to ensure that the plans in which they are enrolled still cover their prescription medications.

The CMS/SHIP performance measures implemented in 2005 have put an increased burden on State SHIP programs to maintain or exceed performance, but the funding base does not support the resources needed to develop a force of volunteers with the specialized knowledge to counsel the growing number of Medicare eligibles.

To appropriately address the increasing demand for assistance from SHIBA, particularly for Part D coverage, it would require having a minimum of one counseling site in every—or in all of Oregon's 36 counties and a volunteer force of not less than 600 active individuals trained in various specialty areas of Medicare.

I could go on, but I would like to say thank you again for this opportunity, Senator Smith, members of the Committee, for the opportunity to share testimony with you today, and I will do my best to answer your questions.

[The prepared statement of Ms. Emerson follows:]

Testimony of

Lisa Emerson
SHIP Director/SHIBA Program Manager

Oregon Senior Health Insurance Benefits Assistance
(SHIBA) Program

Part D Low-Income Subsidy

Before the
U.S. Senate Committee on Aging

May 22, 2008

U.S. Senate Special Committee on Aging
SHIBA Statement
May 22, 2008

Good morning, Chairman Kohl, Ranking Member Smith and members of the committee. I am honored and appreciative of the opportunity to provide testimony before the U.S. Special Committee on Aging today. I am the Program Manager of the Oregon Senior Health Insurance Benefits Assistance (SHIBA) Program, one of many State Health Insurance Programs (SHIPs) funded by a federal grant from the Centers for Medicare and Medicaid Services and some state general fund. I would like to thank Congress on behalf of my state and other national partners for approving additional funding for SHIPs this year. My primary reason for being here is to provide testimony about the Low-Income Subsidy (LIS) in Oregon and alert you to the critical role SHIBA plays with people eligible for Part D coverage.

Oregon SHIBA is a statewide free Medicare counseling service based in Salem, Oregon's capitol. SHIBA has a certified volunteer base of approximately 200 volunteers that provide one-on-one counseling assistance to many of Oregon's over 571,000 Medicare beneficiaries (15% of total population). The overriding goal of SHIBA volunteers is to help people understand and make informed decisions about their Medicare benefits, particularly the Part D options because they are so complex.

Since January 1, 2007, the SHIBA counseling network has provided one-on-one counseling assistance to over 20,000 Oregon beneficiaries. The average time spent with each beneficiary has been approximately 38 minutes. The estimated in-kind value to the program for over 14,740 volunteer work hours during this period translates to over $250,000. These estimates illustrate the public reach and impact of Oregon's SHIP.

SHIBA cannot recruit and maintain a volunteer workforce without the assistance of vital local county SHIBA partners. We currently contract with 22 local SHIBA Sponsoring organizations throughout Oregon to provide local SHIBA counseling services to beneficiaries.

During today's hearing you will hear directly from an Oregon beneficiary about her family's need for the LIS. These kinds of stories illustrate a small sample of the widespread need for more low-income beneficiaries to be eligible for the assistance LIS can provide. The attachments include some additional anecdotal beneficiary stories.

Oregon SHIBA's Experience With Part D Prescription Coverage
Beneficiaries repeatedly have expressed the following concerns to SHIBA about the Part D Low Income Subsidy (LIS) program:

- The income and asset requirements for the LIS are restrictive and do not make the benefit available to enough low-income people who need additional assistance with paying for their prescription drugs. They report that the income and asset eligibility guidelines for the Patient Assistance

Programs (PAPs) offered by pharmaceutical companies are more generous than those for the LIS. They also report concerns with the eligibility criteria using of the cash surrender-value of life insurance policies, in-kind support and maintenance, and undistributed funds in retirement savings plans such as 401(k) accounts as assets.

- They often receive conflicting information about the LIS program from representatives of their Private Fee For Service (PFFS) plan, Medicare, the Social Security Administration, and insurance agents.
- There has been a lag in coordination of the reduction in prescription co-pay for LIS beneficiaries when they join new Part D plans, and it has put the burden of proof that they are eligible for the LIS onto the beneficiaries. Many LIS beneficiaries with 100% subsidy report that they did not realize that their subsidy amounts were determined by the Social Security Administration (SSA) rather than by the particular plans that they had selected.
- Letters from the Social Security Administration can be confusing, and beneficiaries often do not realize that they must apply or re-apply in order to receive LIS status.

I would also like to take the opportunity to address the federal grant for SHIBA. In Oregon, the current federal grant level has been insufficient to support the level of local resources and the volunteer base needed to meet the CMS-SHIP performance standards and manage the growing number of calls from retiring baby boomers. The creation of Part D increased the complexity of the coverage under Medicare and magnified the confusion among Oregonians about their choices and the impacts on their out-of-pocket costs. This, in turn, has increased considerably both the volume of calls to SHIBA and the amount of time volunteers spend providing assistance to each caller. Because the drug benefits offered by individual plans can change so dramatically from year-to-year, beneficiaries still require annual assistance to ensure that the plans in which they are currently enrolled will still cover their prescription medications.

The new CMS performance standards have put an increased burden on state SHIP programs to maintain or exceed performance, but the funding base does not support the resources needed to develop a force of volunteers with the specialized knowledge to counsel the growing number of Medicare eligibles. To appropriately address the increasing demand for assistance from SHIBA, particularly for Part D coverage, would require having a minimum of one counseling center in every one of Oregon's 36 counties and a volunteer force of no less than 600 active individuals trained in various specialty areas of Medicare.

Thank you again Mr. Chairman and members of the committee for the opportunity to share testimony with you today. I will do my best to answer any of your questions.

ATTACHMENTS

Oregon SHIBA Funding and Staffing
Under Section 4360 of the Omnibus Budget Reconcililation Act of 1990 (OBRA) Congress authorized the Center for Medicare and Medicaid Services (CMS) to make grants to States and Territories to fund State Health Insurance Programs, this includes the Oregon SHIBA program. In 2007, the State of Oregon agreed to provide funding for the 2007-2009 state biennium to supplement the budgetary needs of Oregon SHIBA. The SHIP grant and state general funds support the state office infrastructure and its intergovernmental contracts to provide financial and training support to the local SHIBA Sponsoring Organizations in most of Oregon's 36 counties.

Current SHIBA Staffing
The Oregon SHIBA central office currently has 3.5 FTE permanent staff: one Program Manager, a part-time Office Specialist 2 (Administrative Assistant) and two Field Officers/Trainers. Additionally the program retains one Limited Duration Administrative Specialist 2 on a job rotation from another state program working as a Field Officer/Trainer. The current statewide volunteer base is approximately 200 active volunteers with some new volunteers in certification training.

Medicare Population in Oregon
Oregon has over 571,000 Medicare beneficiaries, comprising 15% the total state population of approximately 3.8 million residents. According to statistics from the US Census Bureau, Oregon's aging baby boomers are expected to increase Medicare beneficiaries to 24.2% of the state's population by 2025. In fact, baby boomers are already beginning to call SHIBA with questions about coordination of Medicare benefits with other retirement health insurance plans. They quickly are becoming our dominant and most time-consuming clients.

Part D Plans Offered in Oregon
As of January 2008, about 84%of the Medicare enrollees have a prescription drug plan, compared to 75% nationwide:

- 33% in stand-alone Prescription Drug Plans
- 30% in Medicare Advantage Drug Plans
- 8% in Employer plans taking retiree drug subsidies
- 13% with other prescription drug coverage

In 2008, 22 Insurance companies offered 55 different stand-alone drug plans, and 24 Medicare Advantage Plan companies offer plans with drug coverage. Premiums for the stand-alone plans range from $14.80 to $101.60, the average being $42.26. About 56% offer a zero deductible plan, compared to and estimated 60% nationwide (2007), and 36% offer a $275 deductible, compared to an estimated 31% nationwide (2007). (Source: Kaiser State Health Facts, 2007 reports)

Oregon Medicare Demographics

- Between 2006 and 2013, the fastest growing segments of the population in Oregon will be those 65 to 69 years of age (26% projected growth) and those 70 to 74 years of age (45% projected growth). As these individuals age, their care will begin shifting from the employment-based private insurance system to the publicly financed Medicare program, increasing the demand for education and counseling assistance.
- Those 65-69 years old comprise the largest group of Medicare beneficiaries (23%) and will grow significantly by the year 2010 due to more baby-boomers becoming eligible for Medicare. The percentage is the same nationwide.
- Oregon's next largest Medicare beneficiary age group is ages 70-74 (19%).
- Of the total number of Medicare eligibles, 86% (453,722) are eligible due to their age compared to 85% nationwide, and the rest (72,452) are eligible due disability. (*Source, Kaiser Family Foundation State Health Facts).
- 55% are women, compared to 56% nationwide.
- 65% of retirees do not receive income from pensions.

SHIBA Anecdotal Case Examples

- A 79-year-old woman still works and rides her bike. Those would be the definitions she lists first in describing herself. She lives on a meager $495 monthly social security retirement, necessitating that she continue to work to survive.

  She writes for a senior focused monthly newspaper. Her wages vary from month to month depending on the number of articles she writes, and she is required to pay about $1000 per year in Social Security self-employment tax.

  She averages $500 per month wages from her job, and has a little over $12,000 in a bank CD. The CD is her safety back up "just in case", but it has caused her to be disqualified from being eligible for a variety of resources, including the LIS.

  She has lived in a 25 foot camper trailer for the last 10 years that she owns, but she must pay $300 per month to park it on a cement slab. Her rent, food, medical insurance premiums, taxes and utilities total $915 per month, leaving her a "comfortable" $80 per month in disposable income. Last year, her insurance carrier stopped offering the particular Medicare plan in which she had enrolled, and the premiums for the choices left for her were double what she had been paying. Is it any wonder she is desperate to hang onto her safety net CD?

- This woman is disabled with multiple serious health issues. She had a dual eligible covered by both Medicare and Medicaid prior to 2006. After her husband died, she began to receive widow's benefits, which caused her to lose Medicaid eligibility as well as the LIS, which provided desperately-needed assistance for her expensive prescription medications. Her increase in monthly income put her $44 over the monthly income eligibility level for the LIS. Her living expenses for rent, utilities, food, car, home and medical insurance exceed her net monthly income by $47.

  She uses only generic drugs to limit her out of pocket expenses. She enrolled in a private fee for service Medicare Advantage plan (MA/PFFS) because it allowed her to select a stand-alone prescription drug plan (PDP) that had a copay she could manage. Her doctor prescribed a brand-name drug which would greatly improve her quality of life, but it has no generic equivalent yet. She cannot afford the copay for this drug and must go without it. She cannot access the Glaxo Smith Kline's Prescription Assistance Program until after she has spent $600 out of her own pocket for the brand drug, and she cannot afford that.

- I have worked with many people who "just miss" qualifying for LIS. Actually, my Mom is one of them. Her income per year comes to $17,000, "just" a bit over the eligibility requirements. She lives very frugally. (Wasco County SHIBA)

- An elderly female client has Alzheimer's and cannot communicate very well. She and her husband have an annual income that is below the Federal Poverty Limits, but because they have a couple of life Insurance policies worth about $33,000, they do not qualify for LIS unless they cash the policies out and spend the proceeds. (Washington County SHIBA Volunteer)

- One of our clients is a 69-year old woman with a monthly income of $595. She felt she could not afford Part B, and did not realize that she would incur a penalty for signing up late; she enrolled late and pays a 20% penalty on her Part B premiums, which equal $115.70 per month. She has modest savings "for emergencies" of about $28,000. Because of this, she is not eligible for any Medicare Savings programs and she is not eligible for LIS. At a prior time, she was eligible for the Medicare Savings Program but she decided not to enroll because it would have enabled Medicare to put a claim on her estate. She still owns her own home, and is afraid of losing it. She takes some medications, but is cautious because it is difficult to afford the co-pays. (Multnomah County SHIBA)

- One of our clients is a 65-year old woman who is a new Medicare beneficiary. She delayed enrollment in Part B and Part D until the last point at which she could enroll without penalty due because of the cost of the monthly premiums. Although she is currently healthy and takes no medications, she is aware that she needs insurance for catastrophic coverage. She has an income of about $700/mo from the Social Security Administration. The earnings from part-time self-employment help cover her monthly expenditures. Her estimated monthly income is about $1500, which places her $233 over income requirement for the LIS eligibility. She must use funds from her retirement savings account, valued about $30,000, to supplement monthly expenses. (Multnomah County SHIBA)

- A 48-year old male client had a recent liver transplant. He earns $115 in excess of the requirement for LIS eligibility, and he has $700 in savings. He cannot afford the cost of the post-transplant drugs once he is in the Part D coverage gap. (Multnomah County SHIBA)

- A 64-year old female client has a monthly income that places her $34 over limit for LIS eligibility. He medical conditions require that she use expensive brand medications that have no generic equivalent. The cost forces her to skip the purchase of some of the drugs, resulting in an exacerbation of her

illnesses. (Multnomah County SHIBA)

- A chronically mentally ill gentleman, whose wife works episodically at nursing care facilities, takes one medication that costs over $750 per month. He has applied for LIS twice but was determined to be ineligible for the LIS subsidy because his disability payment and her income exceed the requirements for eligibility. He found himself in the coverage gap since late March of 2008, and he has been trying to subsist on samples since because he cannot afford the out-of-pocket cost of the drug. The medication he takes is not available under the manufacturer's Patient Assistance Program for people with Part D coverage and his particular condition. Because of his mental illness, this person is at risk for harm if he does not have access to his medications. (Josephine County SHIBA)

- The representatives from the Social Security Administration frequently give misinformation to clients in this rural part of Oregon, and this continues to cause confusion among beneficiaries. (Josephine County SHIBA)

- An 83- year old rural woman with a monthly income level of $1600 cannot afford her drugs during the coverage gap. A misinformed community member pressured her to drop her Part D and sign up for Patient (Pharmaceutical) Assistance Program to receive her drugs for free all year long. This particular community member has been telling everyone he knows this is working for him and everyone should be doing it. Some people will likely be hurt by the Part D penalty if they follow this advice and fail to enroll in Part D or if they disenroll and want to enroll later. (Coos County SHIBA)

- Although we have provided education and training to the poverty-focused programs at Community Services Consortium, the local SHIBA sponsor, we have found that the local workers are so overwhelmed with the demands of their regular jobs that they forget to explain the LIS opportunity that is available.

- A rural client assisted by SHIBA receives $1267 per month from Social Security and has no assets at all. He used everything he had to pay off his trailer. His ex-wife still lives with him and she pays him $300 to help him with the heat, utilities and the $250/month trailer space fee. The help makes him ineligible for LIS. He has prior medical bills to pay and so he has to go to the local homeless shelter to get his diabetes medicines. (Benton County SHIBA)

- A rural client is eligible for Medicare coverage because of a long-term disability due to chronic depression. One of his medications is extremely expensive, but it is the only anti-depressant, which works for him. He approached a SHIBA volunteer to enroll in Part D, but the least expensive plan cost well over $4,000 annually in premiums. This was

unaffordable, representing over one-fourth of his total income of $17,214 from the Social Security Administration. He has no other income, and has no assets.

For him the only workable strategy was to forego Part D entirely, apply for LIS and use the LIS denial letter to support an application to the drug manufacturer's Prescription Drug Assistance Program. The manufacturer denied his initial application, but accepted on appeal. As a result, the client receives the expensive antidepressant at no cost, and his other medications have been changed to generics. Although this has been a good solution, he has no guarantee it will continue, because he has to reapply annually to continue coverage by the Prescription Drug Assistance Program. Part D has been no help to him at all, but clearly it would, if only the LIS criteria were more flexible. (Lincoln County SHIBA)

Senator SMITH. Thank you, Lisa.

Laura, as you have studied other States, how is Oregon doing?

Ms. SUMMER. Well, Oregon really does have a very active SHIBA program that is doing a great job.

Senator SMITH. Well, that is great. I appreciate that. As you think about the kind of information, the data that would be useful in helping Lisa help seniors navigate Medicare's low-income assistance program, what would be the most useful data?

Ms. SUMMER. Evaluate people's potential eligibility and try to determine——

Senator SMITH. Exactly.

Ms. SUMMER [continuing]. How to reach them?

Senator SMITH. Yes.

Ms. SUMMER. Well, as I said before, if we didn't have a resource test, then information on the income level of people in various parts of the State would be very helpful in identifying those who are potentially eligible for the benefit. In addition, it is very important not only to know the number of people you are trying to reach, but who those people are.

So, questions about the types of materials, whether they are appropriate linguistically or culturally, are very important to consider.

Senator SMITH. Do you agree with that, Lisa?

Ms. EMERSON. Yes, I do. I would like to just mention the efforts being made by SSA and CMS and the SHIP programs by doing a campaign, an LIS outreach campaign for 2008 that is getting kicked off right now. There is information on CMS's Web site about that.

Ms. SUMMER. Although I would like to add that the site provides materials in English and Spanish and perhaps should be expanded a bit to cover other languages.

Senator SMITH. Such as, in Oregon, perhaps Russian?

Ms. EMERSON. Absolutely.

Senator SMITH. What other languages?

Ms. EMERSON. Asian languages, Russian, Spanish, yes.

Senator SMITH. Judy, like Barbara, I was horrified to hear of your retirement difficulties. Your 401(k) is yours. How did it fall into the bankruptcy of your employer?

Ms. KORYNASZ. Illegally.

Senator SMITH. That is unrelated to this topic, but I am just horrified by such a thing.

Ms. KORYNASZ. Unfortunately, one of the owner's wives, she was the one who administered our 401(k). She owned her own business, which was an insurance business.

Senator SMITH. Is anybody in jail?

Ms. KORYNASZ. Well—you know, yes. The Federal Government came after them for back taxes for a lot of things.

Senator SMITH. This is outrageous.

Ms. KORYNASZ. They received punishment. That is true. They lost a lot. She lost her business. She lost everything. But unfortunately, the people that worked for them lost all that they had in their retirement. There was just nothing there.

Senator SMITH. I am so sorry to hear that. That obviously complicates all the additional difficulties you are having with Medicare,

and that takes us to the purpose of this hearing, I understand you have had some difficulty with 1–800–MEDICARE. I have been all over CMS for some time to try to reduce wait times and increase accuracy in information, and I wonder if you can discuss some of the problems you experienced?

Ms. KORYNASZ. When I tried to reach them, I kept wondering, well, why does this number ring through and then clicks off? So, I actually had asked—when I got in touch with the SHIBA volunteer, I asked if he would know why you couldn't get through. He said, "Well, I think it is the high volume of calls. They simply can't handle them."

Then I read a little piece in The Oregonian that stated that they simply did not have the staff to answer all of the calls. So when they were overloaded, it just simply cut them off. Not that the staff cut you off, the system did because they couldn't answer the calls.

Senator SMITH. Kind of like the Senate phone system when we are dealing with immigration or something. It melts down. [Laughter.]

But it points out the need, and I think the pressure that I and I know many of my colleagues are putting on CMS to deal with this issue. It makes me wonder why the budget requests CMS needs in order to manage this problem was not addressed. This truly is one of the really crying needs out there.

Right now, on the Senate Finance Committee, there has been a real effort to deal with the issue of what is called the "doc fix" around here. It doesn't do you a lot of good to have Medicare if no physicians will take Medicare patients. This is why we have to avoid what are scheduled cuts to them.

My own view is that in taking care of the doctors, which is essential not just for providers, but patients, we do need to address these low-income issues as well. I am going to be in a meeting a little bit later of Finance Committee members, and I wonder what you would tell them? Should we just take care of the docs, or should we also address these issues?

Ms. KORYNASZ. I think it is important to take care of the doctors because we ran into that. I mean, my doctor in Medford, when we moved up to Hillsboro area, recommended a doctor for me that she knew personally. When I made contact with that doctor's office, they said, "Oh, gee, we are really sorry, but we don't take Medicare patients. We simply can't handle any more than we already have."

Then when we tried to find a new doctor recently, we ran into the same problem. The doctor that we would liked to have had said, "Oh, we simply can't take any more Medicare patients. We have reached our quota on what we can handle." We had to hunt around to find a doctor that was willing to take on new Medicare patients.

Ms. PAYNE. Senator Smith, can I elaborate on that?

Senator SMITH. Yes, please, Joyce.

Ms. PAYNE. It seems to me that although the doctors are very—the physicians are very important to this, that it shouldn't have to be an either/or decision. We have to deal with the central issue of the cost of health in this country. We have to deal with creating the kind of system that will be high quality for low-income individuals and for physicians.

So I think we have enough resources, we have enough options. We can look at IT. We can look at evidence-based research. We can look at trying to get drugs into the marketplace, and we have enough solutions. I don't think we have to decide whether it is the physicians or low- income.

Senator SMITH. I agree with you completely, and that is going to be my position in the Committee later today.

Joyce, we are caught between what we need to do, what we want to do, and what the budget rules require under the PAYGO requirement. You know, PAYGO is a great campaign slogan. "Pay as you go."

The truth is, though, that that assumes a static budget and that every dollar spent is equal in terms of its economic impact, its human impact. Every tax dollar, every tax category is equal to every spending dollar. The truth is we don't have a static budget. We have a very dynamic one, and I wonder what would you counsel my friends on the Democratic side, frankly, who insist on this being in there? We are at loggerheads.

There aren't many other budget cuts to be made in Medicare or in other spending programs that they want to make or that I believe are advisable to make. There aren't the votes on the Republican side to raise taxes. So what do we do?

Ms. PAYNE. Well, certainly I am not the budget expert on this, but it seems to me that we need to live up to the code you have, that beautiful code on the wall about "E Pluribus Unum," out of many is one. Because one is Judy's family. One is—there are Judy families all over the country. We hear from them every day.

So it seems to me that however this is worked out, it needs to be worked out in the best interest of families like Judy's who have paid into the system, who have made the kind of sacrifices to live a good life, a decent life in retirement, and we should be providing incentives.

When you look at defined benefits fading away and you look at the issue that she just raised in terms of her 401, there are people who are really hurting. They desperately need these services. So, we need to think in terms of out of many is one not only for the Senate, but for the country.

Senator SMITH. Well, what happened in the last session of this Congress is that it was waived, and I suspect that that is what will happen again this Congress, that it will be waived because, I agree with you, these are not either/or issues. Although we need to take care of the docs, as Judy advises we also need to take care of the low-income issues.

I have asked enough questions. I will turn, before I go to a second round, to Senator Whitehouse.

Senator WHITEHOUSE. Thank you. Once again, I appreciate the Ranking Member having chaired this hearing and giving us the opportunity to hear from these wonderful witnesses.

All I was going to do was to say how much I appreciated your testimony, particularly Ms. Korynasz's personal testimony and Ms. Emerson's, the attachment that told the stories of all the different folks on your SHIBA program and what their lives were like and what they were going through. It is so easy for us to forget that here, when the tassle-shoed lobbyists show up from the pharma-

ceutical industry and try to have their way, that it really harms folks who don't have a voice all across this country.

I thought those were really wonderful stories in your testimony. I appreciate that you assembled them and brought them to us. So that was all I was going to say.

Then, Ms. Payne said what she said about the need for a forum, and I just have to pounce on that because I couldn't agree with it more. I think it is absolutely critical.

We have heard the testimony in the Budget Committee about the $35 trillion in healthcare entitlement costs that is coming at us. Unless somebody figures out how to repeal the passage of time or repeal the aging of humans or make it more likely that older humans cost less for medical care than younger humans, then this is an inevitable, unavoidable fact that is bearing down on us with what our wonderful chairman Kent Conrad has called a tsunami of cost.

If we dawdle around here in Congress and don't do something about it until the wolf is really at the door, then the only tools left in our toolbox are going to be the fiscal tools that can be deployed to solve a problem like this, and there are only three of them.

One is raising taxes. Anybody who knows what American businesses pay for healthcare already and what competitive posture that puts us in vis-&-vis the rest of the world knows that that is a pretty tough sale to make, that American business needs to pay more in taxes for this healthcare system.

The second is to throw folks off of healthcare. In a country that has 50 million people already uninsured, which is a national disgrace, compared to other developed countries, the idea that we would throw more off is pretty awful.

The third is you cut provider payments, which is what Senator Smith was asking about. We are already at the limit with provider payments.

We had this battle in Rhode Island a decade ago when our workers compensation system fell apart, and the industry folks all came in and said, well, this is easy. You take your doctors. You pay them 15 percent less. You chalk up those savings. We will take it.

Common sense, thankfully, prevailed, and instead we went to a medical advisory board for workers compensation. They established protocols of care, and some discipline was put into it. The people from the specialty groups came in and decided, OK, for this, here is the program. They were pretty broad, solid programs. They weren't forcing doctors to make inch-by-inch decisions.

But it really controlled the cost in the workers compensation medical care in Rhode Island after that, and we didn't have to cut because we knew that would be a foolish thing to do. Penny wise for the moment, pound foolish in the long run.

That day is inevitable, and that day is coming soon. Those three alternatives that we have to address that day are sickening ones, frankly. The only way we are going to get ahead of this is if we start doing exactly what you said right now. We have to build a national health information technology infrastructure that doctors can connect to. To expect them to build it all by themselves is as dumb as expecting everybody to build their own roads to work.

There is a national infrastructure issue here, and we have to see it that way, and we have to build that national infrastructure. Then everybody can connect their machines. But there are issues of privacy. There are issues of coordination, what goes into an electronic health record and so forth, how the health information exchange works that need to be worked out on a national level.

We also need to focus a lot on quality of care improvement and prevention. We way under invest in those things in areas where we know it will save money. The Rand Corporation says it could be as much as $346 billion a year from a health information technology system that supports these quality improvements.

There is $2 billion a year in Pennsylvania alone that gets burned from hospital-acquired infections that are completely unnecessary. We kill 100,000 Americans every year from medical errors that don't need to happen.

There is a huge savings associated with properly targeted quality and prevention investments, and we are not pursuing it. We are not pursuing it because of the economics of the system. So we have to change the way it is reimbursed so that those problems get solved.

But between those three things—a national health information technology infrastructure, reform in the area of quality improvement and prevention, and a better reimbursement system—we can drive enormous costs out of the system. I mean, it is burning up 16 percent of our gross domestic product. In the next closest country health care is only 11 percent of their gross domestic product.

The average for the European Union is only 8 percent of their gross domestic product, and those countries have better health outcomes than we do. We are paying twice as much to have worse health outcomes. We are the highest- paying country in the world, and when you look at the outcomes, we are somewhere between 25th and 40th. We rank with countries like Croatia and Cuba. I mean, it is embarrassing.

We have to get after that because we either have to do that now or face those horrible fiscal adjustments a decade from now. It is really vital, and I know it has taken us off point, but I think it is such an important point. I am so glad that you raised it.

I hope that AARP will pick up its stick and go around this building and knock everybody upside the head until they get it because if we don't do that now, time is short.

Ms. PAYNE. We are working on getting a bigger stick.

Senator WHITEHOUSE. Good. Good. [Laughter.]

Senator SMITH. It is going to grow because, as Senator Whitehouse points out, the baby boom generation is here, and so the ranks of the AARP will grow.

I wonder, does AARP have a position—I know how it feels about the donut hole that captures lots of low- and middle-income people, such as Judy's family, is that the wrong place for the donut hole? Medicare Part D is means tested already, but not very much. Should it be means tested?

Ms. PAYNE. Well, we are certainly working on that. We obviously want any asset test to be eliminated. We recognize that there are some problems with the donut hole, and we are certainly working

with a number of staffers and trying to resolve some of those issues. It is a major problem, and we certainly recognize that.

Senator SMITH. Well, we would look forward to your counsel on that because those of us who may or may not be here, whoever is here is going to have to wrestle with these very, very stark and terrible choices.

Senator WHITEHOUSE. Mr. Chairman, I would suggest that we have no farther to look for the solution to the donut hole problem, the senior trap problem—I hate calling it the donut hole, it really sounds like it is something good—is to the Veterans Administration, which has the authority to negotiate with the pharmaceutical industry over the price of prescriptions.

When you put the prices they get compared to the prices CMS pays for Part D side by side, the savings add up to enough to close the coverage gap.

Ms. PAYNE. Those are the two priorities we have, the fact that we want to eliminate the asset test and certainly give the Secretary the authority to negotiate.

Senator WHITEHOUSE. Authority to negotiate. Why would we privilege an industry from being negotiated with?

Ms. PAYNE. Absolutely.

Senator WHITEHOUSE. It is an extraordinary privilege. It is a ridiculous privilege, in my view.

Ms. PAYNE. We certainly have enough models to follow that.

Senator WHITEHOUSE. Yes, you have to look no further than the VA, which does a wonderful job.

Thank you, Mr. Chairman.

Senator SMITH. Thank you, Senator Whitehouse.

I just have a couple more questions for you, Barbara, and you know we have talked about LIS and the asset test. What would happen if it were increased $5,000, $10,000, or $20,000?

Ms. BOVBJERG. Well, actually, I looked at what would happen if your proposal to raise the asset threshold, almost double it roughly, that is in your bill, what would happen there? Based on the data that we got from Social Security, it looked like about half of the people who were denied on the basis of asset levels alone would be brought into the program.

Social Security has estimated that that is about 25,000 people. It is about 6 percent of the applicants. It could be more because we know there are people who would otherwise be eligible who don't apply because either they know or they think they know that their asset threshold is too high. So it could be a considerable number of people.

Senator SMITH. You mentioned in your testimony that you expect a report from Social Security and the IRS in a month?

Ms. BOVBJERG. Next month, in June.

Senator SMITH. What do you think they are going to say?

Ms. BOVBJERG. It is hard to say. When we did this work a year ago, Social Security felt very strongly that they could really use these data to help them narrow the potential eligibles and really focus on the people who were more probably eligible than the whole 19 million.

IRS feels equally strongly that it is not going to help. We didn't have access to the data either, so we couldn't tell. But they have

worked together to develop a methodology, and Social Security is working with some scrambled data that IRS gave them. They have passed some things back and forth.

It is just hard to say what will happen, but then we will know next month. If SSA could use those data to improve their targeting, we will know that. I just think that would be a really important point if we are to tell IRS that they should provide tax information to Social Security.

Senator SMITH. Well, thank you so very much, each of you. If any of you have a closing thought or comment you want to make, we are going to have a vote momentarily on the floor. So any thoughts come to mind that you think we need to have in the Senate record, we would certainly welcome those right now.

Ms. BOVBJERG. I would like to say something about the eligible people, that if you raise the asset limit or remove it, you will certainly have more eligible people. But we will still have this problem of not getting them to apply and not contacting them. I think that there is merit in some of the ideas about Social Security working more closely with community-based organizations. I know that they do that now, but perhaps make strengthening those ties would be really important.

Perhaps there are some other things we could look at with the way that Social Security communicates with individuals—the notices, the letters—that might make a difference as well.

Ms. SUMMER. I would add to that that certainly in your bill and other pending legislation, there are some relatively small administrative changes that can be made. One of the things that we have learned is that sometimes people don't apply for the benefit because they are afraid that if that benefit is counted as income, they will lose other means-tested benefits.

That is problematic for a number of people who otherwise are eligible for the subsidy. We have actually a precedent for that when the drug card was being used, that was not counted as income for people.

So, relatively small changes like that, administrative streamlining, I think sometimes get lost in the conversations about the bigger healthcare system and what we need to do to have everyone have access, which I think no one would argue with. Those are really daunting problems, but some of these small fixes really deserve attention.

Senator SMITH. Lisa.

Ms. EMERSON. I would just like to comment that I hear this a lot that from people that I work with is that nothing replaces that one-on-one noninvasive or nonthreatening help that a neutral counselor can give an individual to walk them through the evaluation and application process. That is what we are trying to do with SHIBA, but we don't know who these people are specifically.

That is the challenge. We get the data of where they are concentrated in the counties, but we don't know their address. We don't know their name. So, it is kind of a shooting in the dark process, but we are doing our best.

Senator SMITH. Great. Are you in Pendleton, too?

Ms. EMERSON. In Pendleton, we are working to get a formal partnership developed there, but we have informal relations with the aging community-based organizations there.

Ms. KORYNASZ. May I interject something?

Senator SMITH. Sure, Judy.

Ms. KORYNASZ. The thing that I found the most frustrating when I was trying to get this information was the hours that you have to spend talking to people who do not have the answer to the problem and will give you what they think is the answer, and you wind up with 10 different answers, none of which agree, and you don't know where to go after that to get the actual answer you need.

Senator SMITH. The right answer.

Ms. KORYNASZ. That is why I really believe that the SHIBA organization has been the most helpful to us because of all of the people that I talked to, and that include people in Medicare when I finally could talk to anyone, they had the most information, the most helpful information, and the most accurate information.

That is what is important, I think, is not just that somebody tells you something. It needs to be accurate.

Senator SMITH. Right.

Ms. PAYNE. Mr. Chairman, I would simply reiterate what Laura just said, the administrative coordination is very—the streamlining of the process is very important, and the Internal Revenue working with the Social Security Administration, we think that could be a substantial benefit to identifying eligible recipients and also getting the word out and outreach activities.

Senator SMITH. Well, you have all been just wonderful. You have been a great panel. It has been a great contribution to the record here in the U.S. Senate. Your time is not in vain. There are things happening that we are trying to push in the direction I think all of you are suggesting, and we will just go to work now.

With that, we are adjourned with a heartfelt thanks.

[Whereupon, at 11:46 a.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY, JR.

Mr. Chairman, thank you for scheduling this important hearing on improving Medicare for our most vulnerable seniors. We meet today to discuss what can be done to enroll all eligible people in the low income assistance programs in Medicare, specifically the low income subsidy in the Medicare Part D prescription drug program, and beyond that ways we can improve the program to help these individuals.

When Congress and President Johnson created the Medicare program over forty years ago they guaranteed every citizen over the age of 65 the right to health insurance. This right is now a fixture in the American health care system and as medicine has changed and advanced in the ensuing years the program has changed as well. One of the largest changes was the addition of the optional prescription drug benefit that was included in the 2003 Medicare Modernization Act. This new benefit acknowledged the role prescription drugs now play in maintaining the health of everyone, but especially the elderly.

One important component of the optional Medicare prescription drug benefit is the low-income subsidy. This is a vital part of the program and without it some seniors would still have to choose between taking medications they need to live and putting food on the table. This subsidy offers low-income seniors additional assistance in paying for prescription drugs. Specifically, couples earning less than $21,000 and having assets worth less than $23,970 are eligible for this benefit. At the beginning of this year, 12.5 million Medicare Part D beneficiaries were eligible for this subsidy, but of those 2.6 million were not enrolled. Two of the main reasons given for this are that beneficiaries do not know how to apply for this benefit, or that they do not know they are eligible for it. I look forward to discussing ways we can work to change that.

The asset limit presents a difficult issue for many seniors. Even though their annual income is within the guidelines, they are considered too "wealthy" to be eligible for this program because they have managed to save a relatively small amount for their retirement. Asset limits exist in many government programs geared towards low-income individuals. While it is important to ensure that these benefits go to those who truly need them, we must also ensure our senior citizens are not punished because they managed to save a small nest egg.

In my own state of Pennsylvania, in January of this year almost 400,000 beneficiaries were enrolled in the low-income subsidy program. Clearly many of our constituents are using this benefit and it is helping them get the medications they need. Now we must look beyond them and see how we can reach out to others who are struggling to pay the cost of their prescription drug medications.

Mr. Chairman, I thank you again for organizing this hearing and drawing our attention to this most important matter. We must continue to examine and develop ways we can help our most vulnerable citizens. This is our duty as public servants and especially as members of this committee. I look forward to hearing the testimony of the witnesses and exploring these ideas further. Thank you.

STATEMENT OF RICHARD GRIMES, PRESIDENT AND CEO, ASSISTED LIVING FEDERATION OF AMERICA

Ranking Member Smith, Chairman Kohl, and members of the Committee, thank you for allowing me to submit this written testimony.

In 2003, Congress enacted one of the most substantive changes to Medicare in recent memory, the Medicare Modernization Act (MMA). The prescription drug benefit (Part D) contained within the MMA has been well documented in providing access and affordability of prescription medicines to America's seniors. However, while Part D has brought control over their own health care into many seniors' owns hands, Part D needs one significant change that will benefit over 100,000 seniors.

Prior to the MMA, all dually eligible individuals (those eligible for both Medicare and Medicaid) were exempt from co-payment for prescription drugs, regardless of the setting in which they chose to receive their care.

Recognizing the vulnerability of very low-income people living in long-term care settings such as nursing homes, and following the precedent set by previous low-income prescription drug assistance programs, the U.S. Congress exempted dually eligible individuals living in nursing homes from any co-payment for Part D prescription drugs.

Unfortunately, the MMA did not eliminate co-payments for dual eligible residents of assisted living, even though the residents of assisted living communities are usually "nursing-home eligible" by definition and have similar needs for medications. That is, while the individual living in a nursing home is exempt from co-payments for Part D prescription drugs, the individual living in an assisted living community is forced to pay the same co-payments for the same Part D prescription drugs.

Like nursing home residents on Medicaid, the over 100,000 assisted living residents (dual eligible) have very limited financial resources. Their personal needs allowances average $60 a month. For many of these assisted living residents, the amount of their Part D co-payments exceeds their monthly personal needs allowances.

Residents in nursing homes and assisted living use a similar number of prescriptions—approximately 8–10, according to recent studies. Even Part D co-payments of $1–$5 per prescription can present financial hardships for dual eligible assisted living residents, and, as we have heard from communities across the country, could impede people from receiving needed medications.

More and more, seniors are looking to assisted living as their preferred senior housing option. Time and again, we hear from seniors who are concerned about being forced to receive their long term care in an institutional setting such as a nursing home. As it stands, the MMA is effectively punishing those dual eligible seniors who have chosen assisted living—a community based alternative to nursing homes.

Congressional staff from both sides of the aisle have indicated to us that the inconsistency in the MMA described above occurred for no other reason than simple oversight on the part of proponents of this meaningful legislation.

The stated focus of this hearing was to discuss ways to improve Medicare for our most vulnerable Americans.

Mr. Chairman and members of the Subcommittee: It is not often that we have an opportunity to go back and correct an oversight. In the upcoming Medicare package, however, you have an opportunity to do just that. Over 100,000 dual eligible seniors in assisted living would be grateful for your swift action to provide this relief with a simple statutory change that corrects this oversight.

Thank you again for this opportunity.

STATEMENT FOR THE RECORD FROM ALLIANCE FOR RETIRED AMERICANS

The Alliance for Retired Americans commends the Senate Aging Committee for holding a hearing on seniors at risk and how to improve Medicare for those who are most vulnerable. Founded in 2001, the Alliance is a grassroots organization representing more than 3 million retirees and seniors nationwide. Headquartered in Washington, D.C., the Alliance's mission is to advance public policy that protects the health and economic security of older Americans by teaching seniors how to make a difference through activism.

The Alliance thanks the committee for a history of commitment to addressing the issues faced by low-income seniors struggling to survive. For example, the well-intended Low-Income Subsidy (LIS) program in the Medicare Modernization Act (MMA) of 2003 was designed to address the fact that some seniors need extra assistance to participate in the Medicare Drug program. Notwithstanding this dire need, it is worrying to learn that in the five years since its passage, the LIS program and other Medicare low-income programs remain underutilized and encumbered by the process and administration of these benefits.

On behalf of our members nationwide, the Alliance for Retired Americans believes that the Senate must act now to simplify and align low-income assistance programs in Medicare such as Medicare Savings Programs (MSPs) and the Medicare Part D LIS. It is imperative that Congress compels appropriate agencies and interested parties to greatly enhance their outreach and participation to the population of seniors currently eligible to participate. Incidentally not "expanding" the program, but realizing its initial intended success. Additionally, legislative action must be taken to stop penalizing seniors for maintaining modest savings. Asset limit tests—which

have not been updated in the last 20 years—should be redrawn to reflect current cost of living standards.

It is our hope that today's hearing will finally result in action appropriate to initiatives highlighted in your previous legislative attempts and reflect our simple, yet fundamental, recommendations for addressing the needs of this vulnerable high-risk population of America's seniors. There is an opportunity for these improvements to be included in pending Medicare legislation currently being drafted in the Senate. These improvements are long overdue, and as this Congress considers ways to address concerns in the healthcare industry generally, we are encouraged that this committee has taken this opportunity to highlight principle ways to make healthcare more affordable to the most vulnerable populations through Medicare beneficiary improvements. In light of the pending Medicare legislation, the timing of this discussion is ideal, and we hope that it affects the final legislative product introduced in the Senate including Medicare improvements.

ECONOMIC CHALLENGES ARE DOUBLE JEOPARDY FOR SENIORS

The need to improve low-income programs (such as LIS and MSP) for at-risk seniors must be considered in the context of current national economic trends that make life extremely challenging for seniors on low fixed incomes. These seniors feel the pressure of rising health care costs. As the price of gas and food rises in tandem, many seniors face a daily choice between whether they can afford to eat, take their prescription drugs, run their electricity, or drive to visit their doctor. Hard choices such as these are between elements essential to one's survival, and it is shameful to consider any federal program a success that has not been able to mitigate this situation for its citizens.

PROGRAM PARTICIPATION

As you know, more than 12 million people are thought to be eligible for help with paying Medicare cost-sharing, especially Part B premiums through the Medicare Savings Programs (MSP) and Part D premiums, deductibles and co-payments through Part D's Low-Income Subsidy (LIS). The Part D Low Income Subsidy (LIS), providing low-income seniors with "extra" assistance in covering their prescription drug costs, was added to the 2003 MMA in order to attract additional Senators' support of the bill. However, while the intent was noble, we know that more than 2.5 million people—about two-thirds of those eligible but not auto-enrolled—are not getting the Part D low-income subsidy. These participation rates are too low, and with minor attention and coordination more eligible seniors could receive life saving drugs and benefits.

IMPROVEMENTS

Now is the time to make needed improvements to these programs, making sure that those seniors currently eligible, and those with low incomes whose eligibility is disqualified because they have managed to save a small nest egg, can get the help they urgently need. One of the principal challenges of participation in these programs is the current asset test limits. These limits have not been updated in 20 years. It is unfortunate to even have to mention that the program needs to be updated to reflect today's cost of living. It is unrealistic to apply economic standards of eligibility on values that are over two decades old. The asset test limits for both MSP and LIS programs needs to be raised to $17,000 for an individual, $34,000 for a couple.

Secondly, the application process seniors must navigate is intimidating and complicated. We hope that as Congress considers a small number of low-cost recommended improvements to simplify and align Medicare low-income assistance programs, eligible seniors will be able to participate in the programs more efficiently. This can de done by, for example, allowing beneficiaries to apply for LIS and enroll in a plan at any time without penalty like they can in MSP programs; or by not including in-kind support and maintenance (ISM) from the LIS eligibility determination. Therefore, actual seniors applying to participate in these programs can be discouraged by the application process due to the daunting questions, forms, and timeline that ultimately even penalizes seniors that have saved modestly. Finally, it is critical that Congress require agencies to coordinate with each other in more streamlined and efficient way. Federal agencies need to work together. The Social Security Administration (SSA) and the Centers for Medicare and Medicaid Services (CMS) should be compelled to coordinate and together enroll needy seniors into

Medicare assistance programs. For example, since SSA already is collecting income and asset information for the LIS application, it would be relatively easy to screen for MSP eligibility at the same time and forward the results to the states.

Additional funding is also needed to increase outreach and enrollment initiatives. Outreach to those currently eligible to increase their participation is essential, and special attention should be given to cultural and language barriers. This coordination and targeting is central to improving outreach and enrollment.

CONCLUSION

The Senate has demonstrated an interest in making improvements to the Medicare program on behalf of at-risk seniors. Currently we are at a watershed moment in health care reform, and it is critical that we enact improvements to Medicare at this time. It is critical to award eligible seniors with the benefits designed for them in order to keep seniors healthy, independent, and in their own homes longer. The impending Medicare legislation needs to include long overdue improvements to the low-income programs for seniors.