MEDICARE SAVINGS PROGRAMS AND LOW INCOME SUBSIDY: KEEPING MEDICARE'S PROMISE FOR SENIORS AND PEOPLE WITH DISABILITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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MEDICARE SAVINGS PROGRAMS AND LOW INCOME SUBSIDY: KEEPING MEDICARE'S PROMISE FOR SENIORS AND PEOPLE WITH DISABILITIES.

TUESDAY, MAY 15, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 2:05 p.m. , in room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., (chairman) presiding.

Present: Representatives Green, Allen, Baldwin, Solis, Matheson, Deal, Wilson, Shadegg, Murphy, Burgess, Blackburn and Barton.

Staff present: Yvette Fontenot, Brin Frazier, Amy Hall, Christie Houlihan, Purvee Kempf, Bridgett Taylor, Robert Clark, Chad Grant, Melissa Bartlett, Ryan Long, and Nandan Kenkeremath.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The hearing is called to order. Today we are having a hearing on Medicare savings plan and low income subsidy, keeping Medicare's promise for seniors and people with disabilities. And I will recognize myself initially for an opening statement.

The focus of today's hearing is on the Medicare savings programs which consist of the Qualified Medicare Beneficiary or QMB Program, the Specified Low-income Beneficiary or SLIMB Program and the Qualified Individual or QI Program. We will also be hearing about the newest financial assistance program available to Medicare beneficiaries, the low-income subsidy that was included as part of the new Medicare Part D benefit.

These financial assistance programs are a vital part of Medicare because they help ensure that millions of low-income beneficiaries are able to access the health benefits that they are entitled to. Many of the Medicare beneficiaries who qualify for these programs are our most vulnerable. They are more frail, more disabled, have greater health care needs that are often more expensive, and they are also more likely to be female, live alone and more likely to be racial minorities.

Ensuring the success of the MSP and LIS Programs means ensuring access to health care services to those who need it most. Without the Medicare savings programs and low-income subsidy, millions of low-income beneficiaries would be faced with the inability to afford the premiums, deductibles and cost-sharing requirements they are responsible for.

According to the Kaiser Family Foundation, in 2005, over half of the people with Medicare lived on less than $20,000 a year. Most of their income came directly from their monthly Social Security checks. And while I applaud the work that has already been done to enroll millions of Americans in these critical programs, there is clear evidence that we are not doing enough to ensure that everyone who is eligible for these benefits is receiving them.

According to the Congressional Budget Office, participation rates for QMB and SLIMB Programs are 33 and 13 percent, respectively. That is pretty awful. Furthermore, there could be up to 5 million Medicare beneficiaries who are eligible for the low-income subsidy under the prescription drug benefit but are not enrolled. According to the Kaiser Family Foundation, more than 2.3 million of those beneficiaries meet the necessary income requirements to qualify for the low-income subsidy but are deemed ineligible due to the asset test.

Now we can and should be doing more to improve participation rates in these programs and ensure these beneficiaries have access to the health benefits they need and deserve. Today we will hear from a number of witnesses about ways we can improve these programs, such as adjusting the asset test under the Medicare Part D LIS Program so it is not so burdensome. We will also hear about the importance of improving outreach efforts, streamlining the application process and increasing income eligibility limits under the MSP Programs.

For the past 6 years, President Bush and the previous Republican-led Congress have shelled out continuous subsidies worth billions of dollars to the prescription drug and insurance industries in an attempt to privatize the Medicare system. Between Medicare Part D and Medicare Advantage, they have made out like bandits in my opinion—these programs have been at the expense of the American taxpayer and the Medicare beneficiaries themselves. We have talked previously about Medicare Advantage and the different payment schedule. The time has now come to refocus our attention and target our resources more effectively so we can provide the most help to our most vulnerable citizens.

I am looking forward to hearing from the witnesses today about these programs and how they are working and how we might be able to improve them. I appreciate your being here today, and I now recognize our ranking member, Mr. Deal. Before I do, let me mention that we do expect to have votes, so it may be that we can't finish with our opening statements or may have to interrupt the panel because I think the votes are expected within the next half hour or so, but we will proceed until we hear the bell. So, at this time, I will recognize the ranking member, Mr. Deal.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you. When I came to Congress in 1993, the Medicare Part D monthly premium was $36.60.

Premiums are set similarly today and are adjusted each year in an effort to ensure that Part D premiums compose 25 percent of the program's cost. But today, at $93.50 a Medicare beneficiary pays almost two and a half times what they paid in 1993. What has changed since I came to office is the overall cost of health care services and in turn the price of the Part D program.

As I am sure everyone in the room is aware, premiums will continue to go up each year unless Congress acts to reform the health care sector to stabilize the sky-rocketing cost of health care services. This hearing focuses on a few programs designed to ensure low-income Medicare beneficiaries have assistance with their Medicare premiums and cost sharing.

The Medicare Savings Programs and the Low-income Subsidy Program target the near poverty senior population by paying for all or part of what is typically the beneficiary's responsibility in Medicare. With the rising cost of health care, these programs have a role to play to ensure our poorest seniors continue to have access to their physicians and medications.

Some of our witnesses today will testify that more could be done to enroll seniors in these programs, and I certainly look forward to their testimony. However Mr. Chairman I believe more could be done to reform the health care industry to stabilize premiums for all beneficiaries.

Additionally, addressing underlying health care costs would assist those beneficiaries who may not qualify for a program which pays for their deductibles and co-insurance. I do not believe the answer to rising premiums and the cost of care is simply for the taxpayer to bear this burden by shifting more people into the Medicare rolls.

It is certainly important for the committee to evaluate the effectiveness of our existing programs. But it is time for us to broaden our focus and evaluate health care reforms which address rising costs for patients with and without Medicare.

Hopefully this would ensure that, in another 14 years, the Congress can continue to fulfill its obligation to our seniors without forcing them to pay a premium two and a half times what they pay today or increasing the burden on already strained State and Federal budgets.

Thank you. I yield back.

Mr. PALLONE. Thank you, Mr. Deal.

Next we have the gentlewoman from New Mexico.

OPENING STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mrs. WILSON. Thank you, Mr. Chairman. I very much appreciate your holding this hearing today.

In New Mexico, there are about 65,000 people who are enrolled in the Medicare prescription drug benefit and in the low-income subsidy that we have there. They get their medicines for little or no premium and no copay and without the gap in coverage. That is about 23 percent of the Medicare population in New Mexico, so we have very high participation in the low-income subsidy program. And it is saving folks a lot of money, about $3,300 a year.

About 95 percent of the seniors in my congressional district now have drug coverage either through Medicare Part D, a former employer or from the Veterans' Administration, which is one of the highest enrollment rates of any congressional district in the country. Still there are many more seniors who are probably eligible for the low-income subsidy but are not enrolled. I want to commend, particularly in New Mexico, the Social Security Administration for their efforts to find eligible seniors and to help them enroll, particularly a wonderful case worker named Eva Lujan who is the liaison with the local Social Security office who has done a wonderful job in finding seniors who might be eligible. And she has been tremendously patient in hundreds of different forms in helping seniors get enrolled through traveling offices and working with our office and others.

For some people, the asset test has really prevented them from enrolling. And I think this is one of the things we do need to look at. In 2007, the asset test of about $11,000 for individuals and $23,000 for a couple really may be too low to expect people to be able to liquefy those assets and somehow spend them on medicine. So we may want to look at increasing those limits.

I think we also need to simplify the application process so that seniors can make their way through the paperwork if they are actually eligible.

I introduced legislation earlier this year that would make, I think, several important improvements to the Medicare Part D drug benefit. And I strongly support the benefit, and we really have made tremendous progress in helping people to be able to pay for their drugs and using competition in the marketplace to keep the premiums low for everyone. That said, there are always things that can be improved.

My legislation would allow States to use Medicare funds to pay co-payments on behalf of dual-eligible seniors, would also allow the Medicare Part D program to cover benzodiazepines, which has been a particular class of drug which was written out in the law and probably shouldn't be. It is used commonly for seniors to relieve anxiety and treating insomnia and seizure disorders, and I think we need to add that back in.

Medicare savings programs are also saving about 27,000 low-income seniors in New Mexico on Part D premiums and deductibles. I support those programs strongly as well. I look forward to seeing how we can make these programs work better, particularly how we can improve the communication between agencies in the Federal Government, Medicare and Social Security so that the Social Security folks know who is registered in what program in a fairly tight turn around because I think the way it is set up now we have often got agencies who are not communicating, who are not sharing information about eligibility of benefits, and enrollment and it makes it much more confusing for seniors and their families. And if we can even improve that part and make it harder to apply, I think we would deal with a lot of the problems that are driving the low enrollment rates as we haven't.

Thank you, Mr. Chairman, I appreciate very much your holding this hearing.

Mr. PALLONE. Thank you.

I recognize our vice chair, the gentleman from Texas.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for holding this hearing on the Medicare savings programs and low-income subsidy available for seniors participating in Part D prescription drug benefit.

These programs provide low-income seniors with much-needed financial assistance with their premiums or other cost-sharing obligations under Medicare. We have a fairly long history of Medicare savings programs in the groups of beneficiaries they seek to assist, specifically the qualified Medicare beneficiaries, the specified low-income Medicare beneficiaries and qualifying individuals. Despite the fact that this assistance has long been available to low-income seniors, enrollment levels unfortunately remain low. Premium and cost-sharing assistance for qualified Medicare beneficiaries have been available for nearly 20 years, yet only one-third of beneficiaries eligible for this assistance take advantage of it. Even worse, only 13 percent of the specified low-income Medicare beneficiaries take advantage of the Part D premium assistance available to them.

We all thought the enactment of Part D benefit and the availability of a low-income subsidy would help increase enrollment levels in other Medicare savings programs. Enrollment levels are higher for low-income subsidy, with about two-thirds of eligible Medicare beneficiaries taking advantage of the subsidy. Yet we haven't seen a corresponding increase in enrollment in Medicare savings programs.

A big problem is the fact that most beneficiaries seek the extra help for Part D through the Social Security Administration which neither screens beneficiaries for eligibility for Medicare savings programs nor refers them to their State Medicaid Program for screening.

We need to streamline this process to make sure that folks are taking advantage of all the extra help available to them. In my area of Houston, we have undertaken an education and outreach enrollment campaign to help low-income Medicare beneficiaries maximize their Medicare benefits. This effort has been coordinated through Gateway to Care, a local community access collaborative that was started with Federal dollars through the community access program which this committee worked to create.

Gateway to Care was one of the nine community organizations across the country to receive a $100,000 grant as part of my Medicare Matters initiative in the National Council on Aging, the Access to Benefits Coalition and AstraZeneca to develop innovative approaches to identify and reach out to low-income people. In Houston, Harris County, Texas, we know there are roughly 60,000 Medicare beneficiaries who qualify for these programs but are not involved. Houston, Harris County, have close knit communities and Gateway to Care is utilizing community health workers who have intimate knowledge of our medically underserved and are trusted with these communities to reach out to beneficiaries.

Gateway to Care is also utilizing our area's 211 system ensuring that inquiries directed toward knowledgeable folks in our community to assist our low-income seniors. The community approach is critical to any outreach and enrollment, and I think My Medicare Matters demonstration will teach us a lot about what works and about what can be improved.

Mr. Chairman, again, I thank you for calling the hearing and our witnesses today, and I yield back my time.

Mr. PALLONE. Thank you.

I recognize the gentlewoman from Tennessee.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman, I thank you for the hearing today.

And I want to say welcome to all of our witnesses. It is important to recognize that programs such as the Medicare Savings Program and Part D low-income subsidy were created to address the needs of a specific population, and they have provided great benefit to those low-income individuals who might otherwise go without their medication. And as we have seen with programs like Medicare Advantage, the Government has been successful in providing access to quality care for low-income individuals.

Today, instead of discussing how CMS is progressing with the administration on these programs, we are listening to a discussion on further expansion of entitlement programs. This is exactly what happened in my home State of Tennessee with the TennCare Program, Tennessee's State-wide nearly universal health care service run by the State.

In 1994, Tennessee implemented managed care in its Medicare Program and used savings anticipated from the switch to expand insurance coverage to the uninsured, uninsurable adults and children. The State basically allowed carte blanche enrollment to anyone. And those people could never get out of the system, even when they decided they wanted to get out of that system.

Since then, Tennessee has faced financial peril in numerous unsuccessful attempts to reign in the State's runaway health care system. State spending accelerated from $2.5 billion in 1995 to $8 billion in 2004 for TennCare alone.

To date, TennCare has consumed over one-third of our State's budget.

Combined State and Federal funding could not sustain TennCare's rising costs, and the program effectively lowered the quality of health care available to all Tennesseans. If Tennessee can't even pay for the program it has, how is the Federal Government going to pay for the unsustainable expansion of current entitlement programs down the road?

I can tell you exactly what continued expansion in Medicare and Medicaid will do to our Nation using TennCare as a model. Since TennCare's inception, Tennessee's doctors and hospitals charged that the $8 billion program was underfunded by the State and Federal governments, forcing providers to bear disproportionately higher costs. Rampant fraud and abuse have plagued the problem. Hospitals have gone out of business, and the poor cannot find providers to take care of them.

Mr. Chairman, I know what runaway health costs and a broken health care delivery system look like. Health care and TennCare are clear evidence that Government managed health care programs allow for serious mismanagement, cost overruns and inadequate service. We have to be very diligent in the oversight. Rather than encouraging expansion of inefficient, ineffective Government bureaucracy in every day health care, I hope we will promote economic growth in the health care marketplace through the private sector, an area that has proven time and again to foster competition, reduce cost and provide choices and options for our consumers. I thank you, Mr. Chairman, for the hearing. And I yield the balance of my time.

Mr. PALLONE. Thank you.

Mr. Matheson.

Mr. MATHESON. Mr. Chairman, I appreciate you calling the hearing. I look forward to hearing from this panel, and I am not going to make any more opening statement than that. I yield back.

Mr. PALLONE. Thank you.

Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. I will reserve time for questions.

Mr. PALLONE. Ms. Solis.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Mr. Chairman. I do want to make a comment. I want to thank you for having this hearing and to welcome our witnesses that are here today. It is very important that we have the discussion on Medicare savings plans and low-income subsidies for our seniors. I represent a very diverse district, highly low-income, heavily Hispanic and large Asian population, so of course, you can imagine the kind of problems that they confront. They deal with problems such as language access, not being able to access current programs that are available and also inadequate numbers of staff, adequate staff available at these key sites where people can gain information and trust.

And one of the things I am working on this year, Mr. Chairman, is a piece of legislation to look at how we can provide support to community workers, community organizers that can help us go out and reach these seniors, particularly in the hard-pressed areas where we could help navigate them through the system to apply where appropriate for these programs and to better understand what options they have. Of course, premiums will vary over various programs, and I think that the more tools and information that we give our community in their language that is legitimate in terms of linguistic and culturally competent services, we know in the long run we can save a lot of money.

So I am promoting that, and I look forward to listening to the testimony from you, and I will submit the remainder of my statement. Thank you, Mr. Chairman I yield back.

[The prepared statement follows:]

PREPARED STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, thank you for holding this hearing today to discuss the importance of Medicare Savings Plans and Low Income Subsidies for our seniors and disabled individuals. Seniors were promised that after a lifetime of working and paying into Medicare, they would have access to health care coverage during their retirement years, regardless of their geographic location, their age, or their income.

Today, more than 44 million seniors and people with permanent disabilities depend on Medicare to meet their health needs. However, health care costs have skyrocketed, and Part B premiums and other out-of-pocket expenses are quickly becoming unaffordable. For instance, Part B premiums are $93.50 this year, which is over $1,100 per year. In addition, the Part A deductible is almost $1,000.

The 2003 Medicare Current Beneficiary Survey found that Medicare beneficiaries in poor or fair health had $2,980 in out of pocket spending, in addition to another $661 in premiums. This is particularly troublesome given the importance of access to quality, affordable health care in minority communities which often encounter greater burdens of disease. They consequently have greater need for medical services but are less likely to afford them.

Low-income Medicare beneficiaries are disproportionately people of color who need help with paying for Medicare's cost-sharing, including premiums, deductibles, and coinsurance. Although Latinos make up only 6 percent of all Medicare beneficiaries, more than 14 percent are low income seniors. This is why the Medicare Savings Programs and Low Income Subsidy Program are critical for our vulnerable populations.

We need to make sure that people are getting the financial help they need. We must change the Low Income Subsidy's asset requirement so that seniors still have incentives to save for retirement We must also work to help the 3 million people who do not have drug coverage but are eligible for the subsidy.

Appropriate outreach to inform hard to reach seniors about these programs is essential. Having timely access to health services and prescription drug coverage can be a matter of life or death.

I thank the witnesses for coming today, and I look forward to hearing their recommendations about how we can reduce barriers to enrollment for these programs.

I yield back the balance of my time.

Mr. PALLONE. Thank you.

The gentleman from Arizona.

OPENING STATEMENT OF HON. JOHN B. SHADEGG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. SHADEGG. Thank you, Mr. Chairman, and thank you for holding this hearing. When the Congress contemplated the Part D in the Medicare Modernization Act, I was firmly of the belief that there was a population in America which desperately needed help. Those for whom people were making a decision or they were forced to make a decision between paying their rent or purchasing their drugs; those who were forced between buying food for their table or purchasing their medications. And I think we all know sadly many of these people would make the necessary choices of paying for their rents or purchasing their food rather than buying the drugs they need. That, of course, is counterproductive and damages their health.

So I think it is important that we look at how the program is operating. And I commend you for holding this hearing, and I also welcome our witnesses.

I have a concern as the evidence has mounted that enrollment continues to be a problem. It has been an issue in many Government programs. We see it as an issue in the SCHIP where we just continue to have a difficult time encouraging people or getting people to enroll.

And anecdotally, I know that in my own State of Arizona, when the SCHIP was enacted, time and again, we ran into this problem where people said, I would just as soon not enroll. I know I can go here and get care. I know I can go there and get care. And I don't want to go through the paperwork burden of enrolling.

So it seems to me it is incumbent upon us to look at ways to try to make sure that people are getting the benefits they are seeking and to get enrolled in these programs.

In that respect, I would like to make a comment, Mr. Chairman, about an initiative I have been pushing since I entered Congress, and that is trying to make the change from life before Medicare to life after Medicare less dramatic.

In that respect, I have introduced in Congress now for the past 10 years legislation that would give a tax credit, and specifically a refundable tax credit, to Americans to get health care and to purchase their drugs. It is important to understand that a refundable tax credit is a tax credit where the Government simply hands you cash and that what this program would look at is that the Government would say to anyone, if you will go out and buy a health insurance plan, and it could be a plan that has at least a certain minimum drug coverage, we will allow you either to reduce the amount of taxes you pay, but in this instance, for the poor—the audience we are talking about for this hearing—it will say, we will pay and we will actually give you the cash to go buy that plan. It seems to me that one of the difficulties in getting people to enroll in a Government plan is that they find it confusing and they find it difficult and they don't enjoy it or they resist the bureaucracy of enrolling in such a program.

If in fact the poor in America, those that we are talking about, those who are in need of assistance to buy their everyday drugs, those forced into the decision of making a decision between paying the rent and buying the groceries and buying the drugs they need, if they were to know ahead of time that even before they became Medicare eligible they were getting a refundable tax credit, that is cash to purchase the drug benefit they needed and the Medicare health care or health care plan they needed and then, once they become Medicare eligible, the same thing were true, I believe we might overcome many of the enrollment problems.

And I believe that that type of a system which provides payment directly for their health care plan or, in this instance their drug program, would be a step forward and might help us overcome the enrollment issue we face. So I look forward to hearing the testimony. I do have a conflicting hearing which I might have to step out from time to time, but I thank you, Mr. Chairman, for holding this hearing.

Mr. PALLONE. Thank you. The gentlewoman from Wisconsin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman, and thank you to the witnesses who join us today. I appreciate the fact that we are highlighting these important programs, whether we are talking about the Medicare savings programs or the Part D low-income subsidy, they all serve an important purpose which is to ensure that low-income seniors have some help in paying for their premiums, deductibles and copayments or more simply these programs make sure that low-income seniors can access health care.

These programs are vitally important, and I look forward to hearing about ways to improve these programs and more specifically to improve coordination between these programs.

I am particularly interested in hearing more from our witnesses regarding the asset test part of the Part D low-income subsidy. This asset test penalizes those seniors who have saved a little bit of money in the bank for a rainy day. This might not be something that my generation and those younger are so good at. But our seniors, the Greatest Generation, they know the value of a penny saved. And I have heard from many seniors in Wisconsin who applied for the Part D low-income subsidy and were then denied because of their modest possessions. Maybe it is a small house that they have owned for the last 40 years or a small savings account, but these are not seniors with millions of dollars in the bank by any means.

We shouldn't be telling our seniors that, in order to get help paying their Medicare costs, they have to give up all of their modest financial security. This isn't right. And I look forward to the committee addressing this issue.

Additionally, I think that we should be making it as easy as possible for all of our seniors to enroll in these programs. Burdensome paperwork and lengthy application processes will only deter those who may need the help the most from seeking it in the first place. So thank you to the witnesses for their willingness to join our discussion today. I look forward to hearing your suggestions on how we can improve these programs to make sure they help even more seniors in affording their health care. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. The gentleman from Pennsylvania.

Mr. MURPHY. I am going to reserve mine for the record. I am looking forward to hearing the testimony, Mr. Chairman.

Mr. PALLONE. Mr. Allen just came in.

Mr. Allen.

Mr. ALLEN. Mr. Chairman, I will waive my opening statement.

Mr. PALLONE. OK, thank you. I think we are completed with the opening statements by the members and any other statements for the record may be included at this time.

[The prepared statements of Messrs. Dingell and Towns follow:]

STATEMENT
OF
THE HONORABLE JOHN D. DINGELL
SUBCOMMITTEE ON HEALTH HEARING ON "MEDICARE SAVINGS PLAN AND LOW INCOME SUBSIDY: KEEPING MEDICARE'S PROMISE FOR SENIORS AND PEOPLE WITH DISABILITIES"

May 15, 2007

Medicare has helped prevent medical costs from consuming the fixed-incomes of millions of elderly and people with disabilities, keeping them from poverty. For beneficiaries of more modest means, however, even Medicare's premium of $93.50 a month can be a substantial burden. In fact, 17 percent of Medicare beneficiaries have annual incomes of less than $10,000 a year.

Beginning in the 1980s, Congress recognized that despite the contributions of Medicare and Social Security to the well-being of Americans, millions still needed financial assistance to pay for their health care. Congress created a number of programs – the Qualified Medicare Beneficiary program, the Specified Low Income Beneficiary program, and the Qualified Individual program – together known as "Medicare Savings Programs" that pay some combination of premiums, deductibles, and out-of-pocket costs, based upon income, to assist seniors and people with disabilities with their Medicare costs.

When Congress enacted Medicare Part D, the Low Income Subsidy program was created to reduce cost-sharing and premium payments for low-income beneficiaries.

Between the two programs, a low-income Medicare beneficiary can receive approximately $10,500 a year in assistance with premiums, deductibles, and cost-sharing in Medicare, including the prescription drug program. In addition, the programs provide cost-sharing for inpatient hospital or outpatient physician services. This is clearly a significant benefit.

Today's witnesses will discuss the benefits of the Medicare Savings Program and the Low Income Subsidy and how we can improve these programs. While millions of seniors and people with disabilities are enrolled in the Medicare Savings Programs and LIS, there are many eligible seniors who are not. Lack of awareness about these programs is the main reason cited for not enrolling. Clearly, this should be addressed.

Simplifying the enrollment process is also important. The complexity of the existing system presents a barrier for those with cognitive impairments or other limitations. If MSP enrollment were coordinated with LIS, we could improve the process even more. For example, it makes sense to allow beneficiaries who apply for one program to be automatically enrolled in the other. Other ideas for improving the program include eliminating the complex and burdensome assets tests.

I look forward to working with my colleagues on this Committee to ensure that we are making the most efficient use of taxpayer dollars to target those with low incomes and individual with disabilities. The MSP and LIS programs are a far superior and more efficient way of getting financial assistance and benefits to those who need it most. In fact, the MSP program provides $2,500 more in extra benefits to the lowest-income beneficiaries than Medicare Advantage plans. And this extra assistance only goes to those who need the help the most.

I thank the witnesses at this hearing today, and look forward to their testimony.

Remarks for Cong. Edolphus "Ed" Towns, NY 10th CD
May 15th "Medicare Savings Programs and Low-Income Subsidy" Keeping Medicare's Promise for Senior and People with Disabilities"

THANK YOU, MR. CHAIRMAN FOR HOLDING THIS CRITICAL HEARING ON MEDICARE SAVINGS PROGRAMS AND LOW INCOME SUBSIDIES. I WELCOME OUR EXPERT PANEL MEMBERS WHO WILL ADDRESS THE SPECIFICS OF THESE PLANS. HOWEVER, I WANT TO MAKE SURE THAT WE FOCUS ON CREATING A COMPREHENSIVE LONG-TERM SYSTEM OF CARE THAT HUMANELY SERVES OUR MOST VULNERABLE CITIZENS – THOSE SENIORS WHO LACK ECONOMIC RESOURCES AND THOSE WITH DISABILITIES AND POOR HEALTH.

TODAY, OVER SEVEN MILLION MEDICARE BENEFICIARIES RELY ON MEDICAID TO FILL GAPS IN THEIR MEDICARE COVERAGE. THESE HUMAN BEINGS ARE THE MOST VULNERABLE MEDICARE BENEFICIARIES. THEY ARE ALSO A STABLE SOURCE OF REVENUE FOR MEDICARE.

WHY THEN DO WE MAKE IT DIFFICULT FOR THOSE MOST VULNERABLE TO ENROLL IN LOW INCOME SUBSIDY PROGRAMS AND MEDICARE PLANS? WHY DO WE HAVE YEARLY MULTIPLE

APPLICATION PROCESSES, ASSET TESTS AND DUAL DATA SYSTEMS THAT OFTEN LEAD TO LONG DELAYS IN GETTING CARE AND CRITICAL MEDICINES? WHY HAVE WE SET UP A SYSTEM TO DENY CARE RATHER THAN FURTHER IT? WHY HAVE WE CREATED A SYSTEM OF CARE THAT ASSUMES THE WORST AND OFTEN DELIVERS IT?

MR, CHAIRMAN, THESE ARE SENIOR CITIZENS WHO HAVE SPENT THEIR LIVES WORKING AND RAISING FAMILIES. WE MUST MAKE SURE THAT THROUGHOUT THIS PROCESS – FROM APPLICATION TO TREATMENT – THAT THEY ARE TREATED WITH CONSIDERATION AND RESPECT. OUR SENIORS ARE NOT SIMPLY NUMBERS ON A MEDICAL CHART, OR STATISTICS IN A COMPUTER. THEY DESERVE QUALITY CARE QUICKLY AND WITHOUT A LOT OF REDTAPE. I BELIEVE THIS HEARING TAKES THE NECESSARY STEPS TO MAKING SURE THAT WE DELIVER THIS KIND OF CARE.

THANK YOU, MR. CHAIRMAN AND I YIELD BACK THE BALANCE OF MY TIME.

Mr. PALLONE. We will now turn to our witnesses.

And first of all, welcome to all of you. Thank you for being here today and let me do a little introduction of each of you. Starting on the left, or my left, is Ms. Monica Sanchez, who is deputy director of the Medicare Rights Center here in Washington. Mr. John Coburn, who is director for the Make Medicare Work Coalition, health and disabilities advocates, and he is from Chicago, Illinois. And then we have Ms. Lilla Sassar, who is a beneficiary, and she is from Alabama. And then we have Gail Clarkson, who is the chief executive officer of the Medilodge Group. And she is from Bloomfield Hills, Michigan. She is testifying on behalf of the American Health Care Association. And last, is Dr. N. Joyce Payne, who is a member of the Board of Directors of AARP, and she is based here in Washington, DC.

Let me say that we will have 5-minute opening statements, and they become part of the hearing record. And you may, at the discretion of the committee, submit additional statements or comments in writing for inclusion in the record, and I will start with Ms. Sanchez.

Thank you.

STATEMENT OF MONICA SANCHEZ, DEPUTY DIRECTOR, MEDICARE RIGHTS CENTER, WASHINGTON, DC

Ms. SANCHEZ. Chairman Pallone, Ranking Member Deal, members of this committee, thank you for this opportunity to testify on the Medicare Savings Program and Extra Help.

The Medicare Rights Center is the largest independent source of health care information and assistance for people with Medicare in the United States. We know, from the experience of the people we serve, that the assistance available through Extra Help and the Medicare Savings Program enables poor Americans to obtain the medical care they need and the medicines they are prescribed. Access to these programs can mean a healthy life instead of one of illness and premature death.

People who are eligible for Medicare Savings Program are more likely to be African American or Latino. They are more likely to be an older female living alone and in poor health. The good news is that those who are eligible and enrolled are more likely to see a doctor and other health care provider and, as a result, they have improved health.

Just last week, an MRC counselor at the One Stop Senior Center on West 90th Street in New York met Altagracia Lopez. Ms. Lopez is 72 years old. Born in the Dominican Republic, she has lived in the U.S. for 40 years, working in a factory, stitching together children's clothes. She gets by on $343 a month, $100 in food stamps and lives in public housing.

When Ms. Lopez had original Medicare and Medicaid, her doctor visits were free. But she was still paying the Part B premium because she was not enrolled in an MSP. Things got worse when she was tricked into enrolling in a Medicare HMO which charged her up to $25 for doctor visits. The plan lost its record of Ms. Lopez's eligibility for Extra Help which she had because she is enrolled in Medicaid. Instead of co-payments of a few dollars under Extra

Help, she was asked to pay $127 for a medicine to prevent blood clots and $42 for her diabetes medicine.

We were able to convince her HMO that it is required to charge Ms. Lopez the $1 and $3 Extra Help co-payments so she was able to get the medicine she needs—to also get the medicine she needs to control her high blood pressure. We also enrolled Ms. Lopez in the Qualified Medicare Beneficiary Program, QMB, and helped her dis-enroll from the HMO. As a result, she will no longer have the Part B premium deducted from her monthly Social Security check and does not have any out-of-pocket costs when she goes to her doctor.

Ms. Lopez's story illustrates a common problem, persistent breakdowns in data exchanges between State Medicaid offices, the Centers for Medicaid and Medicare Services, the Social Security Administration and the companies providing the Part D benefit. These result in low-income people with Medicare who should be receiving Extra Help instead facing deductibles and co-payments that they cannot afford.

Ms. Lopez's story also shows the complicated interaction between Medicaid, Medicare Savings Program and Extra Help and how even individuals who are enrolled in some assistance programs are often not getting all the help that they should be.

Another of our clients is Ms. H, a widow who lives in Manhattan, New York. She is 74 years old and a typical example of someone whose assets disqualify her for Extra Help. She receives $400 a month from Social Security and works part-time to earn an additional $500 to make ends meet. Because she has $12,000 in assets, just $292 over the limit, she is not eligible for Extra Help. But because she lives in New York State, which has eliminated the asset test for the QI Program, we were able to get her enrolled in Extra Help through this back door.

For every person we enroll in MSPs or Extra Help, there are millions more who do not know the help is available or who do not know how to apply for it. Nationally, there are still between 3.4 and 4.7 million people who qualify for this program but are not enrolled. According to CMS estimates, there are nearly 22,000 such people in the counties that make up New Jersey's sixth district and over 16,000 in the 15 counties of Georgia's ninth district. The same story can be told district by district.

How do we fix this situation?

First, Congress should remove the asset test from both the MSP and Extra Help Programs and allow people to qualify based solely on income criteria. Legislation introduced by Representative Lloyd Doggett, Democrat of Texas, takes a small but meaningful step in the right direction by raising the maximum allowable assets for Extra Help and takes some important steps towards simplifying the Extra Help application.

Second, as Congress moves to improve the Extra Help Program, it should also take steps to bring the Federal eligibility criteria for MSPs in line with these new, more reasonable standards for Extra Help. Individuals enrolled in MSP are "deemed" eligible for Extra Help. If criteria were aligned, then deeming could go both ways. With two-way deeming, people with Medicare would actually receive the help that Congress promised them.

Third, Congress must make sure CMS exercises its oversight responsibilities to ensure the plans are not overcharging their low-income enrollees. It also has to make sure the agencies fix these data exchange problems. The alignment of eligibility criteria between MSPs and Extra Help will simplify and streamline these programs and contribute to the solution.

Thank you.

[The prepared statement of Ms. Sanchez follows:]

Medicare Rights Center

Testimony of Monica Sanchez
Deputy Director, Medicare Rights Center

Hearing on
"Medicare Savings Plans and Low Income Subsidy: Keeping Medicare's Promise for Seniors and People with Disabilities"
Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

May 15, 2007

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Chairman Pallone, Ranking Member Deal, distinguished members of the subcommittee on health of the House Energy and Commerce Committee, thank you for this opportunity to testify on the Medicare Savings Programs and Extra Help, the low income subsidy under Medicare Part D. I am Monica Sanchez, Deputy Director of the Medicare Rights Center.

The Medicare Rights Center is the largest independent source of health care information and assistance in the United States for people with Medicare. Based in New York City, we have been working for nearly two years to sign as many people up for Extra Help as possible. With private funding from the Starr Foundation and Robin Hood, among others, but with no federal financial support, we have enlisted hundreds of volunteers to reach out to likely candidates for Extra Help, explain the program to them and, whenever possible, enroll them online. We also have a longstanding partnership with New York City to help enroll individuals in the Medicare Savings Programs.

The Medicare Rights Center knows, from our direct experience with the people we serve, that the financial assistance available through Extra Help or the Medicare Savings Programs enables impoverished older adults and people with disabilities to obtain the medical care they need and the medicines they are prescribed. Literally, access to these programs can mean a healthy life instead of illness and premature death.

Let me begin with a story that illustrates the kind of assistance the Medicare Rights Center provides to people with Medicare. This true story illustrates vividly the importance of Medicare Savings Programs to people trying to get by on limited, fixed incomes. It also illustrates the pitfalls and problems that low-income people with Medicare face in getting that help.

Last week, an MRC counselor was on her daily visit to one of the senior centers that serve low income people with Medicare. At the One Stop Senior Center on West 90th St., in New York she met Altagracia Lopez. Ms. Lopez is 72 years old. She was born in the Dominican Republic and has lived in the U.S. for forty years, spending most of her working life in a factory stitching together children's clothes. She gets by on $343 a month and $100 in food stamps and lives in public housing.

Last spring, Ms. Lopez was accosted on the street by a salesman for a Medicare Advantage HMO. After talking his way into her home, the salesman convinced Ms. Lopez that she would have better drug coverage under the HMO he was selling than under her current plan, and, since Ms. Lopez receives both Medicare and Medicaid, he enrolled her effective May 2006. In her new HMO, Ms. Lopez has been paying copays of up to $25 for doctor visits; with Original Medicare and Medicaid, her copays were zero. Things got worse in 2007 when her HMO switched her to a new plan. During the switch, the HMO lost its record of Ms. Lopez's eligibility for Extra Help, which she receives because she is enrolled in Medicaid. Instead of copayments of a few dollars under Extra Help, she had to pay $127 for Plavix, a blood thinner, and $42 for her diabetes medicine.

Ms. Lopez still owes $90 on her deductible and was trying to find a way to pay for her hypertension drugs.

It's a good thing we ran into Ms. Lopez at the senior center. The Medicare Rights Center counselor faxed the proof of Ms. Lopez's Medicaid eligibility to her HMO and convinced customer service that the plan is required, under federal guidelines, to accept this proof and inform the pharmacy to charge Ms. Lopez the $1 and $3 Extra Help copayments. Now, Ms. Lopez can buy the medicine to control her high blood pressure. We have also enrolled Ms. Lopez in the Qualified Medicare Beneficiary (QMB) program, disenrolled her from her HMO and helped her find a Part D drug plan that covers her medicine. As a result, she will no longer have the $93.50 Part B premium deducted from her Social Security check, she will be automatically enrolled in Extra Help and she will not be charged a copayment when she goes to see her doctor.

The issues surrounding Ms. Lopez's enrollment and disenrollment from her Medicare Advantage plan are not the specific focus of this hearing, although I do hope this committee will look into how dual eligibles—people with both Medicare and Medicaid—have been the particular targets of aggressive marketing by HMOs and other Medicare Advantage plans. For unscrupulous sales agents, people with Medicare and Medicaid can be a gold mine, since they are allowed to change plans on a monthly basis. In fact, another Medicare Advantage HMO parks a van outside the One Stop Senior Center and hounds people who are waiting to go into the Center.

Ms. Lopez's story does illustrate a common problem: persistent breakdowns in data exchanges between state Medicaid offices, the Centers for Medicare & Medicaid Services, the Social Security Administration and the companies providing the Part D benefit result in low income people with Medicare who should be receiving Extra Help instead facing deductibles and copayments that they cannot afford.

Ms. Lopez's story also shows how the complicated interaction between Medicaid, Medicare Savings Programs and Extra Help, and how failure on the part of government—in this case the state of New York's failure to enroll Ms. Lopez in the QMB program—means very poor individuals do not receive the help they need with their medical expenses.

Ms. Lopez's story shows how crucial it is to get eligible people with Medicare enrolled in low income assistance programs. Once enrolled in QMB, Ms. Lopez will be able to go to the doctor without worrying that she cannot afford her copayment. If the doctor recommends treatment, the ability to pay will not prevent her from following her doctor's plan of care. Like other QMB enrollees, she will be automatically enrolled in Extra Help, the low incomes subsidy under Part D. Instead of facing a doughnut hole, when she must pay both premiums and the full cost of her prescriptions, she will pay just $1 for a generic drug and $3.10 for a brand name medicine. If she can afford her medicines, she is more likely to take them as prescribed, preventing complications that send her to the hospital for expensive emergency care.

People who are eligible for Medicare Savings Programs are more likely to be African American or Latina. They are more likely to be older, female, living alone and in poor health. Those who are eligible and enrolled are more likely to see a doctor or other health care provider; as a result they have improved health.

But Ms. Lopez's story should not cause us to congratulate ourselves. For every client that the Medicare Rights Center enrolls in MSPs or Extra Help, there are millions more that do not know the help that is available or do not know how to apply. The following statistics tell the story.

Over the last two years, the Social Security Administration, working in cooperation with State Health Insurance Assistance Programs, community organizations and advocacy groups like the Medicare Rights Center, has enrolled about 2.2 million people into the Extra Help Program. To qualify, an individual must earn less than $1,276 per month, and have less than $11,710 in savings and other financial assets. Despite these efforts, there are still between 3.4 million and 4.7 million people who qualify for this program but are not enrolled.

In the counties that make up New Jersey's Sixth District, which Chairman Pallone represents, there are nearly 22,000 older adults and people with disabilities that are eligible, but unenrolled in Extra Help, according to CMS estimates.

In the 15 counties of Georgia's Ninth District, which Congressman Deal represents, there are over 15,000 people with Medicare who qualify for Extra Help but are not enrolled.

The same story, district by district, can be told about low income people who qualify for Medicare Savings Programs but are not enrolled.

There are roughly 430,000 people enrolled in the QMB program, not counting those individuals who receive full Medicaid benefits. QMB pays the deductibles, premiums and cost sharing under Medicare A and B. That is roughly one-third of the number eligible.

Only 13 percent of people with Medicare, or 370,000 out of 2.8 million, who qualify for SLMB are enrolled. In 2005, fewer than 200,000 were signed up for QI-1. Both programs pay the Part B premium, which is $93.50 per month, a sizable expense for someone earning $1,041 per month, the upper limit for the SLMB program. In all but a handful of states, even individuals who earn this little will not receive assistance if they have more than $4,000 in assets.

How do we fix this situation?

Congress should remove the asset test from both the MSP and Extra Help programs and allow people to qualify based solely on income criteria. These are poor people; let's not begrudge them a small nest egg. In almost all cases, truly large nest eggs produce income to disqualify people without true need from MSPs and Extra Help eligibility.

The asset test complicates the application. For individuals with low literacy or limited English proficiency, it can make the application an insurmountable obstacle. Many individuals who qualify for the help just do not want to reveal the extent of their savings, and refuse to fill out the application, even though their assets fall below the limits.

The asset test creates additional administrative burdens and expense on the states that administer Medicare Savings Programs and on the Social Security Administration, which is processing Extra Help applications.

But most importantly, the asset test is unfair. Hard-working Americans who have scrimped and saved for their retirement are penalized for doing the right thing. $24,000 is a small sum to provide a couple security through their old age, but it disqualifies them for Extra Help with their prescription drug costs.

We know removing the asset test will extend both Extra Help and MSPs to people who need them. According to the Social Security Administration, 42 percent of individuals who were rejected for Extra Help were denied solely because of their assets. The Congressional Budget Office estimates that 1.8 million low-income older adults and people with disabilities will not qualify for Extra Help solely because of the asset test.

Because the Medicare Rights Center works to sign up low-income people with Medicare for both Part D Extra Help and the Medicare Savings Programs, our experience provides a unique picture of the impediments to enrollment that exist in both these programs. We witness first-hand how the presence, or absence, of an asset test can determine whether our low-income clients obtain access to the medical care and medicines they need.

Fortunately for some of our clients, New York State has removed the asset test for the Qualified Individual program, making this Medicare Savings Program available to all individuals with incomes up to 135 percent of the poverty line. Because Medicare Savings Program recipients are automatically eligible for Extra Help, these individuals receive vital assistance with their prescription drug costs as well as payment of their Part B premiums.

One of our clients is Ms. H., a widow who lives in Manhattan, N.Y., is 74 years old and a typical example of someone whose assets disqualify her for Extra Help. She receives a $400 monthly Social Security check and works part-time to earn an additional $500 a month to make ends meet. Because she has $12,000 in assets—just $290 over the limit– she is ineligible for Extra Help. But because she lives in New York State, she is eligible for the QI program, which serves as a back door to getting her Extra Help.

Another Medicare Rights Center client is Ms. S., a widow who lives in Brooklyn, N.Y. She supplements her monthly Social Security income of $800 by slowly depleting her savings. When she came to us last year, her assets were $500 over the limit for Extra Help. But because she lives in New York State and was eligible for QI, she now receives Extra Help and can maintain her savings for an emergency.

Legislation introduced by Rep. Lloyd Doggett, Democrat of Texas, takes a small but meaningful step in the right direction by raising the maximum in allowable assets to $27,500 for an individual and $55,000 for a couple.

Representative Doggett's bill, H.R. 1536, the Prescription Coverage Now Act of 2007, also takes some important steps toward simplifying the Extra Help application and removing eligibility tests that needlessly penalize people with Medicare:

- The cash value of life insurance policies would no longer be counted in the asset test. People often don't know what kind of life insurance policy they have, or what its value is even if they were to cash it in. Many question why a life insurance policy is counted as a cash asset when they bought it with the intention of protecting their family in their absence.
- IRAs and 401(k)s would no longer be counted as assets. Some of our clients over-estimate their assets by counting their retirement account as both income and an asset. Under the law, if they are required to take money out through a periodic distribution, then it is considered income and if not, then it is an asset.
- People with Medicare would no longer be asked to estimate the value of in-kind contributions, such as living rent-free with a relative or receiving groceries from a friend free of charge, and have that help count against the income limit.

We recently heard from a woman who told us about the experience of her 95-year-old mother-in-law. "She has no burial money, no life insurance, no pension—no money," she wrote. "The only income she has is her Social Security check of a little less then $1,000 per month. However, she has four people who donate money to help pay her assistive living room and board. This counts as 'in-kind support' and puts her over the income level so she was rejected for Extra Help." [1]

As Congress moves to improve the Extra Help program, it should also take steps to bring the eligibility criteria for MSPs in line with these new, more reasonable, standards for Extra Help.

Medicare Savings Programs are administered by states. Funding for benefits for the QMB and SLMB (Specified Low Income Medicare Beneficiary) programs comes jointly from the federal government and the states, according to the Medicaid match rate that applies for each sate. The QI (Qualified Individual) is a block grant, funded entirely by the federal government. Although there are minimum federal standards for MSP eligibility, states have leeway to increase enrollment by modifying income and asset criteria.

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[1] Story submitted to the Part D Monitoring Project, Medicare Rights Center, November 2, 2006.

Currently, individuals enrolled in MSPs are "deemed" eligible for Extra Help. If criteria were aligned, then deeming could go both ways, whether they applied through their state Medicaid offices, which administer MSPs, or through the Social Security Administration, which has primary responsibility to administer Extra Help. With two-way deeming, people with Medicare would receive all the help to which they are entitled.

Alignment of eligibility criteria entails a number of changes, some major and others that are smaller, but still significant:

- The major change is alignment of income eligibility thresholds. When Congress passed the Medicare Modernization Act, it recognized that people with Medicare living below 150 percent of the Federal Poverty Line (in 2007, $1,276 for an individual, $1,711 for a couple) would need additional help paying for their premiums and prescription drugs under Part D. The income limits for MSPs stop at 135 percent of poverty. A consistent policy would recognize that individuals earning less than this income level—the population that Congress, in the MMA, decided should benefit from full premium subsidies and low copays under Part D—should receive the full MSP benefit—having all part A and B cost-sharing and premiums paid for through the QMB program. Individuals earning between 135 percent and 150 percent of the poverty line would have their Part B premiums subsidized.
- Align asset thresholds. Six states—Alabama, Arizona, Delaware, Mississippi, New York and Connecticut—have eliminated the asset test for at least one of the Medicare Savings Programs. Florida, Maine and Minnesota have raised the maximum amount of allowable assets. The remaining states have asset thresholds pegged to the statutory maximum, $4,000 for an individual, $6,000 for couple, levels which are not indexed to inflation like those for Extra Help. These maximum levels should be brought into alignment with the Extra Help program.
- Count the same things and in the same way. Ten states allow their residents to keep more valuable life insurance policies, especially policies meant to defray burial expenses. Congress should build on these initiatives and eliminate the value of life insurance policies from the MSP asset test. Eighteen states no longer count in-kind income, which penalizes families that help their loved ones in need. The federal MSP standards should reflect the same fair policy. Extra Help accounts for the full size of the family when determining income so that grandparents who are raising grandchildren are given the help they need. At least ten states have already adopted this policy, which should be extended to federal MSP standards. Finally, MSP programs should exempt IRAs and 401(k) accounts from the calculation of assets, eliminating the penalty that now applies to individuals with defined-benefit retirement programs compared to the dwindling number with traditional pensions.
- Eliminate estate recovery for MSPs. Less than half the states even attempt to recover outlays for Medicare cost-sharing and premiums after an MSP recipient is deceased. The amount recoverable is not worth the cost of collecting. But estate recovery dissuades one in five potential enrollees from applying and it prevents

states from deeming individuals who are determined eligible after applying for Extra Help—no person can be automatically enrolled in a program that might seize the family home or modest savings they hope to pass on to their children.

- The QI program should be folded into the SLMB program. Unlike QMB and SLMB, QI is a block grant, subject to annual or biannual reauthorization and appropriation, and fully funded by the federal government. It expires September 30, 2007. Congress should show its support for this vital assistance by combining the QI and SLMB programs and arriving at a funding formula that does not add to states' financial burdens.

If the criteria for MSPs and Extra Help are aligned, an individual who applied for Extra Help with the Social Security Administration could be automatically enrolled in an MSP. This would leverage the outreach efforts of SSA and grassroots organizations for Extra Help by using it to increase enrollment in a vital assistance program that has abysmal participation rates. It would also reduce states' administrative expenses—income and asset information would already have been verified by SSA.

To make this work, the MSP application process needs to be brought into the twenty-first century. Only five states currently allow MSP applications to be submitted online. Online applications have proven to be a critical tool for community organizations and caregivers that help individuals apply for Extra Help. SSA allows Extra Help applicants to self–attest for their income and assets instead of imposing burdensome documentation requirements. Many states are already moving in this direction although a few states, including Alaska, require individuals to travel to Medicaid offices to apply. Older adults and people with disabilities should not have to run the Iditarod to get help with their medical expenses.

In addition to removing these eligibility and application barriers, we must also recognize that enrollment is low because this population is hard to reach. There are language barriers, literacy barriers; many poor older adults lead isolated lives. Intensive outreach is needed, by states, SSA and community-based organizations but such outreach is only practical if it can be targeted. The Office of Inspector General has recommended using IRS data to target outreach by SSA. Representative Doggett's bill includes sensible proposals to use such data, already in the government's possession, while protecting the privacy of people with Medicare.

However, we will only succeed in getting full enrollment in both MSPs and Extra Help through some method of automatic enrollment or presumptive eligibility. When Congress decided to charge higher Part B premiums to wealthier people with Medicare it decided to use tax data to determine who should pay the higher premium. There is no application or documentation requirement; individuals have to appeal *not* to pay the surcharge. A similar use of income data already in the government's possession could find and enroll everyone who qualifies for MSPs and Extra Help.

Let me conclude by returning to a couple of issues that are raised by Ms. Lopez's case.

Ms. Lopez was enrolled in the Medicaid program, but New York State had never signed her up for the QMB program, even though it had information on her assets and income and she clearly qualified. From our client work, this appears to be a widespread problem, not only in New York, but in other states as well.

Not only does it result in the denial of important financial assistance to people like Ms. Lopez, who are struggling to get by, but it also results in interruptions in assistance from Extra Help that affect hundreds of thousands of individuals. When poor people cannot afford to fill their prescriptions, they stop taking their medicine, often with dire health consequences.

Last fall, 630,000 enrollees in the Extra Help program received letters from CMS and SSA warning them that they were going to lose this valuable assistance on January 1, 2007 and informing them they should apply directly to SSA. These individuals had been deemed eligible for Extra Help for 2006 because at some point in 2005 they were on state rolls for Medicaid or MSP. By January, very few individuals had applied. Once they were hit with high copays at the pharmacy, over 240,000 had applied to SSA, with two-thirds determined eligible. Another 106,000 had been "redeemed" by states; omissions in data files sent to CMS were corrected, while others were requalified for MSPs or Medicaid.

SSA expects that we will see a repeat this fall, with hundreds of thousands of people again dumped from the Extra Help rolls. Many of these men and women receive Medicaid at some point in the year because they are determined "medically needy"—their medical expenses are so high that, even though their incomes are above the cutoff,, they qualify for Medicaid at some point in the year. But because their Medicaid coverage is intermittent, they risk being omitted in the state data files sent to CMS.

Most of these individuals likely qualify for MSPs, which have higher income thresholds. If states made a concerted effort to enroll all Medicaid recipients into an MSP, and if the MSP eligibility criteria were aligned with Extra Help, we would virtually eliminate the problem in this annual "redeeming" process.

In addition, the annual redetermination process for MSPs , particularly in those states that require resubmission of documentation, results in eligible individuals getting dropped from the MSP rolls. Very few low-income older adults with little in the way of financial assets ever experience a change in circumstance. They are poor and they will remain poor for the remainder of their days. Requiring annual redeterminations for MSPs just creates additional bureaucratic hassles for these individuals and additional administrative burdens on states. At the very least, the MSPs should adopt the annual redetermination process SSA now uses for Extra Help. Enrollees are asked if their circumstances have changed, and if nothing has, they are not required to reapply.

Many of our low-income clients, and the clients of other advocacy and community-based organizations around the country, had the same experience as Ms. Lopez when she went to the pharmacy. Though they are enrolled in the Extra Help and should only pay around $5 at most for their prescriptions, they are charged over $100 for their medicines. Because of persistent data exchange problems between CMS, SSA, states and the Part D plans, their eligibility for Extra Help is no longer in the plans' database.

Part D plans have been told repeatedly by CMS that they must accept "best available evidence" of Extra Help eligibility. This means, for example, that a dual eligible should be able to present her Medicaid card to the pharmacist, who in turn will inform the plan that it should correct its database. Part D plans are not following these instructions. As a result, without the services of an advocate knowledgeable enough to read the relevant regulation to the customer service department, low-income people with Medicare are being overcharged for their prescriptions and, too often, walking away from the pharmacy counter without their medicine.

It is inexcusable that 17 months into the Part D benefit, this situation persists. The immediate solution is for CMS to exercise its oversight responsibilities and ensure the plans are not overcharging their low income enrollees. For the longer term, the data exchange problems need to be fixed. The alignment of eligibility criteria between MSPs and Extra Help will simplify and streamline these programs and contribute to this solution.

We are grateful that the committee is looking into how the Medicare Savings Programs and Extra Help programs can better serve low-income people with Medicare and encouraged that members of this committee are developing legislative proposals to get this valuable financial assistance to older adults and people with disabilities struggling with high medical and prescription drug bills. The Medicare Rights Center stands ready to work with members of both parties in support of these efforts.

Mr. PALLONE. Thank you very much.
Mr. Coburn.

STATEMENT OF JOHN COBURN, DIRECTOR, MAKE MEDICARE WORK COALITION, HEALTH & DISABILITY ADVOCATES, CHICAGO, IL

Mr. COBURN. Chairman Pallone, Ranking Member Deal and distinguished members of the committee, thank you for giving me the opportunity to talk to you today about these two important programs and their impact on people with disabilities.

My name is John Coburn, and I am a senior attorney for Health & Disability Advocates and I am the director of the Illinois-based Make Medicare Work Coalition. My agency, our coalition and its partners have assisted hundreds of thousands of beneficiaries in Illinois and other parts of the country with Medicare Part D enrollment and advocacy over the last year and a half. While we assist and advocate for all Medicare beneficiaries, I want to focus my testimony on Medicare beneficiaries with disabilities under the age of 65.

There are approximately 7 million younger individuals with disabilities enrolled in Medicare, representing approximately 16 percent of the Medicare population. Most of these individuals qualify for Medicare because of current or former eligibility for Social Security Disability Insurance SSDI and completion of the required 24-month waiting period. For these younger beneficiaries with disabilities, the Medicare Savings Program and low-income subsidy program are very important.

The average SSDI check is $950 a month. If the average SSDI beneficiary was forced to pay all of the Medicare cost sharing, Medicare would simply be unaffordable. With the assistance of these programs, many individuals are able to access proper and necessary care under Medicare.

In my limited time before you, I want to focus on one very important issue to Medicare beneficiaries with disabilities and that is employment's impact on continuing eligibility for this program. I did not get a chance to read Ms. Sanchez's testimony before, but she did mention, I think, in both of her examples the individuals were working. So this is a big issue, particularly in the younger disability community.

Individuals with disabilities want to live securely and safely in their communities. Employment within the community is a key component of integration into the broader communities in which people live. A 2004 National Organization on Disability/Harris Survey, according to that survey, states that only 35 percent of people with disabilities reported being employed, yet 72 percent of individuals with disabilities surveyed wanted to work.

Over the years, Congress, the Social Security Administration and the Centers for Medicare and Medicaid Services have worked to create and implement programs and policies that remove barriers to employment of working-age Medicare beneficiaries. The hallmark legislation for this was the Ticket to Work and Work Incentives Improvement Act of 1999, which included provisions that extended Medicare eligibility for people who return to work.

Through this and other legislation and regulations, the Social Security cash programs and Medicaid fell in line and created an atmosphere where working was rewarded and a path towards greater self-sufficiency was possible. Unfortunately, our Medicare Savings Program and our low-income subsidy program which came along later don't fall in line with this process. And since Medicare Part D has started, the low-income subsidy has erected a new barrier, wherein people don't want to go back to work for fear of losing their low-income subsidy.

Increases in earned income, even slight, can disqualify people from eligibility for these two programs. We put people in a catch–22. Stay at home, do nothing and keep affordable insurance or go to work and lose the affordable part of that insurance that allowed you to work to begin with.

And what choice do we leave for individuals with HIV, multiple sclerosis and mental illness? Ms. B is an individual in Ohio who is currently receiving $850 in SSDI income, QMB assistance and the Low-Income Subsidy. Ms. B lives with a mental illness, and she wanted to go back to work. She actually went out and found full-time employment. She then discussed her situation with advocates and discovered that if she were to take that employment, she would lose her QMB assistance and her Low-Income Subsidy, thereby making it nearly impossible for her to afford the health care that was provided to her that got her to the point where she can work to begin with.

There are Medicaid buy-in programs in 32 of our States. Many of the members live in States where those programs exist, but there are many others who don't, including Georgia, Florida, Ohio and North Carolina. In those States, people can purchase Medicaid; and it gives them the dual-eligible status where they can get the Low-Income Subsidy. In those other States, that is not possible.

But it doesn't have to be this way. In the SSI, Supplemental Security Income, Medicaid world, we allow people through something called 1619(B) to go back to work and keep their Medicaid with no spend-down until they reach a State threshold. The SSDI beneficiaries with the Low-Income Subsidy and the Medicare Savings Program do not have this option. I hope that eventually the programs will align, and the SSDI beneficiaries will be encouraged and go back to work and keep their affordable health care.

Thank you.

[The prepared statement of Mr. Coburn follows:]

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Statement of

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On

Medicare Savings Plans and Low Income Subsidy: Keeping Medicare's Promise or Seniors and People with Disabilities

Before the Subcommittee on Health

U.S. House of Representatives

Committee on Energy and Commerce

May 15, 2007

Chairman Pallone and members of the Committee, thank you for giving me the opportunity to talk to you today about the Medicare Savings Programs (also known as "QMB", "SLMB" and "QI-1"), Medicare Part D Low-Income Subsidy Program (hereinafter "Low-Income Subsidy Program") and their impact on people with disabilities. My name is John Coburn and I am a Senior Policy Attorney for Health & Disability Advocates and the Director of the Illinois-based Make Medicare Work Coalition. Health & Disability Advocates (HDA) is a national policy and advocacy group that works to promote policies and programs that ensure the economic security and comprehensive health coverage for children and adults with disabilities and older adults, particularly those with limited incomes. A major part of our work is assisting individuals, community-based service providers, and advocates in understanding and navigating the complicated state and federal benefits systems, identifying barriers to accessing those systems, developing policies and solutions that will eliminate those barriers, and assuring that polices promote rather than hinder an individual's efforts to gain or maintain employment.

We are also one of the founding groups, along with AgeOptions and Progress Center for Independent Living, of the Make Medicare Work Coalition. The Make Medicare Work Coalition is a unique collaboration of community-based service providers who are doing the day-to-day education and outreach around Medicare Part D. My organization, HDA, provides technical assistance, training and policy support to this Coalition. We have worked in more than ten other states on issues ranging from auto enrollment, patient assistance programs and impact of Part D on the AIDS Drugs Assistance Programs. We have also worked with more than 30 states who have been working to build Medicaid Buy-In programs and Medicaid-funded employment supports for adults with disabilities – the majority of which are Medicare beneficiaries.

While our Coalition assists all Medicare beneficiaries, I want to focus my testimony on Medicare beneficiaries with disabilities under the age of 65. There are approximately 7 million younger individuals with disabilities enrolled in Medicare, representing approximately 16% of the Medicare population.[1] Most of these individuals qualify for Medicare because of current or former eligibility for Social Security Disability Insurance (hereinafter "SSDI") and completion of the required 24 month waiting period.

For these younger Medicare beneficiaries with disabilities, the Medicare Savings Programs and the Low-Income Subsidy Program are extremely important. The average SSDI check in 2007 is only

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[1] http://www.kff.org/medicare/upload/7615.pdf at page 4.

$950.[2] If the average SSDI beneficiary were forced to pay Part B and Part D costs, Medicare would be unaffordable. With the assistance of the Medicare Savings Programs and Low-Income Subsidy Program, many individuals are able to access proper and necessary medical care under Medicare Part B and Medicare Part D.

For Medicare beneficiaries with disabilities, the issues and concerns with Medicare Savings Programs and the Low-Income Subsidy Program are many and varied. However, these issues are often overshadowed by those of the aging community. In my limited time before you, I will focus on two particular issues that are very important to Medicare beneficiaries with disabilities: the impact of employment income and returning to work on continued eligibility for these programs; and some proposed steps we recommend to improve the auto-enrollment of Medicare beneficiaries into the Low-Income Subsidy Program to ensure that they are enrolled in a Prescription Drug Plan that best meets their needs.

The Impact of Employment Income on Continued Eligibility for Medicare Savings Program and the Low-Income Subsidy Program

Individuals with disabilities want to live securely and safely in their communities. Employment within the community is a key component of any strategy to better integrate individuals with

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[2] www.healthlaw.org/library.cfm?fa=download&resourceID=95155&print at page 1.

disabilities into the daily life of their communities. A 2004 National Organization on Disability/Harris Survey, only 35 percent of people with disabilities reported being employed full or part time, compared to 78% of those who do not have disabilities.[3] However, 72% of the individuals with disabilities surveyed want to work.[4] Over the years, Congress, the Social Security Administration and the Centers for Medicare and Medicaid Services have worked to create and implement programs and policies that remove the barriers to employment of working age Medicare beneficiaries, including the fear of loss of affordable health care. The hallmark legislation behind this effort has been the Ticket to Work and Work Incentives Improvement Act of 1999, which included provisions that extended Medicare eligibility for Medicare beneficiaries that return to work.

I. Eligibility requirements for Medicare Savings Programs and the Low-Income Subsidy Program should encourage, not punish, those individuals who choose to become employed.

The impact of earnings on eligibility for the Medicare Savings Programs and Low-Income Subsidy Program is now a significant consideration for any Medicare beneficiary's decision to return to work. Unfortunately, the Medicare Modernization Act of 2003 (hereinafter "MMA") and its implementing regulations did not adequately address

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[3] http://www.at508.com/040624_national_press_club.cfm.

[4] http://www.whitehouse.gov/news/freedominitiative/freedominitiative.html.

how the Low-Income Subsidy Program would integrate within the existing framework of SSDI programs that promote work – known as work incentives programs. An additional complication is that the Medicare Savings Programs have never been required to create eligibility standards that encourage employment of working-age beneficiaries. These mis-steps have resulted in the derailment of years of policy development work that Congress, the Social Security Administration and the Centers for Medicare and Medicaid have done to assure that SSDI beneficiaries are encouraged to seek employment and a higher level of self-sufficiency.

SSDI beneficiaries do not receive their Medicare benefits in a vacuum. Rather, a negative impact on eligibility for the Medicare Savings Programs and Medicare Low-Income Subsidy Program will continue to serve as disincentives to working despite the presence of the SSDI work incentives. The Medicare Savings Programs and Low-Income Subsidy Program must work in concert with the SSDI work incentives, the Medicaid Buy-In Programs, and the myriad of other state and federal programs that promote work and greater self-sufficiency for individuals with disabilities. By not doing so, we are left with a system that works at cross purposes: what the SSDI work incentives and other employment-related support programs give with one hand, the Medicare Savings Program and Low-Income Subsidy Program takes away with the other.

Eligibility for Medicare Savings Programs and the Low-Income Subsidy Program is determined by level of income and assets. How income is counted for Medicare Savings Programs varies from state to state but most, if not all, programs do count some level of earned income. As required under the MMA, the income calculation for the Low-Income Subsidy Program follows the Supplemental Security Income methodology. Under both programs, increasing earned income puts continuing eligibility in jeopardy.

Given a choice between continued eligibility for Medicare Savings Programs and the Low-Income Subsidy Program, securing employment and working more hours, many individuals will choose to remain in the Programs. Unfortunately, in many typical cases, this makes the most financial sense. The earnings from the new job or an increase in income cannot possibly make up for the loss in benefits that accrue from enrollment in the Medicare Savings Programs and the Medicare Part D Low- Income Subsidy. Instead, individuals are forced to turn down job opportunities, work fewer hours, or not accept raises.

II. Medicaid Buy-In Programs provide a partial safety net from loss of eligibility for the Medicare Part D Low-Income Subsidy eligibility. However, Medicaid Buy-In Programs alone are not enough.

Under Section 4733 of the Balanced Budget Act of 1997 or the Ticket to Work and Work Incentives Improvement Act of 1999, 32 states have implemented Medicaid Buy-In Programs for individuals with disabilities.[5] Recognizing the importance of comprehensive health care benefits to individuals with disabilities, these two Acts provided states with the flexibility to create programs that allow individuals to gain employment and "buy-in" or pay a premium to keep or obtain Medicaid coverage. There are approximately 80,000 people participating in this program.[6]

The vast majority (76%) of Medicaid Buy-In participants are Medicare beneficiaries.[7] In our work with the states and these programs, we find that states who track disability-type report a significant number of their Medicaid Buy-In participants are living with a mental illness. And, states have reported that pharmaceutical expenses are the primary driver of expenditures in their programs. From this, we can deduce with some certainty that individuals worked and joined Medicaid Buy-In Programs prior to Medicare Part D because of the drug coverage that allowed them to work successfully. Now,

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[5] http://www.cms.hhs.gov/TWWIA/07_BuyIn.asp#TopOfPage

[6] Id.

[7] Mathematica Policy Research, Inc., Understanding Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2003-2004. Final Report, January 2006. Page xv.

because Buy-In participants are considered dual eligibles under the Low-Income Subsidy Program, participants will continue enrollment to maintain that dual eligible status.

The Medicaid Buy-In Programs do give many individuals the flexibility to work and maintain their Medicare Part D Low-Income Subsidy Program eligibility. However, the income and eligibility criteria vary from state to state and will not cover all individuals interested in working who need to maintain Low-Income Subsidy eligibility. For example, states such as Maine, Michigan and West Virginia have stricter unearned income guidelines than the Low-Income Subsidy Program. South Carolina requires a higher level of earned income than other states to get into the state's Medicaid buy-in program. Alaska and South Carolina limit an individual's assets to levels lower than that of the Medicare Savings Program and the Low-Income Subsidy Program. Most importantly, individuals living in the 18 states without Buy-In Programs, including large states like Ohio, North Carolina, Georgia and Florida, cannot rely on these Buy-In programs period.

The patchwork of Medicaid Buy-In Programs cannot remove the work disincentive inherent in the Medicare Savings Programs and the Low-Income Subsidy Program. Rather, only a change at the federal level can assure that any SSDI beneficiary is not forced to choose between affordable health care and a job.

III. The Medicare Savings Programs and the Low-Income Subsidy Eligibility Requirements Continue to Prevent Individuals from Working and/or Being More Self-Sufficient.

The examples that follow will give you an idea of the unenviable choices some Medicare beneficiaries have to make when thinking about employment. These examples represent the experiences of many Medicare beneficiaries we and our fellow advocates have assisted in making an informed choice about returning to work.

> *Ms. B lives in Ohio, where no Medicaid Buy-In Program currently exists. Ms. B currently receives $850 in SSDI, QMB assistance, and the Low-Income Subsidy. She is living with a mental illness. It was a huge step for her to decide to return to work, but she made the decision to do it. She secured an offer for a full-time job. When she found out that she would lose her QMB assistance and eligibility for the Low-Income Subsidy, she had to turn the job down. It would be impossible for her to afford her co-pays for her doctor's visits and medications. .*
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> *Ms. J is a single female in her thirties living in Illinois. She currently receives $646 in SSDI, Medicare, QMB assistance with Medicare expenses, Medicaid and the full low-income subsidy. Ms. J really wants to work and was applying for part-time jobs in her community that paid approximately $600 per month. Since she lives in such a rural area, she would need a car. She found a friend who was willing to drive her to work for a while until she is able to save enough from her paycheck to buy a used car. If Ms. J were to take this job, eligibility for these various programs would change dramatically. With an extra $600 in gross income, she will lose eligibility for QMB assistance and will begin to pay the $93.50 premium for Medicare Part B. She could either continue regular Medicaid eligibility with a significant monthly spenddown/share of cost, or join Illinois Health Benefits for*

> *Workers with Disabilities, the state's Medicaid Buy-In Program. That program would cost her another $50 in a monthly premium. After taxes and these additional premiums of $143.50, working at this level is never going to allow her to save money to get the car she needs. By working any more than this, she would lose her eligibility for the Health Benefits for Workers with Disabilities Program and her eligibility for the Part D Low-Income Subsidy. Therefore, Ms. J has decided not to work.*
>
> *Ms. S has a dual diagnosis of mental illness and a visual impairment. She is in her late 50's, is married, and lives in Illinois. Her husband is disabled and retired. Both receive Social Security, Medicare and QMB assistance. Shirley is a part-time student and she works part-time as a local mental health center. Because of her earnings, both she and her husband lost their QMB eligibility. Having to suddenly pick up the cost of two premiums of $93.50 and the 20% cost share of Medicare Part B was unaffordable. Almost all of her earned income was going to pay these expenses. So, Ms. S reduced her work hours in order to re-qualify for the QMB Medicare Savings Program.*

IV. 1619(A) and (B) of the Social Security Act[8] Provide an Excellent Example of How to Assure That the Inability to Keep Affordable Medical Coverage Is Not a Barrier to Employment.

In contrast to the experience of the SSDI beneficiaries receiving Medicare, Supplemental Security Income ("SSI") beneficiaries who receive Medicaid are given wide latitude to work and maintain their affordable health care. They are able to do this through provisions of the Social Security Act commonly known as "1619 Medicaid." Under these provisions, an individual who receives SSI and Medicaid and still needs Medicaid to work can continue to receive Medicaid at no cost up to certain income limits. These income limits are based on each

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[8] 42 USC § 426(b); POMS HI 00820.025.

state's average Medicaid expenditures but can be increased in individual cases. For example, in Illinois, an individual receiving SSI benefits and Medicaid can earn up to $31,011 per year without losing Medicaid coverage.[9]

Creating a similar rule in the Medicare Savings Programs and the Low-Income Subsidy Program would eliminate the work disincentive in those Programs. When conducting re-determinations, work income could be disregarded up to the state's 1619(b) threshold just as it is for SSI beneficiaries. This would allow individuals such as Ms. B, Ms. J and Ms. S to work and maintain affordable health insurance. The cost of such an expansion would be minimal as it would not necessarily add new people to these two Programs. Rather, it would allow current enrollees to gain employment that they would not otherwise accept because of loss of eligibility for the Programs.

Improvements to the Formulary Requirements of Precription Drug Plans to Which Individuals are Automatically Assigned

For those automatically enrolled into the Low-Income Subsidy Program and a Prescription Drug Plan, more can be done to assure that the assignment is appropriate and will meet the person's needs.

> *Mr. G is an SSDI beneficiary with both Medicare and Medicaid. Living with a mental illness, he was prescribed a specific anti-psychotic drug that has worked well for several years. He was auto-enrolled into a Prescription Drug Plan in October of 2006.*

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[9] http://www.ssa.gov/redbook/2007rbnews.htm

> *That plan would not allow him access to this anti-psychotic without trying a preferred drug first even though that violated CMS policy guidance. The exception was denied, so he began taking the preferred drug. He had to be hospitalized and his health has deteriorated significantly.*

Individuals automatically enrolled into Prescription Drug Plans continue to face serious problems in accessing their needed medications. While others will talk more about these issues, I want to briefly identify and discuss one key issue. Many individuals with disabilities find that even after being properly assigned to a PDP that identifies the proper cost sharing, a process that takes entirely too long for some, they still cannot get the medication that they need because of formulary restrictions. Since individuals with disabilities represent over 1/3 of dual eligibles and dual eligibles are auto-enrolled into plans, this is a serious issue for the disability community.[10]

Under the MMA Act, Prescription Drug Plans must carry two drugs in each therapeutic category.[11] Under sub-regulatory guidance to the Prescription Drug Plans, CMS has directed the Prescription Drug Plans to carry "*all or substantially all*" of the drugs in six drug categories: Anti-convulsants, Anti-retrovirals, Immuno-suppressants, Anti-depressants, Anti-psychotics and Anti-neoplastics.[12] These drugs

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[10] http://www.cms.hhs.gov/MCBS/Downloads/CNP_2003_dhsec8.pdf at page 37.
[11] http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidance.pdf at page 7.
[12] Centers for Medicare and Medicaid Services. Medicare Prescription Drug Benefit Manual. Chapter 6 at 30.2.5.

also have enhanced protections from benefits management tools.[13] Because this second requirement is only sub-regulatory guidance, it could be removed in future years by CMS.

These requirements alone are important but inadequate to assure that those who are automatically enrolled into Prescription Drug Plans will have access to the medications they need. In particular, the enhanced protection for the 6 classes is crucial in assuring better access to life-saving medications. We believe that if this requirement was not instituted in the guidance, many more beneficiaries would have suffered serious health consequences. This guidance prevented what would have been an unmitigated, widespread public health crisis into "merely" a serious problem for a substantial number of people.

Two recent studies, dealing with individuals who take at least some drugs within the enhanced protected categories, are evidence of the serious and continuing access problem. The first study was conducted by the HIV Medicine Association and the American Academy of HIV Medicine. Of 452 HIV medical providers surveyed, it found that 76% reported having patient(s) living with HIV who could not access a medication due to formulary restrictions.[14] The second study was published in the American Journal of Psychiatry. Surveying 1183

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[13] Id.

[14] American Academy of HIV Medicine and the HIV Medicine Association, "HIV Medical Provider Medicare Part D Survey." April 2, 2007.

psychiatrists, it found that 30.6% of them reported having dual-eligible patients who were not able to access medications because the Part D plans did not cover or approve the prescription.[15]

Continued access to medications and no breaks in coverage are absolutely necessary to managing serious conditions such as HIV and mental illness. Every attempt must be made to assure access to necessary medications for these and other serious conditions experienced by Medicare beneficiaries with disabilities. If not, these vulnerable Medicare beneficiaries face grave health consequences. Even with the protection for the 6 classes, the medications needs of a significant portion of these Medicare populations are not being met.

More must be done to assure that individuals are assigned to Prescription Drug Plans that meet their needs. Congress should codify into law the important protections for the 6 classes of drugs currently covered by sub-regulator guidance. These protections are absolutely necessary to assure Part D is adequate to meet the needs of the populations taking these medications. The disability community needs more assurance than just sub-regulatory guidance that must be renewed from year to year that these requirements will continue. In addition, CMS should have more authority and be provided more resources to enforce the compliance by Prescription Drug Plans on

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[15] Joyce C. West, Ph.D. et. al. "Medication Access and Continuity: The Experiences of Dual-Eligible Psychiatric Patients during the First 4 Months of Medicare Prescription Drug Benefit." American Journal of Psychiatry, May 2007, page 789.

these and all other requirements. Given the experience of both the HIV and mental health community, it is clear that not enough has been done. While CMS is very responsive when specific examples are brought to its attention, it would be much more efficient and effective if such measures were taken up-front without constant prompting from the advocacy community when gaps and issues are discovered.

The Prescription Drug Plans to which individuals are automatically assigned receive these enrollees with no "acquisition costs." No money must be spent on marketing to encourage them to join the plan and no staff time must be spent enrolling them into the plan. In return for this, it would not be unreasonable to place further requirements on these plans to assure that these individuals have easier access to the medications prescribed to them. Those requirements could include enhanced protection beyond the current 6 categories to include more of the common medications prescribed to the Low-Income Subsidy population.

Conclusion

The Medicare Savings Programs and the Low-Income Subsidy Program are extremely important to Medicare beneficiaries with disabilities. Without them, Medicare would be unaffordable for many. Given the importance of these Programs, it is troubling that current law and policy would force individuals with disabilities to choose between eligibility for these Programs and employment. Expansion of these programs to allow individuals to work and become more self-sufficient within their communities as well as stronger assurances that Medicare Part D covers necessary drugs would go far in improving these Programs for people with disabilities.

Thank you.

Mr. PALLONE. Thanks a lot. We will hear from Ms. Sassar. Thank you for being here today.

STATEMENT OF LILLA SASSAR, BENEFICIARY, SYACAUGA, AL

Ms. SASSAR. I am so grateful that I have an opportunity to tell my story. It is very short, but it has impact, and you can understand it real well.

I am Lilla Sassar, as you all know, from Syacauga, Alabama. I am 83 years old, and I am enrolled in HealthSpring Medicare Advantage Plan. It is the best thing I have ever had since I have been on Social Security.

I am on a very limited income, and I do get assistance from the State. My Social Security premium is paid by the State of Alabama.

Now that I am enrolled with HealthSpring, I can afford to put food on the table and buy my medicines, too, and go to the doctors when I need to. I go to the doctor, and I won't have to worry about my deductibles, about my Blue Cross/Blue Shield and about my medication. I won't pay because I have no co-payment. It is so terrible to have to worry about these things.

I also get to exercise through my HealthSpring membership at a local hospital. I get to stay in shape and see my friends with the Silver Sneakers.

HealthSpring even has a van pick me up and take me to the doctor if I have to go to a doctor. This is good because I have a hard time getting to the doctor. If they didn't offer this benefit—it sure cuts down on expensive gas. They bring me back home, too.

I wish everyone could have a program like HealthSpring. People like me that don't have a lot of money can still see the doctor and get medicines and don't have to worry. This program that I am on would help a lot of people, and I am so glad I had an opportunity to have a little input for others, not just for myself but for others, too. They need to get on HealthSpring.

Thank you for listening to me.

[The prepared statement of Ms. Sassar follows:]

STATEMENT OF LILLA SASSER

- I am an 83 year old woman enrolled in HealthSpring Medicare Advantage Plan
- I am on a very limited income and used to get assistance from the State.
- Now that I am enrolled with HealthSpring, I can afford to put food on the table and buy my medicines and go to the doctor when I need to.
- I get to go to the doctor and not worry about how I will pay because I have a $0 copayment.
- I also get to exercise through my HealthSpring membership at the local YMCA or other facilities. I get to stay in shape and see my friends.
- HealthSpring even has a van pick me up and take me to the doctor and pick up my medicines. This is good because I would have a hard time getting to the doctor if they didn't offer this benefit.
- I wish everyone could have a program like HealthSpring. People like me that don't have a lot of money can still see the doctor and get medicines and not have to worry.

Thank you for listening.

Mr. PALLONE. Thank you very much. We appreciate you being here today.

Let me just say what we are going to do. We are going to try to do both of the other two panel members and then take a break. There is a 15-minute vote followed by four 5-minute votes, and those are the last votes of the day. So that will probably take us maybe 45 minutes. But let's continue with the testimony, and then we will break and come back.

Ms. Clarkson, thank you.

STATEMENT OF GAIL CLARKSON, CHIEF EXECUTIVE OFFICER, THE MEDILODGE GROUP, BLOOMFIELD HILLS, MI, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION (AHCA)

Ms. CLARKSON. Thank you, Mr. Chairman, Ranking Member Deal and members of the committee. I appreciate the opportunity to speak to you today on behalf of the American Health Care Association and NCAL.

My name is Gail Clarkson. I am the chief executive officer of Medilodge. Our 14 skilled nursing and 4 assisted living facilities employ 2,500 individuals and care for more than 2,300 patients and residents in the State of Michigan.

I have worked as a nursing home administrator, director of nursing and an intensive care nurse. I know what it takes to provide high-quality care for seniors and people with disabilities, even when the payments do not cover the care and services they require. I mention this because Medicaid underfunds long-term care by approximate $13 per patient per day nationally and because quality depends on stable funding, something CMS has repeatedly acknowledged.

Most nursing home patients are both poor and elderly, relying on Medicaid and Medicare to pay for their long-term care. So nursing homes have worked long and hard to coordinate care for these dually eligible patients and residents to ensure that these vulnerable Americans get the best care available.

AHCA and NCAL continue to work closely with CMS on Medicare Part D. I am proud to say that no patient or resident being cared for in a skilled nursing facility went without his or her medication during the transition to the new prescription drug benefit. I do not know if the same can be said for the other poor elderly.

Dually eligible beneficiaries in assisted living or residential care facilities or other home-like settings often only have a small personal needs allowance of a few dollars a month, so co-pays of even $1 or $3 can add up when that person needs multiple prescriptions. Like nursing home patients, assisted living residents need, on average, approximately nine medications a day.

The Home and Community Services co-payment Equity Act recently introduced in the Senate would eliminate Part D co-pays for these low-income Americans and would put dually eligible home and community-based individuals on par with those in nursing homes who have no co-pays under Part D. We urge the members of the committee to enact companion legislation.

Programs like Medicare Part D and the Low-Income Subsidy are critical parts of the health care safety net in this country, but what I have found in practice is that accessing these programs can be challenging, as was the case with the auto-enrollment of dually eligible nursing home residents under Part D.

For example, we spent considerable time and effort identifying which Part D plan patients had been automatically enrolled in, and then in determining whether or not that plan met the patients' needs. AHCA and NCAL worked with CMS on what it calls the three-pronged approach to assure that the poor elderly entering the facility and needing prescription drug coverage could access their benefits under Medicare and Medicaid.

Our experience shows that Low-Income Subsidy can take effect in only a couple of weeks, whereas it can be months before Medicaid eligibility is determined. But, in my experience, I have found that patients, families and health care providers are unaware of these benefits or even know how the Medicare and Medicaid benefits work with respect to long-term care needs. So we often must educate and assist patients in accessing these critical benefits.

AHCA and NCAL understand that retrofitting a new benefit is not easy. That is why we have looked at ways to reform Medicare and Medicaid to better meet the needs of a swiftly aging baby boom generation. Our recommendations are included in my written testimony.

Providing high-quality long-term care is a top priority for me and for AHCA and NCAL members like me, who are participating in a national campaign to improve quality of care and quality of life for our patients, residents and staff alike.

We are proud of our commitment to quality and are proud the data is proving our commitment is real. Nursing Home Quality Initiative data shows improvement in pain management, reduced use of restraints, decreased number of patients with depression and improvements in physical conditions such as incidents of pressure ulcers. Last week, independent satisfaction data was released that shows 82 percent, the vast majority of nursing home residents and families, would rate care as good or excellent.

Even as we strive to deliver the best care possible, we still face considerable challenges and seek your assistance in meeting those needs. We are working to be transparent for our consumers. We ask CMS to be similarly transparent in the criteria it uses to oversee the care we provide. We also ask that CMS not place paperwork over patient care and thank Chairman Dingell and those who have already called on CMS to redress its final rule on blood glucose monitoring.

We are proud of our successes and acknowledge there remains far more to do. Mr. Chairman, I have never seen our profession more committed to ensuring we continue to improve care quality.

In short, we recommend working toward a system that delivers an array of long-term care services, adequately funded, administered by knowledgeable, quality-driven providers and where beneficiaries move seamlessly to a long-term care spectrum which every American is likely to need at some point in his or her life.

AHCA and NCAL stand ready to work with your committee and with all who have a stake in the future of our long-term care delivery system in the future. Thank you.

[The prepared statement of Gail Clarkson follows:]

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National Center For Assisted Living

STATEMENT
Of
GAIL CLARKSON
On Behalf Of The
American Health Care Association
&
National Center for Assisted Living
To
House Energy & Commerce Subcommittee on Health Hearing
On
"Medicare Savings Plan and Low Income Subsidy: Keeping Medicare's Promise for Seniors and People with Disabilities"

May 15, 2007

Thank you Chairman Pallone, Ranking Member Deal, and members of the Committee. I appreciate the opportunity to speak with you on behalf of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL), which represent nearly 11,000 long term care providers who employ more than 1.5 million compassionate, well-trained caregivers who care for millions of frail, elderly, and disabled Americans.

My name is Gail Clarkson and I am Chief Executive Officer of Medilodge, which is located in Washington, Michigan. All of MediLodge's 12 facilities participate in Quality First and *Advancing Excellence in America's Nursing Homes*, which promote continuous quality improvement in long term care. We employ 2,500 individuals who care for more than 2,200 patients and residents. I have worked as a nursing home administrator, director of nursing, and an intensive care nurse. I also have been trained and certified in epidemiology by the Centers for Disease Control & Prevention (CDC) and Yale University and I serve on the Board of Governors of the American Health Care Association.

My experiences have made me acutely aware that providing high quality care for seniors and people with disabilities depends on stable funding. However, we continue to care for patients when payments do not cover the care and services required by these individuals. It is important to note that, nationally, Medicaid under funds care for the average patient by more than $13.00 per day. The Centers for Medicare & Medicaid Services (CMS) has proposed a rule that would disallow intergovernmental transfers (IGTs)—in effect, further cutting states' Medicaid funding.

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Congress has recognized CMS' shortsighted approach to Medicaid reform; AHCA/NCAL applauds Congress for addressing this issue in including a one-year moratorium on CMS' implementation of the IGT rule.

The vast majority of nursing home patients who rely on Medicaid to pay for their long term care are also eligible for Medicare coverage as well, drawing on Medicare Part B for their outpatient therapy needs and Medicare Part D for their prescription drugs needs. Because these individuals are both poor and elderly and eligible for both Medicare and Medicaid, they are often referred to as "dual eligibles." Nursing homes have worked long and hard to coordinate care for dually eligible patients and residents to ensure that the services provided under both the Medicare and Medicaid programs for these vulnerable Americans is the best care available.

The link between stable funding and quality has been repeatedly acknowledge by the Centers for Medicare & Medicaid Services, most recently by Acting Administrator Leslie Norwalk, who wrote in this month's *Provider* magazine:

> *Nursing home providers have been on the leading edge of this quality movement. Long before hospitals, doctors, home health providers, pharmacies, dialysis facilities and others came to the table, the nursing home industry was out front with Quality First – a volunteer effort to elevate quality and accountability.*

Ms. Norwalk explains that the recently launched *Advancing Excellence in America's Nursing Homes* campaign, builds on the success of Quality First and other initiatives that have helped to improve care quality in long term care facilities since 2002. Moreover, Ms. Norwalk also acknowledges "the essential connection between quality, adequate payment for services and financial stability" and that working together—providers, consumers, government and others—represents "the best path to a high-quality, patient-centered, provider-friendly system that everyone can afford." We wholeheartedly agree.

Providing high-quality long term care and services is a top priority for AHCA/NCAL and our membership. We are especially proud to note that the data is proving our commitment is very real—the Nursing Home Quality Initiative data shows improvement in pain management, reduced use of restraints, decreased number of patients with depression, and improvements in physical conditions such as incidents of pressure ulcers. Last week, My InnerView, Inc. released independent data based on nursing home resident and family member satisfaction surveys that shows that the vast majority—82%—of residents and families would rate care as good or excellent. I am pleased to note that my company, Medilodge, participated in this independent survey of our patients, residents, and family members.

Even so, the long term care system is under considerable pressure—as are we all—to do even more. We strive to deliver the best care possible, yet we face considerable challenges.

We seek your Committee's assistance in meeting some of those challenges. Our profession is working to meet the needs of consumers, which includes being transparent so that our customers can best select the care and services they need and want from long term care providers. We ask that CMS, which reviews our profession, be similarly transparent about the criteria it uses in overseeing such care and services. In addition, we ask that your Committee review CMS' recent final rule on blood glucose monitoring. CMS' rule now requires a physician order for each finger stick test to monitor patients' blood glucose—an impractical requirement that places an enormous administrative burden on long term care providers while doing nothing to improve patient care. We thank Chairman Dingell and his colleagues who have already called on CMS to redress this rule, which places paperwork over patient care.

As I have noted, improving care quality is a continuous, dynamic, ongoing enterprise. While we are enormously proud and pleased by our care quality successes, we acknowledge there is far more to accomplish. From our profession's standpoint, Mr. Chairman, there has never been a broader recognition of the importance of quality, or a broader commitment to ensure it continues to improve.

AHCA/NCAL worked closely with the Centers for Medicare & Medicaid Services before, during, and since the implementation of Medicare Part D, which began on January 1, 2006. The transition to this new benefit was not easy, but I am proud to say on behalf of my profession that no patient or resident being cared for in a Skilled Nursing facility (SNF) went without his or her medication during the transition to Medicare Part D. I do not know if the same may be said for residents in assisted living facilities and other home- and community-based settings (HCBS) who have prescription needs similar to that of nursing home patients—often requiring up to 9 medications per day—but who may be financially unable to afford the copayments on their Part D prescriptions.

Frequently, dually eligible beneficiaries living in assisted living or residential care (AL/RC) facilities or other home-like settings only have a small personal needs allowance of a few dollars a month, so even a copayment of $1 - $3 per prescription can add up when the individual requires multiple prescriptions. That is why we were pleased to see that a bill has been introduced in the Senate entitled, *The Home and Community Services Co-payment Equity Act (S. 1107),* which would eliminate Part D copayments for more than one million low-income Americans, including dually-eligible residents of AL/RC facilities and other licensed facilities (such as group homes for people with developmental disabilities, psychiatric health facilities, and mental health rehabilitation centers), who receive their services at home under HCBS waivers. This legislation would put dually-eligible home and community based individuals on par with similar beneficiaries in nursing facilities who do not have to make copayments under Part D. We urge members of the Committee to enact and sponsor companion legislation to *S. 1107*.

It is important to recognize the vulnerability and special needs of very low-income people who not only need long term care, but who also need help in getting assistance to pay for the care they need. Federal programs such as the Low Income Subsidy (LIS) and Medicaid are critical parts of the health care safety net in this country, but what I have found in practice is that accessing these programs can be challenging.

Our experience with the auto-enrollment of Medicare dually-eligible SNF residents underscores this point. We spent considerable time and effort working with CMS as well as with our most frail poor and elderly residents—first in identifying into which Part D Plan the resident had been automatically enrolled, and then in determining whether or not that plan met his/her needs. What we learned through that process is that the infrastructure for coordinating Medicare, Medicaid, Social Security and State Medicaid was not up to par and caused delay, confusion, and ultimately, required all of us to work together to overcome the resultant shortcomings.

AHCA/NCAL understands that retrofitting a new benefit with multiple new processes is difficult. In fact, we have looked at ways we might recommend the program that Americans rely on to pay for care of our most vulnerable citizens—Medicaid—reformed to better meet the needs of a swiftly aging baby boom generation—most of whom will require long term care services at some point in their lives. By 2040, the number of older nursing home residents is estimated to more than double to 2.7 million.

It is important to note that Medicare and Medicaid are inextricably linked to each other and to the quality of care provided. Therefore, we recommend working toward a system that delivers an array of long term care services, administered by knowledgeable, quality-driven providers. We also want to ensure that beneficiaries move seamlessly among services across the long term care spectrum; that they receive the services they need and desire; and that funding is adequate to pay for the necessary care delivered by long term care providers for more than a million Americans on any given day. Additional recommendations can be found in our attached *Medicaid Reform Principles.*

As we try to address the complex problems facing health care in America, we should not be so quick to see any one program as the solution; rather, we should seek to work together—all of whom have a stake in the future of our long term care delivery system. As we look toward an ever-expanding continuum of long term care options, we need to ensure that people understand their options and that they are able to choose the care setting that best meets their individual needs and preferences.

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Principles for Long Term Care Reform
Executive Summary

Preamble
Continued Medicaid cost growth and increasing numbers of long term care users are driving states and the federal government to fundamentally reform the Medicaid program. Because long term care costs drive much of Medicaid growth, long term care reform – primarily within Medicaid reform efforts – has become a top policy priority for the federal government and most states.

In order for AHCA/NCAL to best represent member interests, a cross-cutting member work group developed a set of broad long term care reform policy principles – or essential programmatic elements – to guide or serve as a framework for AHCA/NCAL long term care policy development and reaction to federal and state proposals. The long term care reform principles build upon current AHCA long term care and Medicaid policies and will guide future AHCA/NCAL activity. Additionally, the principles also support one or more of AHCA's long term care and/or Medicaid policy goals previously developed by AHCA's Finance Subcommittee.

The member work group determined that managed care warrants its own set of principles.

The Principles
Three key principles frame a long term care program(s) that will: (a) support consumer preferences and needs; (b) foster policy efforts aimed at creating a more sustainable array of long term care financing options; and (c) provide a viable operating environment for long term care providers. Each principle includes several key elements.

Principle I. Publicly and privately financed long term care and related supports and services must meet consumers' and families' needs and be responsive to their preferences.

- *Recognize that consumers are key stakeholders in long term care policy decision making and government must include them in development, oversight and monitoring.*
- *Provide that every eligible individual who needs long term care services receives them in a timely manner in an appropriate setting, taking into account individual preferences and clinical needs.*

- *Acknowledge the key role that family care givers play and provide family care giver supports.*

Principle II. Long term care policies should promote and integrate a comprehensive array of public and private long term care financing options.

- *Encourage individuals to plan for long term care and provide viable private long term care financing options.*
- *Ensure that individuals have the tools they need to manage their long term care services as beneficiaries assume more personal responsibility for services – publicly and privately financed.*
- *Recognize the impact of reimbursement changes on long term care providers.*
- *Ensure that efficient coordination of benefits reduce administrative burdens on beneficiaries and providers.*
- *Encourage individuals, providers and government payers to engage in a policy debate on balancing public and private financing of long term care.*
- *Encourage the design of tax policies that coordinate with long term care financing strategy alternatives.*

Principle III. Through sufficient federal and state governmental infrastructure, policies should ensure that long term care service delivery systems provide an adequate array of services and administered by knowledgeable and quality driven providers across the long term care spectrum.

- *Include a strategic plan for building needed infrastructure and ensure a sufficient supply of long term care providers that engage in a variety of services to meet the needs of the population.*
- *Ensure that beneficiaries may move seamlessly among services across the long term care spectrum.*
- *Foster and support quality and efficiency in Medicaid services, as well as provide operational flexibility.*
- *Managed care plans should recognize that long term care providers deliver services that are distinct from acute care providers.*

- *Funding is adequate and timely in order to provide stability and predictability to meet the needs of long term care recipients at the appropriate time, in the appropriate place, and at the appropriate cost.*

- *Encourage development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement.*

Complete AHCA/NCAL Principles for Long Term Care Reform

Introduction

Patients and their families are increasingly interested in sources of care and sites of services that are non-facility based, including home- and community-based settings (HCBS). Local communities, states, and the federal government are responsive, particularly since they believe that HCBS will be less costly and therefore save money. Because of consumer preferences and related federal and state policy changes, the proportion of long term care services delivered in facility-based settings is smaller than in the past. Medicaid reform has become the major vehicle for these and other long term care reform efforts at both the state and federal levels.

To date, many long term care reform proposals focus on delaying or preventing facility-based placement while encouraging use of personal long term care planning and expanding HCBS availability. The culminating outcome likely will be decreasing use of nursing homes and intermediate care facilities for persons with mental retardation (ICFs/MR).

This is not to suggest that the need for facility-based services will disappear. Rather, facility-based services are likely to play a relatively smaller role at least in the next ten to fifteen years. In the longer term, it is less clear how long term care will be delivered. Short term pressures and out-year ambiguity suggest that AHCA – the largest formal long-term care provider group in the country – adopt a forward-looking, leadership-based approach to shape long term care policies and ensure that there is a sustainable array of long term care services – and related privately and publicly financing options – for all Americans.

In late January, AHCA and NCAL members began the process of developing a set of guiding Medicaid reform principles. Principles were developed and assessed against the following dimensions:

- *Will the principles foster policy efforts aimed at creating a more sustainable long term care financing model?*

- *Do the principles support consumer preferences and needs?*

- *Will the principles foster a viable operating environment for long term care service providers?*

The principles were drafted to encapsulate existing AHCA/NCAL policy and provide a more succinct tool for sharing AHCA/NCAL positions as well as to frame proactive policy initiatives. The principles build on past policies by condensing concepts that are highly interrelated, promoting policies that are viable in the current political and budgetary environment, and providing a proactive positive framework for representing AHCA/NCAL interests. The principles also directly relate to AHCA long term care and Medicaid policy goals developed by the AHCA Finance Subcommittee.

The Principles

Three key principles frame a long term care program(s) that will: (a) support consumer preferences and needs; (b) foster policy efforts aimed at creating a more sustainable array of long term care financing options; and (c) provide a viable operating environment for long term care providers. Each principle includes several key elements and also supports one or more of AHCA's long term care and/or Medicaid Policy goals previously developed by AHCA's Finance Subcommittee.

Principle I. Publicly and privately financed long term care supports and services must meet consumers' and families' needs and be responsive to their preferences. Unlike acute and primary health care services, long term care services are not discrete events (i.e., a sore throat, broken leg, etc.) that require specific medical interventions. Instead, receipt of long term care services becomes a lifestyle for both the person receiving services and his or her family. Long term care services are integrated into virtually every aspect of an individual's life and make the experience of long term care highly personal. To that end, long term care policies must:

- *Recognize that consumers are key stakeholders in long term care policy decision making and government must include them in development, oversight and monitoring.* State Medicaid agencies are required to provide public notice and time for comment when changes to the Medicaid program are proposed. They also are required to respond to stakeholder concerns. The federal government should require documentation that these requirements have been met.

- *Provide that every eligible individual who needs long term care services receives them in a timely manner in an appropriate setting, taking into account individual preferences and clinical needs.* Policies must recognize the individual – to the extent possible – as the key decision-maker regarding their supports and care. For privately financed options, policies also must ensure that these options – particularly insurance products – recognize the importance of consumer preference.

- *Acknowledge the key role that family care givers play and provide family care giver supports.* Family care givers are a critical – but often unrecognized – segment of the long term care spectrum. State and federal programs must provide incentives and assistance for family care giving such as income tax deductions, availability of respite and day programming, and family counseling services.

Principle II. Long term care policies must promote and integrate a comprehensive array of public and private long term care financing options. As the proportion of our population age 65 or older increases and the number of younger persons with disabilities increases, the federal government and states must take steps to increase use of private long term care options. Increasing the use of private options will improve the sustainability of a publicly financed long term care program, currently Medicaid. And, reimbursement policies must recognize the potentially interrelated impacts of payment policy changes to ensure a stable long term care provider marketplace. A stable array of long term care providers will be better positioned to meet consumers' needs and preferences. To increase use of the array of long term care financing options, policies must:

- *Encourage individuals to plan for long term care and provide viable private long term care financing options.* The federal government should promote the development of innovative programs, such as incentives for families to purchase long term care insurance, save money for long term care or otherwise plan for private long term care needs. State and federal government also should fund programs to raise awareness of long term care planning needs and help individuals and families make the best long term care financing decisions.

- *Ensure that individuals have the tools they need to manage their long term care service as beneficiaries assume more personal responsibility for services – publicly and privately financed.* Long term care reform proposals include a wide range of elements that give beneficiaries more control over services and service dollars. Examples include HCBS Individualized Budgeting models, Money Follows the Individual and Cash and Counseling programs. In addition to increased control and responsibility, government also should provide adequate supports to beneficiaries on how to direct their own services and wisely allocate service dollars. Government should have safeguards and oversights in place to ensure that these services are appropriate and effective in achieving the care planning goals of the beneficiary.

- *Recognize the impact of reimbursement changes on long term care providers.* Long term care providers receive payments from private sources, Medicaid, and Medicare for post acute care stays. Policy changes that decrease or otherwise affect revenue streams should be evaluated in the broader context of the array of financing sources, e.g., the impact of changes to Medicare payments when providers experience shortfalls under Medicaid.

- *Ensure that efficient coordination of benefits reduce administrative burdens on beneficiaries and providers.* Beneficiaries should be able to move seamlessly among services across the long term care spectrum without limitation due to burdensome administrative requirements that are commonly placed on providers and beneficiaries. Attention to streamlining coordination of benefits will result in better care as needs change.

- *Encourage individuals, providers and government payers to engage in a policy debate on balancing public and private financing of long term care.* The increasing long term care population and accompanying growing costs results in a need for all stakeholders to be engaged in discussions on how best to finance this expanding population's care. This discussion should examine and weigh both public and private financing options.

- *Encourage the design of tax policies that coordinate with long term care financing strategy alternatives.* Identification of financing strategy alternatives is valuable only to the extent that such alternatives are implemented. Incentives, such as tax policies, will aid implementation efforts.

Principle III. Through sufficient federal and state governmental infrastructure, policies must ensure that long term care service delivery systems provide an adequate array of services and service providers across the long term care spectrum. Long term care reforms are being proposed and implemented at a rapid pace. Changes in service delivery systems, such as significant increases in HCBS use, must be accompanied by adequate increases in state administrative infrastructure including quality assurance and improvement, payment systems, data collection, and consumer and family information and referral services. To ensure market driven long term care system change at an appropriate pace, policies must:

- *Include a strategic plan for building needed infrastructure and ensuring an adequate array of long term care providers.* For publicly financed programs, government should require a reasonable plan for phasing-in changes that require substantial build ups in provider capacity and state infrastructure development. Government also should require that milestones or markers be met before additional changes or expansion. Government should encourage the notion that beneficiaries who need long term care services receive them at the needed intensity level (including facility-based services) as well as an adequate array of care management supports that do not place undue hardship on the individual or family caregivers.

- *Ensure that beneficiaries may move seamlessly among services across the long term care spectrum.* Long term care systems and providers are highly insular. For many beneficiaries, the result is typically a fragmented service system that is confusing and produces questionable outcomes. Government must ensure that long term care providers have the capacity to develop service arrays, partnerships, and business arrangements that foster a seamless service experience.

- *Foster and support quality and efficiency in long term care services, as well as provide operational flexibility.* Long term care providers face significant operational costs including purchasing or upgrading health information technology systems, capital improvements to existing facilities, and financing innovative services that could support specialty populations. Government regulation should not impede long term care service innovations among long term care providers that follow consumer preferences in a cost effective manner.

- *Managed care plans should recognize that long term care providers deliver services that are distinct from acute care providers.* A key long term care reform component is managed care – particularly for Medicaid-financed long term care. Experiences in states like Arizona show both positive outcomes and concerns for long term care providers. As managed care for Medicaid beneficiaries who are elderly, blind and have disabilities is expanded, federal and state officials should avail themselves of the long term care professionals' policy, operational, and clinical expertise as these arrangements unfold.

- *Funding is adequate and timely in order to provide stability and predictability to meet the needs of long term care recipients at the appropriate time, in the appropriate place, and at the appropriate cost.* Government should recognize that demand for long term care services and financial pressure on providers – as well as increased risk bearing at the plan, provider and consumer levels – make additional investment in provider capacity, service quality and efficiency a necessity. Government payment rates at all levels of the long term care spectrum should be sufficient to provide quality services and cover the cost of operating, as well as needed capital improvements.

- *Encourage development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement.* As opportunities to receive services are expanded, the need for uniformity in assessment becomes increasingly important.

Framework for Moving Forward

Since the inception of the Medicaid program, responsibility for long term care financing and delivery gradually has migrated away from the beneficiary and the family to the public sector. Increasing reliance on Medicaid for long term care services raises serious questions about programmatic sustainability. Additionally, demography, care delivery challenges (such as worker shortages), marketplace demands, financing, legal and regulatory, and industry trends, create an unprecedented need for the long term care professionals to help shape its future.

In partnership with consumer groups, long term care providers, including HCBS providers and facility-based, will lead the effort toward development of an integrated, flexible long term care array that responsibly informs and educates Americans about their long term care responsibilities and options, but also delivers Medicaid-financed services in a cost-effective, customized manner. In order to achieve these goals, AHCA/NCAL will partner with other long term care organizations based on its long term care policy principles to address the challenges and opportunities associated with building a sustainable long term care system.

AHCA/NCAL Managed Care Principles

At the AHCA/NCAL long term care reform work group meeting held on January 26, 2006, participants decided that managed care warrants its own set of principles. Staff were assigned the responsibility of drafting such principles for discussion at the March meeting.

Work group participants asked that additional attention be paid to managed care because of growth in:

1. ***Managed care for Medicaid-only Beneficiaries Who Are Aged, Blind or have Disabilities.*** The effects on long term care systems will be: a) increasing pressure to use less costly services including earlier hospital discharges into sub-acute facilities or temporary placement in nursing homes; b) limited use of nursing home services until all less costly options have been explored; c) increased competition among nursing homes based on managed care organizations' (MCO) focus on best price; d) additional bureaucratic layer, which results in the redirection of a significant portion of available dollars from the bedside into administration; e)increased potential for duplication (among and between MCO's) in both quality assurance and regulatory intervention, which is both costly and cumbersome; and f) increased flexibility and opportunity for innovation.

2. ***Managed Medicare and Medicaid Integration Programs.*** The Medicare Modernization Act of 2003 Special Needs Plan (SNP) authority could lead to increased state interest in managed care arrangements that integrate or better coordinate the Medicare and Medicaid programs. Commercial interest has been considerably greater than expected; to date, 296 SNP products are available.[1] Additionally, the 2007 Medicare Advantage plan application includes an expanded SNP section for Medicare and Medicaid integration options. And, Dr. McClellan has made integration one of his top policy priorities. A significant number of states are exploring managed care arrangements that would capitate both Medicare and Medicaid payments to managed care plans. In turn, providers would be reimbursed with rates based on the Medicare and Medicaid capitation payments to plans. While integrated care may be helpful from a continuity of care perspective, Medicare and Medicaid Integration programs will negatively impact provider reimbursement as it will be considerably lower than traditional Medicare

3. ***Managed Care Delivery of Preventive Care (i.e., disease management (DM), care coordination, and wellness initiatives).*** DM, care coordination and disability management programs hold the promise of reducing disability acuity and the impact of chronic illnesses. In turn, such outcomes also result in lower costs and reduce financial strain on the health care system. Many Section 1115 Medicaid waivers include wellness incentive programs for beneficiaries. States also are heavily leveraging Medicaid managed care plans and/or integrated Medicare/Medicaid managed care plans to deliver such services.

Managed Care Principles

Managed care policies should recognize that long term and post acute care providers deliver services that are distinct from acute care providers. A key long term care reform component is managed care. Experiences in states like Arizona show both positive outcomes and concerns for long term care providers. As managed care for Medicaid-only beneficiaries who are elderly, blind and have disabilities or for dually eligible individuals is expanded, federal and state officials should avail themselves of the long term and post acute care professionals' policy,

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[1] Presentation by Jennifer Podulka, MEDPAC staff person using CMS data, at the MEDPAC meeting. January 11, 2006

operational, and clinical expertise as these arrangements unfold. Five key managed care elements should be considered with the managed care principle:

- *Enhanced Flexibility in a More Competitive Operating Environment.* Long term care providers should have the freedom to take on a wide array of roles in the coordination and provision of individuals' long term and post acute care. Policies should allow providers to take on various roles, alone or in partnership, in the delivery of long term and post acute care services including risk contracting, administrative organizations roles, information and referral, care coordination of an individual's clinical needs, as well as care management and disease management.

- *Inclusion in Managed Care Program Development and Operational Decision Making.* Long term care providers should be meaningfully included and engaged in managed care program design. Specific points of engagement should include: (1) ongoing participation in capitation payment methodology and rate development and refinement; (2) agreement on, development and testing of a uniform assessment tool that identifies service needs and will ensure a reasonable and adequate payment by site of service; (3) plan contracting requirements – specifically, plan profit requirements (ensuring that plan profits and overhead costs are not excessive), development of provider rates and processes for reconciliation; (4) ensuring a level playing field, including decisions on "any willing provider" requirements; (5) prompt payment; and (6) coverage, prior authorization and utilization management processes.

- *Special Consideration As Capitation Rates, Risk Adjusters, and Subsequent Provider Rates Are Developed.* Long term and post acute care providers must have the resources to deliver services, meet capital costs associated with facility or unit maintenance, and meet both state and federal licensure and operating requirements. First, MCO contracts and state oversight must ensure that plan capitations payments – including any frailty adjuster – associated with individuals using long term care be fully available for that purpose. Second, in Medicare and Medicaid integration arrangements, states must ensure that rates including or based on Medicare capitation payments to plans and providers also be actuarially sound (currently a Medicaid requirement for managed care capitation payment rates). Third, the long term care provider marketplace faces significant capital costs to maintain aging facilities, upgrade existing facilities, and/or develop new service settings – such as small congregate settings or single occupancy capacity. Payment rates must include a margin that will support critical capital maintenance and development and ensure provider financial viability and sustainability.

- *All long term and post acute care settings should have quality measures tailored to the type of service setting and long term or post acute care populations.* Acute care quality measures and measurement tools are inappropriate for long term care settings and, in some instances, long term care populations. States and plans must work with long term and post care providers to: identify a quality measurement system that is (a) targeted to long term care or post acute care service outcomes; and (b) based on current clinical or social supports best practices. Finally, all willing providers with the capacity to implement and collect data on the quality measures in a managed care coverage region should have the opportunity to participate in the provider network.

- *Managed care plan coverage determination processes (i.e., medical necessity definitions and related procedural guidance) must reflect the difference between acute care service outcomes and long term care service outcomes.* Because of the unique needs of the long term care population and the nature of long term and/or post acute care settings, coverage determinations on access to care should emphasize maintenance of functioning and specialized healthcare needs. Additionally, coverage determinations should reflect that long term care consumers' physical and psychosocial support needs are ongoing and must be tailored to individual preferences to the degree possible.

- *Development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement.* As opportunities to receive services are expanded, the need for uniformity in assessment becomes increasingly important.

Conclusion

The long term care system is under considerable pressure driven by payer and consumer preferences to shift from facility-based care to consumer-directed home- and community-based or more home-like services, along with tighter reimbursement, and difficult to manage Medicare and Medicaid operating requirements. Considerable attention must be given to the potential impact of managed care on the stability of the long term care provider marketplace to ensure erosion of capacity is not accelerated. The principles and key elements above should be used by policymakers, providers and others to help craft policies, including a long term care provider bill of rights to address issues arising from the expansion of managed care for long term care populations.

Mr. PALLONE. Thank you, Ms. Clarkson.

Dr. Payne.

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

Ms. PAYNE. Chairman Pallone and Ranking Member Deal, I am Dr. Joyce Payne, a member of the Board of Directors of AARP.

Thank you for inviting us to testify on the need to improve the Part D Low-Income Subsidy and other Medicare programs for people with limited incomes.

The extra help the LIS provides to those least able to afford their drugs is one of Part D's most important features and a key factor in AARP's continuing support. But the LIS Program has a serious flaw, an asset test. No one with even $1 more than $11,710 in savings or couples with more than $23,410 can qualify. Because of the asset test, the LIS application form is eight pages of daunting and invasive questions that are difficult for many people to answer. That is a serious barrier even for those who meet the asset test's unreasonable limits.

Similar problems plague the Medicare Savings programs, known as MSP, that help pay other Medicare cost-sharing requirements. As with LIS, millions of beneficiaries living on very limited incomes are not getting the help they need from these vital programs.

In addition, there is only limited coordination between LIS and MSP, even though they serve primarily the same populations. Beneficiaries enrolled in MSP are automatically eligible for and enrolled in LIS. However, Social Security does not screen LIS applicants to see if they are also eligible for MSP. This is a serious missed opportunity, as MSP criteria in several States are less restrictive than LIS criteria, and some States have effectively eliminated the asset test all together. Thus, many who are eligible for LIS under their State's MSP rules are being improperly rejected because SSA, the Social Security Administration, of course, only looks at LIS criteria.

AARP believes there should be no asset tests in Medicare. 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.

Until the asset test is fully eliminated, there are interim steps Congress can take to reduce the barrier it creates. AARP supports the Prescription Coverage Now Act, introduced by Representative Lloyd Doggett. This legislation takes solid first steps toward our goal of eliminating the asset test, increasing enrollment and improving coordination between the LIS and MSP. This legislation would increase the asset test limits 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 can provide. Even those who did not oppose an asset test in Medicare's drug plan agree that current limits are far too low.

This legislation would also streamline the LIS application. It would authorize Social Security officials to use income data it already has to target LIS outreach efforts more effectively. It also would require SSA to screen LIS applicants for MSP eligibility.

AARP is committed to working to enact this important legislation this year and eventually completely eliminating the asset test for both LIS and MSP. We look forward to working with the Members of Congress on both sides of the aisle to improve the Medicare drug benefit and Medicare Savings Program to ensure that all Medicare beneficiaries living on limited incomes get the extra help they need so desperately and deserve.

We thank you for this opportunity.

[The prepared statement of Ms. Payne follows:]

AARP

Testimony Before the
Health Subcommittee
Of the
House Energy & Commerce Committee
On
Medicare Programs for Low-Income Beneficiaries

May 15, 2007

WASHINGTON, D. C.

N. Joyce Payne, Ed.D,
Member, AARP Board of Directors

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Chairman Pallone, Ranking Member Deal, distinguished Subcommittee members, I am N. Joyce Payne, a member of AARP's Board of Directors. On behalf of AARP's more than 38 million members, I thank you for inviting us to testify on the need to improve the Part D low-income subsidy (LIS) and other Medicare programs for people with limited incomes.

The extra help the LIS provides to those least able to afford their drug costs is one of Part D's most important features and a key factor in AARP's continuing support for the Medicare Modernization Act. LIS provides greatly reduced costs and no gap in coverage (no "doughnut hole") for beneficiaries with incomes below 150 percent of the federal poverty level ($15,315 for individuals, $20,535 for couples).

We are pleased that the LIS is providing essential help with premiums and copays to millions who otherwise might go without lifesaving medicines because of cost. We commend the Center for Medicare and Medicaid Services (CMS) for providing auto- and facilitated enrollment in LIS for people enrolled in Medicaid, a Medicare Savings Program (MSP), or receiving Supplemental Security Income and deemed eligible for LIS. We also applaud CMS for waiving the late enrollment penalty for anyone found eligible for LIS. We similarly appreciate steps the Social Security Administration (SSA) has taken to minimize the burden of annual LIS eligibility redeterminations.

We have worked diligently with CMS, SSA, the Access to Benefits Coalition, State Health Insurance Assistance Programs, and many other partners on the daunting task of finding and enrolling low-income beneficiaries who are not deemed eligible. Reaching beneficiaries with limited incomes has always been a challenge, but LIS outreach and enrollment is especially difficult because the LIS program has a serious flaw – an asset test.

Penalizing People who Save for Retirement

Millions of people who need the extra help LIS provides are not getting it, largely because of the asset test. To be eligible for LIS, beneficiaries can have no more than $11,710 in savings, or $23,410 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 AARP has consistently opposed the asset test. However, the LIS is currently denied to anyone who has saved even one dollar over these limits.

The asset test directly contradicts efforts to encourage people to save by penalizing even those with modest savings. We should encourage people to save for retirement, not penalize those who do.

The Kaiser Family Foundation has estimated that more than 2.3 million beneficiaries who meet LIS income criteria do not meet the asset test. Almost half exceed the asset limit by $25,000 or less. In fact, the asset test is the leading reason why people who apply for the subsidy are rejected.

Daunting Application Imposes Barrier

The asset test is also proving to be a serious barrier to enrollment even for those who meet its unreasonable limits. CMS projected in its final regulation on Part D that 14.4 million beneficiaries would be eligible for the LIS[1] However, to date, only slightly more than 9 million are enrolled. That means up to 5 million eligible individuals are not getting the Medicare help they need. CMS has estimated that as many as 3 million of these people have no drug coverage at all.

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

Because of the asset test, the LIS application form is eight pages of daunting and invasive questions that are difficult for many people to answer. For example, it:

- requires people to report not just savings but such obscure details as the current cash value of any life insurance policies – information people simply do not have on hand;

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

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

- threatens applicants with prison terms if information they provide is incorrect.

Applying for the LIS thus can seem overwhelming and require many hours, extra help from family members or insurance counselors, and often repeated efforts to find all of the required information.

This asset test and the paperwork barrier it creates is a key reason why between 3 and 5 million people who should qualify for the LIS are not getting it.

Inadequate Coordination with Medicare Savings Programs

Similar problems plague the Medicare Savings Programs (MSPs) that help pay other Medicare cost sharing requirements. As with LIS, millions of Medicare beneficiaries living on very limited incomes are not getting the help they need from these vital programs. In addition, there is only limited coordination between LIS and MSP, even though they serve primarily the same populations.
MSPs are state-administered programs and include:

- the Qualified Medicare Beneficiary (QMB) program which pays Medicare Part B premiums and cost sharing for those living at or below the poverty line,

- the Specified Low-Income Medicare Beneficiary (SLMB) program which pays Part B Premiums for those between 100 and 120 percent of poverty, and

- the Qualified Individual (QI) program which gives states capped allotments – subject to periodic reauthorization by Congress – to pay Part B premiums for those between 120 and 135 percent of poverty.

Beneficiaries enrolled in MSP programs are automatically eligible for and enrolled in the LIS. However, SSA does not screen LIS applicants to see if they are also eligible for MSP. This is a serious missed opportunity, as MSP eligibility criteria in several states is less restrictive than LIS criteria, and some states have effectively eliminated the asset test altogether. Thus, many individuals who are eligible for the LIS under their state's MSP rules are being improperly rejected because SSA only reviews applicants against LIS criteria.

The same kind of barrier to enrollment seen with the LIS exists in the majority of states that still impose an asset test on their MSP programs.

The result, not surprisingly, is that the vast majority of MSP-eligible individuals are not enrolled. Urban Institute researchers estimate that two thirds of beneficiaries eligible for QMB, and fully 87 percent who are eligible for SLMB, are not enrolled.[2]

AARP believes there should be no asset tests for Medicare programs – including both the LIS and MSP. 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, standardized and harmonized to reduce confusion and unnecessary barriers created by varying state rules.

In addition, the QI program should be made permanent by folding it into the SLMB program so it is no longer subject to annual allotment caps and all eligible individuals can be assured of needed assistance.

First Steps

AARP is firmly committed to eliminating the asset test. Until the asset test is fully eliminated, AARP believes there are interim steps Congress can and should take that can significantly reduce the barrier it creates to the LIS and MSP.

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[2] 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).

AARP is proud to support the Prescription Coverage Now Act of 2007 (H.R. 1536), introduced by Representative Lloyd Doggett of Texas. This legislation takes solid first steps toward our goals of eliminating the asset test, increasing enrollment, and improving coordination between the LIS and MSP. We have worked closely with Rep. Doggett's office on this legislation, and greatly appreciate his strong leadership.

Raising the Limits: Most importantly, this legislation would increase the asset test limits 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 can provide. Even those who did not oppose an asset test in Medicare's drug plan agree that current limits – $11,710 for individuals, $23,410 for couples – are far too low.

Streamlining the Application: In addition to raising the asset limits, Rep. Doggett's legislation would streamline the LIS application in two very important ways. First, it would eliminate the question about the cash value of life insurance. Asking for the cash value of life insurance makes the application process unduly difficult – this is information that people – regardless of income – simply do not have on hand. Asking for this data needlessly lengthens the application form and requires individuals to calculate the cash value figure. This unnecessary and harmful red-tape barrier to the LIS application needs to be removed.

The legislation would further streamline the LIS application by deleting the confusing and embarrassing question about whether someone gets occasional help from family or charities with living expenses like groceries. Many low income people get assistance from family, churches, and food banks on a highly irregular, as-needed basis and in very limited amounts. This question, however, requires applicants to enter a specific average monthly amount.

Given the often irregular nature of such assistance, this is a figure that many people are unlikely to know with any degree of accuracy. And those who rely on such assistance are the same individuals who are most in need of the LIS.

Efficiently Targeting Outreach: The Prescription Coverage Now Act would also help SSA target its LIS outreach efforts to beneficiaries who meet the LIS income criteria. The bill would allow Social Security officials to use IRS data -- data they already have to determine income-related Part B premiums -- to also determine who meets LIS income criteria. SSA could then much more efficiently and effectively target LIS outreach efforts to just these individuals.

Currently, the IRS verifies income data submitted by people who apply for the LIS, but SSA does not have authority to use the IRS data it already has to determine which Medicare beneficiaries have incomes that meet LIS eligibility criteria for outreach purposes. The HHS Inspector General has said that legislation authorizing this limited use of income data would help to more effectively and efficiently target LIS outreach efforts.[3]

Coordinating the LIS and MSP: Rep. Doggett's legislation takes an additional important step of requiring SSA to screen LIS applicants for MSP eligibility. Full coordination between the LIS and MSP would mean that many more low-income beneficiaries would get needed help with both Part D and traditional Medicare premiums and cost-sharing obligations. Additional important provisions in the Prescription Coverage Now Act would:

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[3] Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy, Daniel R. Levinson, Inspector General, November 17, 2006, http://oig.hhs.gov/oei/reports/oei-03-06-00120.pdf

- keep the LIS cost sharing affordable by indexing it to the general inflation rate, rather then the increase in overall Part D costs as under current law;
- exclude the value of LIS benefits from counting against eligibility for other low-income assistance programs; and
- permanently waive the late enrollment penalty for people enrolled in the LIS.

AARP is committed to working diligently to ensure this important legislation is enacted into law this year.

Additional Steps

While the Prescription Coverage Now Act is a critical first step, there are additional legislative steps that can and should be taken to help low-income Medicare beneficiaries.

For example, people who are not eligible for the LIS or MSP may be eligible for a state pharmacy assistance program (SPAP). These state-funded programs often help people with income and asset levels above the LIS and MSP eligibility cut-offs. A system to coordinate enrollment applications between LIS/MSP and these programs also could prove to be very useful.

Action also is needed to make MSP eligibility criteria consistent across the states and make the QI program a permanent and reliable source of assistance. We know that members of this Committee are working to develop legislation to address this concern and we look forward to working with you.

In addition, AARP supports legislative efforts to improve the Part D benefit by:

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

Conclusion

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

It is critical that we eliminate the asset test that is penalizing people who save for retirement and imposing a barrier to enrollment in the LIS. The Prescription Coverage Now Act is an important first step to eliminating the asset test and ensuring that more people who need the assistance the LIS provides can get it. We are committed to seeing its enactment this year, and we look forward to working with members of Congress from both sides of the aisle to improve the new Medicare prescription drug benefit and to ensure that all older Americans have access to affordable prescription drugs.

Mr. PALLONE. Thank you all.

Now we are going to take five votes. It will take us between a half hour and 45 minutes, probably more like 45 minutes, but we will ask you to stay so we can come back and ask you some questions.

Thank you. The subcommittee is in recess.

[Recess.]

Mr. PALLONE. The subcommittee is called to order again.

We are going to have questions from the various Members. I am pretty sure most of them will come back.

I will start by recognizing myself for 5 minutes, and I wanted to start out with Dr. Payne.

We heard from Ms. Sassar that she likes her Medicare Advantage private plan. She receives some additional benefits that she described and I am certainly glad about that. The truth, however, is that the Medicare beneficiaries who choose to remain in traditional Medicare, 83 percent of all beneficiaries, are forced to subsidize these additional benefits, such as Ms. Sassar's, because of the way private plans and Medicare are financed.

In fact, each Medicare beneficiary who chooses to remain in traditional Medicare is forced to pay $24 extra every year in Part B premiums to subsidize the extra benefits that only the 17 percent of beneficiaries enrolled in plans receive. And those additional dollars are used to subsidize private plans, administrative costs, marketing costs, aging commissions, profits in addition to some extra benefits. And by way of contrast, the Medicare Savings Program provides low-income seniors with a more generous benefit than Medicare Advantage plans. Under the MSP, the lowest income seniors will have their Part B premiums and Medicare cost sharing paid for, a value of about $3,700 next year.

According to the Administrator of CMS, beneficiaries enrolled in MA plans received a total benefit of a little over $1,000 this year; and traditional Medicare does not have to pay aging commissions, marketing costs and all these other costs. So I wanted to ask you, Dr. Payne, would you agree that expanding the Medicare Savings Program is the most equitable way to target additional benefits to low-income seniors?

Ms. PAYNE. We are certainly glad that Ms. Sassar is enjoying the benefits of Medicare Advantage. But the truth is that she does not get the kind of benefits that one would get under the Medicare Savings Program and under the Low-Income Subsidy Program in terms of additional assistance for paying her premiums. We think that all of the participants should have an option, and Medicare Advantage may be good for some people, but it certainly doesn't provide the kind of advantages that one would get under the Medicare Savings Program and the Low-Income Subsidy.

In addition to that, we are strongly supportive, of course, of eliminating the asset test, of streamlining the process, of having greater continuity between the two programs and, we think, any opportunity to align those programs so that we can have greater choices but at the same time have greater continuity with improved efficiency.

Mr. PALLONE. Well, thank you.

And, Ms. Sanchez, Dr. Payne talked about the inefficiencies and inequalities of overpaying Medicare Advantage plans. Could you comment on that but also talk about Ms. Lopez's story and her interaction with the Medicare Advantage plan?

In addition, can you tell us more generally about your clients' experiences with Medicare Advantage marketing abuses, the higher co-pays, dual sometimes pay under Medicare Advantage or what are some other consumer problems you have seen seniors and people with disabilities having to endure under the Medicare Advantage Program?

Ms. SANCHEZ. Certainly. We do, like Ms. Sassar, have people who are happy in their HMO, and we even sometimes help people enroll in an HMO when it seems to suit their needs. The problem we see a lot is that, unlike Medicare, it doesn't ensure their care over the long term. It is not something that is always there for them.

The benefits change year to year, and people don't know how to read those notice of change. They don't know what is going to happen the next year or the plan drops out.

We had one client that has been in five HMOs that have dropped him over the years, and he says "no more" because of the problems with the continuity of care. The doctor can drop out of the plan; the plan can stop the contracts with providers.

We had a call from someone in Miami whose mother has cancer, and was getting care at a hospital. Mid-year, the plan dropped that hospital from the contract, and she couldn't change anymore. She couldn't change to another plan that would cover that hospital.

So the continuty of care problems are enormous; and, also, you need in some ways to help people even try to figure out what plan would be good for them. You need a crystal ball, because you don't know what disease is going to come down the line, what care you are going to need in a few months or towards the end of the year, and, unlike with Medicare and MSP or Medicare or Medigap, that will cover you no matter what you need, you really have to make sure you have picked the benefits that you are going to need in this plan, and you are locked for in a year.

We have seen a tremendous amount of marketing abuses. Like Ms. Lopez, she was convinced that this plan would offer her all these extra benefits that were actually covered by Medicaid, and we hear that a lot when we hear presentation from marketing people, that we will cover transportation, but Medicaid covers transportation. A lot of these benefits in the end don't outdo the out-of-pocket costs, and they end up having to pay for their regular care and the chronic care that they need like the doctor visit co-pays and very high hospital co-pays.

Mr. PALLONE. All right. Thank you very much.

The gentlewoman from California.

Ms. SOLIS. Thank you, Mr. Chairman.

I want to apologize for not being able to hear all the testimony, but we did receive your testimony in writing, and I do have some questions for Monica. This is for Ms. Sanchez.

I also want to touch on some of the issues that were raised earlier about people or individuals that we represent that may not understand translated information to them appropriately and how that care can be improved upon; and we are also looking at populations that have lower literacy levels in many cases, as I mentioned in my opening statement. I would like to get your feedback on what kinds of things we can do to help improve that and things that you have seen out in the field that might be helpful for us.

Ms. SANCHEZ. We work very hard to maintain several people with different language skills in our organization, but, in the end, I think only streamlining the application process and the services will help.

For example, we are in New York, and there is a tremendous number of different languages, different cultures, and as much as we try to help individuals in explaining these complicated programs to them, unless the programs can be simplified, we are never going to be able to reach everybody on an individual basis to try to explain all this incredibly complicated information.

Ms. SOLIS. So are you suggesting that perhaps more uniformity in those applications or that——

Ms. SANCHEZ. Yes. Certainly. Because, right now, the criteria for the MSPs varies by State; and they are very different from the Extra Help. So people don't even know that when they fill out one application or they have been deemed for one program that there are other programs available. They are not told, generally. And if they went through the process of filling out one application or found an advocate that could help them with one application, I see no reason why they should then have to fill out five other applications for different programs. Streamlining all the assistance programs would help tremendously in helping people get the programs they need.

Ms. SOLIS. One of the issues I constantly come across is data collection and being able to really assess where these populations are that are hard to get, and anyone on the panel can speak to that. I would appreciate information that you might have of how we might do a better job doing that.

Ms. Payne?

Ms. PAYNE. Well, we already know the Social Security Administration has already used income data to work on the premiums for Part B. So, clearly, we could authorize the Social Security Administration to use that same data to reach those eligible for the MSP programs as well as the Low-Income Subsidy. I mean, they are already doing some of that for the Medicare Savings Program, so it seems to me that we ought to give them the authorization to extend that to the Low-Income Subsidy. That is what the Prescription Drug Coverage Act would do, and that is why we are supporting it.

I do think it is also important to go back to your first question to identify some of the activities that AARP is involved in. We have made a tremendous effort at getting involved with the Latino community. We just had a major conference with I think close to about 16,000, 17,000 people in Puerto Rico. We do publish a magazine in the language of the community, and we have held town hall meetings all across the country. We issue briefs for the States to follow in terms of information. We have also published a number of papers and magazines. We have inserts and magazines in all of the languages that we are serving. So we think that it is very important that we meet those communities where they are in terms of their language skills.

Ms. SOLIS. I have one last question. This is directed to Dr. Payne. It kind of falls along the same lines that our chairman was asking.

There has been some controversy regarding Medicare Advantage overpayments. While some low-income beneficiaries in the private insurance plans may be happy with the care they are receiving, overpayments to private insurance plans and Medicare are reducing the trust fund's solvency and are raising premiums for all beneficiaries. 35.5 million Medicare beneficiaries who are not in private plans pay more premiums for the 8 million who are in those plans. Some plans limit the providers that beneficiaries can see relative to regular Medicare. Would you say that using MSP or the LIS would more equitably, efficiently and effectively help low-income beneficiaries with their Medicare cost sharing?

Ms. PAYNE. I think I sort of alluded to that in response to the chairman's questions. We think there ought to be a level playing field between both of those programs—between all of the programs, rather. We recognize, as I indicated earlier, that those in the MSP programs and LIS will get greater help in paying their premiums. Those in the Medicare Advantage will not have that same opportunity. So we think that it just makes common sense to do that.

Ms. SOLIS. Thank you.

Mr. PALLONE. Thank you.

The ranking member, the gentleman from Georgia.

Mr. DEAL. Thank you, Mr. Chairman.

Dr. Payne, let me ask you a couple questions. What is the position of AARP on means testing for Medicare Part B premiums?

Ms. PAYNE. We don't think there should be any means testing on Medicare Part D. Those individuals have already paid their dues in the years of working, and I don't think the means test would facilitate the efficiency of the program, and we see no reason to have it included in that determination.

Mr. DEAL. So you would be opposed to the Medicare Part B premiums that are currently means tested then?

Ms. PAYNE. We would be opposed to any means testing.

Mr. DEAL. So, regardless of whether somebody has a million dollars in savings, their treatment under Medicare should be the same?

Ms. PAYNE. Well, if you look at all of the confusion that is going on right now—as a matter of fact, I was at the Social Security Administration myself just a couple of days ago because they are taking much too much money out for Part B. I understand that there are about 300,000 people out there who have been affected by this. So we think that we really ought to be concentrating on making the program much more efficient than having means testing and asset tests included in the determination process.

Mr. DEAL. OK. Well, it is one thing to maybe means test or not means test based on Part D on the upper income people. But here we, of course, are addressing the ones——

Ms. PAYNE. I am sorry. I thought you said Part B.

Mr. DEAL. No, I said B. That was my question. You answered my question.

Philosophically, I agree with you. Because Medicare was never intended to be a welfare program. Start means testing and you start making it look a welfare program.

Ms. PAYNE. We are concerned that we provide the kind of quality services and meet those individuals who need the kind of drugs we have available in the market today; and the means testing for those who have already paid taxes, for those who have already paid into the Medicare Program, I don't see any utility in that.

Mr. DEAL. But here on the lower end, it is a little bit different issue, even though it is means testing in some of its nature for those who are asking for more than what might be perceived as a fair share. In other words, they are asking for additional assistance. It is not like everybody is paying the same premium in Part B at the upper end. Here we are talking about somebody getting more than.

What about the situation where someone may not have, in terms of liquid dollars on a monthly basis, a lot of money, but they have assets, whether it be large homes—or that would be unlikely because if you got a large home you are going to pay a lot of property taxes. You are going to have some liquid assets that will pay the keeping of that asset.

But you could have people who would have large retirement type accounts or IRA accounts. As I understand the IRA provisions, you don't have to have a mandatory draw-down on those until age 70. Suppose somebody there between 65 and 70 is sitting on a huge amount of IRA money that they are not having liquid access to because they are not drawing down on it, they are not required to draw any part of it down. Does that seem quite fair that the taxpayer supplements them additionally for that?

Ms. PAYNE. Well, let me answer it this way. We have been involved for years in financial literacy. In looking at the defined benefits in this country, in looking at the Social Security struggles we see today, it seems to me we need to be encouraging, in any way possible, people to save for their retirement.

The kind of folks we are talking about in terms of the Low-Income Subsidy are those individuals that don't have huge accounts. They may have a very small nest egg, they may have a house, they may have some other assets that can be liquidated, but it seems to me we don't want to penalize them by applying the means tests or assets tests.

Mr. DEAL. But when you don't do that, you encourage fraud and abuse. In other words, if you don't require any proof that you meet any kind of asset or income test, it seems to me that human nature takes over and people say, oh, well, that is—the taxpayers are willing to pay if I apply for this. I think it just invites fraud and abuse.

Now I am sympathetic with those who have done their best to preserve their assets. Because there is nothing that makes me any madder than the one bumper sticker I saw on a big RV moving down the road that said "I am spending my children's inheritance." because if you have that attitude about your assets then you ultimately are going to be the one who is going to ask the taxpayer to pick up. Because you have lived the good life. You have spent all of your assets during the time you had them.

So it is a delicate balance, and I think we all recognize it is a delicate balance, how to get it all right.

The one piece of testimony we haven't heard, Mr. Chairman, and I assume before we do anything we will have to get it, and that is, what is the cost of these proposals? Obviously, some of them could have rather significant costs that we would have to wrestle with.

But I appreciate your testimony. I apologize for having to be in and out, but some of us have appointments we had to keep in our office. But thank you for being here.

Mr. PALLONE. Thank you.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

I am going to follow up on the question I just heard. As for any of the panelists, as I mentioned in my opening statement, we have a community access collaborative in the Houston area. It is Gateway to Care, working on outreach and enrollment efforts. The organization has come to learn firsthand about the burden of the assets test and the barrier to enrollment that it creates.

The executive director of Gateway to Care said it perfectly when he said, "seniors are proud and honest people. They are proud of what they manage to accumulate, even if it is very little by the standards of an investment banker, for example, particularly in our district."

We know that two-thirds of the qualified Medicare beneficiaries are not getting premium and cost-sharing assistance, and nearly one-fourth of low income seniors are not getting the benefits.

Dr. Payne, your testimony mentioned that the assets test is the primary reason why 3 million to 5 million beneficiaries aren't getting extra help under Part D. What kind of nest egg are we talking about? Are most of the seniors or people with disabilities disqualified because they have hundreds of thousands of dollars in stock annuities or other assets?

I know in my district we don't have folks who have those kind of resources, and yet some of the assets tests still may keep them from qualifying. What is the practical implication of the asset test? Does it really force beneficiaries to make the tough choice between keeping a small reserve for emergencies and getting assistance when they need on a day-to-day basis in the medical bills?

If we can talk about that assets test. I share the concern made by my friend from Georgia, but I also know from some of our experiences, particularly in Texas, it is difficult.

Ms. PAYNE. We think that this—the Prescription Coverage Act, is really a very modest step toward eliminating the asset tests. I mean, we know that we possibly have about 3 million people out there that we aren't serving, and the kind of nest egg you are talking about are those individuals who would still be in a relatively low-income status. So we aren't talking about wealthy folks who have stocks and bonds. We are talking about folks who are barely over the poverty level or within that range, and we need to find a way to serve them. I mean, it is the moral thing to do. It is the right thing to do. It is the humane thing to do. This is a very modest effort.

I think it is also important to point out that if in fact we want to reach those 3 million people that, as several of the panelists have alluded to in their testimony, that we need to make this process much more uniform. We need to simplify the process. We need to eliminate these eight pages of daunting questions that are very invasive, talking about charity, talking about whether your family gave you food.

I think we can do better than that as Americans. It seems to me we need to be concentrating on how we can reach those 3 to 5 million people out there and how we can do a better job at making the application less daunting.

Mr. GREEN. And I agree. And, in fact, Mr. Chairman, I think we keep hearing this in our SCHIP hearings, making the application for the children's health care initiative easier for parents, just like what it should be for our seniors.

Ms. PAYNE. Yes. I helped some people in my neighborhood fill out some of those applications, and it is exacerbated by the fact that you have at the bottom of the application a statement about the penalty in terms of imprisonment. So I think that just exacerbates the whole process. So it seems to me we can do a better job.

Mr. GREEN. Ms. Sanchez do you have a comment?

Ms. SANCHEZ. Yes, in terms of the assets test, there are a lot of States that have eliminated the assets test, and at least one, sometimes all, of the MSPs, and they did it because they found that the administrative cost of actually managing, looking at the documentation of assets was very high, and, second, that any kind of significant assets really led to income that would disqualify the person. So anyone who has a huge amount of stocks, is going to have income from the stocks, they are going to be above the income limits.

Mr. GREEN. If they own a Winnebago, and pay the gas bill and drive that Winnebago down the road, they are probably not going to be eligible.

Ms. SANCHEZ. Exactly.

Mr. GREEN. Mr. Chairman, I have another question. I will just throw it out because we apologize for our vote schedule, but under Medicare Part D, program beneficiaries can sign up any time of the year without ever paying a premium penalty. While CMS has waived the Part D penalty for low-income beneficiaries for the remainder of this year, is there any reason from your perspective to treat Part D different from Part B when it comes to premium penalties for low-income enrollees?

Ms. SANCHEZ. We are not actually against the premium penalty for Part B because we do agree with the premise that people should get insurance and not just wait until they are sick. But with Part D it is so new, it is so different, and it is so complicated, that to start the penalty so immediately we think is unfair. It is really forcing people to make an uninformed decision quickly just because there is a deadline.

Mr. GREEN. Thank you, Mr. Chairman. Thank you.

Mr. PALLONE. I am going to have a second round, if anyone wants to participate, second round of questions that is.

I wanted to ask, Dr. Payne, we know that one of the main reasons people aren't enrolled in the existing programs for extra help is that they weren't aware that the help was available. AARP has millions of members, some of whom are surely enrolled in programs that provide extra help with medical costs like LIS and MSP. But what has AARP done to conduct outreach about these programs with its own members in conjunction with other organizations that help Medicare beneficiaries with enrollment? Obviously I am asking this as a prelude to what we might do to help out.

Ms. PAYNE. Well, Mr. Chairman, as I indicated earlier, we have had a number of town hall meetings all over the country. As you know, we are in Puerto Rico. We are in all 50 States with considerable staff members. We have conducted training of our staff and training of our volunteers.

We are continuing to produce publications for the Hispanic community and publications for low-income communities, targeting those communities that need this the most, especially in rural areas and economically distressed communities.

We have done the same kind of outreach that we did for other initiatives we have been involved in. This is one of our highest priorities. In those town meetings we have devoted most of our attention to enrolling low-income individuals, and with more than practically approximately 77 million more baby boomers coming on, I can assure you we will be doing even more in the future.

Mr. PALLONE. Do you have any recommendation that the States or the Social Security Administration or CMS could undertake to reach those who are eligible but not enrolled?

Ms. PAYNE. Well, again, it seems to me that the Social Security Administration could do the same thing for the low-income subsidy that they are doing for other programs, and that is using some of the income data to do greater outreach, and for us to give them the authority to do that through the Prescription Coverage Now Act.

Mr. PALLONE. OK, thank you.

I wanted to ask Ms. Clarkson, I would like to better understand what you are telling us about the challenges that people in the assisted living facilities face with respect to their medication copayments.

Right now a person who is in an assisted living facility is not eligible to get financial assistance with the Medicare Part D copayments; is that correct?

Ms. CLARKSON. That is correct.

Mr. PALLONE. Now, is there any solid basis for discriminating against these low-income beneficiaries in assisted living? Can you say a little about the beneficiaries in those facilities? Are they wealthier than people in nursing homes? Do they have additional means that they can use to pay for their copayments?

Ms. CLARKSON. No, not the clients we are talking about. They are essentially the same person that would be in a nursing home being taken care of in a different venue. They are an elderly person needing assistance, who is also low income.

Mr. PALLONE. OK. And I just wanted to ask Ms. Sanchez, I know we kind of beat this to death, but I have a minute left here. Do you ever come across somebody who meets the income test, but you know then has a huge amount of assets? Is that a phenomenon that exists at all?

Ms. SANCHEZ. We have never seen it in any of the people we have tried to help, and if they are over, it is by a couple hundred or a couple thousand dollars. And they have saved. They have scrimped and saved their whole lives, and they don't want to give up that little bit of security.

Mr. PALLONE. And that is essentially what we have for the most part.

All right, thank you all.

Mr. Deal.

Mr. DEAL. In that regard that is the problem with setting any kind of artificial limits is that I am either going to be $5 under, or you are going to be $10 over. Now, as I understand it, it does not have an inflation enhancer to it, does it? Or does it?

Ms. SANCHEZ. The LIS does, but the MSP doesn't.

Mr. DEAL. OK. All right. Maybe that is a better way of dealing with it, because that is always a moving target and as long as we have any limit, somebody is going to be just slightly over it and therefore ineligible, so those are always hard decisions.

I was just looking at the statistics on the low-income subsidy as it relates to the Part D premiums and looking at some CNS figures, and it said that, as of the date of this report, there were 13.2 million people eligible for low-income subsidy. And at that point in time, there had been roughly 10 million who had coverage under either Part D or some other source, leaving the 3.2 million others.

And 3.2 million out of 13 million is a pretty high number of presumed eligible people who are just not enrolled. It would seem to me that that is sort of where we ought to focus our efforts and figure out—and you all have alluded to some of the impediments that maybe contribute to them not enrolling even though they would be eligible. That ought to be our priority.

It is sort of similar, Mr. Chairman, to my point on our SCHIP reauthorization is that since that program has as its target children 200 percent of poverty or below, we ought to have a pretty good saturation of that population before we start expanding it. And I feel the same way about this; we ought to figure out why the ones that we think are eligible and are not there, and the reasons you have given, paperwork, maybe not wanting to disclose assets, all of those other things, a lot of that has to do with just education and outreach. I am sympathetic to that.

And hopefully in whatever we do, we can focus on the ones we have already identified ought to be our primary targets and try to get more of them covered before we take on more expansive and more expensive other undertakings, because if we do, we are going to forget the ones that were the original intended target populations to begin with.

So thank you all for what you contributed here today.

Mr. PALLONE. Thank you. That concludes our questions, but I just wanted to thank you all. I think that this is a really important issue that really hasn't received much attention, and, of course, mainly it effects people that have lower incomes. And I think a lot of times their concerns are not heard very often.

So I do appreciate your being here, and we want to take very seriously what you have said to see what kind of action we need to take. So thank you again.

I just remind you that you might get additional questions for the record from Members. They are supposed to submit them within 10 days, so then we might ask you to respond to those, you would be notified within 10 days if you get those kinds of questions.

But thank you again, and without objection, the meeting of the subcommittee is adjourned.

[Whereupon, at 4:25 p.m., the subcommittee was adjourned.]

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