

MEDICARE PROGRAMS FOR LOW-INCOME BENEFICIARIES

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED TENTH CONGRESS FIRST SESSION

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CONTENTS

	Page
Advisory of May 3, 2007, announcing the hearing	2
WITNESSES	
The Honorable Lloyd Doggett, a Representative in Congress from the State of Texas	14
The Honorable Jason Altmire, a Representative in Congress from the State of Pennsylvania	16
S. Lawrence Kocot, Senior Advisor to the Administrator, Centers for Medicare and Medicaid Services	34
Beatrice Disman, Regional Commissioner, New York Region, Social Security Administration	28
J. Ruth Kennedy, Medicaid Deputy Director, Louisiana Department of Health and Hospitals, Baton Rouge, Louisiana	74
N. Joyce Payne, Ed.D, Member, AARP Board of Directors	78
Patricia Nemore, Center for Medicare Advocacy	89
Emelia Santiago Herrera, Moore Consulting Group, Inc., Orlando, Florida	101
SUBMISSIONS FOR THE RECORD	
National Council on Aging, statement	110
Senior Citizens League, statement	116

MEDICARE PROGRAMS FOR LOW-INCOME BENEFICIARIES

THURSDAY, MAY 3, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:04 a.m., in room 1100, Longworth House Office Building, the Honorable Fortney Pete Stark (Chairman of the Subcommittee) presiding.
[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 03, 2007
HL-9

CONTACT: (202) 225-3943

Chairman Stark Announces a Hearing on Medicare Programs for Low-Income Beneficiaries

House Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) announced today that the Subcommittee on Health will hold a hearing on financial assistance programs for low-income Medicare beneficiaries. **The hearing will take place at 10:00 a.m. on Thursday, May 3, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

While Medicare provides universal coverage for senior citizens and people with disabilities, it can require significant out-of-pocket spending. Congress recognized the need to help low-income beneficiaries with Medicare costs through the creation of the Medicare Savings Programs (MSP), which help cover premium and cost-sharing charges. Individually, these programs are the Qualified Medicare Beneficiary Program (QMB), the Specified Low-income Medicare Beneficiary Program (SLMB) and the Qualified Individual Program (QI). Congress also acted to help low-income Medicare beneficiaries in the new Part D prescription drug program by creating a Low Income Subsidy (LIS). Together, these programs help millions of beneficiaries afford needed medical services and medications. However, millions of beneficiaries who are eligible for these programs are not participating.

Medicare Savings Programs

The Federal Government broadly defines three categories of beneficiaries and programs that comprise the MSP. Under current law, Qualified Medicare Beneficiaries (QMBs) have income at or below 100 percent of the federal poverty line (FPL) (\$10,210—individual/\$13,690—couple in 2007), but above eligibility for full Medicaid coverage. State Medicaid programs pay Part B premiums and all Medicare cost-sharing for QMBs. Specified Low-Income Beneficiaries (SLMBs) have income between 100 and 120 percent of the FPL, and state Medicaid programs pay their Part B premiums. Qualifying Individuals (QIs) have income between 120 and 135 percent of the FPL and the Federal Government pays their Part B premiums. The QMB and SLMB programs are entitlements for which state Medicaid programs pay a share of these costs. The QI program is funded through an annual capped appropriation passed through the Medicare Part B Trust Fund. Federal law sets the income eligibility requirements, application procedures and asset limitations to qualify for these programs differ substantially across the states.

The MSP are a vital safety net for approximately 1.6 million beneficiaries. However, estimates suggest that only 40 to 60 percent of eligible beneficiaries are participating. Onerous application requirements, personal disclosures about income and assets, and lack of awareness of the programs are largely responsible for the low enrollment rates. States also have a financial disincentive to find and enroll these low-income Medicare beneficiaries because state expenditures increase when beneficiaries enroll in MSP.

Low-Income Subsidy Program for Prescription Drugs

The LIS program provides extra help for beneficiaries with limited income and resources in paying for Medicare prescription drug plan costs. For 2007, beneficiaries with incomes below 150 percent of the Federal Poverty Level (FPL)—\$14,700 individual/\$19,800 couple and with assets under \$10,210 (individual) or \$20,410 (couple)—qualify for the LIS. However, benefits in the LIS differ substantially based on where beneficiaries fall on the income and asset spectrums—“ranging from complete premium assistance with no deductible and copayments of \$1-\$5.35, to partial premium assistance with a deductible and copayments that are lower than standard coverage.

Beneficiaries with full Medicaid benefits (“dual eligibles”), those in a Medicare Savings Program and those who receive Supplemental Security Income (SSI) are deemed eligible for the LIS and automatically enrolled in a prescription drug plan. Thus, of the approximately nine million beneficiaries currently enrolled in the LIS program, more than six million were automatically enrolled into a plan. However, CMS estimates that more than 3 million beneficiaries eligible for the LIS are not enrolled in a prescription drug program at all. Targeted, aggressive outreach programs are necessary to get these beneficiaries enrolled. Numerous Medicare advocates and analysts have also called for an end to the complicated asset test, which has kept millions more from qualifying for extra help and, they argue, penalizes beneficiaries who have managed to accrue even modest savings or assets.

Increased enrollment in LIS and MSP would provide financial security to millions of Medicare beneficiaries who can't afford Medicare's out-of-pocket costs. Improved outreach, less burdensome application processes, and adjusted income and asset limits could greatly increase enrollment, improving both the financial and physical health of Medicare's most vulnerable beneficiaries.

“We must determine how best to ensure that Medicare remains affordable for all senior citizens and people with disabilities,” said Chairman Stark in announcing the hearing. “Improving the Low Income Subsidy and Medicare Savings Programs is the most efficient and direct way to guarantee affordable, comprehensive Medicare coverage to low-income beneficiaries.”

FOCUS OF THE HEARING:

The hearing will focus on the current state of the Part D Low Income Subsidy the Medicare Savings Programs, and opportunities to increase enrollment and expand eligibility in these programs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “110th Congress” from the menu entitled, “Committee Hearings” (<http://waysandmeans.house.gov/Hearings.asp?congress=118>). Select the hearing for which you would like to submit, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the on-line instructions, completing all informational forms and clicking “submit” on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday, May 17, 2007**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for

the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, and telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days' notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. If our guests would like to join us and find a seat, we will begin our hearing on help for low income Medicare beneficiaries.

Medicare is and should always remain an entitlement for seniors and people with disabilities. I think we have a duty to ensure that the most vulnerable low income Medicare beneficiaries are assured access to this entitlement.

Recognizing this, I introduced the Medicare Catastrophic Coverage Act 20 years ago, at the request of President Reagan, it perhaps was the shortest lived piece of legislation to come out of this Committee, but it did have a decent drug benefit, which we do not have now, and it did have a catastrophic cap, but that is history.

What is left of it, however, is what we now know as the QMB part of our legislation and the last vestiges of that Act.

We in this Committee have a history on these issues to protect and advance the coverage of low income beneficiaries. Fifty percent of the people over 65 have incomes below \$20,000 a year and by the time you add up \$1,100 in Part B premiums and \$131 Part B deductible that is going up each year, and \$300 or so in Part D premiums, and a Part D deductible that may be \$265 and a couple of hundred bucks more in out-of-pocket costs, many of these beneficiaries are spending over 10 percent of their already limited income on medical care.

The two major programs that target financial relief for low income beneficiaries are the Medicare savings programs, which comprise QMB and SLMB and QI programs, help low income beneficiaries pay Medicare premiums and cost sharing.

The low income subsidiary programs help beneficiaries pay for prescription drugs under Part D.

These programs provide vital financial safety nets for millions of Medicare beneficiaries, but they are unnecessarily complex, and the participation rates are unacceptably low.

Estimates suggest that three to four million people are eligible but not enrolled in the Part D LIS and in MSP, estimates that 40 to 60 percent of the eligible low income beneficiaries—only 40 to 60 percent get the help to which they are entitled.

Bottom line is that millions of people who could benefit from these programs do not. I would wager it is not because they do not need or want the help, it is just they do not know it is there or how to go about getting it.

Improving the low income subsidy and Medicare programs, savings is the most efficient and effective way to help the beneficiaries who need it most.

Medicare Advantage plans would have us believe they are the ones offering the most help to the most vulnerable. That is just not true. Medicare MSP and LIS are far and away the most important and comprehensive sources of supplemental coverage for low income Medicare beneficiaries.

Unlike Advantage plans, these programs protect the choices that matter to beneficiaries. Choice of doctor, choice of hospital, and full “subsidation” of cost sharing. No games. No profiteering. No low balls. Just straight up help.

Done right, it is a strategy that is equitable, efficient and effective.

Today we will hear more about the current state of these programs and the options for improving them. Simple changes to eligibility and enrollment rules coupled with strong outreach programs could help millions more beneficiaries get the support and medical care they need and deserve.

I hope my colleagues will join us in our efforts to do that this year. I look forward to hearing from our friends, Lloyd Doggett and Jason Altmire from Pennsylvania. They will discuss legislation that they have to improve the LIS program.

In the second panel we will hear from CMS and Social Security about how these programs are running, and I hope help us identify opportunities for improvement.

The final panel, the State of Louisiana and several advocate and beneficiary organizations, will discuss the positive and negative aspects of the low income programs and what we can do to improve financial support for vulnerable beneficiaries.

I look forward to the testimony of our witnesses and would like to yield to Mr. Camp for any remarks he would like to make.

Mr. CAMP. Thank you, Mr. Chairman. I, too, welcome our panels today. Today we will examine programs that provide help to low income Medicare beneficiaries and certainly these programs are critical to our most vulnerable seniors who without them would not have access to health care services.

As we consider ways to improve these programs, we must focus on measures that give beneficiaries the ability to choose how they get assistance and also promote the most cost effective strategy for administering these benefits.

For over 30 years Medicare has provided assistance to low income seniors through Medicare savings programs, which have

helped to pay premiums, cost sharing and deductibles for eligible low income beneficiaries.

Yet these programs have not reached enough of the eligible beneficiaries. Some have suggested we should expand these programs and possibly even require beneficiaries to be automatically enrolled.

This approach raises a number of potential concerns. A mandatory enrollment program could also raise significant privacy concerns. In order to automatically enroll all eligible seniors, multiple Government agencies would have to share sensitive and confidential information which may require changing existing privacy protections.

These programs are not, however, the only way to assist low income Medicare beneficiaries.

We will hear today from Ms. Emelia Santiago-Herrera, a Medicare beneficiary from Orlando, Florida. Ms. Herrera is enrolled in a Medicare plan that helped her qualify for the low income subsidy which coupled with her Medicare Advantage plan provides her with free prescription drugs.

Ms. Herrera's plan also pays her co-payments and other costs as well as providing extra benefits that Medicare does not cover, like diabetes disease management and transportation to her doctor appointments.

Without these additional benefits, Ms. Herrera would likely be forced to live in a nursing home.

As we consider ways to assist low income beneficiaries, I hope that we will consider Ms. Herrera's testimony as an example of how beneficiaries can select how they receive their assistance and not force them into an one size fits all model.

With that, Mr. Chairman, I yield back the balance of my time.

Chairman STARK. Thank you. Now I guess we will hear in either order—

Mr. DOGGETT. I am glad to lead.

Chairman STARK. Mr. Doggett, a distinguished member of our Committee. You have a bill analysis before us.

Mr. DOGGETT. Mr. Chairman, I have passed that out, I believe, and a bill analysis that we did on each section of that.

[The information follows:]

Denied Applicants for "Extra Help" with Medicare Part D Through the End of 2006

The Office of Policy has analyzed denied applicants for extra help through the end of 2006. This study is based on the full universe of denied applicants in the Social Security Administration's Medicare Database.

For purposes of this analysis, a denied applicant is an individual for whom at least one application for the low-income subsidy (LIS) under Medicare Part D has been denied. If an individual has applied more than once, we consider only the most recent denial. Denials in this study exclude applications that have been approved on appeal and those for which appeals remain open. As of January 1, 2007, we find a total of 2,486,140 denied applicants¹.

Overall Reasons for Denials

Reasons for denials are shown in Table 1. Analysis is at the individual level. The "couple" category represents the number of individuals who applied with their spouses and were denied, and the total of 2,486,140 denied applicants includes both members of denied couples. The denial categories are mutually exclusive and sum to 100 percent in each row. Table 1 includes a category for denials based on both income and resources. In all other cases where multiple denial reasons were reported, the individual is assigned to the first applicable category. For example, an individual who was not eligible for Medicare and who also reported high resources would be classified as "Not a Medicare Beneficiary," but an individual who listed resource and income amounts in excess of program limits would be classified as "Both Income and Resources."

Individual or Couple Application	Reason for Denial by Type of Applicant (in Percent)							All	Number of Persons
	Not a Medicare Beneficiary	Not a U.S. Resident	Failure to Cooperate	Question 3 ¹	Resources but not Income Itemized	Income but not Resources	Both Income and Resources		
Individual	1.8	0.4	7.2	24.0	13.1	43.0	10.5	100.0	1,555,689
Couple	5.0	0.5	3.8	13.7	6.1	48.0	22.7	100.0	930,471
All Denied Applicants	3.0	0.4	5.0	20.1	10.5	44.9	15.1	100.0	2,486,140

¹When the response to Question 3 indicates excess resources, the applicant does not need to provide income information.

Source: Social Security Administration, Medicare Database, January 1, 2007

The most common reasons for denial were income and resources. Applicants did not need to provide resource amounts if they checked that resources exceeded program limits in Question 3 of the application. Therefore, resource denials are divided between individuals who noted excess resources in Question 3 and those who were required to provide itemized resource information. Income amounts were not always determined for applicants who indicated excess resources in Question 3. Therefore, the income denials shown in Table 1 are a lower bound for the true percentage of denied applicants with excess income. Nonetheless, income is observed to be a factor for 60 percent (44.9% plus 15.1%) of denied applicants, and it was the only factor for about 45 percent. Resources were a factor for over 45 percent (20.1% plus 10.5% plus 15.1%) of denied applicants, and they were the only factor for about 31 percent.

¹ A small number of additional cases on the Medicare Database may also be denials even though no reason for denial is given. Most of the ambiguous cases were processed on November 20, 2006. Our analysis, which is limited to unambiguous denials, covers more than 99 percent of all possible denied applicants through the end of 2006.

Table 2 includes the denial categories by month of application. Resources declined from being a factor in over 50 percent of the earliest denials to playing a role in only one third of denials for March 2006 applications. The table provides evidence that the role of resources has increased somewhat since March 2006. In an effort to ensure that beneficiaries receive the correct LIS determination, SSA holds applications that may potentially be affected by the new resource levels, which CMS provides in late December, and the new Federal Poverty Guidelines, which are available in late January. These held applications are missing from the distribution of denials for applications submitted since September 2006.

Month of Application	Not a Medicare Beneficiary	Not a U.S. Resident	Failure to Cooperate	Resources but not income Question 3 ¹	Income but not Resources	Both Income and Resources	All	Number of Persons
June 2005 or Earlier	1.7	0.7	6.6	27.4	8.5	39.8	15.4	382,858
July 2005	2.4	0.4	5.6	26.1	9.4	41.1	15.1	504,056
August 2005	1.9	0.2	6.8	23.0	10.5	42.4	15.2	378,452
September 2005	2.2	0.3	5.7	19.4	12.0	42.8	17.6	176,545
October 2005	2.2	0.3	5.3	18.6	11.7	42.6	18.3	231,215
November 2005	2.6	0.4	5.8	17.5	12.2	44.2	17.5	183,677
December 2005	3.1	0.4	5.9	12.0	12.7	50.4	14.7	110,131
January 2006	4.1	0.7	7.2	10.2	12.0	54.0	11.8	88,803
February 2006	4.1	0.9	6.6	10.7	12.0	54.2	11.5	43,950
March 2006	4.2	0.8	6.7	10.4	10.8	55.2	12.1	53,414
April 2006	3.7	0.4	5.8	10.3	11.3	55.4	13.0	37,584
May 2006	3.2	0.5	7.7	9.8	12.0	54.0	13.0	69,487
June 2006	3.3	0.4	7.5	12.7	12.9	60.1	13.1	30,703
July 2006	3.6	0.2	7.2	13.5	11.6	51.1	12.4	32,226
August 2006	2.1	0.3	4.3	12.8	12.4	53.8	14.6	23,094
September 2006 or later ²	12.3	0.2	4.4	7.2	8.8	58.0	9.1	139,956
All Denied Applicants	3.0	0.4	6.0	20.1	10.5	44.9	15.1	2,486,140

¹When the response to Question 3 indicates excess resources, the applicant does not need to provide income information.

²These statistics exclude applications since September 2006 that are held by SSA to ensure correct LIS determinations with respect to new resource levels (provided by CMS in late December) and/or the new Federal Poverty Guidelines (available in late January).

Source: Social Security Administration, Medicare Database, January 1, 2007

Resource Detail when "Resources" is Reason for Denial

Analysis of resource types is limited to the 429,322 individuals who did not check that their resources exceeded the cutoffs but who were nonetheless found to have excess resources. This group includes a portion of the applicants who were denied due to income as well as resources. The Office of Policy tabulated excess resources in two different ways: providing the distribution of resource types that cause denial, and indicating whether denied applicants had each resource type at all.

In Table 3 a resource type is defined to be a reason for denial if the amount of this resource is sufficient to disqualify the individual and if all other reported resource types combined would be insufficient to disqualify the individual. This tabulation shows that bank accounts and investments, which included stocks, bonds, and individual retirement account (IRA) balances, were both responsible for substantial proportions of resource denials. Almost one third of the applicants in Table 3 were denied based on a combination of resource types. Resource denials for couple applicants were more likely than those for individual applicants to be due to a combination of resource types.

Individual or Couple Application	Bank Accounts	Stocks, Bonds, and IRAs	Cash	Real Estate Other than Home	Life Insurance	Multiple Resource Types	All	Number of Persons
Individual	38.6	21.2	0.3	3.4	7.4	29.1	100.0	293,141
Couple	25.3	20.4	0.2	5.6	7.8	39.8	100.0	136,181
All Denied Applicants	34.7	21.0	0.3	4.1	7.5	32.5	100.0	429,322

This table excludes people who were denied because they checked that resources exceeded annual limits in Question 3.

Source: Social Security Administration, Medicare Database, January 1, 2007

For cases where resources are a reason for denial, Table 4 shows that over 96 percent of individuals reported bank accounts, and over half owned stocks or bonds.

Type of Resources	Single	Couple	All
Bank Accounts	96.0	96.7	96.2
Stocks, Bonds, and IRAs	47.6	57.6	50.8
Cash	10.6	12.3	11.2
Real Estate Other than Home	8.6	15.4	10.8
Life Insurance > \$1500 Face	34.9	52.2	40.4
Expects Burial Expenses	72.0	80.0	74.5
Number of Persons	293,141	136,181	429,322

This table excludes people who were denied because they checked that resources exceeded annual limits in Question 3.

Source: Social Security Administration, Medicare Database, January 1, 2007

Resource limits are higher for applicants who indicate that they expect to use some of their listed resources for their funeral or burial expenses. As shown in Table 4, nearly three quarters of those denied due to excess resources anticipate burial expenses.

The distribution of amounts by which countable resources exceeded subsidy limits are presented in Table 5. This table also includes mean and median excess resources. The mean of about \$32,800 was calculated omitting about 700 outlier cases with reported resources over one million dollars. The median amount of excess resources was \$14,500.

Table 5: Amount by which Countable Resources Exceeded Subsidy Limits By Individual and Couple Applications When Itemized Resources were a Reason for Denial						
Excess Resources	Single		Couple		All	
	Percent	Cumulative	Percent	Cumulative	Percent	Cumulative
\$100,000 or More	5.3	5.3	7.4	7.4	6.0	6.0
\$90,000 to <\$100,000	1.9	7.2	1.9	9.4	1.9	7.9
\$80,000 to <\$90,000	2.8	10.0	3.2	12.5	2.9	10.8
\$70,000 to <\$80,000	2.0	12.1	4.4	17.0	2.8	13.6
\$60,000 to <\$70,000	2.6	14.7	3.2	20.2	2.8	16.4
\$50,000 to <\$60,000	3.3	18.0	4.2	24.4	3.5	20.0
\$45,000 to <\$50,000	2.0	20.0	2.4	26.7	2.1	22.1
\$40,000 to <\$45,000	2.7	22.7	2.7	29.4	2.7	24.8
\$35,000 to <\$40,000	3.3	25.9	3.2	32.6	3.2	28.0
\$30,000 to <\$35,000	3.4	29.3	3.9	36.5	3.6	31.6
\$25,000 to <\$30,000	4.3	33.7	5.1	41.6	4.6	36.2
\$20,000 to <\$25,000	5.6	39.2	5.4	47.0	5.5	41.7
\$15,000 to <\$20,000	7.9	47.1	7.2	54.2	7.6	49.3
\$10,000 to <\$15,000	11.6	58.6	9.6	63.9	10.9	60.3
\$7500 to <\$10,000	6.4	65.1	5.7	69.6	6.2	66.5
\$5000 to <\$7500	7.0	72.1	8.6	78.2	7.6	74.0
\$3000 to <\$5000	8.3	80.4	7.3	85.5	8.0	82.0
\$1500 to <\$3000	7.8	88.3	6.9	92.4	7.5	89.6
\$1000 to <\$1500	3.4	91.7	2.8	95.3	3.2	92.8
\$500 to <\$1000	4.3	96.0	2.1	97.4	3.6	96.4
< \$500	4.0	100.0	2.6	100.0	3.6	100.0
Median Excess Resources	\$13,500		\$17,500		\$14,500	
Mean Excess Resources ²	\$30,893		\$36,980		\$32,824	
Number of Persons	293,141		136,181		429,322	

¹This table excludes people who were denied because they checked that resources exceeded annual limits in Question 3.

²Mean is calculated excluding about 700 outliers over \$1,000,000.

Source: Social Security Administration, Medicare Database, January 1, 2007

Income Detail when "Income" is Reason for Denial

Income is a denial reason for 1,490,968 applicants. An income type is defined to be a reason for denial if the amount of this income is sufficient to disqualify the individual and if all other reported income types combined would be insufficient to disqualify the individual. Table 6 shows the distribution of income types that are reasons for denial. Social Security was the most common single income source that was a reason for denial (30 percent). Over half of the applicants in Table 6 were denied based on a combination of income types.

Individual or Couple Application	Social Security Benefits	Railroad Retirement Benefits	Other Pensions or Annuities	Wages or Self-Employment	Veterans Benefits	Other Income	Multiple Income Types	All	Number of Persons
Individual	21.4	0.8	5.8	5.6	1.1	3.0	62.3	100.0	633,087
Couple	41.1	0.9	3.4	1.1	0.4	1.3	51.8	100.0	657,871
All Denied Applicants	30.1	0.8	4.8	3.6	0.8	2.3	57.6	100.0	1,490,968

Source: Social Security Administration, Medicare Database, January 1, 2007

In-kind support is not listed in Table 6 because it is never sufficient to cause a denial by itself. However, some people who were denied due to a combination of income types would be allowed in the absence of in-kind support. Income denials would have been about 2.2 percent (32,310 individuals) lower if in-kind support were not counted as income.

As seen in Table 7, over 98 percent of applicants with excess income received Social Security benefits, and 43 percent received pensions other than veterans or Social Security benefits.

Type of Income	Single	Couple	All
Social Security	98.0	99.0	98.4
Railroad Retirement Benefits	2.6	2.0	2.3
Other Pensions or Annuities	44.9	40.1	42.8
Wages or Self-Employment	23.8	18.6	21.6
Veterans Benefits	4.8	3.9	4.4
Other Income	20.1	13.0	17.0
In-Kind Support	8.8	3.3	6.4
Number of Persons	833,097	657,871	1,490,968

Source: Social Security Administration, Medicare Database, January 1, 2007

Table 8 provides the amounts by which annual income exceeded subsidy limits for applicants denied due to income. The median amount of excess income was nearly \$6,000, and over 90 percent of denied applicants were \$1000 or more above the income cutoff. Mean excess income was calculated to be nearly \$15,000 after the deletion of about 1,200 outlier cases with over one million dollars of income.

Table 8: Amount by which Countable Income Exceeded Subsidy Limits by Individual and Couple Applications When Income Was a Reason for Denial						
Excess Annual Income	Single		Couple		All	
	Percent	Cumulative	Percent	Cumulative	Percent	Cumulative
\$75,000 or More	3.4	3.4	3.1	3.1	3.3	3.3
\$50,000 to <\$75,000	1.2	4.6	1.1	4.2	1.1	4.4
\$40,000 to <\$50,000	0.9	5.5	0.9	5.1	0.9	5.3
\$30,000 to <\$40,000	1.9	7.4	1.9	7.0	1.9	7.2
\$25,000 to <\$30,000	1.9	9.3	1.8	8.8	1.8	9.0
\$20,000 to <\$25,000	3.2	12.5	3.0	11.7	3.1	12.2
\$15,000 to <\$20,000	5.9	18.4	5.3	17.0	5.6	17.8
\$10,000 to <\$15,000	12.8	31.2	10.9	27.9	12.0	29.8
\$7500 to <\$10,000	10.9	42.1	10.2	38.2	10.6	40.4
\$5000 to <\$7500	14.7	56.8	15.5	53.6	15.0	55.4
\$3000 to <\$5000	11.7	68.5	17.1	70.7	14.1	69.5
\$1500 to <\$3000	14.4	82.9	15.6	86.3	14.9	84.4
\$1000 to <\$1500	6.3	89.2	5.6	91.9	6.0	90.4
\$500 to <\$1000	7.2	96.4	5.5	97.4	6.4	96.8
< \$500	3.6	100.0	2.6	100.0	3.2	100.0
Median Excess Income	\$6,115		\$5,504		\$5,840	
Mean Excess Income ¹	\$15,012		\$14,740		\$14,892	
Number of Persons	833,097		657,871		1,490,968	

¹Mean is calculated excluding about 1,200 outliers over \$1,000,000.

Source: Social Security Administration, Medicare Database, January 1, 2007

Denials by State

Table 9 includes the distribution of denial reasons for each state. Address data are only available for Social Security beneficiaries, but these beneficiaries comprise almost all (98 percent) of the denied applicant population. The number of denied applicants through the end of 2006 ranged from about 2,600 in Alaska to over 160,000 in Illinois.

At least 10 states have required some beneficiaries to file for extra help: Connecticut, Delaware, Illinois, Indiana, Maine, Massachusetts, Montana, Nevada, Rhode Island, and Vermont. Information on these states appears in bold in Table 9. For these states the distributions of reasons for denials are not dramatically different from those of other states.

Table 6: Reasons for Denial by State (in Percent)									
State	Not a Medicare Beneficiary	Not a U.S. Resident	Failure to Cooperate	Resources but not income Question 3 ¹	Income but not Resources	Both Income and Resources	All	Number of Persons	
Alabama	1.7	0.0	7.2	12.6	8.8	57.9	11.7	100.0	48,099
Alaska	1.6	0.0	8.3	29.5	9.1	40.8	10.5	100.0	2,821
Arizona	0.9	0.0	5.6	18.7	7.6	56.3	15.9	100.0	36,712
Arkansas	1.5	0.0	5.9	15.7	11.0	54.1	12.1	100.0	31,257
California	1.1	0.0	7.3	21.9	9.5	45.1	14.8	100.0	155,200
Colorado	1.1	0.0	5.5	24.6	9.7	44.5	14.5	100.0	26,275
Connecticut ²	0.5	0.0	4.1	24.8	10.8	39.4	20.3	100.0	33,693
Delaware ²	0.8	0.0	3.9	18.4	10.3	46.1	20.5	100.0	5,157
District of Columbia	1.0	0.0	11.5	14.5	9.5	53.5	9.6	100.0	2,819
Florida	1.0	0.0	8.2	18.9	10.8	45.9	15.6	100.0	144,122
Georgia	1.2	0.0	6.9	15.4	10.6	52.2	13.7	100.0	67,227
Hawaii	1.0	0.0	8.2	29.0	14.8	28.8	18.4	100.0	12,607
Idaho	0.9	0.0	4.2	22.8	10.3	45.0	15.0	100.0	13,563
Illinois ²	0.7	0.0	4.0	29.7	9.6	34.6	21.3	100.0	161,318
Indiana ²	0.9	0.0	5.0	18.4	12.0	47.5	15.2	100.0	61,694
Iowa	0.6	0.0	3.1	31.1	14.0	31.4	19.7	100.0	38,226
Kansas	0.7	0.0	4.3	24.7	11.9	40.4	19.0	100.0	29,282
Kentucky	1.2	0.0	5.3	17.9	11.3	50.7	13.5	100.0	50,209
Louisiana	1.7	0.0	9.4	13.1	10.8	55.1	19.0	100.0	34,357
Maine ²	0.8	0.0	3.5	20.4	12.1	49.8	14.5	100.0	14,730
Maryland	0.9	0.0	5.9	17.6	10.4	48.5	16.7	100.0	39,091
Massachusetts ²	0.5	0.0	4.4	22.1	12.1	43.0	17.9	100.0	61,648
Michigan	0.9	0.0	5.0	20.1	11.2	47.5	15.3	100.0	73,311
Minnesota	0.5	0.0	3.8	25.4	13.9	37.9	17.5	100.0	37,801
Mississippi	1.4	0.0	8.8	12.5	9.9	55.3	13.1	100.0	29,551
Missouri	1.1	0.0	4.4	23.1	13.5	46.2	14.7	100.0	57,831
Montana ²	0.8	0.0	4.3	25.9	12.1	41.5	15.4	100.0	10,345
Nebraska	0.5	0.0	3.3	29.7	15.2	32.2	19.0	100.0	21,922
Nevada ²	1.1	0.0	7.1	18.1	5.8	54.3	12.6	100.0	13,818
New Hampshire	0.7	0.0	4.8	17.8	12.5	48.8	15.6	100.0	10,511
New Jersey	0.8	0.0	7.6	21.2	11.9	41.4	17.2	100.0	64,027
New Mexico	1.2	0.0	6.9	19.5	9.3	50.1	12.0	100.0	18,005
New York	0.9	0.0	8.9	18.8	12.4	44.2	14.8	100.0	133,702
North Carolina	1.1	0.0	5.5	14.6	11.3	53.7	14.8	100.0	95,037
North Dakota	0.6	0.0	4.1	29.9	18.6	30.3	17.5	100.0	6,532
Ohio	1.0	0.0	5.6	21.2	10.2	48.3	13.6	100.0	90,884
Oklahoma	1.2	0.0	5.3	17.3	9.8	53.0	13.3	100.0	33,881
Oregon	0.8	0.0	4.7	22.1	9.4	47.7	15.4	100.0	29,911
Pennsylvania	0.7	0.0	5.6	25.5	10.2	41.2	15.5	100.0	120,481
Rhode Island ²	0.4	0.0	4.3	18.0	13.6	46.4	17.3	100.0	12,062
South Carolina	1.4	0.0	7.5	13.3	11.1	53.0	13.5	100.0	45,150
South Dakota	0.6	0.0	4.7	23.5	18.6	31.6	15.9	100.0	9,803
Tennessee	1.4	0.0	4.5	17.0	10.7	52.3	14.1	100.0	57,202
Texas	1.8	0.0	9.6	15.2	9.7	52.1	11.5	100.0	147,925
Utah	0.6	0.0	4.2	18.6	9.6	49.7	16.9	100.0	12,411
Vermont ²	0.7	0.0	3.6	28.4	14.9	36.9	15.5	100.0	7,146
Virginia	1.2	0.0	5.7	16.6	10.5	50.0	14.0	100.0	61,561
Washington	0.6	0.0	4.4	21.9	9.0	48.1	15.8	100.0	40,010
West Virginia	1.5	0.0	5.1	15.8	10.2	55.5	11.9	100.0	24,043
Wisconsin	0.8	0.0	3.7	26.8	9.8	34.4	21.7	100.0	41,849
Wyoming	0.7	0.0	5.2	24.8	10.8	42.7	16.4	100.0	4,932
No Valid Data	50.9	10.5	4.0	9.0	3.7	16.9	4.9	100.0	97,673
All Denied Applicants	3.0	0.4	6.0	20.1	10.5	44.9	15.1	100.0	2,486,140

¹When the response to Question 3 indicates excess resources, the applicant does not need to provide income information.

²States in bold have required some beneficiaries to file for extra help.

Source: Social Security Administration, Medicare Database, January 1, 2007

Please contact Jim Sears at (202) 358-6104 with any questions or requests for additional analyses.

May 2007

Chairman STARK. Proceed, and enlighten us in any way you are comfortable.

**STATEMENT OF THE HONORABLE LLOYD DOGGETT, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. DOGGETT. Thank you for convening this important hearing. Mr. Camp, thank you for your constructive statement. Fellow Members of the Committee, I appreciate the opportunity to discuss the needs of low income seniors and individuals with disabilities to receive extra help to get the life saving and pain relieving medication that is so important to them.

The supporters of the Medicare Modernization Act of 2003 highlighted the ability of the extra help provisions of that legislation to afford 13 to 14 million low income Medicare beneficiaries the assistance that they need.

Unfortunately both Part D and extra help have been plagued with problems that are keeping millions of individuals from receiving that assistance that was promised to them.

We have, as all you know, debated in this Committee the pros and cons of that bill. Some of us think it is great. Some of us think it is not so great.

I am not here today to re-visit those arguments. Rather, the sole purpose of this very modest bill is to simply see that the original intent of the supporters of the Part D Medicare provision have their promises fulfilled, and that we extend that extra help to those that need it the most.

In her testimony to this Committee on February 13th, Acting CMS Administrator, Lesley Norwalk, indicated that at least 3.25 million eligible people with Medicare are not receiving extra help.

For all the things that may be said pro or con about the Part D bill, one thing that is not subject to debate is that for some individuals, some of the poorest individuals in this country, the Medicare Part D bill is 100 percent failure. They are not getting extra help. They are not getting any help. It is those folks to which this legislation is targeted.

H.R. 1536, which you have before you, has been endorsed by AARP, which will be testifying later, the National Committee to Preserve Social Security and Medicare, the Center for Medicare Advocacy, which will be testifying, Families USA, Consumers Union, the National Council on Aging, and a number of national health care organizations in addition to that, particularly those concerned with individuals with disabilities and prolonged illnesses.

It is co-sponsored by over 160 of our colleagues. My colleague, Jason Altmire, shares a strong concern for seniors and the disabled. He will be addressing his bill, which addresses one of the issues that mine touches in part.

I salute his active and informed role in ensuring that our seniors and individuals with disabilities get the assistance that they need.

In 2003, Medicare itself estimated to us on this Committee that over 58 percent more seniors and individuals with disabilities would sign up for extra help than have actually done so since that time.

Many of the eligible individuals who thought they would receive assistance with this Act are not in fact covered today. The bill has just really four very simple objectives.

Identify the eligible people. Notify them. Simplify the process. Adjust the asset test.

First, on identification. As to those three and a quarter million people that are not now covered, the Inspector General of the Health and Human Services Department last Fall said "Access to IRS data would help CMS and the Social Security Administration identify the beneficiaries most eligible for subsidy."

Indeed, the Social Security Administration realized this when it requested this same data shortly after the Medicare bill was adopted.

The Internal Revenue Service said it could not supply that information without a change in the law.

Mr. Camp has referenced privacy protections and as a member of the Privacy Caucus here in Congress, I am keenly aware of the need to do that.

This particular bill would simply require identification not of all income, but where IRS simply gives a yes or no on potential eligibility based solely on income. This does not automatically enroll anyone. It does not automatically force anyone into a Medicare prescription drug plan if they do not want to be in it.

IRS will say if someone has less than \$13,783 in income this year that they are probably eligible. They may not be, but they are someone to look at, and if they are above \$15,315 in income, they will say they are probably not eligible. Only for the narrow group in between those figures will there be any actual income information supplied to Social Security, and there are other safeguards on confidentiality included.

On notifying, we provide for a much clearer and direct and precise notification than has occurred to date.

On simplifying, it is a fairly complex application that is required to be filed right now. Some of that relates to matters that are included in income.

For example, if a child assists their parents with their groceries or something else, cleaning the house, this may be calculated as income. I think it is neither good family values nor good Government to demand that be calculated.

My bill removes those items from the income calculation and simplifies that application.

Fourth, the asset test adjustment. No one wants to provide the wealthy with free prescription drugs or discounted prescription drugs under this extra help program. The current limitation of lifetime savings is less than \$8,000 for an individual, all the savings that they have been able to accumulate all their life and about \$12,000 for a couple, in order to get the full subsidy.

I make modest adjustments in those levels, raising them to \$12,000 and \$18,000 appropriately, and modest adjustments for the partial subsidy.

The people who meet this income requirement but are disqualified by the restrictive asset test are by the way, according to the studies, mostly women, widows, living alone with no college degree. For the full subsidy, an individual would still be restricted to no

more than \$12,000 for an individual, \$18,000 for a couple in savings. That is hardly a luxurious retirement.

There are other changes that are made in the bill. I see I am over my time, and I would be glad to respond to questions.

I hope we can build bipartisan support for modest changes that we can afford and reach more of these people and fulfill the promise of the Medicare prescription drug bill.

Thank you, Mr. Chairman.

Chairman STARK. Thank you very much.

Jason, would you like to enlighten us on your bill?

STATEMENT OF THE HONORABLE JASON ALTMIRE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. ALTMIRE. Thank you, Mr. Chairman and Ranking Member Camp. I want to include my colleague Phil English from Pennsylvania.

Chairman STARK. Jason. I am sorry, not Justin.

Mr. ALTMIRE. That is okay.

I very much appreciate the opportunity to testify today about my bill, H.R. 1310, the Relief and Elimination of the Medicare Enrollment Deadline Penalty Act, REMEDY Act.

As part of the Medicare Modernization Act of 2003, Congress included provisions to apply a late enrollment penalty to the monthly premiums of Medicare beneficiaries who failed to select a prescription drug plan by the end of the initial enrollment period, which concluded on May 15, 2006.

A late enrollment penalty, one percent of the base beneficiary premium, is added to each uncovered month that a beneficiary was eligible for coverage but did not enroll.

For Medicare beneficiaries who were on the rolls prior to January 1, 2006, the clock began after the initial enrollment period ended.

Their next opportunity to enroll was not until the annual enrollment period, which ran from November 15, 2006 through December 31. Individuals who deferred enrollment during the initial sign up period and decided to wait until the open enrollment period would therefore have seven uncovered months and are penalized an additional seven percent, starting with their 2007 monthly premium.

This penalty applies for as long as the beneficiary is enrolled in Part D.

The MMA does include exceptions. Individuals who are able to maintain creditable coverage through a current or former employer, or union, for example, are exempt. Other examples include TRICARE, the Federal Employees Health Benefits Plans, and coverage through the VA.

In Pennsylvania, seniors are able to maintain creditable coverage through the PACE, PACENET and PACE Plus Medicare programs.

Certain categories of low income populations, including dual eligibles, enrollees in Medicare savings programs, and supplemental security income recipients, are automatically enrolled in the plans, and therefore, face no penalties.

The MMA also extends low income subsidies to individuals with incomes below 150 percent of poverty and with assets below \$10,000

for an individual and \$20,000 for a couple, but these beneficiaries may be subject to the late enrollment penalty.

Outside of those exceptions, Medicare beneficiaries are subject to a late enrollment penalty for all uncovered months. It is permanently added to their monthly premiums and the amount is expected to increase each year as it is recalculated annually to the greater of the amount CMS determines is actuarially sound or one percent of the base beneficiary premium.

In the months leading up to the initiation of the Medicare Part D program, beneficiaries were inundated with information about coverage options which often caused confusion and frustration among seniors.

In my home in the Pittsburgh area, seniors had to choose from over 60 different plans that were submitted to them. It is simply too much information to consume within a short period of time.

On top of the new plan options, the initiation of the program led to a number of access issues to the beneficiaries. Thousands of seniors were forced to wait days and in some cases weeks to obtain vital prescriptions.

Considering the hurried initiation of the program, I introduced H.R. 1310 to provide Medicare beneficiaries with sufficient time in which to evaluate the myriad of coverage options available to them. Choosing a health care plan is one of the most important decisions one can make. It is only fair to provide beneficiaries with the time necessary to properly choose the appropriate plan.

My bill provides the needed relief to millions of Medicare beneficiaries, particularly those with limited incomes. My bill delays implementation of the late enrollment penalty for the first two years, 2006 and 2007, of the program. These are the people that were directly impacted by the fact that it was a hastily prepared program and did not get off to a quick start.

The bill directs HHS to devise a system in which to distribute rebates to any Medicare beneficiaries who paid the late enrollment penalty and it permanently eliminates the late enrollment penalty for low income subsidy beneficiaries who might find it otherwise difficult to pay for the increase in their monthly premium.

I note that CMS in January did delay the late enrollment penalty for these people for one year, and my bill simply codifies this waiver and makes it permanent.

Approximately 4.5 million eligible Medicare beneficiaries did not have prescription drug coverage last year at the deadline and thus, may be subject to the late enrollment penalty.

In my district, the Pennsylvania Department of Aging estimates that 14,000 individuals are eligible for this coverage but are not enrolled.

I urge the Committee to delay the late enrollment penalty for two years and provide seniors with the time necessary to evaluate their health care options without being penalized. It is a straightforward approach that maintains the current design of the program and protects against adverse selection while providing relief for millions of seniors.

Thank you again, Mr. Chairman, and the rest of the Committee for the opportunity to testify.

[The prepared statement of the Honorable Jason Altmire follows:]

**Prepared Statement of The Honorable Jason Altmire, a Representative in
Congress from the State of Pennsylvania**

Thank you, Mr. Chairman, Ranking Member Camp, and Members of the Committee, including my colleague from Pennsylvania, Mr. English, for providing me with the opportunity to testify today about my bill, the Relief and Elimination of the Medicare Enrollment Deadline Penalty (or REMEDY) Act, H.R. 1310.

As part of the Medicare Modernization Act of 2003 (MMA), Congress included provisions to apply a late enrollment penalty to the monthly premiums of Medicare beneficiaries who failed to select a prescription drug plan by the end of the initial enrollment period on May 15, 2006. The rationale for a late enrollment penalty was based in part on experience with the Medicare Part B program and to prevent adverse selection.

The late enrollment penalty—1% of the base beneficiary premium—is added for each uncovered month that a beneficiary was eligible for coverage and did not enroll. For Medicare beneficiaries who were on the rolls prior to January 1, 2006, the clock began after the initial enrollment period ended on May 15, 2006. Their next opportunity to enroll was during the annual open enrollment period, which ran from November 15, 2006 through December 31, 2006. Individuals who deferred enrollment during the initial sign-up period and decided to wait until open enrollment would have a total of seven uncovered months and would be penalized an additional 7% starting with their 2007 monthly premium. The average monthly penalty in this case is \$1.91 and the percentage penalty applies for as long as the beneficiary is enrolled in a Part D plan.

MMA does include exceptions. Individuals who are able to maintain creditable coverage through a current or former employer, or union for example, are exempt. Other examples include TRICARE, the Federal Employees Health Benefits Plans, and coverage through the Veteran's Affairs Administration. In Pennsylvania, seniors are able to maintain creditable coverage through the PACE, PACENET, and PACE Plus Medicare programs.

In addition, exceptions are made for low-income individuals. Certain categories of low-income populations, including Dual Eligibles (those eligible for Medicare and Medicaid), enrollees in the Medicare Savings programs, and Supplemental Security Income recipients, were automatically enrolled in plans, and therefore face no penalty. The MMA also extends low-income subsidies to individuals with incomes below 150% of poverty and with assets below \$10,000 for an individual and \$20,000 for a couple, but these beneficiaries may be subject to the late enrollment penalty.

Outside of these exceptions, Medicare beneficiaries are subject to a late enrollment penalty for all uncovered months. It is permanently added to their monthly premiums and the amount is expected to increase each year as it is recalculated annually to be the greater of: (1) the amount CMS determines is actuarially sound or (2) 1% of the base beneficiary premium.

In the months leading up to the initiation of the Medicare Part D program, beneficiaries were inundated with information about coverage options, which often caused confusion and frustration among seniors. In the Pittsburgh area, seniors had the option of selecting one from over 60 available plans. It was simply too much information to consume within too short of a time frame.

On top of the new plan options, the initiation of the program on January 1, 2006 led to a number of access issues for beneficiaries. Thousands of seniors were forced to wait days, in some cases weeks, to obtain vital prescriptions. It was clear to all outside observers that the Medicare Part D program was not ready for prime time.

Considering the hasty initiation of the program, I introduced the REMEDY Act, H.R. 1310, to provide Medicare beneficiaries with sufficient time in which to evaluate the myriad of coverage options available to them. Choosing a health care plan is one of the most important decisions one can make. It is only fair to provide beneficiaries with the time necessary to properly choose an appropriate plan. The REMEDY Act provides much needed relief to millions of Medicare beneficiaries, particularly those with limited incomes.

H.R. 1310 does the following:

§ It delays implementation of the late enrollment penalty for the first two years, 2006 and 2007, of the program.

§ It directs the Secretary of Health and Human Services to devise a system in which to distribute rebates to any Medicare beneficiaries who may have paid a late enrollment penalty.

§ It permanently eliminates the late enrollment penalty for low-income subsidy beneficiaries, who may otherwise find it difficult to pay for the increase in their monthly premium. I note and applaud the announcement of Centers for Medicare and Medicaid Services (CMS) in January to delay the late enrollment penalty for

low-income enrollees for one year. My bill will codify this waiver and make it permanent.

As of June 11, 2006, approximately 4.4 million Medicare beneficiaries did not have prescription drug coverage and thus may be subject to a late enrollment penalty. CMS has not released data about the specific number of Medicare beneficiaries who have started to pay the penalty in 2007. But in my district, the Pennsylvania Department of Aging estimates that 14,000 individuals are eligible for coverage, but are not enrolled.

I urge the committee to delay the late enrollment penalty for two years and provide seniors with the time necessary to evaluate their health care options without being penalized. It is a straightforward approach that maintains the current design of the program and protects against adverse selection, while providing relief for millions of seniors.

Thank you again, Mr. Chairman, for the opportunity to testify today in support of my bill.

Chairman STARK. Thank you. Thank you both. The Rector of Justin was the founder of the Groton School. I don't know where that comes from in my memory bank, but I apologize again. You first heard about these problems in your town meetings?

Mr. ALTMIRE. That is right. As I said, I have 14,000 Medicare beneficiaries who are subject to the penalty and a number of them have approached me.

Chairman STARK. They all come to your town meetings?

Mr. ALTMIRE. They do not all come, but a number of them have, and the chief complaint was they were inundated with so much information in a short period of time.

Chairman STARK. Your bill now makes this permanent; is that correct?

Mr. ALTMIRE. Correct. It's a two year fix.

Chairman STARK. You are not suggesting that we do away with the other late enrollment penalties, charges for say late enrollment into Medicare and those sorts of things which keep us from having adverse selection?

Mr. ALTMIRE. I am not; right.

Chairman STARK. Thank you very much.

Lloyd, often we can solve the problems that you suggest through administrative changes when there is cooperation. Did you discuss this with CMS or the administration on how we might correct this in an administrative fashion?

Mr. DOGETT. I attempted to. I must say I have not met with great success in that regard and after some months, they determined that there was a need for an actual change in the law, but just to give you some background, actually, one year ago exactly today, the head of CMS, at that time, Dr. Mark McClellan, was sitting in this chair testifying to the Committee.

I was asking him about these problems. Because I did not feel I was getting a very complete response about what was being done for the low income individuals, on May 26th, after his testimony, I was joined by 145 colleagues in sending a letter to him, at that time, thinking this could all be done administratively.

It took over four months for us to get a response back that was essentially "don't worry, be happy," we are doing a great job, not indicating there was a statutory barrier to targeting these low income individuals.

We also wrote him again in June following further testimony he had given to the Subcommittee, seeking information. That also was a communication that was very delayed in getting back and very incomplete.

Only when the Inspector General of the Health and Human Services Department came out with his report recommending that we do exactly what we had been asking CMS to explore, did I get any firm indication that a statutory change would be necessary.

The fact that Ms. Norwalk, the current acting head of CMS, told this Subcommittee in February that despite all of their efforts, all their outreach, they still had about the same number of people that were not signed up that they had a year ago indicates that more needs to be done.

A fact, which had not been made known to me previously, the fact that the Social Security Administration essentially asked for the same information this bill would authorize to IRS, because they thought that was the best way to target the information.

Chairman STARK. Excuse me. The Social Security Administration asked for the same information?

Mr. DOGGETT. According to the Inspector General's report, and without going through all of—

Chairman STARK. Did they get it?

Mr. DOGGETT. They were told that a change in the law would be necessary, that under existing law, they could not provide that.

I have tried to work to craft, sharing the same concern Mr. Camp voiced about privacy, to craft the narrowest change possible. It is very similar to an approach that Senator Gordon Smith and Senator Jeff Bingaman have offered, after we filed this bill over in the Senate, trying to work with them to see how can we target rather than do a scatter shot.

I have sought to work with the folks at CMS right through last night when unfortunately they again declined to really give a careful review of this legislation that has been pending, to tell us if there were any aspects that would create problems for them in administratively, or that would not achieve the goal.

There is no doubt they are doing significant outreach, but that significant outreach has not brought in many of the people that need to be reached.

I am not suggesting we replace what they are doing, but target it and do it with a simple, direct application that has a better chance of achieving success.

Chairman STARK. Thank God you did not turn the problem over to the military recruiters. You might have even worse results.

Mr. DOGGETT. I would just bring to your attention, today's USA Today has several articles outlining this problem with an article entitled "Many Low Income Seniors Don't Get Drug Benefit, Advocates/Feds Failing to Reach Out to the Neediest." It really is just a summary of the same problems that I have been testifying about, that this bill is designed to correct.

Chairman STARK. Maybe we can make some steps in that direction. Mr. Camp?

Mr. CAMP. Thank you, Mr. Chairman. Mr. Doggett, thank you for your testimony today. Obviously, we would like to reach out to

those eligible for the prescription Part D benefit as much as possible.

Tell me, with the changes that you are proposing, have you had a chance to have this scored?

Mr. DOGGETT. Other than protecting privacy, that is my biggest concern, because I'm committed to pay as you go, and I requested a score or the Subcommittee requested a score on this about two months ago. We continue to encourage the Congressional Budget Office to move forward on it, but we do not have it today.

I have asked for a section by section analysis so that if we cannot do all of this, perhaps we can do some of it within the budget constraints that we face. I do not have a score today.

Mr. CAMP. As you know, the cost of the entire prescription Part D program received a lot of attention. Unfortunately, it is coming in under what was suggested, but still the costs of this are going to be absolutely critical, and will be a big part of the policy changes that we are going to be able to make.

Mr. DOGGETT. Absolutely. That concern is a very legitimate concern. Many of the advocacy groups that we work with that are concerned about protecting more people wanted to move to more of an automatic enrollment and eliminate the asset test entirely.

There are some good arguments for that. I did not do that, and in fact, I reduced the asset test so that it makes some adjustment but a fairly modest adjustment, because of cost concerns.

Mr. CAMP. Yes. Once you get that and then obviously how then we meet those PAYGO rules will be something we will have to grapple with within the Committee.

Thank you very much for your testimony.

Mr. DOGGETT. Thank you.

Mr. CAMP. Thank you. Thank you, Mr. Chairman. I yield back.

Chairman STARK. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Just one feature, and I intend to pursue it more extensively with the Social Security Administration representative in the next panel.

It is my understanding that SSA was given some initial funding, which has now expired, relative to handling the inquiries and making the eligibility determinations for the extra help.

I have been informed that without additional funding continuing, they are literally diverting resources away from the normal work of a Social Security office on a zero sum gain. We want them to tend obviously to the enrolling of those that are appropriate for extra help and making those determinations. We want the Social Security activities to continue.

It is a little mind boggling to think that they would just think after an initial start up period there would not be any staffing consequences for the work that SSA has carried on this extra help determination.

Lloyd, are you aware of anything regarding that?

Mr. DOGGETT. I believe there will be some modest adjustments necessary. As you know, yesterday in the Subcommittee on Social Security, we were concerned about the same issue as it related to handling disability claims. They are going to be best positioned to answer that.

We basically seek to have the Social Security Administration go back and re-ask the same inquiry to the Internal Revenue Service they did originally, perhaps with some variation given the privacy protections we have here, get that data, and then use it for a targeted notice out to these folks.

There would be some costs attendant to that. I know costs was a concern that you had in deciding to join as a co-sponsor of this legislation, which I appreciate, the same concern Mr. Camp raised.

Hopefully, when we hear from Social Security and we get back the score, we can focus any new dollars where they will do the most good to get the most people.

Mr. POMEROY. Great. Thank you. Thank you, Mr. Chairman. I yield back.

Chairman STARK. Mr. Hulshof?

Mr. HULSHOF. Thank you, Mr. Chairman. I accept to my colleague, Mr. Doggett, your invitation to move forward, but I think I need to take a quick glance in the rear view mirror, having been in many hearings leading up to Part D.

We heard the complaints that there were going to be zero choices for seniors, and then of course, we saw the flood of plans because the private sector saw this was something that could happen, and then the complaint was there were too many choices.

It was proposed by some that we should actually have to legislate the monthly premium because we were not going to see \$35 premiums. In fact, we have not. In fact, in Missouri, you can find a monthly premium as low as \$15, and every senior in Missouri has had the opportunity to have the doughnut hole covered.

There have been wild estimates of costs, as Mr. Camp pointed out. There was an attempt to embarrass the White House in this Committee, and now as some of us predicted, cost estimates were over blown.

We supported the idea, for instance, Mr. Doggett, of means testing Part D for wealthy seniors. That was in the House version of the bill. I remember when we had that discussion on the Floor, if memory serves, that vote of means testing for wealthy seniors was rejected unanimously by those on your side.

I am not here to play "gotcha." When we had the debate on the Floor about drug negotiation, I asked the Majority Leader, why is it so difficult to at least provide some credit for those of us that got at least part of it right.

I think this place would work a lot better when we did not care who got the credit when things go well.

Mr. Altmire, you said "hastily prepared program." "Hasty initiation." Well, I respectfully disagree in that we had the interim drug card. Yes, there were glitches during the massive roll out, but the fact that eight out of ten senior citizens think this has been a good program for them.

Yes, we should improve where we should improve.

I would ask you, Mr. Altmire, you waived the penalty for Medicare beneficiaries who do not enroll in Part D, there are about 800,000 beneficiaries who pay a late enrollment penalty in Part B. Why do you not address those folks?

Mr. ALTMIRE. In answering both of your comments, and I appreciate the question, in saying it was "hastily prepared," maybe I did not articulate. It was not a pejorative statement.

I was merely getting to the fact that in my home state of Pennsylvania, beneficiaries had 60 different plans to choose from in a relatively short period of time, something they had not been asked to do before, and then the fact that the penalty kicks in for seven months before they have the opportunity to make their next plan.

It was not an editorial comment on the program. It was just merely getting to the fact that as you pointed out, there were more choices than people thought they were going to have, and as a result, some of them were unable to make their selection in time and then were subject to the penalty, which leads me into the second part, unless you want to follow up on that.

Mr. HULSHOF. I would follow up in the sense that your written statement said "It was clear to all outside observers that the Medicare Part D program was not ready for prime time."

You were on the health care side before coming here, were you not? A lobbyist or in some fashion?

Mr. ALTMIRE. I was. I took that part out of my—you are right. That was in my written statement. I took it out for my comments. I thought that was over the top, admittedly.

Mr. HULSHOF. Let me ask you, either from your experience in the health care industry before coming here, or now that you have joined this body, is there a reason for a late enrollment penalty?

Mr. ALTMIRE. Yes. There is absolutely a reason with regard to adverse selection, and that is the reason, and Mr. Camp mentioned costs, as you did as well. That is the reason this is only a two year fix. This not an open-ended situation.

I just wanted to resolve or remedy the problem for people who were caught in this trap of having too many plans to choose from in a short period of time and are now subject to the penalty.

I understand how adverse selection works and the cost issues associated. I only made this a two year bill for that reason.

Mr. HULSHOF. I would say and would you agree that there are some seniors, I do not know what the percentage might be, we are all concerned about those that are not covered, but there are some seniors, healthy seniors, or maybe even some that just choose not to participate in some Government run program? Would you agree with that?

Mr. ALTMIRE. Absolutely. They still would have the right to do that.

Mr. HULSHOF. Again, I appreciate each of you, as we try to—no one on this side or either side is saying there is not room for improvement. Certainly, providing access to those who need it, certainly on the low income side, again, the original version said for those that are the affluent who do not need help with drugs, we had that in the original House version, but it did not make the final version, but I appreciate the Chairman indulging me with my time.

Chairman STARK. If the gentleman would yield, I would yield him time to yield back, I do want to suggest that your review of how we got where we are was accurate.

I think that now, I do not suspect any of us want to repeal this law and start over. It is incumbent on us in the nature of oversight to see what we can do. We have the law. We ought to see that it gets administered fairly and probably directing some help to those who are less capable of understanding it.

I think we have all had in every town meeting come and say I do not understand it, and we have had people call our district offices and try to get it explained.

To that extent, I hope we could work together either to simplify or to make the process more user friendly. I think that is the intention of this hearing.

Mr. HULSHOF. Would you yield?

Chairman STARK. I would be glad to; yes.

Mr. HULSHOF. I absolutely acknowledge and agree with the statement you just made, Mr. Chairman. What is extraordinary is that given the difficulty and almost the unanimous opposition when this plan first came out, the fact that if you believe the polls, and some people may not—

Chairman STARK. It was not unanimous. It passed by one vote.

Mr. HULSHOF. I am saying the unanimous—just a handful, Mr. Chairman, on your side, that supported the bill. Again, I am not here to point fingers. It is just as difficult as it was to get Part D passed, and certainly the implementation, I think it is extraordinary in the short amount of time to have the vast majority of senior citizens who now are covered with drugs that they need and the satisfaction rate given the difficulty to get it passed and certainly the almost unanimous opposition on the gentleman's side of the aisle.

Yes, let's fix what needs to be fixed.

Chairman STARK. If it will help the gentleman in deliberating on this issue, I will admit that I am happy we lost, and I think—

Mr. HULSHOF. I am going to write that down.

Chairman STARK. We think we now have the bill. It is not the bill I would have written, and it may not have been the bill the gentleman would have written.

All I can say is let's live with it and improve it in whatever way we can afford to improve it to help the people who we hope are served by it.

Mr. DOGGETT. Mr. Chairman, may I respond if there is time? I am not so happy that we lost, but we did, and you prevailed. The thrust again is only on ensuring that since you prevailed, we fulfill the promise that was made at that time.

I am concerned that one of the reasons, not perhaps the major reason, but one of the reasons those cost figures have come in much lower than were predicted is that a significant number of the 13 to 14 million people that Billy Tauzin talked about and that Medicare estimated would qualify for extra help, that they just have not gotten it.

If there is a way to achieve that within the cost constraints and within the privacy constraints, that is all I am trying to do.

Chairman STARK. I thank the gentleman. Mr. Kind, would you like to inquire?

Mr. KIND. Thank you, Mr. Chairman. Just briefly. I want to thank my two colleagues for the good work they are putting into both of these measures.

Mr. Doggett, first of all, we are taking a look at the bill. We are quite frankly just waiting for some cost figures to come back. I think for some time now, we have to take a look at the asset limit for LIS individuals, but if you could refresh my recollection, are you proposing indexing those assets for future inflationary, or are you just bumping the asset limits up to increase eligibility?

Mr. DOGGETT. I think we are just proposing to raise them and not to index them. They do need to be indexed. That might be an appropriate adjustment to the bill.

Mr. KIND. Mr. Altmire—

Mr. DOGGETT. If I might clarify that, apparently they are already indexed under current law. I know the income limit is indexed or has an inflation factor in it under current law. Our bill does not change that. There is something there already.

Mr. KIND. You are also proposing in your legislation that you would waive the penalties for low income subsidy individuals on a permanent basis?

Mr. DOGGETT. We do, and that is similar—it covers part of the population that Mr. Altmire does in his bill.

Mr. KIND. Mr. Altmire, you are just proposing a two year waiver?

Mr. ALTMIRE. Correct.

Mr. KIND. Not only for low income subsidy but for?

Mr. ALTMIRE. Anyone that is subject to the penalty.

Mr. KIND. I agree. I had a lot of forms as far as sign up sessions when Part D eligibility enrollment period first opened up, tremendous amount of confusion, the complexity of it. A lot of people were not quite sure where to go for accurate information. It was difficult. If they did not enroll during that limited sign up period, they were shut off for about seven months and those penalties were accruing during that time.

It is my understanding that CMS has waived the penalty in 2007 for low income subsidy individuals, but that is it so far. Is that correct?

Mr. ALTMIRE. Yes. In my bill, I codify that into the legislation.

Mr. KIND. Very good. Thank you again for your work. Thank you, Mr. Chairman.

Chairman STARK. Mr. Emanuel, would you like to inquire?

Mr. EMANUEL. Thank you, Mr. Chairman, I would. I apologize for coming in late. I thank my colleague, Mr. Doggett—

Chairman STARK. Did you bring a note from your mother?

Mr. EMANUEL. My mother has a couple of other things she would like to bring besides a note, but I will make sure she knows you said that. She usually carried a 2 x 4 for her kids. My mother would actually like this whole forum just for her. That is the dedication of a Jewish mother.

Mr. Doggett, you cited the USA Today story and the fact is that outside of the automatic enrollment, those low income seniors have not actually enrolled in the prescription drug Part D benefit. I was going to take note of that, but if it has been noted already in the interest of time, I will not do that.

If you go back to the debate we had on the Floor, all those who were champions of the bill said how well it would do for low income seniors. In fact, the data shows it has not reached those, and there are about 3.2 million low income seniors who are not enrolled who would clearly benefit.

I think our obligation is how do we figure out how to get to those folks. There are a lot of things to do. I want to compliment my colleague from Pittsburgh for his idea of waiving the fee.

You have it obviously for everybody, but at a bare minimum, and I would hope, Mr. Chairman, we take note of his idea, at least codifying what CMS did for an one year proposal. If it was good for one year, it may be good for the second year when you have 3.2 million folks who are not enrolled that could be enrolled.

We have to be doing everything we can. I would hope that obviously we look at this and take some recommendations of our two colleagues here. I am most impressed with the idea of codifying and expanding this idea of waiving the fee for seniors so we do not put up road blocks.

If it was intended to get people in, they got in. Those who are left out, it is clearly not working for its intention. The intention was to have a fee to move people. We are past that stage. Now we have to figure out what we have to do to get them in because the late fee is a penalty to incentivize you to move, and that is past its prime. Its best days are behind it.

I would point to my colleague from Pittsburgh who has come up with a piece of legislation where I cannot stress enough that we take consideration of and look into.

To the debate between you and my colleague from Missouri, I will say that I wish this was not the plan. I do not think it was right. I think when we had the debate about \$395 billion and it turned out to be closer to \$800 billion, we should have know that information.

We would have had a different judgment about whether we should have done this bill. That said, it is here. One of the things that concerns me and I hope as we look at it and debate this is the fact is when we looked in the 1980s and 1990s at the HMO and the privacy industry to save costs, the reason people looked at those plans was because they were supposed to be cheaper than Medicare fee for service.

By the time we got to 2000, the advantage of the private plans from being more efficient than Medicare, the only way we got to those plans if we had to give them a 12 percent bonus on top of the fee for service.

Their sales pitch in the 1980s and 1990s was they were cheaper, better, more efficient. By 2000, it became we had to pay them extra to get them to take on the Medicare.

I am not suggesting that we eliminate all of the HMO benefits. They may work better in rural areas where you do not have a density, et cetera. All that we are doing here is trying to find after this period of time a better way to deliver a benefit in a more cost effective way, because it was never going to be \$394 billion. It is now \$800 billion.

We have got to be better with taxpayer money so we can get a better benefit.

Mr. HULSHOF. Would you yield for clarification, Mr. Emanuel?

Mr. EMANUEL. Only if my mother is here. Yes, I will.

Mr. HULSHOF. The Congressional Budget Office certified that the drug benefit was \$395 billion and the Congressional Budget Office has not budged off that number.

The reference to the larger number was the Office of Management and Budget under the administration that made different assumptions than the Congressional Budget Office, and it is the Office of Management and Budget that has indicated that because of the prevalence of wellness and preventive drugs, that the cost has been coming down.

The record should indicate that CBO, the official score keeper for this institution, has held firm to the \$400 billion or less. It is the administration's budget numbers that were the number.

Mr. CAMP. Would the gentleman yield for one minute?

Mr. EMANUEL. I think I need my mother.

Mr. CAMP. It went down 30 percent from the initial projection. The fact is the costs are down 30 percent. That is unprecedented in the history of any Government program.

Mr. EMANUEL. As you both know, because you are both very good and very studious and committed, one of the reasons the costs are down is because enrollment is not up. Fact.

As Ronald Reagan used to say "Facts are a stubborn thing."

The truth is and we all know it, yes, they are down, no doubt. B, one of the reasons they are down is enrollment is not up. C, one of the things that our two colleagues, from Texas and Pittsburgh, are trying to do is trying to figure out how to get enrollment up among the audience and parts of the population that are in most need of it. D, Richard Foster nearly lost his job for having—it was a different set of numbers, granted, but I believe had we known that, I do not think we would have gotten this bill.

That is all I have to say. Thank you, Mr. Chairman.

Chairman STARK. Would any of the members like to further inquire?

[No response.]

Chairman STARK. If not, I want to thank both the witnesses. I know Mr. Doggett will stay with us. Jason, if you would like to join us for the rest of the session up here and sit in and listen, you would be welcome.

I am going to call our second panel with the caveat that we are expecting two votes sometime between 11:00 and 11:15. If Mr. Lawrence Kocot, Senior Advisor to the Administrator for CMS, and Ms. Beatrice Disman, Regional Commissioner of the New York Region of the Social Security Administration, would like to come forward, we will empanel you.

Ms. Disman, if you would like to proceed to enlighten us. I think we will have time to get through the summary of your presentation, and then if we can prevail on you to stick around for a few minutes, the members will return after the vote and may wish to inquire.

Please go ahead and enlighten us in any manner you are comfortable with.

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

Ms. DISMAN. Thank you, Mr. Chairman, and Members of the Committee. On behalf of Commissioner Astrue, I thank you for inviting me to provide an update on Social Security's ongoing efforts to sign up eligible Medicare beneficiaries for the low-income subsidy or "extra help" as it is known in the community.

As you said, I am Bea Disman. I am the Regional Commissioner of the New York Region, and I have had the good fortune for the last three years to chair Social Security's Medicare Planning and Implementation Taskforce.

In doing this, I have had the opportunity of seeing the truly tireless and dedicated efforts of so many Social Security employees as they have attempted to reach out to those individuals who could benefit from the "extra help."

I am pleased to provide you with an update of our story. During the last year, Social Security has continued to use every means at our disposal to reach those who could benefit from "extra help."

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

We have also continued to work with State pharmaceutical programs, State health insurance programs, area agencies on aging, local housing authorities, community health centers, prescription drug providers, and others to identify those with limited income and resources.

Throughout these efforts, Social Security's goal has been to reach every potentially eligible Medicare beneficiary multiple times in a variety of ways. Whether there were 300 or three million people, Social Security's job is the same, find them. Find them where they live. Find them in the communities where they work, find them in any way we can.

Our message is simple. If you could possibly benefit from this program, Social Security will help you apply.

For more detail on the many avenues Social Security has used to inform low-income beneficiaries about "extra help," for example, our multiple targeted mailings, telephone calls or targeted events, I refer you to my written testimony.

Today, however, I would like to focus on a new initiative. On behalf of Commissioner Astrue, I am pleased to announce a new strategy in our continuing efforts to inform the public about "extra help."

This outreach initiative, "Show Someone You Love How Much You Care," is designed to inform relatives and care givers, the sons, daughters, grandchildren and family friends who count a Medicare beneficiary among the important people in their lives.

By specifically focusing on these caregivers, SSA hopes to reach even more individuals who could be assisted through the "extra help" program.

Last week, Commissioner Astrue met with the advocacy organizations, some of whom will be testifying later, and encouraged them to help us in this new strategy. We have actually worked with all these organizations over the last three years.

We plan to launch this new initiative around Mother's Day as we celebrate the most important special people in our lives. This year we are asking that people show someone they love how much they care by learning more about that "extra help" that is available with Medicare prescription drug costs.

We are asking them to take a further step to help their loved ones apply. In the week preceding Mother's Day, Social Security employees around the country will be visiting their flower shops, restaurants and place of worship to make information about the "extra help" available. That is where mothers spend Mother's Day.

I personally will be visiting one of the largest African American churches in Jamaica, New York on Mother's Day, and I filmed TV spots publicizing extra help for NBC's local consumer reporter yesterday.

I have seen the activities from around the nation, in which my colleagues and their staff are actively engaged. Social Security also plans to publish related articles in the local media.

Outreach efforts have also included distribution of special pamphlets explaining "extra help," and I provided those pamphlets to each one of you so you could see them. The campaign will also continue throughout this year with a second series targeted at Father's Day.

We also did officially send you pamphlets within the last day or two with a note from Commissioner Astrue. We are excited about this new initiative and its timing during Older Americans Month and its prospects for assisting low-income Medicare beneficiaries.

I would now like to turn to another topic of great importance to SSA and this Committee, outreach to individuals potentially eligible for Medicare savings programs.

In May 2007 as in prior years, Social Security will be sending an annual notice to approximately six million beneficiaries who based on our data and systems matching of data with Veterans Affairs, Office of Personnel Management and the Railroad Board, are potentially eligible for Medical Savings Programs (MSP).

As in prior years, the MSP letters are tailored to address the programs which they are potentially entitled to based on our records. These letters also address "extra help" where appropriate.

In addition to the notices we send information about MSP assistance to the various States. Information such as income along with names, and addresses of those individuals are shared electronically right after the mailing, thus providing vital information for the States to use in their own outreach programs.

SSA also assists the States in MSP through the buy-in process. In 32 States and the District of Columbia, SSA has an agreement where a determination for SSI imparts Medicaid eligibility, therefore, MSP. Even in those States where we do not have an auto enrollment agreement with the State, we generate an alert that the State can use in assessing MSP.

Finally, I would like to let you know that SSA decision letters about "extra help" have information about MSP. Information on "extra help" decisions themselves are transmitted to CMS, thus, CMS knows about whether "extra help" is approved or denied. They also receive certain information on income and resources.

In terms of “extra help,” SSA has made a special effort with CMS to reach those beneficiaries who lost their deemed status effective January 2007. Of the approximately 630,000 individuals affected, 247,000 have applied for “extra help” and 168,000 are eligible. This is in addition to those who have been re-deemed.

Social Security is currently calling 188,000 individuals who have not yet filed.

For this fiscal year, almost 850,000 beneficiaries have filed for the “extra help,” about 200,000 of these are unnecessary—I have about another 15 seconds, if I can continue—because they automatically were eligible or because they filed more than one application.

For this fiscal year, we have found 350,000 individuals that are eligible for the “extra help.” We continue to receive about 30,000 applications a week or over 100,000 a month.

In conclusion, I want to express to this Committee my personal thanks and the thanks of Commissioner Astrue for your continuing support for the Agency. I can assure you that the dedicated employees of Social Security will continue to do our very best in administering the “extra help” assistance and in partnering with the state and CMS in the promotion of Medicare Savings Plans.

We realize our job is not complete. We continue to look for ways in which we can reach out to those in need.

We look forward to our continued dialogue with organizations, advocacy groups and of course, this Committee.

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

[The prepared statement of Beatrice Disman follows:]

Prepared Statement of Beatrice Disman, Regional Commissioner, New York Region, Social Security Administration

Mr. Chairman and Members of the Committee:

On behalf of Commissioner Astrue, I thank you for inviting me to provide an update on the Social Security Administration’s (SSA’s) ongoing efforts to sign-up eligible Medicare beneficiaries for the low-income subsidy (LIS)—or “extra help” as it is commonly called, under the Medicare Prescription Drug Program. I am Bea Disman, and I have served for over a decade as Regional Commissioner of the New York Region. I have also spent the past 3 years as Chair of SSA’s Medicare Planning and Implementation Task Force. In this role I have seen the truly tireless and dedicated efforts of so many SSA employees, as they have reached out to those individuals who could benefit from “extra help.” I am pleased to provide you with an update of our story—exactly one year to the day after we last met to discuss this very important issue.

Since we last spoke, SSA has continued its intensive efforts to locate low-income Medicare beneficiaries, and provide them with an opportunity to apply for “extra help” assistance. We have used targeted mailings, phone calls, computer data matches, community forums, partnerships with State agencies and non-profit organizations, public information fact sheets, word-of-mouth—in short, any and all means at our disposal—to reach those eligible to receive assistance with out-of-pocket costs associated with Medicare prescription drug coverage. Today’s testimony looks back at some of those efforts, but more importantly, it looks at how SSA’s outreach initiatives are moving forward.

Background

To begin, it may be helpful to recap Social Security’s role and responsibilities regarding the new Medicare Prescription Drug Program. This provides the context to further describe SSA’s activities in getting low-income people the “extra help” intended by Congress.

SSA was given the responsibility by Congress to take “extra help” applications and to make eligibility determinations for individuals who were not automatically eligible, by virtue of their receipt of full Medicare and Medicaid, Supplemental Security Income (SSI), or Medicare Savings Programs (MSPs). In order to be eligible for

“extra help,” individuals must have incomes below 150 percent of the poverty level applicable to their corresponding household size. In 2007 this is \$15,315 for an individual and \$20,535 for a couple. Individuals with incomes between 135 percent and 150 percent of poverty are eligible for a subsidy amount based on a sliding scale. The income limits adjust annually, based on the Federal Poverty Level (FPL).

Individuals must also meet a resource test. The resource level is \$11,710 for single individuals or \$23,410 for couples. (These figures include the \$1,500 credit given to individuals who will use their resources for funeral or burial expenses.) Those who have countable resources of less \$6,120 for an individual and \$9,190 for couples, receive the most cost-sharing assistance. The resource limits adjust annually based on the Consumer Price Index, or CPI.

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

Application Process Improvements

When we last met, I described for you the extensive research and review that went into the creation of SSA’s application for “extra help.” Focus groups and cognitive testing experts, automation experts, advocate organizations, form design professionals, and Congressional staffs all contributed to this undertaking. The resulting application was the most extensively tested form SSA has ever produced. But you should also know that our efforts to improve the application—to provide an easy way for beneficiaries to apply for “extra help”—are continuing.

For example, we have added fields to the application that allow the applicant to enter the amount of his or her Social Security benefit. Of course SSA already knows this information, and the original application instructions stated that the applicant did not need to supply Social Security benefit amounts. But our analysis of applications received showed that applicants were trying to enter the information anyway, and this was frequently leading to inaccurate entries and inaccurate eligibility determinations. In addition, we revised the application to request the applicant’s date of birth, so that we can identify him or her if they entered the wrong Social Security number. In another example, we simplified the question about filing as a couple and changed the resource amounts to reflect the 2007 resource limits.

In response to advocates and Congressional concerns, SSA is currently reviewing the paragraph at the end of the “extra help” application (sometimes referred to as the “penalty clause”). Our review has been prompted in response to concerns some have raised that such language might inhibit individuals from filing.

Another interesting note is the way Medicare beneficiaries are currently filing for “extra help.” Since the beginning of Fiscal Year 2007, about 22 percent of new applications are Internet filings. This means that, as a percentage of applications received, the online “extra help” application has even exceeded the success of SSA’s online Application for Retirement benefits. The online application has been a real success story, receiving one of the highest scores ever given to a public or private sector organization by the American Customer Satisfaction Index.

Outreach Efforts

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

We have been in the communities—“in senior citizen centers, pharmacies, public housing, churches—“any place in which we thought senior citizens or the disabled were likely to be found. We also continue to work with States that have their own pharmaceutical programs, State Health Insurance Programs, Area Agencies on Aging, local housing authorities, community health clinics, prescription drug plans, and others to identify people with limited income and resources who may be eligible for the “extra help.”

Throughout these efforts, SSA’s goal has been to reach every potentially eligible Medicare beneficiary multiple times, in a variety of ways: for example, by targeted mailings and events, and follow-up phone calls. And while we are confident we have

taken appropriate steps to reach out to those who may be eligible for the “extra help,” our outreach efforts are continuing. Because there is no enrollment period for the “extra help,” a Medicare beneficiary can apply at any time. This means there is no inappropriate time to reach out to our lower-income beneficiaries, and there is no wrong time for these individuals to complete an application.

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

SSA’s Initial Outreach Efforts

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

As I described to you in last year’s testimony, during the initial start-up phase of the new Medicare prescription drug program, SSA mailed almost 19 million applications to Medicare beneficiaries who, based on systems data available to SSA, appeared to have incomes below 150 percent of the FPL. Our goal was to have as many potentially eligible lower-income Medicare beneficiaries as possible file for the “extra help” before the Medicare prescription drug program started in January 2006.

I also described for you some of the many ways in which SSA followed-up with those individuals who did not return the applications sent in the initial mailing.

- Through a vendor contract, we called 9.1 million people and mailed 5 million follow-up notices. SSA representatives provided one-on-one assistance to nearly 400,000 beneficiaries.
- Through a separate analysis, we identified approximately 1.5 million disability beneficiaries who received an “extra help” application mailer, but did not file an application. We mailed a special follow-up notice to all of these beneficiaries, assuring them that filing for “extra help” would have no adverse effect on their disability benefits.
- We personally called over 300,000 beneficiaries who did not respond to an “extra help” application mailer, but had previously applied for and received the Medicare \$600 drug discount card credit during 2004 or 2005.
- We coordinated targeted advertising efforts with national organizations, such as AARP, and targeted outreach events with state organizations such as the Elderly Pharmaceutical Insurance Coverage program in New York.

Ongoing Outreach

SSA continues to use our standard Agency mailings to inform the public. For example, the cost of living adjustment notice sent in November 2006 to over 50 million Social Security beneficiaries, contained information about the new drug program and the availability of “extra help.” In additional efforts to reach specific communities, SSA has undertaken targeted mailings to beneficiaries with representative payees, beneficiaries who speak Spanish, Asian-American and African-American households, and beneficiaries age 79 and older who lived in zip codes with a high percentage of low income households. During the period of June through August, 2006, 2.5 million “extra help” applications were mailed to these individuals. SSA has also made a special effort to reach and re-sign those “extra help” recipients who have lost “deemed” or automatically eligible status. As I previously described, some individuals received the subsidy automatically, by virtue of Medicaid, SSI or MSP eligibility. In some cases, however, these individuals lost eligibility to these other programs, and thus their deemed status, as of January 2007. Working with CMS, in September 2006, SSA mailed more than 600,000 applications with CMS notices to Medicare beneficiaries who would no longer be automatically eligible for “extra help.” To date, more than 247,000 have reapplied and 168,000 are now eligible. This is in addition to a number of individuals who have regained automatic eligibility through re-entitlement to certain State programs. Social Security is also personally calling 188,000 of these individuals who, according to our records, potentially have incomes below the Federal Poverty Level. In addition to the many specific outreach activities SSA has performed in the past year, the agency also provides educational outreach to Medicare attainers—those current Social Security beneficiaries who turn 65 or reach the 25th month of their disability. If our records indicate an attainer may potentially be eligible for “extra help,” SSA sends an application. This means between 120,000–130,000 beneficiaries receive “extra help” applications every month. Similarly, many individuals call our 800 number or visit our field offices to

conduct traditional Social Security business. We educate these individuals about the “extra help,” and we will take the application if it is appropriate.

Reaching Caregivers: A New Strategy

On behalf of Commissioner Astrue, I am also pleased to announce today, a new strategy in our continuing efforts to inform the public about the “extra help” program. This outreach initiative, themed “Show Someone You Love How Much You Care,” is designed to inform relatives and caregivers—the sons, daughters, grandchildren and family friends—who count a Medicare beneficiary among the important people in their lives. By reaching these care providers, SSA hopes to reach even more individuals who could be assisted through the “extra help” program. Last week Commissioner Astrue met with the advocacy organizations that SSA has engaged as partners over these last three years, to ask their assistance in the new strategy.

We plan to launch this new strategy around Mother’s Day. On Mother’s Day, we celebrate some of the most special people in our lives. This year, we are asking that people show someone they love how much they care, by learning more about the “extra help” that is available with Medicare prescription drug costs. We are also asking them to take a further step—help these loved ones to apply. In the week immediately preceding Mother’s Day, SSA employees across the country will be visiting their local community centers, grocery stores, restaurants, and places of worship, to make information about the “extra help” available on or around the Mother’s Day weekend. SSA also plans to publish related articles in the local media. The outreach effort includes distribution of special pamphlets explaining “extra help,” entitled “This Mother’s Day, Show Someone You Love How Much You Care.” The campaign will continue throughout this year. There will be a second series of targeted events scheduled for Father’s Day. You should have received copies of these pamphlets within the past day or two, along with an announcement letter from Commissioner Astrue. We are excited about this new initiative, and its prospects of assisting low-income Medicare beneficiaries.

Making a Connection with Medicare Savings Plans

I would now like to turn to another topic of great importance to SSA and to this Committee—outreach to individuals potentially eligible for Medicare Savings Programs, or MSPs.

In May 2007, as in prior years, SSA will be sending our annual notice to approximately 6 million beneficiaries who, based on SSA’s systems matching of data with Veterans Affairs, the Office of Personnel Management and the Railroad Retirement Board, could be potentially eligible for MSPs. These programs (Qualified Medicare Beneficiaries/QMB, Specified Low-Income Medicare Beneficiaries/SLMB, Qualifying Individuals/QI, and Qualified Disabled and Working Individuals/QDWI) provide cost-sharing assistance or “wrap-around” coverage to low-income recipients of traditional Medicare. They are a vital safety net, and SSA is pleased to cooperate with CMS in this effort. The MSP letters are tailored to address the programs to which, based on the matched records, an individual may be eligible. Since the inception of the Prescription Drug component of Medicare, the letters have also addressed “extra help,” where appropriate.

In addition to the notices we send to inform individuals about MSP assistance, SSA also shares our list of potential eligibles with State Medicaid agencies. Information such as income, along with names and addresses of these individuals are shared electronically right after the mailing, thus providing vital information for the States to use in their own outreach programs.

SSA also assists the States’ MSP outreach through the “buy-in” process—generally speaking, the purchase of Medicare Part B by a State on behalf of a low-income Medicaid recipient. In 32 States (and the District of Columbia) SSA has an agreement that our determination of SSI eligibility imparts Medicaid eligibility as well, and therefore MSP eligibility. And even in situations where SSA has no auto-enrollment agreement with the State, we still generate an alert that the State can use in assessing MSP eligibility.

Finally, we would also note that all SSA decision letters regarding “extra help” provide generic information about Medicare Savings Programs. Information on the “extra help” decisions themselves are also transmitted to CMS. Thus CMS knows whether an “extra help” application is approved or disallowed. They also know whether the resource level is below \$6,120 for an individual, or \$9,190 for a couple, and the income as a percent of FPL.

Current Status of Beneficiaries Filing for “Extra Help”

From the beginning of the fiscal year (October 2006) through mid-April, almost 850,000 beneficiaries have filed for “extra help” with SSA. About 200,000 of these filings were unnecessary, because either the applicants were automatically eligible

or because they had filed more than one application. Based on these filings we have found about 350,000 individuals eligible for assistance.

Generally, SSA continues to receive 30,000 applications for “extra help” every week. This continued level of interest from beneficiaries tells us our outreach campaign is working.

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

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

Conclusion

In conclusion, I want to express to this Committee my personal thanks, and the thanks of Commissioner Astrue, for your continuing support for the Agency. I can assure you that the dedicated employees of SSA will continue to do our very best in administering the “extra help” assistance, and in partnering with State and other Federal Government agencies in the promotion of Medicare Savings Plans.

We look forward to our continued dialogue with organizations, advocacy groups, and of course, this Committee.

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

Chairman STARK. Thank you very much. Mr. Kocot, if you would proceed. At the conclusion of your summary, we will recess for a few minutes to go vote. We should be back in 15 minutes. Please proceed.

STATEMENT OF S. LAWRENCE KOCOT, SENIOR ADVISOR TO THE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. KOCOT. Thank you. Chairman Stark, Congressman Camp and distinguished Members of the Subcommittee, thank you for inviting me to discuss the low income subsidy available under Medicare Part D and the Medicare savings programs, the MSPs, which are joint Federal and state partnerships to assist qualified beneficiaries with Medicare premium and out-of-pocket costs.

I am Larry Kocot, Senior Advisor to the Administrator of the Centers for Medicare and Medicaid Services. In my role at CMS, I have been deeply involved in the policy development and implementation of Medicare Part D, including outreach efforts designed to reach beneficiaries who may qualify for extra help.

Today, roughly 39 million Medicare beneficiaries, more than 90 percent of all those eligible for prescription drug benefits, are receiving the drug coverage they need. Without question, Part D has had a positive impact on the lives of people with Medicare, especially those who receive the low income subsidy.

A primary goal of the Medicare Modernization Act was to provide access to prescription drugs and generous financial assistance to beneficiaries with the greatest need. That is what CMS is doing today.

The low income subsidy provides substantial help to beneficiaries with limited incomes, and includes the Federal premium subsidy ranging from 25 to 100 percent of the monthly premium cost for qualified plans and minimal cost sharing for covered drugs.

Over 75 percent of low income beneficiaries eligible for extra help now receive comprehensive drug coverage at little or no cost. That is 10 million out of an estimated 13.2 million people. With the extended special election period allowing subsidy approved beneficiaries to enroll without penalty, we expect these numbers to continue to grow throughout 2007.

Compared with other means tested programs, enrollment in the Medicare low income subsidy is impressive. However, we will not rest until we have reached and assisted every Medicare beneficiary who qualifies and wants to apply for the low income subsidy.

Our work to identify and enroll these beneficiaries has been a multi-faceted and continuous effort that did not stop with the end of the statutory enrollment periods. Given that many of these beneficiaries are very difficult to reach through traditional means, CMS has designed special ongoing initiatives to target those living in areas that general community outreach efforts may miss.

To reach the estimated three million beneficiaries who may be eligible who have not yet enrolled in the low income subsidy, CMS will pursue innovative non-traditional outreach techniques. We will sponsor multi-media campaigns, and we are going to expand our grassroots networks.

We are working closely with more than 40,000 partners who sponsored and participated in over 12,700 events to date.

The one-on-one counseling and personalized attention made possible by these partnerships have enabled CMS to reach tens of millions of people one at a time.

CMS recently launched a targeted data driven outreach effort with the Administration on Aging to provide resources to community based organizations and the National Aging Services networks, so they may provide personalized assistance to low income Medicare beneficiaries.

Additionally, CMS recently announced \$34.2 million in direct grants and program support to the state health insurance assistance programs, the SHIPs, which will build capacity for local counseling sites to reach LIS eligible individuals in the hard to reach populations.

Our just launched initiative, "A Healthier U.S. Starts Here," is another component of this comprehensive effort. CMS and HHS will crisscross the country by bus to raise awareness about disease prevention. At more than 300 public events, we will promote Medicare covered tests and screenings, as well as the availability of the extra help with prescription drug coverage.

In fact, eligible Medicare beneficiaries will have the opportunity to apply for the low income subsidy on-site at these 300 locations.

People enrolled in Medicare savings programs, the MSPs, are automatically eligible for the Part D low income subsidy.

Through these joint Federal/state programs, qualifying low income Medicare beneficiaries are entitled to limited assistance with Medicare Part A and B premiums, deductibles and cost sharing, depending upon their income status.

In general, the MSPs make Medicare coverage more affordable for low income beneficiaries and thus promote access to critical health care services.

While MSP enrollment has grown in recent years, reaching this population is especially challenging and time and resource intensive. To assist states with MSP enrollment, beginning this year, CMS will begin sharing leads data, that is data on those who have applied for LIS and have either been accepted or rejected, on a monthly basis, so they may target outreach to potential MSP eligible individuals in their states.

Outreach to promote and increase enrollment in the Medicare Part D LIS and related benefits, including the state based Medicare savings programs, is now part of the permanent campaign at CMS.

We look forward to working with SSA, our partners here, and our partners in the local communities, as well as the Subcommittee, to refine our efforts to achieve even greater success in finding and enrolling all of the LIS eligible beneficiaries in Medicare.

Again, thank you for the opportunity to appear today, and I would be happy to answer any questions that you may have.

[The prepared statement of S. Lawrence Kocot follows:]

**Testimony of
S. Lawrence Kocot
Senior Advisor to the Administrator
Centers for Medicare & Medicaid Services
Ways and Means Subcommittee on Health Hearing
“Enrollment in Medicare Part D Low Income Subsidy
and Medicare Savings Programs”**

May 3, 2007

Thank you Chairman Stark, Congressman Camp and distinguished members of the Subcommittee, for inviting me to discuss two very important programs for people with Medicare: the Low Income Subsidy (LIS) under the Medicare prescription drug benefit, and the Medicare Savings Programs (MSP) that leverage Medicaid resources to assist qualified beneficiaries with Medicare’s out-of-pocket costs.

The new Medicare prescription drug benefit (Part D) is probably the single most important addition to benefits in the history of the Medicare program. Because of the extraordinary importance of this new benefit, CMS outreach to Medicare beneficiaries has been unprecedented. Beginning in 2005, Medicare embarked on a multi-faceted campaign to reach out to the more than 42 million people with Medicare, with a special emphasis on reaching those beneficiaries potentially eligible for LIS.

Medicare’s partners, including grassroots organizations, local, State and Federal agencies, State Health Insurance Assistance Programs (SHIPs), the faith community, and individual volunteers sponsored and attended thousands of Medicare events and opportunities across the country for people to get personalized assistance. Some of our strongest partners were the organizations represented here today: the Social Security Administration (SSA), State Medicaid agencies, and beneficiary advocates. The one-on-one counseling and personalized attention these partnerships made possible enabled Medicare to reach tens of millions of people—one person at a time.

This ongoing Part D outreach effort has been part of the transformation in the way Medicare does business, from a bill-paying agency to a real partner in beneficiaries' health. Moreover, it is working. Today, more than 90 percent of people with Medicare have coverage for prescription drugs through Part D or another source. Additionally, more than 10 million low-income Medicare beneficiaries are getting comprehensive drug coverage for little or no cost. We estimate that this is more than 70 percent of those beneficiaries potentially eligible for LIS. By any measure, enrollment in Medicare Part D is impressive and participation by LIS beneficiaries is unprecedented for a new public sector benefit program.

Like the LIS program, the Medicare Savings Programs (MSPs) are also an important benefit to low-income Medicare beneficiaries. As we will discuss below, these programs assist low-income Medicare beneficiaries with their Medicare out-of-pocket expenses such as the Part B premiums. But, identifying and enrolling those eligible for these programs has historically been very challenging.

Overview of the Low-Income Subsidy

Prescription drug coverage is absolutely essential for older Americans and people with disabilities – but it's especially important that people with limited incomes have access to affordable prescription drug coverage. One of the main objectives of the Medicare Prescription Drugs, Improvement and Modernization Act of 2003 (MMA) was to provide the greatest assistance to those with the greatest need. The LIS provides substantial help to Medicare beneficiaries with limited incomes: a federal premium subsidy ranging from 25 to 100 percent of the monthly premium cost for qualified plans, and minimal cost-sharing for covered drugs.¹

By "qualified plan" we mean a plan with a premium at or below the LIS benchmark. Note that LIS beneficiaries may select any plan in their service area, but will have to pay an additional premium for plans that bid above the LIS benchmark. As required by law, the Low-Income Subsidy is a means-tested public benefit. In order to apply and qualify, Medicare beneficiaries generally must meet both an income and asset test. In 2007, the maximum income to qualify for the LIS is \$15,315 for singles without dependents or \$20,535 for married individuals without dependents. Assets may not exceed \$11,710 for a single person or \$23,410 for a couple (this includes \$1,500 per person for burial expenses).

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

- Beneficiaries who are eligible for and enrolled in both Medicare and Medicaid due to their income level—the “full-benefit dual-eligibles.”
- Beneficiaries enrolled in the Medicare Savings Program. These are the Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs) under a State’s Medicaid Plan.
- Beneficiaries receiving Supplemental Security Income (SSI), but not Medicaid.

Beneficiaries not falling into one of these categories must apply for the LIS. This means they must submit an application to their state Medicaid agency or SSA, which is responsible for determining eligibility. Upon receipt of approval from SSA, beneficiaries may begin receiving subsidized benefits. Of course, these individuals need to be enrolled in a prescription drug plan to get these benefits. CMS automatically enrolls – or facilitates enrollment – into a plan those beneficiaries who have been approved for LIS but have not enrolled in a plan on their own.

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

Our work to identify and enroll these beneficiaries is a multi-faceted, continuous effort that did not stop with the end of the first enrollment period; rather it has been a sustained and ongoing effort. We continue to target potentially eligible LIS individuals with a multi-pronged education and outreach campaign that leverages existing information

intermediaries and resources. Initiatives include direct mailings and targeted telephone calls to beneficiaries, along with local outreach from community groups, intergovernmental partners, and health care providers, including pharmacists. Given that many beneficiaries may be difficult to reach through traditional means, CMS has special initiatives targeting both urban minority beneficiaries, and beneficiaries in rural areas who may be isolated from general community outreach efforts.

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

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

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

In addition, the U.S. Administration on Aging (AoA) has been crucial to both the success of LIS beneficiary enrollment, as well as the success of Part D in general. Prior to the open enrollment period, AoA granted a contract to assist with the enrollment of beneficiaries into Part D. A large part of this contract supported grassroots efforts to

target hard-to-reach populations, especially in minority and disability communities. Partner organizations included National Adult Day Services Association, Meals on Wheels Association, National Alliance for Hispanic Health, and American Association of Homes and Services for the Aging, just to cite a few.

Also, CMS has worked collaboratively with the USA Freedom Corps and the U.S. Department of Housing and Urban Development to distribute LIS literature and materials to people living in subsidized housing, and the US Department of Agriculture to identify individuals through the food stamp program who might be eligible for the LIS.

The SHIPs and the Health Assistance Partnership (HAP) that supports them also have been invaluable partners to CMS in helping LIS eligible beneficiaries. SHIPs in each State offer local one-on-one counseling and assistance to people with Medicare and their families. Through CMS funded grants directed to States, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. Although SHIPs have a diverse portfolio of health care issues for which they help beneficiaries, the CMS grant provided to SHIPs directed them to increasingly focus their attention and efforts during enrollment opportunities on hard-to-reach populations, including the LIS eligible population.

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

CMS is also grateful for the assistance of the National Council on Aging (NCOA) and ABC-Rx in supporting our outreach efforts. CMS and AoA worked together to contract with NCOA to develop an on-line Low-Income Subsidy application service from June 2005 to September 2006. In addition, NCOA received a CMS-funded grant to reach and assist beneficiaries in applying for LIS, and subsequently enroll beneficiaries in a plan. Also, as part of its coalitions – ABC-Rx and Benefits Checkup Rx -- NCOA came up with innovative outreach strategies to find and help people file for the low-income subsidy.

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

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

CMS continues to leverage existing relationships with hundreds of community-based organizations around the country. These include schools, senior-centers, community centers, and places of worship. Having a unique relationship with the community, these organizations are able to understand the populations they serve and can best identify their

needs. CMS has also conducted over 1,200 “train-the-trainer” events with local and national partners on LIS-specific outreach, including SHIP counselors, physicians, pharmacists, Federal/State/local government partners, and hundreds of community organizations across the country to reach LIS beneficiaries and provide individual guidance. In addition, as natural partners, CMS works in ongoing efforts with physicians, providers and their staff to provide counseling services and enrollment activities for the low-income population.

Medicare Savings Programs

Under Medicaid, the term “dual eligibles” generally refers to low-income Medicare beneficiaries who also qualify for medical assistance from the State. Those entitled to full benefits under Medicaid generally have most of their health care expenses paid for by a combination of Medicare and Medicaid. However, Federal law also specifies several groups of elderly and disabled Medicare beneficiaries whose income and/or resources are too high to qualify for full Medicaid benefits but who need assistance with Medicare premiums and cost-sharing requirements. While these beneficiaries are not entitled to full Medicaid benefits, they are entitled to more limited medical assistance, specifically payment of Medicare Part A or Part B premiums or cost sharing, such as payment of Medicare deductibles and coinsurance. These state-run programs are referred to collectively as Medicare Savings Programs (MSP). The specific groups that make up the MSP programs are Qualified Medicare Beneficiaries (QMBs), Specified Low-income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). These programs enable low-income Medicare beneficiaries to afford Medicare coverage and thus promote access to necessary health care.

Qualified Medicare Beneficiary (QMB)

Through this program, States are required to provide assistance to Medicare beneficiaries with resources at or below twice the standard allowed under the Supplemental Security Income (SSI) program (\$4,000 single, \$6,000 couple) and income at or below 100% (\$851 single, \$1,141 couple per month) of the Federal poverty level (FPL). Benefits under this program are limited to payment of Medicare Part A and B premiums,

deductibles, and coinsurance (excluding Medicare Part D cost sharing). The federal government matches the costs of this assistance at the same rate that it matches the costs of the full benefits package.

Specified Low-Income Medicare Beneficiary (SLMB)

Through this program, States are required to provide assistance to Medicare beneficiaries with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% (\$1,021 single, \$1,369 couple per month) of the FPL. The benefit under this program is limited to payment of the Medicare Part B premiums, which is \$93.50 per month in 2007. The federal government matches the costs of this assistance at the same rate that it matches the costs of the full benefits package.

Qualifying Individuals

Qualifying Individuals (QIs) are those who are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program, and if their income exceeds the SLMB level, but is less than 135% (\$1,149 single, \$1,541 couple per month) of the FPL. QIs receive assistance in the form of payment of their monthly Medicare Part B premiums. Unlike QMB and SLMB, the QI program is not an entitlement. Unlike QMB and SLMB, federal funding for QI is capped each year so States serve eligible people on a first-come, first-served basis until the State reaches its federal funding limit. The QI program is completely federally funded: States are not required to provide a State match.

Program	Income Limit	Resource Test	Benefit
<u>Qualified Medicare Beneficiary (QMB)</u>	Less than 100% FPL (\$851 single, \$1,141 couple per month)	Twice the standard allowed under the Supplemental Security Income (SSI) program (\$4,000 single, \$6,000 couple)	Part B premium; Part A premium (if any); Part A and Part B deductibles and coinsurance
Specified Low-Income Medicare Beneficiary	More than 100% FPL but less than	Twice the standard allowed under the	Part B premium

(SLMB)	120% FPL (\$1,021 single, \$1,369 couple per month)	Supplemental Security Income (SSI) program (\$4,000 single, \$6,000 couple)	
Qualifying Individuals	At least 120% but less than 135% FPL (\$1,149 single, \$1,541 couple)	Twice the standard allowed under the Supplemental Security Income (SSI) program (\$4,000 single, \$6,000 couple)	Part B premium

Enrollment in Medicare Savings Programs

Rates of enrollment in MSPs are well below those of other means-tested programs. According to the Congressional Budget Office (CBO), enrollment in the QMB program was only 33% of the expected QMB eligible-population and SLMB enrollment was at a 13% of the estimated eligible population.

Identifying and enrolling Medicare beneficiaries in the MSP is difficult, as well as time- and resource-intensive. The programs are difficult to explain and understand. The need for education extends beyond potential eligibles to county workers, health care professionals, aging service providers, and volunteers. Cultural values of self-reliance, an unwillingness to disclose personal circumstances, and a distrust of government are particularly strong in many ethnic communities where potential MSP-eligible beneficiaries reside. The welfare stigma associated with government programs is a significant barrier to enrollment for many older Americans. Contacting and informing potential beneficiaries about the program is particularly challenging in geographically isolated and sparsely populated regions.

Increasing enrollment is crucial to relieving the financial burden of healthcare to our most vulnerable population. Research consistently shows these beneficiaries are more likely to be old, female, African-American, or Hispanic, and living alone. Their health status is more likely to be fair to poor. However, we continue to strive to help these people enroll

in the MSP program as enrollment in a MSP helps improve access to healthcare services, ultimately improving one's health status.

In 1999, under the Government Performance and Results Act (GPRA), CMS launched an initiative to "improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance." As part of its efforts to achieve this goal, CMS convened a group of federal and state representatives to create a national strategy for increasing enrollment in the MSPs. To support these efforts, CMS contracted with researchers to profile the characteristics of enrollees and those eligible but not enrolled, assess the effectiveness of state and federal outreach programs, and estimate the enrollment rate in the Medicare Savings Programs. To further this CMS GPRA goal, CMS contracted with RTI International to provide information on the effects of the Medicare Savings Programs, as well as factors that influence program participation.

Looking Ahead: Reaching the Those Yet to be Enrolled in LIS and MSP

Despite all the progress made to date, CMS is committed to doing more. Working with our partners, we will continue our outreach and education effort beneficiaries who could be eligible to apply for LIS or one of the Medicare Savings Program. We continue to believe that the best way to learn about these benefits is to receive personalized assistance on getting the most out of their Medicare benefits.

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



Chairman STARK. Thank you very much. I think at this point, we will recess for about 15 minutes until we return from the vote, if you two would not mind waiting for us. Maybe we can even find you a cup of coffee while we are gone.

[Recess.]

Chairman STARK. The Committee will resume the hearing. Members will be returning a bit at a time from the Floor and their votes.

Mr. Kocot, I guess I'm disappointed in the lack of suggested solutions or a discussion in your testimony of the problems that need to be solved.

It was a marvelous ten pages of praising the Agency and detailing your past efforts, but I did not find that you acknowledged what more could or should be done or even any evaluation of the effectiveness of some of the strategies you mentioned, that you have had contracts for programs, but I could not gather from your testimony what the results were.

At the bottom of page ten, you give us a little hope in that you pledge a commitment to do more. I could not find out what "more" was.

Could you help us help you help the beneficiaries? I would like to know what you think can be done administratively to get more folks the benefits of LIS and MSP, to which they are entitled.

Tell me what you can do and what you plan to do administratively, and then would you suggest what we can do legislatively that you will support to help accomplish this goal.

Mr. KOCOT. I will be happy to, Mr. Chairman. First, let me take a step back because I want to just kind of ground this discussion and the fact that we are only in the second year of this program. It is a brand new benefit. Our primary objective was to get the benefit up and running and get the people in that needed the help that we could get.

We undertook a massive effort——

Chairman STARK. This is also about the Medicare savings programs.

Mr. KOCOT. I understand that, sir. I am getting to that. We undertook a massive effort to reach a lot of people in a very short period of time, get them in. Get them enrolled. Get them signed up for a benefit, in addition to signing up for the Medicare benefit.

Going back to the MSP programs, back in the early part of the decade, we did a lot of research on what was effective and what was not effective. We learned quite a bit from that research, particularly in that large Government programs, large Government efforts, largely do not work for the people who are the hardest to find, specifically those in minority communities, the poorest of the poor, and so forth.

It is the one-on-one counseling and outreach to them through local organizations, through trusted intermediaries, that works best with that population. We have penetrated quite a few in the initial stages of this benefit. We are now focusing our campaign towards those hardest to reach, those most resource intensive and most expensive population to reach, to get those in the community to work with us on targeting them on a one-on-one basis.

In terms of what we are actually doing specifically in terms of the minority communities, I mentioned in my testimony and in my oral what we are doing with some of the larger organizations, but it is really the on the ground organizations that count the most.

We are working with the NAACP, the National Center for Black and Aged, the National Hispanic Council on the Aging, the National Asian Pacific Center on the Aging, the Office of Minority Health.

We have targeted efforts in the African American community planned, and already, I will say our minority enrollment, particularly in the African American, Hispanic and Asian populations, is above the average.

We feel like we have had a considerable amount of success so far, but our effort really has to turn now to a more focused hand-to-hand—

Chairman STARK. Are those both LIS and MSP or just LIS, those outreach programs?

Mr. KOCOT. This is primarily for LIS. Remember, on MSP, our charge is a little bit different. Specifically with MSP, we do alert beneficiaries in the Medicare and You Handbook they get about the MSP program. We participate with the 1144 letters with Social Security that go out to MSP eligibles or who we think are MSP eligible.

We are launching a campaign this year to provide more data to the states for MSP enrollment, our leads program, and we will continue.

As a matter of fact, the campaign that we have going on in the grassroots community dove tails very, very nicely with what the states might want to do on MSP.

Remember, the MSP program is a Federal/state initiative. It really is a partnership with the states, so the states have to participate as well. We are making those opportunities available, but that is for them to decide on how they want to participate.

Chairman STARK. What can we do legislatively that you would support? Anything?

Mr. KOCOT. I do not know that you can do anything legislatively for us to reach these people on an one-on-one basis. That is really up to partnerships with local organizations, and that is relationship building.

We are doing everything that we can right now, we think, that we possibly can, but obviously, we can do more, more creativity and working with us and having these discussions that we find very, very helpful. If you have ideas, we are happy to incorporate them into our efforts, and certainly we have not found the magic bullet, but we are going to keep banging away at it.

Chairman STARK. I would just note that your recent handbook does not mention MSP until somewhere back after 70 odd pages. Any reason you hid that toward the back of the book?

Mr. KOCOT. I cannot speak to that directly, sir. Although I will tell you that much of that handbook, I believe, is mandated by statute. I am not so sure about the ordering, but there is a lot in that because a lot is required.

Chairman STARK. It is my understanding, Ms. Dismar, that you send Mr. Kocot and his colleagues a lot of information that you re-

ceive for people who apply for various programs. You send them asset information, income information that you receive; is that correct?

Ms. DISMAN. We provide information to CMS on our daily decisions.

Chairman STARK. Both people who qualify and do not qualify?

Ms. DISMAN. Both people.

Chairman STARK. What do you do with that information, Mr. Kocot?

Mr. KOCOT. I am sorry, I did not follow the answer.

Chairman STARK. You get a lot of information from Ms. Disman about people who apply for various programs through Social Security. That information includes income information, asset information, a whole host of very valuable stuff. What do you do with it?

Mr. KOCOT. As I said, we are going to be providing quite a bit of it to the states.

Chairman STARK. But right now you do not do anything with it?

Mr. KOCOT. I will have to get back to you on the specifics of—

Chairman STARK. What do you think the states will do with it?

Mr. KOCOT. Presumably, if we are giving it to them and they want it—

Chairman STARK. There is somebody that knows what you do with it. In terms of the LIS data, let me give her a raise.

Mr. KOCOT. I am sorry?

Chairman STARK. Never mind. Go ahead.

Mr. KOCOT. We use the LIS data to facilitate enrollment for those who are not dual eligibles.

Chairman STARK. Facilitate what?

Mr. KOCOT. Facilitate enrollment.

Chairman STARK. How?

Mr. KOCOT. We place LIS eligible beneficiaries who have not selected a plan by the end of the enrollment period into a plan.

Chairman STARK. You just automatically enroll them without consulting them?

Mr. KOCOT. We automatically enroll them if they have applied for the subsidy or if they are qualified for the subsidy and they have not enrolled in a plan. It does not do them much good to have a subsidy if they are not enrolled in a plan.

Chairman STARK. Again, I guess your answer to the other question is you really cannot think of any legislation that we could do that would help you.

Mr. KOCOT. I cannot think of any right now.

Chairman STARK. Okay. Put your thinking cap on.

Mr. DOGGETT. Will you yield?

Chairman STARK. Sure, Lloyd.

Mr. DOGGETT. Mr. Kocot, I gather that you agree with the thrust of Mr. Camp's opening statement and comments others of us have made that on this program, the low income extra help program, as with all other aspects of Government, what we are after is the most cost effective solution.

Mr. KOCOT. That is right.

Mr. DOGGETT. How much on this multi-media campaign that you say you are about to launch, how much money is the Medicare

Administration expending to try to get more people in the low income extra help program?

Mr. KOCOT. I do not have an exact figure for you.

Mr. DOGGETT. Is that something you could give us next week?

Mr. KOCOT. I can try.

Mr. DOGGETT. You cannot think of any legislative ideas, but of course, you are aware, although I know you are Director of Legislation at Medicare and was not aware even as of the day before yesterday that the Social Security Administration, about the first thing they did after this bill was enacted, was to ask the Internal Revenue Service for information on who should be targeted to receive this benefit.

You are aware of that today, are you not?

Mr. KOCOT. I defer to SSA in the conversation they had with IRS.

Mr. DOGGETT. I am asking you, sir. Are you aware today from my testimony—have you ever looked at the Inspector General's report?

Mr. KOCOT. Yes, I have, sir.

Mr. DOGGETT. You are aware, if you have read it, that the Social Security Administration shortly after this bill became the law, asked the Internal Revenue Service for information about who would be eligible for this extra help program, are you not?

Mr. KOCOT. Yes.

Mr. DOGGETT. Yes, sir. They declined to give it. The Inspector General, a Republican appointee, Health and Human Services, said "Access to IRS data would help CMS and SSA identify the beneficiaries most likely to be eligible for the subsidy."

They pointed out similar information that is used with other programs.

Do you disagree with the conclusion that I have just read from the Inspector General?

Mr. KOCOT. I do not know that I disagree with the conclusion. I do not know that the conclusion is as well informed as it could be, with all due respect.

Mr. DOGGETT. You do not disagree with the conclusion, but you think there is more to the story?

Mr. KOCOT. Yes, I do.

Mr. DOGGETT. If you do not disagree with the conclusion that access to the data would help identify the beneficiaries, instead of doing a scatter shot multi-media approach, why has not CMS come forward and recommended and why are you not recommending in answer to the Chairman's question that we change the law to make that information, that limited information, available so you can do a better job?

Mr. KOCOT. First of all, sir, the information that you are talking about, because of the population that we are talking about, it is questionable how effective that information would be in terms of finding the beneficiaries that we are looking for.

Mr. DOGGETT. It would find some, would it not?

Mr. KOCOT. It would exclude some.

Mr. DOGGETT. It would identify some individuals who have less than \$13,000 in income, would it not?

Mr. KOCOT. I do not know about specific income thresholds.

Mr. DOGGETT. I am talking about the threshold that applies to this program. There is no reason that you could not identify—you might get all three million—you could identify some of them.

Mr. KOCOT. No, the IRS, in conversations that we have had with the IRS, they have indicated that we might identify 100,000 to 200,000 people of the entire population.

Mr. DOGGETT. Let me ask you, when did you first ask the IRS for that information?

Mr. KOCOT. I do not know the exact date.

Mr. DOGGETT. When did you personally get involved? In anticipation of this hearing within the last few days?

Mr. KOCOT. Yes.

Mr. DOGGETT. Yes, sir. Who did you talk to over there?

Mr. KOCOT. Yesterday, we had a conversation with your staff. I do not know exactly who—

Mr. DOGGETT. You do not know the names of anyone you talked to at the Internal Revenue Service?

Mr. KOCOT. We can get it for you.

Mr. DOGGETT. I will continue in a few minutes. Thank you, Mr. Chairman.

Chairman STARK. Mr. Camp?

Mr. CAMP. Thank you, Mr. Chairman. Thank you both for your testimony.

I have a question particularly. The low income subsidy has an outreach or enrollment of 10 million out of the 13 million eligible in just 14 months of the program, which means 75 percent of those eligible are enrolled.

The MSP has in the QMBs about 33 percent enrolled, and in the specified low income Medicare beneficiaries, about 13 percent enrolled, and that is over a 30 year period.

You correctly pointed out in your answer to Mr. Doggett that one is simply a Federal run program, one is a combination of state and Federal programs.

In terms of the Part D program, we have a fairly high level of outreach that has been very successful.

My question, Mr. Kocot, what flexibilities are currently available to the states to help simplify the application and enrollment process for the MSP program as that is a Federal/state partnership?

Mr. KOCOT. Actually, the states have quite a bit of flexibility in terms of the MSP programs. At least a few years ago, we actually developed a model application with the states that many are now using. The states have a lot of flexibility in determining—for example, the states can do on line enrollment if they wished. A lot of their rules vary by states. They can alter their rules. They do not have to use some of the asset and income restrictions that some of them do use. Those are choices they make.

There is quite a bit of flexibility in terms of how they determine addition a liquid assets and so on. The states have quite a bit of flexibility to tailor their programs.

Mr. CAMP. There is an asset test with these programs. What is the reason behind that? What is its purpose? Why does it exist?

Mr. KOCOT. These are means tested programs. If people have sufficient assets to afford their health care, that is something they should be paying for rather than the state.

The asset test is designed to really exclude those people who can afford this benefit without the state financing it.

Mr. CAMP. I have a question for both of you. In my district, we have encountered some difficulties in the premium withholding part of Medicare Part D. As you know, this is when the Social Security Administration tracks a beneficiary's premium for a monthly Social Security benefit.

We have experienced some difficulties that I have heard from my constituents in my district office when beneficiaries change their plans but continue to have the premiums withheld from their old plan.

My office has contacted CMS and SSA. They have tried to speed this process along. We are routinely told it will take three to four months to have people get their money back and to fix the situation. In my view this is far too long, it is unacceptable.

I am concerned that as we require different agencies to share information, more problems like this can occur. How are SSA and CMS working to resolve this problem, if you know, and if Congress requires or allows more automatic enrollment, how will we be certain that agencies will work together on these issues?

Ms. DISMAN. We share your concern that the Social Security payments be accurate and also be timely. Certainly, CMS and SSA have worked together over the last three years in first setting up the requirements for the premium withholding, and I need to step back a moment because you (the beneficiary) tell your prescription drug plan that you want to have premiums withheld from your Social Security check.

That then goes to CMS and CMS sends the data to Social Security. Certainly, the accurate and timely transmission of data is a very significant factor.

Both organizations, CMS and SSA, have worked extremely close to resolve the issues that we did experience during 2006 and certainly I am pleased to tell you that for 2007, all of the premium withholding transmissions that have come have been greatly improved.

I will say, and I will turn to Larry Kocot for 2006, we actually are working with CMS on the issue. We have sent them an abstract of our files. They are in the midst of a reconciliation. They, themselves, are looking at 2006.

More importantly, we have joint task forces that are looking at every aspect of the data exchange. I can tell you we had a major meeting in February to go over and identify problems, not just the IT people, but the program people, the business rules people. We really needed to get everyone in the same room to understand what was happening.

We set up five major subgroups with priorities on things to look at, and the status that I have is that these groups are working very well. It is my understanding that we expect to hear their recommendations shortly.

The good news is that 2007 is proceeding in a much smoother way.

Mr. CAMP. Thank you very much. If you could just briefly answer. My time has expired. If you could just be brief, Mr. Kocot.

Mr. KOCOT. I would just echo that. We had some early problems, as you know, with beneficiaries changing plans in the first few months of 2006. The systems that we had designed early on frankly did not accommodate a lot of quick changes the way our rules allowed, so we had a lot of things that we had to do with business rules. There is a lot of complex interfaces between our systems and so forth.

As Ms. Disman has said, we have done quite a bit of work and we will continue to do as much work as we need to do to get these systems working together so beneficiaries have little problem.

Mr. CAMP. Thank you. I thank the Chairman for the extra time. Thank you.

Chairman STARK. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Yes, I would, Mr. Chairman.

The extra help dimension of the Medicare Part D plan is an extremely significant benefit, but I am informed that the estimates are 40 to 60 percent of eligible beneficiaries are participating; is that correct?

Mr. KOCOT. No, that is incorrect. Seventy-five percent of those who are eligible for some form of extra help are in the program.

Mr. POMEROY. If you exclude those automatically enrolled, the dual eligible population, how many?

Mr. KOCOT. If the auto enroll population is approximately 6.6—

Mr. POMEROY. The data I have is you have six million that are dual eligibles and automatically enrolled that is the low income help part. You have three million that are in on the extra help part, and that represents roughly 40 to 60 percent of those, aside from the dual eligibles, that are eligible for this extra help.

Does that roughly strike you as correct?

Mr. KOCOT. That is probably ballpark; yes.

Mr. POMEROY. We have a tremendous benefit that is basically free drug coverage, and we have about half the population in it. We have a product that is essentially free money and only one out of two is taking it.

This is the worse sales job in the history of the country, if you cannot give away free money to more than half of those eligible.

I understand some serious efforts that been made. I think we have some program design issues, and I really admire my colleague, Congressman Doggett, in his leadership to try and get to the bottom of this.

A concern I have is that we are not doing an adequate job of getting people enrolled, and by the way, while we are at it, we are hurting our Social Security regional offices in terms of providing the work they need to do on Social Security.

We had a hearing two days ago in the Subcommittee on Social Security that showed the backlog on disability determinations just as one aspect of the program is at an all time high, never higher. This is really before the baby boomers retire.

What we are in for scares me to death, without really taking a look at these systems.

Ms. Disman, I thought that your report on what SSA has been attempting to do was really positive. I think you all have done yeoman's work. I know they have in North Dakota.

I will never forget sitting at an enrollment forum with a couple from the North Dakota regional office, and they could not even get their phone answered because there had been a hiring freeze and they had lost personnel. They were down to two in the office. They just could not get it all done. They were trying their little hearts out.

What extra resources have come into SSA relative to the new expectations we have now with trying to get people signed up for extra help on the Medicare Part D proposal?

Ms. DISMAN. Let me go back a little bit.

Mr. POMEROY. I do not have much time, so do not go too far.

Ms. DISMAN. I will not go too far. With MMA itself, initially, I think you know that Social Security received \$500 million to implement MMA in 2004 and 2005. We actually carried over \$111 million of that into 2006. Right now, the expenditures that we do for MMA come from our limitation account, our LAE account.

We actually draw down from the Supplemental Medical insurance trust fund, and a very significant item is that while we have hired people before, trained 2,200 people on the front line in those offices that you were talking about for MMA. The fact that the President's budget has not really received the Congressional support for the last five years for Social Security, we did not receive its funding, certainly does have an impact on all of our workloads.

I certainly am aware of the hearing that you had the other day.

Mr. POMEROY. We are going to do better than what the President has asked for this year, and it has been shameful that those other Congress' have not funded Social Security, and there is no co-incidental relationship between the failure of earlier Congress' under different management to fund the President's request for SSA and the fact that we have a record number on Social Security disability.

We also have them waiting to have their Social Security disability determined, among other things. The wait in service deteriorated dramatically. People waiting an hour to get their phone calls answered, not their questions answered, their phone calls answered, and on and on.

You just told us the money that was allocated to SSA for purposes of getting extra help is spent; is that correct?

Ms. DISMAN. Yes, it was. It was funds for 2004 and 2005 and \$111 million was moved to 2006.

Mr. POMEROY. Did the administration request more funds for that?

Ms. DISMAN. The funding for this comes from our regular LAE accounts, and we draw down from the Supplemental Medical Insurance Trust Fund. There really is not targeted funding specifically.

Mr. POMEROY. Our SSA offices are out of money for this purpose, yet we have only signed up about half of those eligible. We have a lot of work to do. Looking at the capacity in our systems to do the work we are asking them to do has got to be a part of what this Congress requires.

I think there have been significant efforts on the front line, but we have to get you enough resources so you can realistically get done what we are asking you to do.

Thank you, Mr. Chairman. I yield back.

Chairman STARK. Mr. Ramstad, would you like to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman. Thank you to both of you expert witnesses. Appreciate the good jobs you do out there every day, tough jobs, and you are doing them well.

Mr. Kocot, I want to ask you a question. I want to focus on the broader health care needs of lower income individuals. The empirical data certainly support the claim that lower income people typically suffer from more chronic conditions and have greater health care problems.

I believe that traditional Medicare does the best job it can with the resources, limited resources, it is given. There is often little disease management and coordination of care

On the other hand, Medicare Advantage relies on these types of programs to both keep beneficiaries healthy and to save money.

Can you talk about the importance of disease management and coordinated care, especially for lower income beneficiaries, and also could you elaborate on how this can save Medicare dollars in the long run, is it not in fact the cost effective way to go?

Mr. KOCOT. The simple answer to that, sir, is we truly believe that to be the case, but rather than just believing it, the MMA gave us many tools to try to test those hypotheses, and that is what we are doing.

As you point out, the low income, particularly the population that is eligible for LIS, is typically a sicker population and coordination of care is a true issue with their health needs.

We have a lot of different plans that are experimenting with not only coordinated care but also disease management. We have special needs plans that are specifically focused on specific conditions and the coordination of care. We have demonstration projects on disease management and coordinated care.

We are really looking forward to seeing what the results of those demonstrations are to tell you exactly on the question you are asking, how much money does it save.

Intuitively, coordinated care is going to save money. Disease management on the other hand, we need to see what specific programs work the best with these populations. Multiple chronic conditions and so forth, what works best together in order to really target the resources so we can save the maximum amounts possible.

We will have a lot of data coming, but we are not there yet.

Mr. RAMSTAD. When do you believe the findings in these studies will lead to definitive conclusions? In other words, when are the studies going to get back to you?

Mr. KOCOT. In terms of some of the disease management and coordinated care demonstrations, I believe we have some interim reports. We have others coming over the next couple of years.

That is not to say that all of those will be definitive. What the demonstrations are doing is looking at specific protocols, specific programs and seeing if they work. That is not to say that we have reached or penetrated all that might work, and we are going to continue working on this as we move into an era of better data and better coordinated care and probably a lot more evidence based results that we can put into practice.

Mr. RAMSTAD. I have another question, Mr. Kocot, I would like to ask you. I will try to be brief. We all know about the really huge burden that long term care is placing on state Medicaid programs. Certainly, my state of Minnesota is no exception. States often are seeking waivers to move dual eligibles from intensive and costly long term care to more appropriate and less costly assisted living facilities, as you know.

This creates a problem for a lot of people. Under Part D dual eligibles who live in nursing homes and other institutions do not have to pay co-pays while assisted living residents must pay them, even though they are nursing home eligible.

In the last Congress, several of us introduced the Co-Pay Equity Act to address this problem, but it did not get to the Floor for a vote.

As we begin to consider this problem again in the 110th Congress, I wanted to ask you why should these dual eligibles have to pay co-pays? What is the policy reason for that?

It seems to make no sense.

Mr. KOCOT. The exact provision you are pointing to is, it is institutionalized dual eligibles that get the zero co-pay. As you know, assisted living is not considered an institution under our interpretation of the statute. That does create a problem for assisted living facility patients, particularly dual eligibles.

We certainly support and share with you the goal of providing the right incentives to get people out of long term care facilities and into assisted living facilities and into community based care. We will continue to pursue that.

However, I think we still need to do a little work to determine whether or not providing a zero co-pay will provide the appropriate incentives. For example, most of the people that you are talking about, if they are not dual eligible, they would be either LIS or dual eligible, non-institutionalized beneficiaries and are only paying a couple of dollars in co-pays, is that enough for these beneficiaries to incent them to go to assisted living.

It is a complex problem. We are continuing to look at it.

Mr. RAMSTAD. It is a complex problem, I understand that. Can we simplify it by eliminating these Part D co-payments? Would that not in fact remove a disincentive for Medicaid beneficiaries to live in assisted living or the community rather than in a more costly institution?

Mr. KOCOT. Again, I do not know whether the co-pay itself would be enough to incent someone to go to an assisted living facility from a long term care facility. I think there are a lot of other factors in play. There are a lot of other expenses in play as well.

Mr. RAMSTAD. Other factors, you are alluding to overall health and the economics of it as well?

Mr. KOCOT. Precisely.

Mr. RAMSTAD. You sound willing to look at it and work together to delve into it.

Mr. KOCOT. Absolutely; yes, sir.

Mr. RAMSTAD. Try to solve what I see as a real dilemma and one that needs to be fixed. Thank you very much, both of you. I yield back.

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Yes, Mr. Chairman. Thank you. To the two of you, thank you very much for your testimony and we look forward to working with you as we try to resolve some of these issues.

If I gave you 15 seconds each, tell me how we make the system work better under the current operating structure that we have. I will start the clock running.

Mr. KOCOT. Which system? We have quite a few.

Mr. BECERRA. How do you get those who qualify for the low income subsidy to better enroll and those who qualify for the savings programs under Medicare to enroll? How do we get the millions who we know are eligible, as Mr. Pomeroy said, it is free money in essence, how do we get them to better enroll under the current system in 15 seconds or less?

Mr. KOCOT. I will take my 15 seconds first and talk fast. I think for the LIS population, we have done, as I said earlier, quite a bit of research on this. It is the hand-to-hand partnerships, trusted relationships, the community based relationships that are going to get those people into the program.

We are using those relationships. We are leveraging them now. We will be doing quite a bit more in the coming year.

With regard to the MSP programs, we are providing data. We are offering the opportunity for states to partner with us on these relationships, and if we can reach them with states, I think we have a good chance of enrolling some more of those as well.

Mr. BECERRA. Good job.

Ms. DISMAN. I want to talk about who we are, Social Security. We are in the community.

Mr. BECERRA. Fifteen seconds.

Ms. DISMAN. We are in the community. We do deal with people one on one, whether it be our field offices or 800 number. The focus that we really need to do is to get targeted types of individuals to deal with, we make phone calls to people that we think might be eligible.

We just made 300,000 calls to people that had the 600 dollar credit to see if they would be eligible for the Low-Income Subsidy (LIS).

It is how you narrow the list to identify people that might be eligible.

Mr. BECERRA. What I am hearing is that within the current system, you think that we can do a better job of getting the millions who have not yet for whatever reason decided to take advantage of a way to save money that they right now use for rent or food or could use for rent or food and right now they are using for their medical care.

Is there no belief that we have to sort of put a little explosive there under the current system and say it has not worked. We have 40 to 50 percent of people who could apply for some of these programs who do not, and go with something that changes the paradigm here?

For example, why are you not proposing to us that we take the two programs and say rather than have different criteria for eligibility, that we will standardize that, so that instead of filling out one very complicated four or five page form in one case, and then have to fill out another very complicated four or five page form

which asks for different information, which means you may qualify for one but may not for another, why not just come out with one form so that some of these seniors on fixed income, some not really financially literate, have an opportunity to qualify for that which they work for, and that is the benefits of these Medicare programs?

Ms. DISMAN. I think you are referring to both the Medicare Savings Programs and the LIS.

Mr. BECERRA. Correct.

Ms. DISMAN. I can talk about the LIS because certainly there are different standards.

Mr. BECERRA. Ms. Disman, I want you to tell me what is wrong with what I just proposed? Why do we have to have two different sets of criteria to qualify for a benefit that is provided through Medicare?

Ms. DISMAN. I would have to yield to Mr. Kocot, since the whole Medicare program is under their jurisdiction.

Mr. BECERRA. Let's go to Mr. Kocot.

Mr. KOCOT. Let me point out that the MSP program is actually a Federal/state partnership run by the Medicaid agencies. It is partially funded by the Federal Government and partially funded by the states. There are other parties at interest here as well.

Mr. BECERRA. You provide them with the information that helps them qualify these folks for the program; right?

Mr. KOCOT. We are beginning to, yes.

Mr. BECERRA. Without the information you provide them, they cannot qualify anybody for the program?

Mr. KOCOT. No, that is not true. They can qualify people for MSP within their states. They have the means to do that.

Mr. BECERRA. Are they going to do it?

Mr. KOCOT. That is a decision that every state has to make in terms of the level of effort.

Mr. BECERRA. Have they done it?

Mr. KOCOT. Some states have done it better than others.

Mr. BECERRA. Maybe you can provide us for the record which ones have because what I find is when you have millions of seniors who are on fixed income, who are using their money to pay for a Medicare benefit to which they would be entitled to receive at no cost or very low cost, and are trying to figure out how they buy groceries for the next week, I would think that you would want to change the paradigm that we have now, rather than talk about how the states might come up with a system because they have a Medicaid office.

Does not the Social Security Administration have these 1,300 offices, Ms. Disman, that you mentioned, that make it so valuable to try to reach out to all those seniors? Could we not use those 1,300 offices to do this joint effort instead of having some who know about one program and some who know about the other program and in some cases, many people knowing about neither one?

It is crazy. This is what drives people bonkers about Government bureaucracy. Explain to a senior why they would have to apply to two different places, filling out two different applications, complicated applications, for a benefit under in essence the same Government program?

Mr. KOCOT. They are not the same Government program. That is the point. These are different Government programs. That is the way Congress designed it.

Chairman STARK. Will the gentleman yield? We could change it, could we not?

Mr. BECERRA. Yes. Mr. Kocot, we want to get past the bureaucratic obstacles that seniors have to getting health care; right? Is that a shared goal?

Mr. KOCOT. Yes.

Mr. BECERRA. Ms. Disman.

Ms. DISMAN. Yes.

Mr. BECERRA. We want to get there. We also acknowledge that we have millions of seniors who we know qualify for these medical benefits, whether it is prescription drugs or just general health care under Medicare who are not receiving them. Agreed?

Mr. KOCOT. The numbers clearly show that; yes.

Mr. BECERRA. Ms. Disman.

Ms. DISMAN. Yes.

Mr. BECERRA. We know that part of this is that folks do not understand the programs or are not aware of the programs or find them too complicated to navigate. Fair?

Mr. KOCOT. In part; yes.

Mr. BECERRA. Ms. Disman.

Ms. DISMAN. Needs based programs are complicated; yes.

Mr. BECERRA. Why not try to find the simplest way to make sure folks who are eligible because they worked hard for these benefits in their years, productive years, who are now in retirement and able to receive these programs by simplifying the process, not making it more susceptible to fraud, not making it a giveaway to those who do not deserve it, but for those who deserve it, simplifying it so they do not have to worry about whether they are actually applying for something they are entitled to receive?

Mr. KOCOT. One of the things that we are both committed to is providing more data to the states because as you know, qualification for the MSP program is going to get someone LIS qualification as well.

Mr. BECERRA. Have you not given them enough data over the years? What you are saying is you need to give them more data. We have not given them enough data to help them get enrolled, all these seniors who have not enrolled?

Mr. KOCOT. We are committed to giving them more data.

Mr. BECERRA. That does not—

Mr. KOCOT. So, they have better targeting.

Mr. BECERRA. My time has expired, Mr. Chairman. I will yield back. This is the difficulty. You are either saying to me that you have been derelict in providing data to the states and therefore, they have not enrolled these seniors who are qualified and entitled to these benefits, or that the states have not been receiving the information they need to be able to know whom to enroll in programs that these seniors are eligible for and entitled to receive.

Both of those are bureaucratic and I think unacceptable responses because there is no guarantee if you provide one more bit of information or data to the states that they will actually enroll more people, that the end result will be more people enrolled.

While you are providing that data and during the bureaucratic running in place, there are seniors who are spending a lot of money for health care instead of on other basic necessities that should not have been spent for that.

I think that is unconscionable that we do that. I would hope that you all would be able to work with us to figure out ways to streamline the system to remove the bureaucracy so we get these folks what they have earned over the years of their work.

I yield back, Mr. Chairman. You have been gracious with the time.

Chairman STARK. Mr. Doggett?

Mr. DOGGETT. Thank you very much.

Let me ask you, Ms. Disman, as I understand it, you were designated by the Commissioner of the Social Security Administration as an expert to present on behalf of the SSA today on the low income or extra help program.

Ms. DISMAN. Yes, sir.

Mr. DOGGETT. I appreciate your testimony and your interest in working with us to reach more of these individuals.

In your professional work, have you had an opportunity to look at either the document or a summary of the document that the Social Security Administration sent to Internal Revenue Service asking for information about those who would be eligible for extra help?

Ms. DISMAN. I actually participated in the meetings, sir, with the Internal Revenue Service. We knew identifying the potentially eligible individuals would be a daunting task.

Mr. DOGGETT. Yes, indeed.

Ms. DISMAN. We wanted to really narrow the field for the outreach. We looked at what the Lewin Group had done for the Medicare Savings Programs over the years, and it was really important to identify a targeted population that we could really focus on.

Mr. DOGGETT. Indeed, because of the millions of people eligible for Part D, only a small portion of them were eligible for extra help; correct?

Ms. DISMAN. We did have a discussion with them.

Mr. DOGGETT. Did you have a written communication?

Ms. DISMAN. No, there was not a written communication, sir. We were there in a session talking about what kind of data. Being the Regional Commissioner of New York, I am very familiar that we get 1099 data and other data for the SSI program. I know we do not have data from our matches on pensions and other kinds of things.

We really wanted to narrow the 19 million, which we ultimately sent initially, by doing the screening. Of course, based on the statute, IRS had indicated to us that there would have to be a modification of 6103 in order to be able to use the data for screening.

We do understand there are privacy concerns and other concerns. As a matter of fact, sir, we have been talking to IRS about the potential for us even to do a study. For example, if we send you some names and stuff, without you telling us, can you tell us how helpful some of your data would be? We are actually still currently talking to them.

Mr. DOGGETT. You are aware that on November 17th, the Inspector General, Mr. Daniel Levinson, of the Department of Health and Human Services, sent a communication to Leslee Norwalk, the Acting Administrator at the Centers for Medicare and Medicaid Services, concerning the Social Security request to the Internal Revenue Service, and recommending that legislative action be taken to make that data that Social Security had sought and been denied, to make that available?

Ms. DISMAN. I have seen the letter; yes, sir.

Mr. DOGGETT. Since November 17, 2006, are you aware of anything that Ms. Norwalk or Mr. Kocot or anyone else at the Center for Medicare and Medicaid Services has done to attempt to get that legislative approval?

Ms. DISMAN. I am aware they were involved in discussions but I was not a party to those, so I cannot comment.

Mr. DOGGETT. Is there any disagreement that you have with the recommendation of the Inspector General?

Ms. DISMAN. I think the data would be helpful to screen beneficiaries to determine whether or not there is potential eligibility. It would make our process much more efficient in trying to narrow the scope of people.

Mr. DOGGETT. Thank you. That is the sole objective of that portion of the legislation that I have discussed with the Committee this morning, H.R. 1536.

Let me ask you about one other aspect of that, and that is the complexity for seniors who are visiting with people all over the country trying to decide if they are eligible under the asset test.

If someone receives help from their children in regularly paying their grocery bills, if they receive Meals on Wheels, a hot meal from a community service, if they receive breakfast from their church, is it possible those things will get included in the in-kind support and maintenance portion?

Ms. DISMAN. I would like to refer, sir, to the application. Very specifically, we do say that certain things are not to be counted. If you look at our application, and you certainly do not have it in front of you, it says "Do not include food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels, and medical treatment and drugs."

It tends to be assistance that people receive in paying for their rent, paying for their telephone bills, paying for some of their groceries. It has to be regular. This comes from the SSI statute, which is really the directive of MMA.

Mr. DOGGETT. If a family member buys food for a senior, would that fall within in-kind support and maintenance?

Ms. DISMAN. If it is regular throughout the year.

Mr. DOGGETT. If a church that is not Meals on Wheels provides a breakfast program or hot meal program for its members?

Ms. DISMAN. That would not be included.

Mr. DOGGETT. Would not be included, although it is not mentioned on the application specifically.

Ms. DISMAN. That is correct.

Mr. DOGGETT. It might involve some discretion around the country in how that is done.

I suppose that if there were a way to fulfill the objectives of the law and simplify the application, Social Security would have no objection to that?

Ms. DISMAN. Any simplification of a means tested program makes it easier to administer and easier for the public to understand.

Mr. DOGETT. Would you agree that there are a number of people of very modest incomes, poor seniors, who have been denied participation in the low-income subsidy program?

Ms. DISMAN. We have provided some information to your staff and to yourself.

Mr. DOGETT. I appreciate that.

Ms. DISMAN. About the people that are denied. We have also done a further longitudinal study. We will have some more information for you. I think really one has to look at what is the question, actually implementing the law as it is written.

Mr. DOGETT. I see my time has expired, Mr. Chairman, but I will have some questions if time permits for Mr. Kocot if we do a second round.

Chairman STARK. I thought I might take a little bit of a second round, and then you can have a second round, too.

Mr. Kocot, you have suggested that one of the reasons for low enrollment in Medicare Savings Programs is likely the—I think this is the quote—“the welfare stigma associated with Government programs.” Do you recall that? It is either in your testimony or you mentioned it to us yesterday. Is that your assumption?

Mr. KOCOT. Actually, that was specifically cited in a research report that we commissioned in the early 2000s.

Chairman STARK. I do not suppose that people associate Social Security with that kind of a stigma because we all pay into it. Is that a fair assumption?

Mr. KOCOT. I cannot speak for those beneficiaries, sir. I think many of them, based on the research that we have seen, are skeptical of Government programs in general. Any time anybody is talking about—

Chairman STARK. Those are just the Republicans, Mr. Kocot, and there are not many poor ones.

I would seriously question that people associate Social Security—Ms. Disman, do you think people associate your offices as welfare offices or an office which is going to provide them a payment to which they are entitled because they paid taxes?

Ms. DISMAN. I do not think they associate us with a welfare office. As a matter of fact, I think the Kaiser Foundation said we were the third trusted source of Medicare beneficiaries.

Chairman STARK. There you go. Given this stigma will attach to those applying for state assistance, why should we not just in an effort to increase enrollment ask the SSA offices to provide information on the program and to enroll the individuals there? What would be wrong with that? We would do away with that stigma, would we not?

Mr. KOCOT. To the extent there is a stigma associated with Medicaid offices and you switch to Social Security, if there is no stigma, I suppose that might move it.

Chairman STARK. Maybe we can do that. That is a great thought. Each year, Ms. Disman, you mail out a COLA adjustment notice to Medicare beneficiaries. You are going to include—you did include information this year on the LIS program, did you not?

Ms. DISMAN. Yes, we did, sir.

Chairman STARK. Could you not also include the MSP programs in the same mailing?

Ms. DISMAN. Sir, I would have to take a look at the letter. I assume from what you are saying it is not included. Let me take that back to the Agency.

Chairman STARK. Okay. One other question. You were kind enough in past testimony and at request to provide us with a lot of information about why people were turned down.

It was as near as I could tell missing in your written testimony this morning. This would be those who fail and why do they fail, asset tests, incomplete application.

Do you have those figures currently and could you submit them to us?

Ms. DISMAN. I have the results where I think Acting Commissioner McMahon sent you a letter on what our 1,000 case study showed. We do have a report that will be coming out shortly that is being done by our Office of Policy that will have more longitudinal kind of information. Certainly, when it is available, sir, we would be delighted to share it.

Chairman STARK. When you say “shortly,” will that be here in time to be included in the record of this hearing, do you suppose? In the next week or so?

Ms. DISMAN. Let me just check, sir.

Chairman STARK. As I say, you have done it in the past and it was very helpful to us to know whether it was income limits or asset tests, what was the bigger barriers to approval. That would be useful information. I appreciate that.

Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Yes, Mr. Chairman. First, I would ask unanimous consent to include a copy of the Inspector General’s report that I have referred to in the record.

Chairman STARK. Without objection.

[The information follows:]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

NOV 17 2006

Washington, D.C. 20201

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy, OEI-03-06-00120

BACKGROUND

Medicare Prescription Drug Program. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-173, established the Voluntary Prescription Drug Benefit Program, also known as Medicare Part D. Effective January 1, 2006, this program provides an optional prescription drug benefit for all Medicare beneficiaries. Beneficiaries who choose to enroll in the Medicare prescription drug program will be responsible for certain out-of-pocket costs that may include a monthly premium, annual deductible, and copayments.

Subsidy Assistance. Beneficiaries with limited income and assets are eligible to receive assistance to pay for the out-of-pocket costs associated with their prescription drug coverage (42 U.S.C. 1395w-114). The fewer resources an eligible beneficiary has, the lower his or her out-of-pocket costs will be. Some beneficiaries receive drug coverage with no monthly premium, no annual deductible, and no copayments. Other beneficiaries pay copayments ranging from \$1 to \$5, but will not pay monthly premiums or annual deductibles. Still other beneficiaries have a sliding-scale monthly premium, a \$50 deductible, and coinsurance of 15 percent.

To be eligible for the subsidy, a beneficiary's annual income in 2006 must be less than 150 percent of the Federal poverty level (\$14,700 for an individual and \$19,800 for a married couple living together) and assets should be below \$10,000 for individuals and \$20,000 for married couples. Assets include things such as bank accounts, stocks, bonds, and real estate other than the beneficiary's primary residence.

Outreach to Beneficiaries. The Centers for Medicare & Medicaid Services (CMS) has overall responsibility for implementing the prescription drug benefit. The Social Security Administration (SSA) was given responsibility for processing the subsidy applications and determining eligibility. CMS and SSA are both working to educate beneficiaries about the subsidy. CMS and SSA have divided outreach responsibilities for this population.

Page 2 – Leslie V. Norwalk, Esq.

CMS Outreach to Beneficiaries. In May and June 2005, CMS sent notices to approximately 7.2 million beneficiaries who were automatically eligible for the subsidy program. The notice informed beneficiaries about their automatic enrollment in the prescription drug benefit and subsidy programs. Beneficiaries who were automatically eligible and did not need to apply for the subsidy included: (1) those eligible for both Medicare and full Medicaid benefits, (2) Supplemental Security Income recipients, and (3) participants in the Medicare Savings Programs through which Medicaid pays for beneficiaries' Medicare premiums and cost sharing.

SSA Outreach to Beneficiaries. Between May and August 2005, SSA conducted a mailing to almost 19 million beneficiaries potentially eligible for the subsidy.¹ SSA provided beneficiaries an application form and instructions on how to apply for the subsidy. SSA also hired a contractor to conduct follow-up phone calls to beneficiaries who did not respond to the initial mailing. Beneficiaries potentially eligible for the subsidy can apply through SSA or by going to their State Medicaid agency. SSA began accepting applications in May 2005 and State Medicaid agencies began taking applications in July 2005.

SSA's goal was to have as many potentially eligible beneficiaries as possible apply for the subsidy before the prescription drug program began in January 2006. As of July 14, 2006, approximately 5.2 million subsidy applications had been processed. Just over 889,000 did not require approval because the beneficiaries already were deemed eligible or filed a duplicate application. Of the remaining 4.3 million applications, approximately 2 million were approved. Enrollment in the subsidy is ongoing and outreach efforts will extend beyond the initial prescription drug plan enrollment period, which ended May 15, 2006.

METHODOLOGY

We contacted officials at CMS and SSA to learn about their efforts to identify the pool of beneficiaries potentially eligible for the subsidy. We requested information to identify the data sources these agencies used to identify this population. We reviewed legislation, regulations, agency guidance, and congressional testimony relating to the subsidy. In addition, we reviewed data from CMS, SSA, and the Congressional Budget Office to compile general information on the prescription drug benefit and specific information on the subsidy.

¹ This mailing excluded those beneficiaries CMS deemed automatically eligible for the subsidy.

Page 3 – Leslie V. Norwalk, Esq.

RESULTS

Currently, there is no way to effectively identify the pool of beneficiaries who may be eligible for the subsidy. Neither CMS nor SSA has a comprehensive source of income data to accurately identify potentially eligible beneficiaries who need to apply for the subsidy.

CMS Data Sources. CMS has estimated that 6.1 million beneficiaries would meet the income and asset requirements if they applied for the subsidy. However, this estimate represents the size of the population likely to be eligible but does not identify which beneficiaries comprise this population. The estimate was based on information from the “Current Population Survey” and the “Survey of Income and Program Participation” conducted by the U.S. Census Bureau.² It did not identify individual beneficiaries to whom outreach efforts could be targeted.

SSA Data Sources. When developing its database for outreach to potentially eligible beneficiaries, SSA attempted to target its effort by using earnings data from the Internal Revenue Service (IRS). However, IRS objected to SSA’s use of the information which would have enabled SSA to identify individuals who met the income requirement for eligibility.

IRS reported to SSA that it could not permit use of the information because of the application of Title 26, section 6103, of the United States Code, which addresses confidentiality and disclosure of tax return information. Pursuant to 26 U.S.C. § 6103(c), IRS is authorized to disclose a taxpayer’s tax return or return information only to a person designated by the taxpayer. Therefore, this requirement does not allow SSA to use a beneficiary’s IRS records until the beneficiary completes the subsidy application form.³ Since no exception to this principle was authorized by the MMA, SSA was not able to use IRS information to target beneficiaries for outreach.

Without the ability to use IRS data, SSA used financial data from other Federal sources to identify beneficiaries who might be eligible for the subsidy. SSA identified these beneficiaries by compiling data from sources such as Railroad Retirement Board pensions, Veterans Administration benefits, and Social Security benefits. Based on this data, SSA mailed subsidy application forms to nearly 19 million beneficiaries. This mailing was an overestimate of the actual potentially eligible population because SSA did not have comprehensive income data for these beneficiaries.

² The Current Population Survey (CPS) is a monthly household survey on employment and unemployment conducted by the U.S. Census Bureau for the Bureau of Labor Statistics. CMS used data from the 2004 CPS for its estimate. The Survey of Income and Program Participation (SIPP) is conducted by the U.S. Census Bureau and provides information on the income and program participation of individuals and households in the United States. CMS used data from the 2001 SIPP for its estimate.

³ When beneficiaries sign the subsidy application form, they authorize SSA to obtain information relating to their income and assets from Federal, State, and local agencies, including IRS.

Page 4 – Leslie V. Norwalk, Esq.

CONCLUSION

Beneficiaries who qualify for the subsidy will receive substantial savings on their prescription drug costs. Therefore, it is important for these beneficiaries to be identified and informed about the subsidy so they can take advantage of the benefit.

Legislation is needed to allow CMS and SSA to more effectively identify beneficiaries who are potentially eligible for the subsidy. The identification of these beneficiaries would allow for more efficient and effective targeting of outreach efforts. Access to IRS data would help CMS and SSA identify the beneficiaries most likely to be eligible for the subsidy. Specifically, IRS earnings data would help identify individuals who meet the income threshold for eligibility.

This type of data sharing already occurs under the Medicare Secondary Payer program. Section 1862(b)(5) of the Social Security Act, enacted by the Omnibus Budget Reconciliation Act of 1989, authorizes CMS, SSA, and IRS to share information about Medicare beneficiaries and their spouses to identify situations in which another health insurer, and not Medicare, should have been the primary payer for health care services. The process of sharing this information is known as the IRS/SSA/CMS Data Match. A similar type of data exchange would help identify beneficiaries who are potentially eligible for the Part D subsidy.

Even though SSA mailed nearly 19 million subsidy applications, as of July 2006, only 2 million or approximately 33 percent of the 6.1 million beneficiaries whom CMS estimated would be eligible for the subsidy were approved for the benefit. Legislation that would allow data sharing among CMS, SSA, and IRS would help to create a more accurate pool of potentially eligible beneficiaries. The identification of these beneficiaries would allow for a more targeted and effective outreach effort to ensure that all those who qualify for the subsidy receive this important assistance. Without knowing the true population of potentially eligible beneficiaries, it is difficult to judge the success of current outreach and enrollment efforts.

We hope you will find this information useful as you look for ways to ensure that beneficiaries who are potentially eligible for the subsidy are effectively and efficiently identified. If you would like to discuss this matter further, please contact me, or have your staff contact Judy Holtz at (202) 619-1343 or through e-mail [Judy.Holtz@oig.hhs.gov]. Please refer to inspection number OEI-03-06-00120 in all correspondence.

Mr. DOGGETT. Mr. Kocot, referring you to that Inspector General's report again, it was sent to the Acting Administrator for whom I understand from your testimony you are a senior advisor, on November 17, 2006. That is almost four and a half months ago.

If I understand your testimony, since that time, CMS has not recommended the legislation that the Inspector General recommended, correct?

Mr. KOCOT. We have not.

Mr. DOGGETT. In fact, until this week, you did not bother to even contact the Internal Revenue Service about it.

Mr. KOCOT. I do not know if that is true or not, sir.

Mr. DOGGETT. You are not aware of it in your role as a senior advisor to the Administrator?

Mr. KOCOT. I am not aware of conversations we had, specific conversations we had with IRS on this specific topic, no.

Mr. DOGGETT. The recommendation of the Inspector General said "Legislation is needed to allow CMS and SSA to more effectively identify beneficiaries who are potentially eligible for the subsidy. The identification of these beneficiaries will allow for more efficient and effective targeting of outreach efforts. Access to IRS data would help CMS and SSA identify the beneficiaries most likely to be eligible for the subsidy. Specifically IRS earnings data would help identify individuals who meet the income threshold for eligibility. This type of data sharing already occurs under the Medicare Secondary Payor program."

Since getting that recommendation, as I understand your testimony, you do not have the level of enthusiasm for this recommendation that Ms. Disman voiced, but you do not think that it would be harmful to have that information.

Mr. KOCOT. We are concerned about the privacy aspects of sharing this magnitude of data and this amount of data for the benefit that it will bring. I think we have had these privacy concerns for some time now.

I believe in the letter sent back to you, Ms. Norwalk even expressed those privacy concerns.

Mr. DOGGETT. You have been offered an opportunity to evaluate specific legislative ways of addressing and protecting those privacy concerns, but as late as 6:00 last night, on that and on the other provisions that are contained in the legislation that I presented today, you have declined to comment specifically on any of those provisions, have you not?

Mr. KOCOT. I have not personally, sir. With regard to the IRS—

Mr. DOGGETT. You were involved in a phone call conversation—

Mr. KOCOT. Yes, I was; last night.

Mr. DOGGETT. Responding to my letter of about a year ago that occurred finally last night, and CMS declined to respond on any of the provisions of the bill.

Mr. KOCOT. No, that is not accurate. I was in that conversation. We had a long discussion about the utility of using the IRS data, which my understanding—

Mr. DOGGETT. CMS declined to discuss any of the other provisions.

Mr. KOCOT. I think we said we were not prepared to discuss it.

Mr. DOGGETT. Yes, sir. You were not prepared almost a year after the legislation was introduced, after it was forwarded to you, after we had meetings, after we sent it to you in advance of the telephone conversation, and indeed, you are still not prepared to discuss the other aspects of the legislation this morning, as you have declined to do in your testimony.

Mr. KOCOT. Are you answering my question?

Mr. DOGGETT. No, sir. I am asking you if that is not true, you have declined to do it in your testimony.

Mr. KOCOT. That is not true.

Mr. DOGGETT. You have not addressed any of the aspects other than in response to questions in that legislation. In fact, your ten pages of testimony praising the Agency for its good work devotes two summary paragraphs of conclusions about your desire to work together in the future, but does not respond to any of the details of the legislation.

Mr. KOCOT. As I began to say, we are not prepared yet to respond to your legislation. One of the major points that you raised is expanding or doing away with or altering the asset test. That has a cost associated with it. We have gone to our actuaries and asked for an estimate of what that cost would be so we could further engage in a more meaningful discussion with you about this.

We have not received word back from them. We are not trying to avoid your legislation or avoid you, sir. We want to be prepared when we have a discussion on specific provisions.

Mr. DOGGETT. You are still saying today, sir, that you have had great success in reaching the low income beneficiaries, and it is correct that you have near 100 percent on the dual eligibles who were automatically enrolled or facilitated enrollment for extra help, but with reference to the people who had to enroll themselves, you predicted that about 57 percent of them would enroll and only 36 percent of them enrolled.

It reminds me a little of the fellow who is standing with one foot on the embers and the other foot on a block of ice and thinks on the average things are just about right.

You have done fine where you had automatic enrollment, but for the other people, the record has been very modest. This would be one thing if we were talking about matters that were not critical to the life saving prescriptions, pain reducing prescriptions, but frankly, I find the lack of responsiveness not only to me and the 140 some odd members of this Congress that asked you to respond to us, but to the Inspector General's recommendation, a Republican appointee, from November, to not get any more responsiveness than we have gotten, it does not surprise me there are over three million people that are poor people in this country that are not getting the benefits they need.

As Members of Congress, we cannot get a timely complete and thorough response, and only get indifference and delay, and what some might call deceit, it is no surprise that poor people are not getting treated fairly under this legislation.

I yield back.

Mr. KOCOT. May I respond?

Chairman STARK. Please.

Mr. KOCOT. I will point out, sir, that compared to other public programs, some programs have been around for more than 40 years, this program, even if you take away the dual eligibles, which I do not think is fair in terms of evaluating our treatment of this program and the LIS, frankly, 38.7 percent of those dual eligibles do switch plans.

We do have to track them. We do have to keep them in the program. We do have to make sure they are serviced the way they need to be, so we treat the LIS population as one population. We do not segment them out the way you are.

Even if you do and you take between 40 and 60 percent of them are in, compared to Medicaid, the GAO has said that Medicaid right now is a 66 to 70 percent participation rate. The SCHIP program, 44 to 51 percent. Temporary assistance for needy families, 46 to 50. SSI, 63 to 73 percent. Head Start, 44 to 54 percent. Food stamps, 46 to 48 percent. Housing vouchers, 13 to 15 percent.

By any measure, in the second year of this program, sir, I think we are doing well. We have a lot more to do. There is no one debating that. This is not CMS issue. It is not an SSA issue. It is not a Congressional issue. This is an American—it should be an American priority to get these people in.

That is something that all of us have to do. That is why we are reaching out to the communities. That is why we are going very deep into the communities. That is why we are going to minority organizations.

We have a lot more to do, admittedly. We will continue to bang away at this. It is not going to happen in the first year of a program.

Chairman STARK. Mr. Camp?

Mr. CAMP. Thank you, Mr. Chairman. I appreciate Mr. Doggett is very much an advocate for his legislation. Frankly, we have not even been able to get CBO to respond with the costs.

I would urge you to work on CBO, and once we get the costs, I think it is something we certainly want to evaluate. I think you are correct in you cannot go out front until we know what this is. We have very tight budgets all the way around. We have new PAYGO rules.

We all know the difficulties Medicare is in, particularly with the wave of baby boomers retiring that costs are spiraling up and up. Obviously, we want to reach out to people who are entitled to the program.

I think frankly on Part D, the outreach has been commendable. I want to thank so many of the workers in the Social Security Administration who were there at my town meetings, who met—as you said, Ms. Disman, you do meet one on one with individuals, and really helped facilitate that.

I think last year there were difficulties with the automatic enrollment, particularly on Part D. Many of those have been corrected. I am glad to hear in terms of the testimony that you feel much more confident about those who are having withholding in Social Security, that if they change plans, it will be handled in a much easier way.

We cannot just evaluate the efficacy of a proposal without also looking at its cost. Once we get that, I hope we can have a meaningful discussion about it.

I appreciate the Chairman's time. Thank you.

Chairman STARK. I wanted to just try this. Mr. Kocot, I think I have heard you mention 15 times this morning in regard to MSP that you felt because it was a joint state/Federal program, there were certain things you could not do. Is that a fair assumption?

We are going to hear shortly from a Ms. J. Ruth Kennedy, who is involved with the Louisiana Department of Health and Hospitals. Have you read her testimony by any chance?

Mr. KOCOT. I have not.

Chairman STARK. Let me just see if you would stipulate, and you can come back at me if I am really wrong, but Louisiana has done a bang up job of enrolling people, and from what I can gather, doing all the things right to get out there and get people enrolled in these programs.

What would be wrong with CMS requiring certain procedures in all states, so they could come up to the level of Louisiana?

Mr. KOCOT. Any such requirement will have a cost to the states. I am not ready to tell you whether or not that is a good idea because I do not know what that cost would be.

Chairman STARK. What if you paid for it?

Mr. KOCOT. Again, I do not know what the costs would be.

Chairman STARK. What you are saying is there is a cost for providing health care to poor senior citizens beyond which you do not think it is right to go? Is that what you just said?

Mr. KOCOT. No, that is not what I said.

Chairman STARK. That is how I would interpret it.

Mr. KOCOT. No. What you are saying is——

Chairman STARK. Let me put it this way. Is there any cost too great that would prevent us from seeing that poor senior citizens get proper medical care?

Mr. KOCOT. I believe that senior citizens should get the appropriate care that they need and deserve.

Chairman STARK. Regardless of the cost?

Mr. KOCOT. No. Whether or not we can reach all these beneficiaries, it has a cost associated with it, we know there is a diminishing return and more expense associated with getting——

Chairman STARK. You are going to suggest to me that the only reason to not require the states to take certain steps is it might cost the states something; right?

Mr. KOCOT. No. I am talking about effectiveness. If the states are not going to be as effective with more money, is it worth spending more money to have them have the same level of effectiveness, I think is the appropriate question.

We have determined that reaching these beneficiaries, there is a stigma with state Medicaid offices. We have a lot to do on this. Just throwing more money at the states is not necessarily going to get——

Chairman STARK. That is not what I said. Requiring the states to follow certain procedures, which is certainly traditional, when they are getting assistance from the Federal Government, what would be wrong with that?

Mr. KOCOT. I would have to see the procedures first before I could comment on what specifically you are referring to.

Chairman STARK. Let's say they are as good as Louisiana's. Would you accept theirs?

Mr. KOCOT. I would commend Louisiana for doing a good job, and again, I am not familiar with their program. Whether other states have the wherewithal or whether they want to put the priority into this, that is really a state by state determination.

Chairman STARK. No, it is not. There is nothing wrong with the Federal Government requiring the states to do certain things when they are in the best interest of seeing our programs succeed, and when we are paying the majority of the funds. That is pretty traditional.

I would be glad to yield. Go ahead.

Mr. DOGGETT. Mr. Kocot, we have tried to work with CMS for a year. We have written letters. We have asked questions politely and not so politely at hearings. We now are in a situation a year later where as you say, you have actuaries, but we still do not have a response on the details of provisions in this bill from CMS.

We are five months after an Inspector General made a recommendation. We do not have really a response from CMS on that recommendation.

We have you testifying that you are satisfied that although CMS has enrolled, on those it self-enrolled, about 60 percent fewer people than you estimated you would enroll, that is good enough.

I think that demonstrates the problem that we have. We welcome your further response on any of the details. I am interested in a cost-effective system, as I said in my testimony. I want it to be cost effective. I know we have limitations here.

Having the input from the agency about cost effectiveness and about a targeted effectiveness to reach the people that need this help is critical. We are talking about people that have died, that have suffered because they are not getting extra help. They are not getting any help.

According to your own estimates, well over three million people. I know we will never sign up every single one of them. We can do a heck of a lot better job than has been done to date if we work together on it.

Mr. KOCOT. May I respond?

Mr. DOGGETT. Yes, sir.

Mr. KOCOT. I agree with you. Nowhere in my testimony will you see that we said we have done good enough. Additionally, I want to also correct something for the record because we did send a letter back to you on February 12, 2007 where we addressed using the IRS data, and we told you that we had privacy concerns about it. It is not as if we have not responded to that as well.

I do hope we can work together on this issue. As I said, I think this is an American priority. It is not just an agency priority. This involves a lot of other people, a lot of outside groups beyond Government. We all have to work together if we are going to achieve exactly what you are looking to do.

Mr. CAMP. Mr. Chairman, would you yield?

Chairman STARK. Yes.

Mr. CAMP. I just have one last question, and that is, Mr. Kocot, are there any other ways to enroll low income beneficiaries that you can suggest to us?

Are there any ideas that you might have? If not, if I am putting you on the spot, please follow up in writing at some point. If there are any other methods or ideas you have on how we might try to enroll low income beneficiaries, it would help the Committee a great deal to receive that information.

Mr. KOCOT. We actually have contracted with an outside organization to look at that very question. What I would like to do is pull some of our organizations who are closest to these beneficiaries to get their recommendations. That is really what we are talking about, going to the people who are on the ground who are touching them on a day-to-day basis, who these beneficiaries trust.

They do not necessarily trust Government, those of us in Government. We do not necessarily have the best solutions.

Let us go back and talk with our partner organizations and come back to you with some recommendations.

Mr. CAMP. If there are any existing programs that you might highlight in that, I would be interested in hearing that as well.

Mr. KOCOT. Will do.

Chairman STARK. Were you just referring, Mr. Kocot, to the RTI contract?

Mr. KOCOT. Not specifically in answer to Mr. Camp's question.

Chairman STARK. There is an RTI contract out there?

Mr. KOCOT. Yes, there is.

Chairman STARK. That was done in 1999, was it not?

Mr. KOCOT. 1999 or I think the results were in 2000.

Chairman STARK. When do you expect we will hear back on the results of that contract?

Mr. KOCOT. I will have to get back to you. I do not know what the status of it is.

Chairman STARK. It has been out there going on eight years. It would be interesting to find out what you got for your money and if you would share it with us, we would appreciate it.

Mr. KOCOT. I am familiar with some iterations of this, Mr. Chairman. However, I do not know if there has been follow-up on contracts and so forth.

Chairman STARK. It was not Bechtel?

Mr. KOCOT. I am sorry. I did not hear you.

Chairman STARK. I said it was not Bechtel with whom you contracted for that report?

I want to thank the witnesses for your good humor and patience with us this morning, and we look forward to some results for helping poor people in the future. Thank you very much.

I would like to now call the panel. Ms. J. Ruth Kennedy, who I took the liberty of referring to earlier, who now is going to prove she has one of the best programs in the country. She represents the State of Louisiana Department of Health and Hospitals in Baton Rouge.

Dr. N. Joyce Payne, a member of the AARP Board of Directors, Ms. Patricia Nemore, from the Center for Medicare Advocacy, and Ms. Emelia Santiago-Herrera, representing the Moore Consulting Group of Orlando, Florida.

Ms. Kennedy.

STATEMENT OF J. RUTH KENNEDY, MEDICAID DEPUTY DIRECTOR, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Ms. KENNEDY. Chairman Stark, Ranking Member Camp, and distinguished Members of the Subcommittee on Health, good afternoon. My name is Ruth Kennedy and I am an Medicaid Deputy Director for the Louisiana Department of Health and Hospitals.

I am responsible for Medicaid and SCHIP eligibility and enrollment for our state. For the past seven years, we made a concerted effort to increase enrollment in our Medicare Savings Programs. By any measure, we have been successful.

Now that MSP enrollees are automatically eligible for Extra Help with the Medicare prescription drug plan, these benefits are greater than ever.

Since January of 2000, enrollment in the Medicare Savings Programs in Louisiana has increased by about 43,000 people, and for us, that represents a 44 percent increase.

I want to thank the Committee for the invitation to highlight some of the strategies that have led to those enrollment increases.

Increased enrollment in Louisiana is a result of three things: Simplifying the application process, focusing on retention once someone has enrolled, and third, aggressive outreach. Outreach alone is of limited usefulness, we believe, without changes in the application and renewal process.

For us, improving retention rates was essential, since many people were having their MSP cases closed at renewal solely because they did not return the paperwork. We now conduct ex parte reviews. We use other systems to verify income and resources, and workers can now complete that annual review by phone without getting a signed application form.

Beginning in July, we intend to begin using the method that Social Security used in 2006 to conduct low income subsidy renewals for our MSP renewals. We are going to mail a letter and request that enrollees contact us only if our information is incorrect or their situation has changed.

This is because our administrative data shows that our MSP cases are almost never closed at renewal because of an increase in income or resources.

Keeping eligible people enrolled or plugging the holes in the bucket is important, not only to increase our participation, but to prevent what we believe is undue hardship.

Someone who is closed at renewal is often not even aware of it until several months later, when the direct deposit of their Social Security check is about \$280 less than they expected it would be. That is because the back premiums that they owe are automatically deducted. Then we get the calls.

Outreach is important because many people are unable to navigate even our kinder and gentler bureaucracy.

Our Medicaid employees throughout the state, in our 45 eligibility offices, have been the backbone of our grassroots efforts to increase enrollment. They live in these communities, in towns where they conduct outreach, and they are creative, imaginative, and passionate about what they are doing.

They believe that it is important and deserving of their time and effort, and they manage their regular eligibility caseload in addition to outreach.

We forged hundreds of partnerships in Louisiana with community organizations, medical providers, social service agencies, SHIP, and our local Social Security offices. These MSP partners have made a major contribution to our success as well.

Our outreach model is relatively low cost, but without some funding for outreach, we could not have achieved the increases in enrollment.

In 2002, we applied for and received a multi-year grant from the Robert Wood Johnson Foundation. We have also received through that grant valuable ongoing technical assistance from the Center for State Health Policy at Rutgers University.

While our administrative costs have been relatively modest, as you can imagine, we have seen a large increase in the monthly bill for our share of Part B premiums, a 44 percent increase in enrollment translate to a 44 percent increase in our share on the payments.

More eligible getting help with MSP translates to more eligible Louisianans enrolled in and getting Extra Help with the Medicare prescription drug plan, and we think that is a good thing.

Yet, we know for all our success, many eligible people still do not realize that help through the Medicare Savings Programs is available, or if they do, their perception is that the application process is simply too onerous for them to try to navigate.

We believe we have changed the reality, so now we continue to work to change their perception so they can get this very important benefit.

Again, I want to thank you for the opportunity to share our experience, and I would be happy to answer any questions.

[The prepared statement of J. Ruth Kennedy follows:]

**Prepared Statement of J. Ruth Kennedy, Medicaid Deputy Director,
Louisiana Department of Health and Hospitals, Baton Rouge, Louisiana**

Chairman Stark, Ranking Member Camp and distinguished members of the Health Subcommittee: Good morning. My name is Ruth Kennedy and for the past seven years I have been a Deputy Medicaid Director for the Louisiana Department of Health & Hospitals. In that position, I am responsible for Medicaid and SCHIP eligibility and enrollment in our State. During those seven years, we have made a concerted effort to increase enrollment of eligible seniors and people with disabilities into our Medicare Savings Programs. Most recently, one of the immediate goals of Governor Kathleen Blanco's 2004 Health Care Reform Plan included increasing participation of eligible but unenrolled persons in the Medicare Savings Programs (MSP).

I want to thank the Committee for the invitation this morning to share some of the methods and strategies that have proven successful in substantially increasing enrollment in the Medicare Savings Programs in Louisiana. In the period from January 2000 to April 1st of this year we have seen enrollment in the Medicare Savings Programs increase by just under 43,000 individuals, which for us represents a 44% increase. The biggest **percentage** increases were in our Pure SLMB and QI-1 Programs: 161% and 401% respectively. I make mention of this because nationally, the SLMB and QI-1 have lower take up rates than QMB.

Background

Louisiana first began to focus on increasing enrollment in MSP in late 1999 in response to correspondence from CMS [at that time HCFA] which urged states to take pro-active steps to increase participation of eligible but unenrolled people into the Medicare Savings Program.

For MSP qualifying seniors and people with disabilities, the current \$93.50 increase in their monthly Social Security check represents as much as a 17% increase in “spendable” dollars. Now that MSP enrollees are also automatically eligible for Extra Help with out-of-pocket costs and immediate enrollment into a Medicare Prescription Drug Plan, the value of MSP participation is even greater.

The increase in enrollment in Louisiana has resulted from a combination of administrative simplification and intensive, ongoing outreach. Outreach alone is of limited usefulness unless both the application **and** renewal processes are streamlined and simplified.

Application Simplification

Low literacy levels, poor eyesight, hearing impairments, memory loss and other health care problems are barriers to enrollment which we have identified and are working to mitigate. We designed a simplified Application Form specifically for the Medicare Savings Programs, eliminated the requirement for a face-to-face or telephone interview, relaxed verification requirements, and we use less restrictive methods when calculating countable resources. These are all options allowed the States by CMS. Information and application assistance is readily available through a widely publicized toll-free MSP hotline that is manned by knowledgeable Medicaid eligibility professionals.

Focus on Retention

The annual renewal process has been addressed as well, since we found in our State that many enrollees were having their cases closed **not** because they were no longer eligible for MSP, but solely because they did not return the required paperwork. We began conducting *ex parte* reviews where possible, *i.e.*, using our inquiry rights to other systems such as Food Stamps to verify income and resources. When an *ex parte* renewal is not possible, caseworkers can complete the review of circumstances subject to change by **telephone**, without the need for a signed renewal form. These procedures have resulted in less than 1/2 percent of our enrollees having their case closed for failure to return a renewal form.

Beginning in July, we are further simplifying MSP renewals by adopting the technique used by the Social Security Administration to conduct renewals for Low Income Subsidy. We will mail letters advising enrollees of the income and resource information on our records and request that they contact us **only** if our information is incorrect or their income or resources has changed. Otherwise they need not do anything. A careful review of our administrative data revealed that our MSP cases are almost never closed at renewal because of increased income or resources so we believe this is responsible public policy.

We know that keeping **eligible** people enrolled—or plugging the holes in the bucket—is an important key to increasing Medicare Savings Program participation. Reducing closures at renewal for purely procedural reasons and simplifying the renewal process have resulted in significant administrative savings for the Department as well.¹

Closures at renewal can result in undue hardship for this vulnerable population. Persons closed at renewal are often not aware that their case has been closed until they discover that the amount of the Social Security check directly deposited into their checking account is ~\$280 less than anticipated. The retroactive and current premiums due to SSA were automatically deducted.

Importance of Outreach

We have made substantial administrative changes. But the reality is without help, many people in our target population are unable to navigate even our “kinder, gentler” bureaucracy. The **only** way to reach them is through intensive outreach and face-to-face interaction—contact with them, but also with their sons and daughters, with their grandchildren, with their nieces and nephews, with caring friends and neighbors, and with sources of information they trust.

Community Partners

We have forged partnerships with hundreds of those sources of information: SHIP outreach workers, the Social Security Public Affairs Specialists in Louisiana, community organizations, medical providers, and local social service agencies. They are valuable partners for identifying and disseminating information to potential enrollees, many who are homebound or live in rural areas. These local partners have day-to-day contact with our target audience and have credibility and the trust of their

¹ Summer, Laura **Administrative Costs Associated With Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Louisiana**, 2004 http://www.statesolutions.rutgers.edu/Reports/LA_CaseStudy_v1.pdf

communities. We have found that the messenger is very important. Our targeted population responds well to a representative at the local Social Security Office, Council on Aging, Meals on Wheels, their doctor, pharmacist, or home health provider. Without question, the MSP partners we have engaged have been instrumental in helping raise awareness and increasing enrollment.

Role of Medicaid Eligibility Employees

Medicaid eligibility employees who work in the 45 local Medicaid eligibility offices throughout the state have spearheaded our MSP community **outreach** efforts, logging literally thousands of hours. These employees—caseworkers, supervisors, and managers—live in the cities, towns, and communities where they are conducting outreach. They understand the culture. They can identify those trusted sources of information in the community and recruit partners. They have the knowledge and experience to assist with application completion and answer questions about MSP. Our eligibility offices have recruited community partners, distributed and kept stocked MSP applications in “Take One” holders, given presentations about MSP, and conducted special direct mail initiatives. They have raised awareness of MSP and provided one-to-one assistance at hundreds of events and locations, with much of the activity taking place after normal working hours and on weekends.

This past month for example—April of 2007—some of the settings in which our eligibility staff conducted MSP outreach were the Gusher Days Festival in Oil City, a Walgreens Pharmacy in New Iberia, the Etouffee Festival in Arnaudville, a community health center in Luling, the Delta Music Festival in Ferriday, a Family Life Conference in Hammond, health fairs at places of worship in Baton Rouge and Monroe, and a senior citizen’s center in eastern New Orleans.

Our initiative to empower and provide opportunities for eligibility staff to conduct outreach for the Medicare Savings Programs is the same model we had earlier used beginning in late 1998 to increase enrollment of children in our Medicaid and SCHIP Programs. Their performance has greatly exceeded our (high) expectations. Our employees have demonstrated a strong commitment to helping seniors and people with disabilities who have limited income and resources. They have proven to be creative, imaginative, and passionate about outreach and they believe that what they are doing is important and deserving of their time and effort. Staff engaged in outreach work tirelessly to maintain their regular workload while also engaging in MSP outreach efforts.²

Funding MSP Outreach

The outreach model we have employed is relatively low cost. But without monetary investment in outreach, we could not have achieved increases of this magnitude Medicare Savings Programs enrollment. In our case, funding for outreach as well as valuable technical assistance was provided by the Robert Wood Johnson Foundation through a three year *State Solutions* grant (\$140,000 annually) and a subsequent, one year, “post-Katrina” grant. We were able to claim federal matching funds for Medicaid administration (50% FFP).

With that funding we held annual conferences for staff involved in MSP outreach at which they shared promising practices, heard from national subject matter experts and networked with local MSP partners. We purchased promotional items, which we found to be essential for generating interest at our outreach events. We provided compensation to employees for travel and for work performed outside normal working hours and on weekends, we printed posters and flyers, we paid for radio commercials, and we paid for follow up mailing to individuals identified through the Social Security Administration’s “leads” file.

I must acknowledge the Rutgers Center for State Health Policy which, in conjunction with the *State Solutions* grant, provided technical assistance, guidance, and support. They provided important expertise and additional resources such as opportunities to network with other States and organizations who are working to increase enrollment in MSP.

It is important to evaluate outreach activities to assure that we are getting “the biggest bang for the buck.” We closely monitor the number of phone calls requesting MSP information or an application and the actual number of new applications received as well as enrollment and retention trends in each geographic region of the State so that we can quickly and make adjustments as needed.

² Sofaer, Shoshanna, **Assessing the Louisiana State Solutions Project**, May 2006 <http://www.statesolutions.rutgers.edu/Reports/Shoshanna%20Brief.pdf>

Program Costs in Louisiana

While the costs for outreach have been relatively modest, the same cannot be said for the impact of increased enrollment on the Medicaid Budget. A 44% increase in enrollment translates to a 44% increase in our budget for Medicare Buy-In, at the same time that Medicare Part B premiums have been sharply increasing. Unlike regular Medicaid budget cuts, in which reductions in payments to providers is an option, we do not have the latitude to reduce our state match for the “fixed” Medicare Part B premium.

I previously alluded to the rapid growth in enrollment in our QI-1 program. In FFY 05, our QI-1 allotment was not sufficient to continue enrollment beyond March. We were unable to enroll additional eligible individuals for five months while CMS was working to get us a supplemental appropriation.

Conclusion

We have found effective outreach for the Medicare Savings Programs to be more challenging than outreach to enroll uninsured children. Our target population is more likely to view government-funded programs with fear and mistrust, and stigma is certainly a factor.

Nevertheless, largely as result of Louisiana’s aggressive and sustained Medicare Savings Program outreach and administrative simplification initiative, 43,000 more Louisiana citizens with limited income and resources are now receiving much needed help with Medicare costs than received help in 1999. We had the infrastructure in place to actively participate in outreach for the Medicare Prescription Drug Program Low Income Subsidy and did so. Reducing the number of people eligible for, but not enrolled in MSP has reduced the number of people eligible for, but not enrolled in or receiving Extra Help with a Medicare Prescription Drug Plan.

For all our success in connecting with and enrolling additional people into these programs, we have reason to believe that thousands of other people in Louisiana who would greatly benefit from enrollment in MSP are not yet enrolled.

They **still** don’t realize that help through the Medicare Savings Programs is available. If they do, they’re not aware that we have simplified the application and requirements for enrollment. Their **perception** is that the application process is onerous and that it is highly unlikely that their application would be successful. We’ve all heard the axiom “perception is reality”. We’ve **changed** the reality and we are working to change the erroneous **perception**—for the sake of needy Louisiana citizens who qualify for, but are not yet enrolled and receiving the benefits, of the Medicare Savings Programs.

Thank you for the opportunity to share with your our experience.

Chairman STARK. Thank you very much.
Dr. Payne.

STATEMENT OF N. JOYCE PAYNE, ED.D. MEMBER, AARP BOARD OF DIRECTORS

Ms. PAYNE. Chairman Stark and Congressman Camp, I am Joyce Payne of AARP’s Board of Directors. Thank you for inviting us to testify on the need to improve Part D low income subsidy and other Medicare programs for people with limited incomes.

The “extra help” that 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. However, the LIS program has a serious flaw, an asset test.

No one with even one dollar more than \$11,710 in savings or a couple 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 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 MSPS, that help pay for 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 programs are automatically eligible for and enrolled in the 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 altogether. Thus, many who are eligible for the LIS under their states. MSP rules are being improperly rejected because SSA only looks at LIS criteria.

AARP believes there should be no asset test in Medicare. As a matter of public policy, we should encourage people to save for retirement, and to not penalize them for those savings.

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 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 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 they already have 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, into law this year, and eventually completely eliminate the asset test for both LIS and MSP.

We look forward to working with you. We look forward to working on both sides of the House. We ensure that we will continue to work to serve those populations that are most vulnerable in America today.

We thank you for this opportunity.

[The prepared statement of N. Joyce Payne follows:]

Chairman Stark, Ranking Member Camp, distinguished Subcommittee members, I am Dr. 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 LIS¹. 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.

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

Page 3

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.

Page 5

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.

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).

Page 6

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.

Page 7

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:

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>

Page 8

- keep the LIS cost sharing affordable by indexing it to the general inflation rate, rather than 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.

Page 9


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.



Chairman STARK. Thank you, Doctor. Ms. Nemore.

**STATEMENT OF PATRICIA NEMORE, CENTER FOR MEDICARE
ADVOCACY**

Ms. NEMORE. Good morning, Mr. Chairman, Mr. Camp, and Mr. Doggett. Thank you so much for this opportunity to testify.

I am Patricia Nemore from the Center for Medicare Advocacy. In our work, we are in contact daily with thousands of beneficiaries and advocates around the country, and we are aware of how important these programs are, which mean the difference, and we know this from the literature and we know this from our experience, they mean the difference for people with LIS between going to the doctor or not for people with an MSP benefit, and they mean the difference between getting your prescription drug or walking out of the pharmacy without it because the co-pay for your single drug is \$500. These are very, very important programs.

I want to focus on a particular aspect of this, but before I do, I just wanted to highlight your comments at the beginning, Mr. Stark, about the importance of the Medicaid program for low income Medicare beneficiaries. This is truly the place where the most low income beneficiaries get the other health care they need that is not covered by the Medicare program. While we have a lot of work to do with MSP and LIS, we need to remember what an important part of the whole protection for low income Medicare beneficiaries the Medicaid program is.

I want to just quickly tell two stories that I think illustrate some points that have been made this morning with respect to MSP and LIS.

My husband recently turned 65 and he had retired earlier, was receiving Social Security, and he received his Medicare card. With his Medicare card, he got something or other that said if you do not want Part B, let us know, and we will not take the premiums out of your Social Security check.

In contrast, if you are a low income disabled person with emphysema in the State of New York, for example, because New York's programs are not quite as enlightened as some other states, and you got the same thing my husband got. You would look at the premium and say, wow, that Part B premium is kind of expensive, I only have \$800 a month income.

I wonder if there is any way that I do not have to pay that, you would look through your Medicare and You Handbook and find references to three or four different pages which would finally tell you to call 1-800-MEDICARE, which would tell you to call your state agency, which would tell you to call your local Social Services office, which would have not a single word on any of its voice menu's about this program, so you would not really know what to do.

If you found an office near you, you would go to that office, wait for several hours, talk to someone who might not know of the existence of the program because we know that Medicare savings programs are not known, not only to beneficiaries, but not known to a lot of agency people.

When you finally found someone who did know it, they would tell you that you needed documents to prove your income and your residence and your assets, and if you did not have those documents,

you would have to go home and find them and find a way to copy them and mail them back.

If you did not mail them back, you would be terminated because you had not completed the process.

For our middle class, better off Medicare beneficiaries, we have a process of enrollment that is streamlined and easy. For our sick, frail, less well educated, isolated, often not English speaking beneficiaries, we have a process that is incredibly difficult.

I would urge this Committee and the Congress and the administration to think about ways that we can seek parity in our process, so that low income people do not bear the brunt to get the benefits that they need, that they are not bearing the heavier burden than higher income people do.

One of the things that we have heard about today is that Social Security does have some way of identifying low income beneficiaries. Mr. Doggett's legislation would target that better and make it more focused.

We know that Social Security sends letters to potentially eligible beneficiaries. What we do not know is what the states do with the data about potentially eligible beneficiaries. The states are given those data. We know there is a little bump in enrollment when people get those letters from Social Security, which come once a year. We also know that if the states were doing something with it, there might be a greater bump in enrollment, and we have no information that I am aware of as to how the states use those data.

We have heard the administration talk about sharing data with the states from the LIS applications. We have no knowledge about how or if states would use those data.

Louisiana has made a concerted effort to improve its program. It is not necessarily in the interest of states to increase their enrollments because it does cost them more money. If we really care about getting beneficiaries into these programs, we need to make them not bear the brunt of going through these very, very complex processes.

Mr. Chairman, my written testimony has many recommendations or suggestions for policy options, and I am happy to answer questions or work with the Committee further.

Thank you very much.

[The prepared statement of Patricia Nemore follows:]

Prepared Statement of Patricia Nemore, Center for Medicare Advocacy

Mr. Chairman, Representative Camp, distinguished Members of the Subcommittee. Thank you very much for this opportunity to testify about the Medicare Savings Programs (MSP) and the Part D low-income subsidy (LIS), programs that, together, provide extra assistance to low-income Medicare beneficiaries for some or all of their cost-sharing in Medicare Parts A, B, C and D.

The Center for Medicare Advocacy has a long history of serving dually eligible Medicare beneficiaries in the state of Connecticut and nationally. From our daily connection both with beneficiaries directly and with their advocates around the country, we know firsthand about the frailty of this population and the challenges they face getting the health care they need. We know of the challenges of finding and enrolling them in programs that make a huge difference in their access to care.

The Center is grateful to the Committee for its oversight of and legislative concern about these issues and to Mr. Doggett and Mr. Altmire for the important pieces of legislation they have introduced, H.R. 1536 and H.R. 1310, respectively, both of which we support.

I would like to begin my testimony with a story.

My husband turned 65 in the summer of 2005. He was reasonably healthy at the time (and still is). A few months prior to turning 65, he had retired and lost his employer-based health insurance. By filling out a very simple form, he and I were added to my employer's insurance for which we make a monthly contribution that is deducted from my paycheck. Shortly before he turned 65, he received notice from the Social Security Administration of his impending Medicare eligibility with a simple form for him to complete, including a way to inform SSA if he did *not* want Medicare Part B. My husband's switching to my insurance and then enrolling in Medicare required almost nothing of him; what was required could be done by mail and phone.

Contrast his story with that of a 58 year-old disabled New Yorker with emphysema who we'll call Mr. Gonzales. Mr. Gonzales receives \$800/month in Social Security disability payments. After his 24-month waiting period to be eligible for Medicare, he receives the same packet of information that my husband received. The question about whether he wants Part B is a hard one for him to answer because it costs \$93.50/month this year, nearly one eighth of his monthly income. Since he does speak and read English, unlike many low-income Medicare beneficiaries, he is able to read his *Medicare & You Handbook* and finds, near the front, a reference to help paying health care costs on pages 63–70. On page 63, he sees a reference to help paying premiums, discussed on page 67. On page 67, he sees that to get this help you have to have income less than \$1,123 (so he qualifies on that score) and resources of \$4,000 or less. He has a checking and savings account and a couple of small life insurance policies and thinks the accounts don't add up to \$4,000, so he might be okay.

Mr. Gonzales follows the instruction to turn to page 90 to find out how to apply and there is directed to call 1–800–MEDICARE to get the number for his state Medicaid agency. When he calls the number, he is directed to call his local Department of Social Services. When he calls that number, none of the voice menu choices sounds like the right one for information about help paying Medicare premiums, nor does it tell him how to reach a live agent with his question, so he listens for where the closest office is. He starts the voice menu over again, because he hears one choice that tells him what documents to bring to apply, although again, it does not speak specifically about help paying Medicare premiums.

Mr. Gonzales decides to take his chances and go to the office, which, fortunately for him, is only about 60 blocks away. He waits for two hours before seeing a caseworker. The caseworker he finally sees is not familiar with a program to help pay Medicare premiums, but, again, luckily for him, a caseworker nearby overhears them and tells his caseworker what to do. She asks what papers he has brought to document his name, date of birth, home address, other health insurance and income and resources (actually she is incorrect in asking him to document resources, but she never heard of the program before so didn't know that).

Mr. Gonzales realizes he has left some papers at home and asks how he can get them to her. She says he can fax them, but he doesn't have a fax machine, or he can copy them and send them to her. He leaves the office; it is now late in the day and he is having trouble breathing. He will go to a copying place tomorrow, if he is feeling up to it. If, for some reason like illness or another emergency intervening, he fails to send the papers back to her, his case will be closed for failure to follow up. He is fortunate that he speaks and reads English because he was able to find the program to help him, something that millions of beneficiaries are not able to do. If Mr. Gonzales is found eligible for benefits, he will have to requalify each year by completing forms and documenting his income and resources again.

Mr. Gonzales' story is not nearly as complicated as those of other low-income beneficiaries, who might be sicker, less literate, not speak English, not have a telephone or in other ways be less able to find the program and take the steps needed to enroll in it, but nevertheless, it demonstrates the extreme demands placed on those attempting to qualify for necessary benefits and support, often at a time when they actually need health care.

Mr. Chairman and distinguished members, I ask that we make our policy and implementation goals the creation of parity between wealthier Medicare beneficiaries and low-income beneficiaries in ease of enrollment in health insurance programs. Right now, the burden is much heavier on those who are poorer and sicker and far less able to endure the rigors of complex processes.

Most of the rest of my testimony will suggest ways to move toward that parity by expanding benefits and aligning eligibility rules of the programs, by improving identification of and outreach to beneficiaries, and by addressing enrollment challenges. I will also comment briefly on issues that arise for beneficiaries who are enrolled in these programs in using those benefits.

Medicaid

But before I talk about MSP and LIS, I want to remind us all that the program that most comprehensively serves low-income Medicare beneficiaries is Medicaid. Medicaid was passed in 1965 as a companion to Medicare, in large part to act as a supplement to Medicare's coverage for older people. More than 6 million Medicare beneficiaries get, through Medicaid, such services as long-term care, dental care, foot care, and eye care that are not available under Medicare. They get Medicare Part B premiums paid for them. Until 2006, they got prescription drugs from Medicaid. Now, their Medicaid status entitles them to the full Part D low-income subsidy. Medicaid is the single largest program of extra assistance to low-income Medicare beneficiaries, serving more people with more extensive benefits than, for example, Medicare Advantage plans.¹ Its creation, early on, is a recognition that Congress has long been concerned about assuring access to care for this very vulnerable population.

Low-Income Beneficiaries and Other Programs to Help Them

Medicaid recipients and other low-income Medicare beneficiaries are frailer, more disabled, higher users of health services, have less education, and are more likely to be minorities, more likely to be females, more likely to live alone or in an institution than better off beneficiaries. Over the past two decades, beginning in 1986, Congress has responded to their health care needs by creating programs to increase their access to care. These are the programs we know today as the "Medicare Savings Programs" (Qualified Medicare Beneficiary or QMB, Qualified Disabled and Working Individual or QDWI,² Specified Low-Income Medicare Beneficiary or SLMB, Qualified Individual or QI) and the Part D Low-Income Subsidy or LIS.

Medicare Savings Programs

The Medicare Savings Programs are operated through state Medicaid programs. The benefits are Medicaid benefits, paid for with federal and state dollars, using each state's Medicaid matching rate for federal financial participation. In determining eligibility for benefits, states must use at least the federal standards for measuring income and resources, but are allowed to be more generous. States differ in the ways they choose to be more generous, if at all.

The salutary effects of Medicaid and Medicare Savings Programs on low-income beneficiaries were noted by the National Academy of Social Insurance (NASI) in its June 2006 report "Improving the Medicare Savings Program."³ NASI cites the Medicare Payment Advisory Commission's (MedPAC) finding that *while 23% of Medicare-only beneficiaries report that they delay seeking medical care because of costs, only 8% of those with Medicaid so report*. Other research cited by NASI finds that QMB enrollees, for whom Medicaid assumes responsibility for all Medicare cost-sharing, are half as likely as non-enrollees to avoid visiting a doctor because of concern about cost. (NASI 2006)

Despite the identified health benefits associated with these programs, participation rates for MSPs have been abysmal (33% for QMB-only, 13% for SLMB-only, according to the Congressional Budget Office⁴). Barriers to MSP enrollment, which have been documented in countless studies and reports over the past nearly two decades, include health, literacy, language and transportation deficits of the target population; lack of awareness of the programs on the parts of potential beneficiaries, community-based organizations and agency workers; and the complexity of eligibility rules and enrollment processes, including requirements to report and document assets and, in some cases, requirements, such as Mr. Gonzales experienced, for face-to-face interviews with eligibility workers.

Differences between the Part D Low-Income Subsidy and Medicare Savings Programs

Part D's fully federal low-income subsidy and its implementation were modeled on MSPs, with slight, but nonetheless significant, differences. These differences, or

¹Edwin Park and Robert Greenstein, "Low-Income and Minority Beneficiaries Do Not Rely Disproportionately On Medicare Advantage Plans: Industry Campaign to Protect Billions in Overpayments Rests on Distortions." Center on Budget and Policy Priorities, April 12, 2007 at 2.

²The QDWI program, enacted in 1989, is little used and is not part of the discussion in this testimony.

³Report of the Study Panel on Medicare/Medicaid Dual Eligibles, "Improving the Medicare Savings Programs," National Academy of Social Insurance June 2006. http://www.nasi.org/usr_doc/Improving_the_Medicare_Savings_Programs.pdf (last visited April 29, 2007).

⁴Congressional Budget Office, "A Detailed Description of CBO's Cost Estimate for Medicare Prescription Drug Benefit." July 2004 <http://www.cbo.gov/showdoc.cfm?index=5668&sequence=0> (last visited April 30, 2007).

non-alignments, make it difficult to assure that low-income Medicare beneficiaries get all the benefits that will best help them gain access to the health care they need. Differences include:

- LIS applications can be taken at both the state Medicaid agency and at the Social Security Administration; MSP applications are taken only at the state Medicaid office.
- LIS applications can be submitted on-line; this is true only in a few states for MSPs.
- LIS applicants can certify to the truth of the statements in their applications, without having to provide documentation with the application; this is true only in some states for MSPs.
- LIS application process does not require a face-to-face interview; a few states do for MSPs.
- LIS income and resource counting rules are uniform throughout the country; MSP rules vary by state.
- LIS resource levels are higher than those of most states' MSPs and the income level for the partial LIS subsidy is higher than that of MSP in all but two states.
- LIS does not count non-liquid assets such as vehicles and equipment; MSPs vary by state.
- LIS does not seek to recover benefits from the estates of deceased beneficiaries; in some states, MSP benefits are recovered.
- LIS is effective the first day of the month in which an individual expresses an interest in applying; the MSP QMB benefit is effective only the first day of the month after a beneficiary's eligibility has been determined; SLMB and QI can be effective up to three months prior to the month of application, if the beneficiary was eligible in those months.
- LIS measures income against the poverty level for the actual size of the applicant's family; MSPs in most states use a measure of one or two person families only.⁵

It was hoped and perhaps expected by policy makers and advocates that the streamlined enrollment process and higher income and resource eligibility standards of the LIS would help overcome some of the barriers that have plagued MSP enrollment over the years. Yet enrollment numbers tell us something different. More than 3 million of the estimated 13.2 million thought to be eligible for the low-income subsidy have not applied for the benefit; indeed only 14% of those CMS estimates are eligible for the benefit have enrolled through the processes created for applying for LIS.

*By contrast, nearly 8.5 million people, or 80% of those who were receiving LIS in June 2006 received it because they are deemed eligible by virtue of their enrollment in full Medicaid, a Medicare Savings Program, or the federal income benefit, Supplemental Security Income (SSI) and did not have to take any action themselves to get it.*⁶

This "automatic" enrollment, through deeming by virtue of eligibility for another benefit, corresponds more closely to my husband's experience of signing up for Medicare Parts A and B than it does to Mr. Gonzales' experience of trying to get MSP benefits in New York. In fact, we know that Medicare Parts A and B have among the highest participation of any benefit programs (99% and 95.5% respectively, according to one source⁷); eligibility for Part A is automatic for most beneficiaries; for Part B, beneficiaries must opt out if they do not wish to participate.

This knowledge suggests that while we might take many steps toward improving participation rates, the ones that will be most effective are those that put the least burden on the beneficiary, just as signing up for Medicare placed little burden on my husband.⁸ This, in turn, suggests a stronger federal role in MSP and expanded federal screening opportunities for LIS, which I will discuss further.

⁵For a detailed discussion of these differences, see Patricia B. Nemore, Jacqueline A. Bender and Wey-Wey Kwok, "Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules," Kaiser Family Foundation May 2006.

⁶"Medicare: Prescription Drug Coverage Among Medicare Beneficiaries," Kaiser Family Foundation June 2006. Source: HHS, June 14, 2006. www.kff.org/medicare/upload/7453.pdf (last visited April 28, 2007).

⁷Dahlia K. Remler and Sherry A. Gile, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," The Commonwealth Fund, May 2003.

⁸See National Council on Aging, "Cost-Effective Strategies for Finding and Enrolling Low-Income Medicare Beneficiaries in the Limited Income Subsidy (LIS) And Other Key Public Bene-

First, I would like to talk about program expansions and modifications that will promote ease of enrollment.

Expanding Program Benefits

Make the Qualified Individual program (135% FPL) permanent and align MSPs with LIS income levels.

The QI program, originally scheduled to sunset in 2002, has been extended for short periods of time over the past five years. Each time it is scheduled to end, states and beneficiaries suffer great turmoil with the uncertainty of its existence. Congress, in setting the full LIS benefit at 135% FPL, established that level as a minimum for full benefits. MSPs should be amended to reflect that development in Congressional thinking.

Several approaches have been discussed among advocates and policy makers to achieve this. One is to roll the QI program into the SLMB program, so that QMB would go to 100% FPL and SLMB would go to 135% FPL. The 135% aligns them with the LIS full subsidy; the partial subsidy would remain at 150%, with no corresponding MSP.

A variation on increasing SLMB to 135% FPL, suggested by NASI in its 2006 report, is to increase QMB to 135% FPL so that those who receive the full subsidy for LIS under Part D would also get full cost-sharing assistance for Parts A, B and C. This approach is the most logical one, again reflecting Congress recognition that people with this amount of income need full benefit assistance, not merely help with their Part B premiums, as SLMB provides. Under this approach, QMB and full LIS would be aligned vis a vis income; SLMB might be expanded to 150% FPL to align with the partial LIS.

Make QMB benefits retroactive to three months before application.

This is a relatively small change that could be very significant for beneficiaries. Currently, QMB is the only Medicaid program that does not provide retroactive coverage to three months prior to application if the beneficiary was eligible during those months. In fact, QMB coverage is available only beginning the month after eligibility has been determined. The significance of this is that many beneficiaries become aware of programs at the point of need (see NASI study), i.e. when they are using health benefits. They will need the benefit to pay for the services they are receiving; if it cannot be granted with retroactive coverage, it is less valuable to them.

Expand and align, or eliminate the assets test.

For years, advocates and researchers have identified assets tests as a barrier to benefits for several reasons.⁹ To meet the test itself, beneficiaries must engage in time consuming and sometimes complex documentation of the value of various things they own, from bank accounts to vehicles to other property, other than their home. This process results in administrative costs to agencies processing applications and can result in beneficiaries being denied, not for being over assets but for failure to complete the process, such as might have happened to Mr. Gonzales if he didn't get his papers back to the caseworker. Moreover, some potential beneficiaries are unwilling to divulge their assets to anyone and will forego benefits rather than having to reveal the value of what they own.

As part of a program (such as MSP) whose income eligibility increases each year with new poverty guidelines, the MSP asset test (like those in other parts of Medicaid) is especially unfair because it is not indexed. Thus, while income limits for 100% FPL have nearly doubled since 1988 when the QMB program became mandatory (\$5,770 in 1988 to \$10,210 in 2007 for one person), the asset level has remained the same over that 20 year period. Once again, Congress has finally recognized the

fits" for discussion of creative state strategies to reach across programs to identify and enroll beneficiaries in low-income programs. Submitted as Appendix to Testimony of Howard Bedlin before U.S. Senate Special Committee on Aging, January 31, 2007. Copies are available through pnemore@medicareadvocacy.org.

⁹For discussions of the effects of the asset test on Medicare Savings Programs and on the LIS, see NASI, *supra* note 2, Thomas Rice, PhD and Katherine A. Desmond, M.S. "Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test," prepared for the Henry J. Kaiser Family Foundation, April 2005; Laura Summer and Lee Thompson, "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits," The Commonwealth Fund, May 2004; Laura Summer and Robert Friedland, "The Role of the Asset Test in Targeting Benefits for Medicare Beneficiaries," Commonwealth Fund, October 2002; Marilyn Moon, Robert Friedland and Lee Shiry, "Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs," Henry J. Kaiser Family Foundation, June 2002.

unfairness of an unindexed asset level; the LIS level changes each year according to the Consumer Price Index.

The asset test excludes many low-income beneficiaries. In 2002, researchers identified that 40% of all Medicare beneficiaries, not just those with low-incomes, had assets less than \$12,000.¹⁰ Other research, reported the same year, identified that only 48% of those who met the income requirements in effect that year also met the asset requirements.¹¹ Modest assets exclude many people from program benefits: SSA found that about 40% of those who did not qualify for LIS in 2006 were over assets, but the average total amount of assets of those disqualified was only about \$25,000.¹² Most State programs for pregnant women and children do not consider assets at all in determining eligibility for help with medical care.¹³ Only six states have eliminated the asset test for MSPs.¹⁴

The most streamlined way to proceed would be to eliminate the asset test for both programs. This approach, coupled with increasing QMB or SLMB to 135% of FPL would bring the two programs into closest alignment and make cross-deeming easy and logical. Mr. Doggett's bill proposes to increase the assets test to \$27,500 for the partial subsidy. This level, indexed, would capture many of those denied eligibility in 2006 due to being over assets. The bill includes changes to counting assets, described earlier, to eliminate consideration of life insurance and of retirement accounts. Such modifications will be important if the asset test is not eliminated. Any asset test, however, retains the barriers of administrative complexity and beneficiary reluctance to divulge information. I know Mr. Doggett is aware of those limitations.

Closer alignment would, in turn, make screening and enrolling at either a Medicaid office or a Social Security office more efficient and effective.

Screening, Enrolling, and Deeming

Screen and Enroll. Mr. Doggett's legislation, H.R. 1536, includes an important provision to expand screening: a requirement that CMS inform all new Medicare beneficiaries of the Part D LIS and give them an opportunity to be screened for the benefit, including through the use of IRS data about income and assets. Mr. Doggett also proposes to have SSA screen all LIS applicants for MSP eligibility. The next step is to determine a streamlined way to enroll them.

Screen (and enroll when eligible) all SSI applicants. Even under current law and program rules, the Social Security Administration could screen for LIS and basic MSP¹⁵ all applicants (or at least those 65 and older) for SSI who are found ineligible for that benefit. While SSA already does this screening for those who are Medicare beneficiaries, some applicants may not have Medicare because they didn't "earn" it through quarters of coverage and they cannot afford the Part B premium. If they were found eligible for MSP, they could then get Medicare and be eligible for Part D and deemed eligible for LIS. According to NASI, SSA already screens for MSP eligibility, but it does not enroll beneficiaries in those programs. It refers them to their state Medicaid agency; advocates report that requiring this entire second process makes it unlikely that beneficiaries will follow up. SSA's experience, as reported by NASI, confirms this view. In addition to requiring screening for unsuccessful SSI applicants, the law could be amended to provide for automatic QMB eligibility for all SSI recipients.

Cross-deem. Under current law and implementation, all MSP beneficiaries are deemed eligible for LIS without having to file an application; the same is not true for LIS enrollees to receive MSP. Even without the proposed expansions described above, Congress could allow for cross-deeming that would improve enrollment in both programs by assuring that whichever "door" to eligibility beneficiaries entered, if found eligible for one program, they would also receive the benefits of the other.

Avoid adverse consequences. Any process that deems or auto-enrolls beneficiaries into a public program must include the assurance that the beneficiary will be pro-

¹⁰ Moon, *supra* note 9.

¹¹ Summer and Friedland, *supra* note 9.

¹² Social Security Administration, "LIS Denial Studies," 12/11/06.

¹³ See ChipCentral chart on SCHIP eligibility at http://www.chipcentral.org/_catdisp_page.cfm?LID=121 (last visited April 28, 2007). See also Donna Cohen Ross and Caryn Marks, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," The Kaiser Commission on Medicaid and the Uninsured, January 2007 at <http://www.kff.org/medicaid/upload/7608.pdf> (last visited April 28, 2007).

¹⁴ AZ, AL, DE, ME, MS, VT. In addition, MN has raised its asset limit to \$10,000.

¹⁵ By basic MSP, I mean MSP based on federal rules, rather than the varying more liberal rules used by the states. Such a screen and enroll by SSA would capture many MSPs; those found ineligible through this process could be referred to their states for further consideration.

tected from losing other public benefits as a result of the program. With respect to MSPs, this would require amending the law to ensure that MSP benefits are not subject to Medicaid estate recovery requirements, as they currently are at the option of the state. With respect to LIS, a change in the law might assure that so-called medically needy Medicaid recipients would not cycle on and off Medicaid and the low-income subsidy from year to year.¹⁶

Other Steps to Improve Program Participation

Additional steps to improve enrollment and continued participation might be categorized as:

- Identifying/reaching out to beneficiaries and providing help with applications, and
- Simplifying enrollment and redeterminations.

Identify, Reach Out, and Help Beneficiaries

Advocates believe that potential beneficiaries could most accurately be identified through IRS data; Mr. Doggett's legislation proposes a one-time review of IRS data for current Medicare beneficiaries to improve identification of low-income beneficiaries, with a prospective use of the data, for new beneficiaries, only with their permission. IRS data would more precisely target potential beneficiaries who are, under current law, identified by SSA only by reference to their sources of federal income (from Social Security, Railroad Retirement, Civil Service and Veterans).¹⁷

While it is important to notify beneficiaries of their entitlement to benefits that can help them, experience tells us that a letter informing individuals of a benefit and how to apply for it, without more, has limited success. To the extent that beneficiaries must continue to be faced with the challenges of navigating complex eligibility rules and requirements, federal funds must be provided either directly to the entities that are the "trusted" source for specific hard to reach populations, or to states to provide grants to such entities, so that those entities can help potential eligibles apply for benefits. Congress, SSA and CMS should explore the possibilities of providing private, non-profit beneficiary-oriented "trusted sources" with specific beneficiary identifying information, by zip code to promote enrollments.

Simplify Enrollment and Redeterminations

Application

- In-kind support and maintenance. The LIS application asks for information about help the applicant gets from other family members—what SSA calls In Kind Support and Maintenance (ISM). The question is confusing and advocates report from experience that clients often don't understand what is being asked of them and give wrong answers that may disqualify them. Moreover, the consideration of ISM in determining eligibility provides a disincentive for families to help their members. More than a third of the states have eliminated this inquiry from their MSP eligibility considerations. SSA could probably do the same under existing law through the Medicare Act of 2003's directive to it to create a simple application process.
- Value of life insurance. Similarly, SSA asks applicants to report the cash surrender value of life insurance, an amount that is not known from the face value of the policy. Advocates believe this question poses a stumbling block, slowing down the application completion while the beneficiary tries to figure out how to find out what is asked of her or him. Moreover, research shows

¹⁶The plight of medically needy Medicaid recipients is particularly complex and difficult with respect to Part D and the LIS. The medically needy must show their state that they have accrued certain medical bills before they are entitled to Medicaid. Once they have accrued their "spend down" amount, Medicaid will pay the rest of their health care costs for a certain period of time, usually between one and six months. A medically needy person who met spend down at any time in 2005 was deemed eligible for LIS for all of 2006. But if they had met spend down in 2005 with high prescription drug bills, they did not have those bills for 2006 because of LIS. So they may have lost Medicaid in 2006 and thus not have been deemed for LIS for 2007. If they do not know to apply for LIS, or if they do not qualify, they will again have high drug bills in 2007, requalify for Medicaid and likely then be deemed eligible for LIS for 2008 (at least, if they are on the Medicaid rolls in the months that CMS looks at them to determine who will be deemed eligible for LIS. This roller coaster eligibility for Medicaid and LIS would be substantially mitigated, if not fully resolved, if the amount Medicare pays for the LIS counted toward their medically needy spend down.

¹⁷Section 1144 of the Social Security Act directs SSA to identify Medicare beneficiaries potentially eligible for MSPs and LIS and to communicate that information to those beneficiaries and to the state in which they reside. The information upon which SSA makes such determinations does not include non-federal sources of income, nor does it include any estimate of resources.

that about one-third of people with incomes at the poverty level would be disqualified because they have a life insurance policy above the allowed amount of \$1,500.¹⁸ Some states have eliminated this requirement for MSPs; others allow a higher amount of life insurance. SSA could probably eliminate this requirement for LIS under existing authority; it has already exercised discretion to modify the SSI rules to which LIS is linked by not counting non-liquid resources. Mr. Doggett's bill would eliminate consideration of life insurance for LIS; it would also eliminate consideration of retirement accounts in determining eligibility. This provision creates parity between those whose retirement benefits are through a company pension program (value not counted for LIS) and those whose benefits are primarily from an Individual Retirement Account or a 401(k) type account (value counted for LIS). While states are free to eliminate consideration of both of these resources, they are not required to do so. Better aligning MSP and LIS would require legislation addressed to this issue for both programs.

- Attestation under penalty of perjury. While SSA's LIS application does not require documentation of the information provided, its attestation clause is overly precise and frightening. It suggests to applicants that if they make an honest mistake, or forget to include some requested information, they can go to prison. This language should be softened.
- Authorization of information sharing between SSA and states. Currently, SSA plans to send brief identifying information about LIS applicants to states to allow them to screen for MSP eligibility. But the information to be provided is not precise enough for the state to determine eligibility without finding the potential beneficiary. SSA's LIS application could include a check off box by which the applicant authorizes SSA to share details of the application with the state so the applicant can be screened for other benefits.

Eliminate Estate Recovery for MSP Benefits

Nearly half the states require recovery of MSP benefits from the estates of deceased beneficiaries; federal law authorizes but does not require this. Estate recovery has long been identified as a barrier to enrollment for MSPs. Its elimination would promote greater interest in the benefits and make various automatic enrollment opportunities more salient. As noted above, it is essential to make this change if beneficiaries are automatically enrolled in MSP programs through other connections.

Redeterminations

The law requires the Commissioner of SSA to re-determine eligibility for the subsidy at least once after initial determination and after that, as he determines necessary. Advocates encourage programs to use processes that require the least amount of response from a beneficiary. SSA sent beneficiaries letters asking them if their circumstances had changed and if not, they were not required to do anything more. Once the initial redetermination is completed, SSA might consider, as it has authority to do, requiring nothing more of beneficiaries than that they report changes in circumstances.

Additional paths exist for requalifying for LIS can be confusing, especially for those whose circumstances fluctuate over the course of a year. Those who were deemed eligible for LIS—that is, those who are also enrolled in Medicaid, a Medicare Savings Program, or SSI—were re-deemed for 2007 if they were on the rolls in one of these programs in July of 2006. If they had been eligible earlier in the year, but not in July, they were informed they would not be deemed again and sent an application to apply for LIS through SSA. If they became eligible through Medicaid, MSP or SSI later in the year, they were once again deemed. So much moving in and out of deemed status, and having applications pending results in errors in plans' and pharmacies' knowledge of the correct cost-sharing to apply to beneficiaries. This, in turn, results in beneficiaries being unable to get drugs because they cannot afford the non-LIS co-pays charged.

When a Medicaid beneficiary loses eligibility for Medicaid benefits, states have an obligation under Medicaid law to determine if that person is eligible under another category of the state's program. For example, someone losing Medicaid eligibility might, nonetheless, still be eligible for a Medicare Savings Program, since these income and resource limits are higher than Medicaid in most states. If states routinely undertook these new determinations of eligibility for other Medicaid benefits before terminating people from the program, fewer LIS recipients would find them-

¹⁸Laura Summer and Lee Thompson, *supra* note 9.

selves in the limbo of not knowing about their LIS status. Similarly, even for those individuals no longer eligible for any benefits under the state Medicaid program, the state or the Social Security Administration (SSA) could undertake independently to determine their eligibility for the LIS, the income and resource limits for which are higher than those of most states' Medicaid programs.

CMS could remind states of their obligation to screen for eligibility for other Medicaid programs when a recipient loses Medicaid in one category and monitor their compliance. Congress could amend the law, if necessary, to require states to undertake independent determinations of LIS eligibility when a beneficiary loses benefits under the state Medicaid program.

Making the Benefit Better for Those who are Enrolled

While I know the Committee's focus for this hearing is on opportunities to increase enrollment and expand eligibility, it is impossible for me not to talk about ways to improve the benefits themselves, both so that they are perceived to be valuable and so that they are valuable. Three areas warrant particular attention:

- Failure of LIS co-pay information to be available at the pharmacy
- Lack of clarity about whether and how states pay cost-sharing for QMBs in Medicare Advantage plans and
- Lack of clarity about Medicare providers' obligation to serve QMBs without charging them cost-sharing or balance billing.

LIS Fails To Be Available at the Pharmacy Counter

Too often low-income beneficiaries with full LIS arrive at the pharmacy to discover that the pharmacist does not have access to their correct co-pay level. Some of these beneficiaries take 20 medications, or have co-pays for one prescription of over \$500. They often leave without the medication(s). The lucky ones find advocates who will work the system for them and get the problem corrected. Even "corrected" problems are sometimes only corrected for the transaction at hand; the same problem occurs when the beneficiary seeks to fill another script.

The failure of LIS eligibility and co-pay level to be available at the pharmacy is among the most common complaints we hear both directly from beneficiaries and from advocates around the country. It happens in part because of the lack of real time information exchange among all parties to a Part D transaction for low-income beneficiaries: states, CMS, SSA, the Part D plan and independent contractors who track LIS information. It also results from plans' failure to follow CMS policies which direct them to use the best available information to determine proper cost-sharing amounts.

There Is a Lack of Clarity About Whether and How States Pay Cost-Sharing for QMBs in Medicare Advantage Plans

CMS policy directs that states pay copayments for QMBs in Medicare Advantage plans.¹⁹ But states do not necessarily have systems to fully identify all the benefits in the plan in which a QMB is enrolled, nor do they all have systems for paying either the plan or the plan's providers any copayments required under the plan.

Correcting this lack of clarity and oversight for QMBs in MA plans will improve the benefit for all such individuals. It will also mitigate the damage done by marketing scams where agents of health plans go door-to-door at senior housing facilities to solicit enrollment in MA plans, enroll beneficiaries with diminished capacity or limited English proficiency, or enroll beneficiaries in an MA-PD when they wanted to enroll in a PDP. Under such circumstances, low-income beneficiaries end up in plans they did not intend to choose. Moreover, we know that, while MA plans purport to provide better and more benefits than original Medicare, their relative value depends in large measure on what services are used. We know of plans, for example, that have \$90/day co-pays starting at day 4 of a skilled nursing facility benefit; under original Medicare, by contrast, days 1–20 have no cost-sharing at all. Some plans charge 25–30% coinsurance on Part B-covered drugs, which are often expensive. Such a coinsurance would be unaffordable to someone with \$850/month income, as a QMB would have. Cost-sharing assistance would be critical to making the benefit work. CMS must assure that states have systems to identify QMBs in MA plans and to pay their cost-sharing.

¹⁹ DHHS, Health Care Financing Administration, Medicaid Letter Number: 00–09, Subject: Medicaid Obligations to Pay Medicare Cost-sharing Expenses for Qualified Medicare Beneficiaries in Medicare Health Maintenance Organizations or Competitive Medical Plans or Medicare Plus Choice Organizations—INFORMATION. August 2, 2000. Available from pnmored@medicareadvocacy.org.

There Is a Lack of Clarity About Medicare Providers' Obligation To Serve QMBs Without Charging Them Cost-Sharing Or Balance Billing.

Medicare does not permit providers to pick and choose for which Medicare beneficiaries they will bill Medicare and for which they will bill privately. If they take care of a patient with Medicare, they must bill Medicare and can bill the beneficiary only the remainder up to the Medicare allowed amount. For a person with QMB, the beneficiary's portion is paid by the state, or in some cases, not at all. It is not the responsibility of the person with QMB. CMS policy, however, seems to permit providers to decide that they will serve a person with QMB as a private pay patient and not bill Medicare at all.²⁰

This policy, together with a provision of law that permits states to forego paying the person with QMB's share of cost-sharing if the state's Medicaid payment for the same service is less than what Medicare has paid has resulted in people with QMB being denied access to health care providers, according to a federally-mandated study released in 2003.²¹ Perhaps Congress could direct CMS to correct its policy of allowing providers to bill people with QMB as private patients; such action would promote greater access to health care providers for people with QMB and make the benefit more valuable.

Conclusion

In summary, we recommend that Congress expand the benefits, make the enrollment processes easier, with greater emphasis on deeming and other nearly automatic methods of enrollment and promote improved implementation of both programs, so that low-income beneficiaries can actually use the benefits once they are enrolled.

I thank the members of this Subcommittee for an opportunity to speak on behalf of the Center for Medicare Advocacy and the thousands of beneficiaries we represent. I look forward to working with you further on these important matters.

May 3, 2007

Appendix

Medicare Savings Programs (MSPs)

Basic Subsidy Eligibility:

- **Qualified Medicare Beneficiary (QMB).** Income at or below 100% federal poverty level (FPL) (\$10,210/year in 2007); resources at or below \$4,000/individual or \$6,000/couple.
- **Specified Low-Income Medicare Beneficiary (SLMB).** Income at or below 120% FPL (\$12,252/year in 2007); resources as QMB.
- **Qualified Individuals (QI).** Income at or below 135% FPL (\$13,784/year in 2007); resources as QMB.

Indexing: Income levels change each year when federal poverty levels are announced between January and March; states must use the new levels by July 1. Asset levels are not indexed.

Income/Resource Counting Rules: Start with rules for Supplemental Security Income program, but states, under a statutory provision known as 1902(r)(2), can use more liberal rules.

Enrollment Path: The State Medicaid Agency.

Payment: Federal and state dollars. MSP benefit is medical assistance, eligible for the state's matching rate for federal financial participation (FFP). FFP for administrative costs is 50%.

²⁰ State Medicaid Manual, Part 3 Eligibility Section 3490.14 B at <http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10> (last visited April 23, 2007).

²¹ Report to Congress, State Payment Limitations for Medicare Cost-Sharing, Tommy G. Thompson, Secretary of Health and Human Services 2003, transmitted by letter of May 20, 2003 to Speaker of the House of Representatives, J. Dennis Hastert.

2007 Medicare Savings Program Groups

Category	Year Enacted	Income Limit	Resource Limit	Medicaid Pays	Entitlement
<i>Qualified Medicare Beneficiaries (QMBs)</i>	1988	100% poverty	200% of SSI limit (\$4,000/individual, \$6,000/couple)	Part B premium; Part A premium, if any; all deductibles and coinsurance	Yes
<i>Specified Low-Income Medicare Beneficiaries (SLMBs)</i>	1990	120% of poverty	200% of SSI limit (\$4,000/individual, \$6,000/couple)	Part B premium; only	Yes
<i>Qualifying Individuals (QIs)</i>	1997	135% of poverty	200% of SSI limit (\$4,000/individual, \$6,000/couple)	Part B premium; only	No

Chart Source: "Report of the Study Panel on Medicare/Medicaid Dual Eligibles: Improving the Medicare Savings Programs," National Academy of Social Insurance, June 2006
Medicare Part D Low-Income Subsidies (LIS).

Basic Subsidy Eligibility: Full subsidies for beneficiaries with incomes at or below 135% of federal poverty levels (FPL) (\$13,784/year in 2007); resources up to \$7,620/individual and \$12,190/couple in 2007. Partial subsidies for those with incomes at or below 150% of FPL (\$15,315/year in 2007); resources of not more than \$11,710/individual or \$23,410/couple in 2007.

Indexing: Income levels based on federal poverty levels announced between January and March; increases retroactive to January. Asset levels adjusted prior to January, based on the Consumer Price Index.

Income/Resource Counting Rules: Generally, those of Supplemental Security Income (SSI) program.

Enrollment Paths:

- Deemed status. For those who receive benefits of full Medicaid (dual eligibles), Medicare Savings Programs (QMB, SLMB, QI), or SSI.
- SSA door. By application, through a local SSA office, through the SSA toll-free number, or through the SSA website at www.socialsecurity.gov.
- Medicaid agency door. By application at the state Medicaid agency. If a beneficiary applies for LIS with the state, the state must also screen for MSP and other Medicaid benefits.

Payment: Benefit is all federal dollars. When states enroll beneficiaries, the states are paid at the Medicaid administrative match rate of 50%.

2007 Low-Income Subsidy Groups and Costs

Out-of-Pocket Costs	Standard Benefit	Group 1	Group 2	Group 3	Group 4
		Dual Eligibles	MSP (QMB, SLMB, QI) SSI w/o Medicaid	Income ≤ 135% FPL Resources Below \$7,620/\$12,190	Income ≤ 150% FPL Resource Below \$11,710/\$23,410
Premium	Varies by plan (\$27.35 national average in 2007)	\$0	\$0	\$0	Sliding scale: \$0 up to "benchmark" (Based on income)
Deductible	\$265 per year	\$0	\$0	\$0	\$53
Cost Sharing*	Up to \$3850 out-of-pocket	Co-pays: \$0 if institutionalized \$1/\$3.10e ≤ 100% FPL \$2.15/\$5.35>100% FPL	\$2.15/\$5.35 co-pay	\$2.15/\$5.35 co-pay	15% coinsurance
Catastrophic Coverage	Greater of 5% or \$2.15/\$5.35 co-pay	\$0	\$0	\$0	\$2.15/\$5.35 co-pay

* Individuals in the four LIS groups do not have the "Donut Hole" gap in coverage.

Chairman STARK. Patricia, thank you, and thank you for the help you have provided to the Members of the Committee, for advising us and enlightening us both today and previously.

Ms. Emelia Herrera? Did I pronounce that right?

Ms. SANTIAGO-HERRERA. Santiago-Herrera.

Chairman STARK. Welcome to the Committee. You have come a long way. Why not just tell us what you would like to tell us in any way you would like?

**STATEMENT OF EMELIA SANTIAGO-HERRERA, MOORE
CONSULTING GROUP, ORLANDO, FLORIDA**

Ms. SANTIAGO-HERRERA. First, I would like to thank you, Chairman Stark, and the Ranking Member, Mr. Camp, and Subcommittee members.

My name is Emelia Santiago-Herrera. I am from Orlando, Florida. I am 81 years old, and I have 8 grown children and 54 great grand's and 18 great great grand's.

I have had five heart attacks and three strokes. I have a lot of health problems and I need assistance. I am a low income Medicare beneficiary and receive low income benefits. I am enrolled in Medicare Advantage with prescription drug coverage and receive the full Part D low income subsidy.

I received information from a neighbor of mine about Evercare, although I did have the Medicare and You Handbook, reading it myself, but there were so many things in there that I could not decide which would be beneficial to me.

She said go with Evercare. I called Evercare. They sent two people out to the house to talk to me. I decided to enroll with them,

which I have not regretted. I depend on them and I appreciate everything they are doing for me.

They also have me with a disease management program and their nutrition program assistance. They also send someone to my house twice a week to help me clean and do errands for me because I have no transportation.

They also give me advice on my diet, which I developed diabetes in the last year. I also was told that I needed diabetic shoes, which cost \$50 an inch, which I could never afford.

Evercare got me the shoes for nothing. They also help me with a doctor who comes out to my house and does my nails because I cannot go to a regular foot doctor.

Someone from Evercare also comes to my house and sees if I am being treated right, at least every three months. They ask me questions about the attitude, disposition and personality of the person who comes to see me.

Since I am low income, all of the services I receive are a blessing. I used to have to pay my doctor a co-payment and I used to have to pay so much on certain types of medication that were not over the counter, which I cannot afford.

I want to thank you all for letting me come here today and try to explain some of the advantages that Evercare has given to me, and I hope they can continue in the future.

[The prepared statement of Emelia Santiago-Herrera follows:]

Prepared Statement of Emelia Santiago Herrera, Moore Consulting Group, Inc., Orlando, Florida

Thank you Chairman Stark, Ranking Member Camp and Subcommittee Members. My name is Emelia Santiago Herrera and I am from Orlando, Florida. I am an 81 year-old mother to 8 children, a grandmother to 54 children and a great-grandmother to 18 children!

I've had 5 heart attacks and 3 strokes, so I have health problems and need assistance. I am a low-income Medicare beneficiary and receive low-income benefits. I am enrolled in a Medicare Advantage plan with prescription drug coverage and receive the full Part D low-income subsidy.

I received information about Evercare and other Medicare Advantage plans in my "Medicare & You" Handbook. My friend told me to "Go with Evercare, they treat you with dignity and respect!" I called to see about enrolling in a plan and an Evercare representative came to my house to discuss my different options and go over everything with me. I then decided to listen to my friend's advice and enroll in an Evercare plan. I have not regretted it, I love Evercare and appreciate all the benefits I receive and depend on.

My Evercare Plan provides me with disease management, preventative care and nutritional assistance. Evercare is available to take me to the doctor 10 times a year, they give me diabetic shoes that would normally cost \$50 per inch, and a foot doctor comes to my house to clip my toe nails to avoid complications with diabetes. Evercare goes grocery shopping for me, and to help manage my diabetes, I have 14 meals delivered to my house every month. Someone from Evercare even comes to my house to clean twice a week!

To top it all off, someone from Evercare comes and checks on me every three months to make sure I am being treated well by the Evercare representatives.

Since I am low-income, all of the services I receive are just a blessing. I used to pay a \$9 co-pay for my prescription drugs but now I don't pay anything at all because of the extra help I receive. Even though I am a low-income senior, they treat me like a queen and I don't know what I would do without them and all the benefits of this plan! It is for all of these reasons: disease management, preventative care, nutritional assistance and especially the no co-pay, I don't have to live in an assisted living home.



Chairman STARK. Thank you very much. I will start the inquiry here. We may get called away again for about 15 minutes if a vote comes up. I hope some of you will be able to stay, if all of the members do not have a chance to inquire.

Ms. Kennedy, I am not sure I completely understand the Louisiana Charity Hospital setup, but it has been suggested that in some states, the governors are not too keen about enrolling more people in these plans because it costs the state something to enroll them.

That certainly would not be any of the governors you and I know, because they are all kind-hearted folks.

In Louisiana, would they not, if they were not in the MSP program, for instance, would they not become eligible for the Charity Hospital program in Louisiana? In a sense, if you get them into MSP, the state might save a little because the Federal Government would pay part of that and it would not have to be entirely born by the Charity Hospital, or is that not a correct understanding of your state program?

Ms. KENNEDY. Chairman Stark, the major benefit of the Medicare savings program is that we pay the Medicare Part B premium, which in 2000, January of 2000, was \$45.50. Now, it is \$93.50.

Whether or not someone gets their health care at one of the safety net hospitals in Louisiana, their Medicare premium for Part B coverage is \$93.50.

Chairman STARK. You mentioned all the things you do, and I am impressed by the increase that you have had. Do you have any idea to help us? We have heard today people say they do not want to impose costs on states.

Let's suppose that we said to Mississippi, you have to do what Louisiana does, maybe they do, but let's just assume they do not have as good a program as you do, what would you guess it would cost the State of Mississippi just to increase their efforts to enroll MSP people at the level you do?

Any idea how much we are talking about?

Ms. KENNEDY. I think as an indicator, I could use the amount of the Robert Wood Johnson Foundation grant, which was \$140,000 annually for three years, and then we got an extension because of Katrina and the issues with enrollment. The Robert Wood Johnson Foundation gave us an additional year.

We were able to get Federal matching funds which parlayed that \$140,000 into \$280,000. Also, that technical assistance from the Rutgers Center for Health Policy, that kind of technical assistance is helpful for states.

I might add, Chairman Stark, that a model that could be used perhaps is the 1999 Ticket to Work legislation, set aside money for states for administration, Medicaid infrastructure grants they are called. They are not mandatory. States can voluntarily apply for those grants and get help for outreach, coalition building, to improve enrollment in that program and the optional Medicare for Working People with Disabilities program.

I know those grants vary from \$500,000 annually to \$1 million. These are administrative grants with no state match requirement. Those are, I think, are an incentive for states.

Chairman STARK. Give me an idea, let's say, in round figures, you have been spending \$280,000, maybe \$300,000 a year, about how many people have you enrolled as a result, would you guess, of that kind of revenue, with that kind of expenditure?

Ms. KENNEDY. Of the 44,000—the annual mailing, even before we got the grant in 2002, we had used the Social Security leads file, but that identifies everyone who is a Social Security beneficiary. It is just as the name implies, a leads file, because it does not contain information about assets, about a spouse's income, or other income other than Social Security.

There was a mailing in 2002 by Social Security that had state specific information, the number in Louisiana to call, and we got a surge there.

I think the estimate by the GAO was that there was a .9 percent increase as a result of that mailing in Louisiana.

Chairman STARK. I am just trying to figure out with this \$300,000 that you used, about how many numbers of people do you think you signed up as a result of spending that money? Can you make a guess?

Ms. KENNEDY. 40,000 over seven years.

Chairman STARK. 6,000 people a year.

Ms. KENNEDY. About 5,000 a year, as a result of outreach and improvements in our system.

Chairman STARK. For \$60 a head, you got people signed up.

Ms. KENNEDY. It would seem.

Chairman STARK. That is pretty good, is it not?

Ms. KENNEDY. Yes, sir.

Chairman STARK. I wonder why the Federal Government thinks that would be so horribly expensive. It does not sound as expensive as fixing Katrina, does it?

Dr. Payne, I just want to commend you and your organization for pitching in here to help us. I have a suspicion that many of the people that will be helped if we follow your suggestions are not members of AARP. They probably do not have enough money left over to take advantage of all the wonderful discounts you offer the members in a variety of areas that your members can participate in.

I do appreciate your outreach and your assistance and your suggestions. I want to thank you for that.

Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Yes. Thank you very much, Mr. Chairman. Ms. Kennedy, I do thank you for your leadership and that of your agency. I would hope that the Center for Medicare and Medicaid Services could take some lessons from your success and commitment there in Louisiana.

Ms. Santiago, I am particularly pleased that you are here today because you are what this is all about. You had the good fortune to be automatically enrolled in this program. You did not have to go through a lot of hoops to get in it.

I believe that there are tens of thousands of seniors that are out there just like you that need help with their feet, that have heart medications, that have other needs, many of them probably some of your friends, that are not even able to come up to Washington as you have been able to do.

The reason that I am expressing such outrage this morning about the indifference and the delay from the Centers for Medicare and Medicaid Services is I am worried about those people, that they are not getting any of the kind of help you are getting.

When you come here today, you really demonstrate why we need to act and why we need to force a bureaucracy that has been indifferent and has delayed to get its job done, and that is what we are trying to do.

Ms. Nemore, you have focused attention on some of the practicalities of what happens when people go to apply for benefits. One of the areas that I know you and Dr. Payne support and your organizations support is what I propose to do with reference to sharing Internal Revenue Service data, but that is only one part of the bill.

Talk to our Committee a little bit about the application process itself, and some of the things in the current asset test as mandated by law, that we are trying to change, and how they make it more difficult for a person like Ms. Herrera who might want to apply and are not automatically enrolled, to get the benefits that she got.

Ms. NEMORE. Yes. Mr. Doggett, I can speak to several very particular things in the application that we believe could be changed administratively, and then I would like to talk also to your comment that Ms. Santiago-Herrera was automatically enrolled.

There are several things on the application. One, there was some conversation with the administration earlier about where you get help from your family, what is referred to as in-kind support and maintenance.

The questions on that in the application are confusing, and we understand from advocates in the field that people often do not understand exactly what is being asked in that question, and they give incorrect—they give information that is not really what is being asked, and that can disqualify them.

We believe that could be eliminated administratively because while the Social Security Administration and CMS are linked into the Supplemental Security Income program's rules, they have deviated from those rules already, and they have deviated in ways that are helpful.

Mr. DOGGETT. Has your Center asked them to do that administratively?

Ms. NEMORE. Yes, we have.

Mr. DOGGETT. How long ago was that request?

Ms. NEMORE. We and many other advocacy organizations have made those comments at every opportunity, before—

Mr. DOGGETT. Going back to 2003?

Ms. NEMORE. Yes, before the law went into effect.

Mr. DOGGETT. CMS has declined to do that so far administratively?

Ms. NEMORE. That is correct. That pertains to counting income, how you count income. Another piece that is commonly referred to that pertains to how you count assets is a question about life insurance.

Life insurance is again a confusing question because life insurance is allowed if the face value of your policy is under \$1,500, but if it is over that, then you have to report the cash surrender value.

These are terms, when I was briefing your staffs earlier this week, we realized that even among—

Mr. DOGGETT. Experts.

Ms. NEMORE. People who work on this all the time, that is very confusing terminology, and the amount has been \$1,500 since the beginning of time, and has never ever been indexed at all.

Both the lack of indexing of that amount and the confusion of having to report it, we think are obstacles on the application.

Mr. DOGGETT. You might have a senior who bought a life insurance policy early in their life, a small policy, and by this time, that insurance company may have changed hands three or four different times. They have misplaced the policy. They hoped it would be there to cover their burial expenses or help their family at the end of their life, and they are confused about that, and finding all that is an obstacle to them getting these benefits.

Ms. NEMORE. Those are the kinds of things that make it hard for people, and they end up having their application disapproved because they were not able to find it or to provide the documentation. We know that is a factor.

There is another thing, the question that you have in your legislation to get data from IRS, we believe it may be possible for Social Security to get those data if they had the permission of the beneficiary, and they could perhaps put a check off box on their application that would say I agree to have SSA check IRS data and send it to my state.

Finally, SSA has done something that many states have not done, and it is beneficial. They allow people to certify the truth of the contents of their application. We would be much better off if more states would adopt that. Unfortunately, SSA has used language that is quite intimidating by including a reference to crime and going to prison for giving mis-information.

The reference to the crime is in the context of fraud. It is intimidating language, and I think people may fear that if they just made a mistake or they forgot to report something that they could go to prison. We believe that is a barrier.

I would just like to quickly go back to this issue getting automatically enrolled. I think it is an important one both administratively and legislatively for us to look at.

According to CHS's numbers from June 2006, eighty percent of the people getting the low income subsidy are automatically enrolled. Eighty percent of the people getting the low income subsidy are automatically enrolled. That is how we get people into programs, by not making it difficult for them.

If we could have, as other people testifying have suggested, a sort of cross deeming, meaning if you are in this program, you are deemed eligible for this program, we do that for MSP. If you are in MSP, you are deemed into the low income subsidy.

If we could align the programs closely enough so you could do that both ways, then if I went to Social Security to sign up, I would get both programs. If I went to my state agency to sign up, I would get both programs. That would be a big step towards improving the enrollment in both programs.

Mr. DOGGETT. Thanks to all four of you for your statements.

Chairman STARK. Mr. Camp.

Mr. CAMP. Thank you. Thank all four of you for being here. Thank you for your testimony.

Ms. Kennedy, my first question was going to be after sort of reviewing your testimony and looking at the things Louisiana has done and this flexibility is available to all states, why have not other states done what Louisiana has done, and then I saw you did receive a grant from a Foundation, and also the matching funds.

What about states who do not have these resources? Do you think that is a big barrier to not adopting some of the flexibility and changes that Louisiana did?

Ms. KENNEDY. I cannot speak for them. I think it would be a factor.

Mr. CAMP. Would Louisiana have been able to proceed with those reforms without the Foundation and matching dollars?

Ms. KENNEDY. No.

Mr. CAMP. Dr. Payne, if we expand the number of people—first of all, if you look at the MSP programs, between 13 and 30 percent of the eligible low income beneficiaries are actually signed up. It is not a high enough number.

What I heard in your testimony was let's expand the number of people eligible for those programs. Should we not focus on the currently eligible people and try to get more of them enrolled before we expand the program?

Ms. PAYNE. No. We feel that there are a large number of people who need these benefits, desperately need these benefits, and we ought to do everything we possibly can to bring in those vulnerable populations.

Mr. CAMP. Absolutely.

Ms. PAYNE. There are some administrative efficiencies that can be employed to improve the program, but we certainly think that we need to remove all of the barriers to enrollment in Part D, especially for low income communities.

Mr. CAMP. Yes. That is not suggesting an expansion of the program, but that is trying to get those who are currently eligible enrolled, which Part D has done a much better job of than MSP. Would you agree?

Ms. PAYNE. Yes, I would agree with that. I think several have mentioned the integration of programs. We think if one is eligible for LIS, then certainly they ought to be eligible for MSP and vice versa. I think there needs to be more integration of the programs.

Mr. CAMP. Ms. Santiago-Herrera, if you were to lose access to your current plan and had to go back to the plan that you had before, what would that mean?

Ms. SANTIAGO-HERRERA. I would have to go into a nursing home because there would be no one to come to see about my feet or no one to come to help me clean the house or take a bath, and there would be no food for me, because I am a diabetic. I became a diabetic a year ago.

When they sent me the handbook to choose from, I did not know what to choose from because the book is very confusing, believe me, when I tell you. I just did not know.

My neighbor came over and she was telling me about Evercare. I said, well, I do not know, it is too much for me. I just put the book aside. The next day I called Evercare, and they sent a man

and his wife out to my house, and they sat down and went through the whole thing to make me understand it.

Also, I forgot to mention, they give me ten trips a year to my doctor, back and forth. They would wait for me and bring me back. I have had the five heart attacks and the three strokes.

Mr. CAMP. Thank you.

Ms. SANTIAGO-HERRERA. I could not exist without them, sir.

Mr. CAMP. You were not automatically enrolled then, you signed up yourself?

Ms. SANTIAGO-HERRERA. No, I signed up.

Mr. CAMP. At the suggestion of a friend.

Ms. SANTIAGO-HERRERA. Yes.

Mr. CAMP. Thank you. Thank you all. Thank you, Ms. Nemore, for coming to the previous briefing and helping us understand these issues. I appreciate all of your testimony. Thank you very much.

Thank you, Mr. Chairman.

Ms. SANTIAGO-HERRERA. Thank you, Mr. Chairman.

Chairman STARK. Mr. Doggett?

Mr. DOGGETT. If I could direct a query to Dr. Payne and Ms. Nemore really on this same point that Mr. Camp raised, because it is a critical issue for you to comment on.

We see so many people that are not covered now, who are eligible, according to Social Security and Medicare, over three million people.

Comment, if you will, on the observation, and it appears to have some good reason behind it, that if you have three million people that are not covered, why should we raise the asset test or adjust it in order to expand that number?

What is the rationale behind doing that? You did that to some extent, Dr. Payne, but I know you have not inquired on it. I believe the people we are talking about expanding it, you would like to see it expanded much more than my bill, but the group we are expanding it to slightly in this bill are not rich people. They are people of fairly modest income.

If you would just close focusing on that question that I am so pleased Mr. Camp raised.

Ms. NEMORE. Thank you, Mr. Doggett. I think if we look at the rules for the low-income subsidy and the way it has been administered both by how Congress described it and how SSA has done it, and the Medicare savings programs, what I see is that Congress has grown in its understanding over the last 20 years about the needs of low income beneficiaries.

We started in 1988 with 100 percent of poverty, and by the time we got to Medicare Part D, we recognized that people needing full benefits need to be at 135 percent of poverty. It took us 20 years—it took us until 1997 to get to that level for the Medicare Savings Programs.

We also recognized in Part D what had not been recognized before, that you have to index the asset test. The asset test for the Medicare Savings Program is frozen at a number that was chosen in 1988 based on an existing number in the SSI program that had never been indexed.

If we expanded the MSP programs so they were aligned with LIS and increased the assets so those were aligned, we would then be in a position where either program would be a way to get into the other program.

What your legislation does is recognize that there are a lot of people who have very low incomes who have just a little more assets than we allow, and that it is important to reach those people to get that asset test at least higher.

As you know, we along with AARP and other groups, support the elimination of that test because the very existence of it can be a barrier to enrollment.

Increasing it we know will bring some more people in who are very low income people.

Ms. PAYNE. Mr. Doggett, I will simply make two points. We think it is incredibly reasonable to simplify the process, streamline the application, remove the asset test, to reach out to those low income communities, as I said earlier, that need these services so desperately, and to look at better alignment between the programs.

We think it is incredibly simple to identify those individuals. Social Security is already making that information available or IRS is making the information available to Social Security. They are using it for Part D premiums.

Why can we not use the same process for identifying poor people? We think again that it is a reasonable step. Your bill opens the door for all kinds of opportunities for those that are most vulnerable, and there are some very simple techniques that we can use.

Social Security has been very good at protecting privacy. We think they can play a much greater role in ensuring a process, a simple process, for identifying those who need these services.

Mr. DOGGETT. Thank you very much for all you have contributed this morning and what you are doing in your individual professional capacities, and thank you, Mr. Chairman, for focusing attention on this major problem.

Chairman STARK. Thank you, Mr. Doggett, for your efforts. I want to thank all the witnesses for being here with us today.

Ms. Santiago-Herrera, is this your first trip to Washington?

Ms. SANTIAGO-HERRERA. Yes, sir.

Chairman STARK. Pretty exciting, is it not?

Ms. SANTIAGO-HERRERA. Yes, sir.

Chairman STARK. Are you going to do some sightseeing?

Ms. SANTIAGO-HERRERA. Yes.

Chairman STARK. Nice of you to be here.

This meeting is adjourned.

[Whereupon, at 1:32 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of the National Council on Aging

The National Council on Aging (NCOA) is the nation's first organization formed to represent America's seniors and those who serve them. Founded in 1950, NCOA's mission is to improve the lives of older Americans. Our programs help the nation's seniors improve their health, find jobs and job training, discover meaningful opportunities to contribute to society, enhance their capacity to live at home, and access public and private benefit programs. Our members include senior centers, area agencies on aging, faith-based service agencies, senior housing facilities, employment services, and consumer organizations. NCOA also includes a network of more than 15,000 organizations and leaders from service organizations, academia, business and labor who support our mission and work.

NCOA chairs the Access to Benefits Coalition (ABC),¹ comprised of national and community-based organizations dedicated to ensuring that Medicare beneficiaries with limited means know about and make the best use of resources available to access their needed prescription drugs and reduce their prescription drug costs. Established in 2004, the Access to Benefits Coalition has involved hundreds of community-based nonprofits through 55 local coalitions in 34 states and the District of Columbia, in educating and enrolling tens of thousands of beneficiaries in the Medicare Part D Low-Income Subsidy (LIS) and other prescription savings programs.

ABC and its network of local organizations use powerful web-based tools such as NCOA's BenefitsCheckUp® decision support tool² to help beneficiaries—as well as family caregivers and organizations who wish to assist them—to understand, apply for, and enroll in public and private prescription savings programs. BenefitsCheckUp® also helps determine if individuals qualify for the LIS, Medicare Savings Programs (MSPs), and other prescription savings programs with application forms available on the site, or enabling users to apply online for some of the benefits.

NCOA is committed to finding and enrolling low-income Medicare beneficiaries in the available needs-based benefits programs for which they are eligible. We are pleased to submit this statement to the Subcommittee to highlight the need to simplify and streamline both the LIS and MSP. The statement also includes discussion of cost-effective strategies for finding and enrolling qualified eligibles in needs-based benefits programs.

The Medicare Part D Low-Income Subsidy (LIS) and the Medicare Savings Programs (MSPs)

The LIS and MSP programs provide substantial financial assistance to low-income Medicare beneficiaries both in accessing their needed prescription drugs and paying their Medicare premiums and cost-sharing. Although this assistance is available, enrollment rates in both programs remain unacceptably low. Some of the reasons for the low enrollment rates include confusing and difficult applications and eligible people not knowing the programs exist. Removing these barriers to enrollment is critical to increasing enrollment rates and providing low-income Medicare beneficiaries with the assistance they need.

The Low-Income Subsidy

It has been estimated by the U.S. Department of Health and Human Services that at least 75 percent of the Medicare beneficiaries **still without any** prescription drug coverage are eligible for the Low-Income Subsidy.³ NCOA estimates that only between 35 and 42 percent of Medicare beneficiaries who needed to voluntarily file an application with SSA in 2005 and 2006 to receive LIS have successfully done so (2.2 million out of 5.2 or 6.2 million). The remaining 58 to 65 percent are not receiving the assistance for which they are eligible. It is important that efforts to find these people continue as the remaining LIS eligibles stand to gain the most from the prescription drug benefit and are least likely to have had prescription drug coverage before Part D began.

To find the remaining LIS eligibles, certain changes need to be made to the Part D LIS program. NCOA and the Access to Benefits Coalition (ABC) released a report entitled *The Next Steps: Strategies to Improve the Medicare Part D Low-Income Subsidy*⁴ in January 2007. The report outlined legislative, administrative and regu-

¹ www.accesstobenefits.org.

² www.benefitscheckup.org.

³ Statement of Michael Leavitt, Secretary of U.S. Department of Health & Human Services, May 2006.

⁴ <http://www.accesstobenefits.org/library/pdf/TheNextSteps.pdf>.

latory changes that should be made to the LIS program to improve access for low-income beneficiaries. The most important legislative recommendations include:

- **Eliminate the asset eligibility test.** The asset test is the single-most significant barrier to the LIS for low-income seniors and people with disabilities. The asset test penalizes retirees who did the right thing by creating a modest nest egg to provide some security in their old age. People who manage to save a modest sum for retirement and still have very limited incomes should be encouraged and rewarded, not denied the extra help that they need. Of the LIS applications filed, the Social Security Administration (SSA) reports 41 percent of denials were because the asset limits were exceeded. Eliminating the asset test would provide coverage through the “donut hole” for 1.8 million low-income beneficiaries in greatest need of help.
- **Fund the National Center on Senior Benefits Outreach and Enrollment and support organizations that use a person-centered approach to outreach, which has been shown to be one of the most efficient ways to find and enroll LIS eligibles.** Finding and enrolling seniors and people with disabilities with limited resources in needs-based benefits programs has been a significant challenge for many years. The Older Americans Act (OAA) includes an authorization for the National Center on Senior Benefits Outreach and Enrollment that will use cost-effective, person centered approaches to reach the remaining LIS eligible beneficiaries. We recommend that \$4 million be provided to support the work of the National Center to create Benefits Enrollment Centers that will: maintain web-based decision support tools; develop and maintain an information clearinghouse on best practices; and provide training and technical assistance.
- **Permit beneficiaries to apply for LIS and enroll in a plan at any time without penalty.** We are grateful to the Centers for Medicare & Medicaid Services (CMS) for extending the Special Enrollment Period (SEP) and waiving the Late-Enrollment Penalty (LEP) for LIS eligibles through 2007. However, we urge Congress to make these protections permanent. Finding the remaining LIS eligibles will take time, as the experience in other needs-based benefits programs indicates. Under Medicare Part B, low-income beneficiaries eligible for Medicare Savings Programs can enroll any time and are exempt from penalties. The Part D rules should be made to be consistent with the Part B rules. **Remove the LIS application questions on the cash surrender value of life insurance policies, and the value of in-kind support and maintenance (ISM).** Many beneficiaries do not have this information and paperwork readily available. Insurance policies often are no longer held by the company they were originally purchased from, making it difficult to track down the company currently holding the policy. Beneficiaries also often plan for their families to use the life insurance benefit to pay for their burial expenses. Questions on ISM should also not be included because the amount is very difficult for applicants to estimate, due to its fluctuating nature and if people had assistance with their prescription drug costs they often would not have to rely on ISM.
- **Do not count funds in retirement savings plans such as 401(k) accounts as assets.** Forcing people to cash in their 401(k) plans to become eligible for LIS penalizes seniors for doing the right thing by saving for retirement. Defined benefit pensions are not counted as an asset when determining LIS eligibility. For most of those without a defined benefit pension plan, the resources in their 401(k) are their only retirement savings. It makes no sense to discriminate against those who rely on their 401(k) plan. Periodic distributions from 401(k) accounts may constitute the only income people have to supplement their Social Security benefits.
- **Index the copayments for people between 100 and 150 percent of the Federal Poverty Level to the Consumer Price Index (CPI), not Part D drug cost increases.** LIS-eligible people with incomes *below* 100 percent of the FPL have their prescription drug copayments increased each year according to the CPI. This roughly corresponds with beneficiaries Social Security cost-of-living adjustment (COLA) reflecting beneficiaries’ ability to pay. However, for LIS-eligible beneficiaries with incomes between 100 and 150 percent of poverty, their co-payments are indexed to increases in Part D prescription drug costs, which rise at twice the rate of beneficiaries COLAs. Therefore, copayments become increasingly unaffordable and the value of the benefit for people between 100 and 150 percent of the FPL diminishes significantly over time.

- **Require the Internal Revenue Service (IRS) to provide SSA with tax-filing data to better target outreach efforts, while recognizing privacy concerns.** Strategic partnerships among federal agencies, such as SSA, CMS, and IRS, will allow for targeted outreach directly to the people who are most likely eligible for LIS. CMS and SSA should have access to income and resource data contained in IRS files, thereby allowing them to more accurately identify potential LIS eligibles. This information would allow these agencies to target their outreach and enrollment efforts and would result in increased enrollment in the LIS program. Such data sharing has been permitted for the Medicare-approved drug discount card Transitional Assistance (TA) program and for administering Part B income related premiums.
- **Do not count prescription drug LIS assistance when determining benefits under other benefits programs.** The effect of the LIS is compromised when reductions are made in other needs-based assistance, due to receipt of the LIS benefit. Congress should pass legislation to ensure that benefits under other needs-based programs, such as food stamps, Section 8 housing, and the Medicaid Medically Needy program, are not lost or reduced on account of receiving LIS benefits. Low-income beneficiaries should not be forced to choose between their housing or food needs and receiving help to pay for their prescription drugs. The Medicare Modernization Act (MMA) included this type of provision for the \$600 TA under the Medicare-approved drug discount cards.
- **Have SSA screen LIS applicants for participation in the Medicare Savings Programs (MSPs).** State Medicaid offices are required to screen for MSPs when a person applies for the LIS. However, most LIS applications are not filed at state Medicaid offices, but instead are processed by SSA. SSA should also be required to screen for MSP eligibility at the time of the LIS application. Participation in any of the MSPs automatically qualifies a person to participate in the full LIS. Since SSA already is collecting income and asset information for the LIS application, it would be relatively easy to screen for MSP eligibility at the same time. A study by the Access to Benefits Coalition found that 71 percent of the people who were found eligible for LIS also screened eligible for one of the MSPs. There is precedent for this as SSA already enrolls Medicare beneficiaries who receive Supplemental Security Income (SSI) in Medicaid in 32 states and the District of Columbia.

The Medicare Savings Programs

MSP is a joint Federal and State program that provides needed financial assistance to Medicare beneficiaries with their premiums and cost-sharing. There are four MSP programs: the Qualified Medicare Beneficiary program (QMB) pays Medicare premiums and cost sharing for people under 100% of the Federal Poverty Level (FPL); the Specified Low-Income Medicare Beneficiary program (SLMB) pays Part B premiums for people between 100 and 120% of FPL; the Qualifying Individual program (QI) pays Part B premiums for people between 120 and 135% of FPL, and the Qualified Disabled and Working Individual program (QDWI) pays Part A premiums for people with Medicare who are under age 65 and disabled, whose incomes are at or below 200% FPL and who no longer qualify for premium-free Medicare Part A only because they returned to work. Additionally, people eligible for QMB, SLMB or QI are automatically eligible for the LIS. Although MSPs provide much needed assistance, enrollment rates in the program are low. Only 33 percent of people eligible for QMB and 13 percent eligible for SLMB are enrolled.

QMB and SLMB are entitlement programs jointly financed with both Federal and State money. This means that anyone who meets the qualifications can enroll in the program. QI, however, is not an entitlement program and is entirely financed by a grant from the Federal Government to the states. Because QI is not an entitlement program, people who are otherwise eligible may not be able to receive the benefit if the money available to the states through the Federal grant is used up. Additionally without Congressional action, the QI program is set to expire at the end of Fiscal Year 2007.

Changes to simplify the MSP application and align the program with the LIS would increase the number of people enrolled in the program. Some of the recommended changes to the MSP program include:

- Merge the QI program with the SLMB program to make QI permanent, and provide funding to the states for SLMB at the increased SCHIP rate.
- Eliminate the asset test for MSP eligibility. If this cannot be done, we support increasing and aligning both the MSP and LIS asset tests to be more reflective of people with limited incomes who have managed to save a modest

amount of money for retirement. More closely align MSP and LIS programs (see earlier LIS recommendations on life insurance, in-kind support and maintenance, 401(k)) by gradually increasing income eligibility to 150 percent of the Federal Poverty Level. Also deeming should take place between both programs—those eligible for LIS should automatically be eligible for MSP.

- Do not require face-to-face interviews for MSP eligibility, as it deters people from seeking assistance under the program. In addition, the MSP application should be available both in multiple languages and online in all states to encourage potential eligible beneficiaries to apply.
- State Health Insurance Assistance Programs (SHIPs) should be given \$1 per Medicare beneficiary to conduct outreach and education. In addition, first year funding of \$4 million should be provided for the National Center on Senior Benefits Outreach and Enrollment authorized under the OAA. Funding should be targeted to MSP and LIS eligibles. Eliminate estate recovery for the MSP program in all states that have not already done so on their own. It does not amount to a significant amount of money for the states, it is administratively expensive, and it serves as a barrier to MSP enrollment for people who need the assistance offered under the program.
- The SSA Commissioner should include information on MSP for those people who are likely eligible when the letters for newly eligible Medicare Parts A and B beneficiaries are sent. One of the reasons MSP enrollment numbers remain low is that most people do not know the programs exist. In addition to sending letters, other outreach efforts need to be made to increase awareness of the program.
- IRS data provided to SSA for the indexing of Part B premiums should be used by SSA to screen potential eligibles for participation in MSPs and LIS.
- We support three months of retroactive eligibility for people found eligible for QMB, as it is for both the SLMB and QI programs.
- NCOA supports extending the LIS rule for determining family size to the MSP program. This would allow those with larger families to have more resources, making it consistent with their larger family responsibility. Many states currently do not take into account family members in addition to the spouse.

Simplifying and aligning the LIS and MSP programs will encourage low-income Medicare beneficiaries to enroll in the programs as people eligible for one of the programs are likely eligible for the other.

Cost Effective Strategies for Enrolling Beneficiaries in Needs-Based Benefits

Over the past three years, NCOA has been testing a variety of strategies for increasing enrollment in the LIS and other key needs-based public benefits. Various pilot projects have been funded primarily by The Commonwealth Fund, The Atlantic Philanthropies, CMS, and Kaiser Permanente.

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

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

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

A major benchmarking study by The Bridgespan Group and NCOA examining more than 30 different single-benefit outreach and enrollment projects shows that, consistently, about 55 percent of the total costs per enrollment are related to identifying qualified individuals and persuading them to apply and only 45 percent of the costs relate to actual assistance with applications.⁵

Most federal agencies are limited by statute and/or practice from conducting outreach for more than a few benefits (e.g., USDA conducts Food Stamps outreach; SSA conducts LIS and SSI outreach; CMS conducts Medicare Part D outreach). As a result, the government is incurring the same costs of identification and persuasion over and over again. Much more could/should be done to increase the cost-effectiveness of government-sponsored outreach and enrollment efforts by encouraging/requiring screening for multiple benefits.

2. Invest in the aging network and trusted, non-profit community-based organizations that can create broad-based networks to effi-

⁵ <http://www.accesstobenefits.org/library/pdf/PathwaysToSuccess.pdf>

ciently connect people who are likely eligible for needs-based benefits to enrollment specialists who will help them apply.

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

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

Warm transfers to LIS enrollment centers result in the highest numbers of actual applications and are, on average, almost five times more cost-effective than direct mail and three times more cost-effective than outbound calls. In every community, there is a need for some targeted funding, particularly to focus on enrollment assistance (helping people to fill out the application forms once they have been identified).

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

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

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

The BenefitsCheckUp® program, which is supported by foundations and corporations, served 232,000 clients in 2006 and its consumer edition (serving people and/or their caregivers directly accessing the site) is currently producing enrollments in major public benefits at a cost \$15 per benefit. If the online service was sponsored and/or promoted by government, it could reach and serve many more people and would likely achieve enrollments for \$7–\$10 per major benefit. Online tools also increase the efficiency and effectiveness of community-based organizations. Enrollment centers that assist consumers by filing online for LIS (either directly to SSA or through BenefitsCheckUp®) are more cost-effective than organizations filling out application forms and mailing them in. Online tools make person-centered screening (for multiple benefits) and application filing much easier to do.

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

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

By cross-matching a list of 300,000 PACE enrollees with a list of 250,000 Property Tax and Rent Rebate program enrollees (list came through Department on Aging from Department of Revenue), *the State identified 100,000 Property Tax and Rent Rebate program enrollees that were likely eligible for and not receiving PACE.* By cross-matching the 250,000 Property Tax and Rent Rebate program enrollees against the list of 300,000 individuals receiving PACE/PACENET, *the State identified 90,000 PACE/PACENET enrollees who were likely eligible for and not receiving Property Tax and Rent Rebate.* By cross-matching the 300,000 PACE file with the Department of Public Welfare (state Medicaid office) file, *the State identified 100,000 PACE enrollees who were likely eligible for and not receiving MSP benefits).*

Using state lists of people enrolled in other public benefits has resulted in higher percentages of people who apply for and, ultimately receive, other benefits, as compared to lists that have less accurate income and contact information (i.e., people “believed to be” eligible). Response rates and application conversion rates are higher when outreach efforts are able to use pre-existing benefit lists. Accuracy of both the financial and contact information provided by the Property Tax/Rent Rebate program has resulted in response rates for benefits application that are 250% greater than those resulting from efforts using purchased commercial lists. From an economic perspective, this means the cost of getting people into the benefits is also two and a half times less when using a well-targeted list. In other words, for the same fixed cost, more people are being helped at a much lower cost when efforts are much more targeted. Furthermore, the residual effect is that people who were in just one public benefit program in the beginning potentially end up being enrolled into three programs.

The National Center on Senior Benefits Outreach and Enrollment

A more focused, coordinated effort that utilizes person-centered assistance, web-based decision-support tools, and sophisticated lists of likely eligibles is needed to find and enroll low-income beneficiaries. Drawing directly on these strategies, the recently reauthorized Older Americans Act now provides a clear path to solving the problem by harnessing the potential of the aging network, new technology, and best practices based on lessons learned. The OAA includes new authorization for a National Center on Senior Benefits Outreach and Enrollment that will:

- maintain and update web based decision support and enrollment tools and integrated person-centered systems;
- utilize cost-effective strategies to find those with greatest economic need;
- support efforts for community-based organizations and coalitions to serve as benefit enrollment centers;
- develop and maintain an information clearinghouse on best practices; and
- provide training and technical assistance regarding the most effective outreach, screening, enrollment and follow-up strategies.

Now that the Center is authorized, initial funding of \$4 million is needed to:

- Work with trusted, experienced community-based and state organizations to support 25 Benefits Enrollment Centers (BECs) across the country with funding at \$100,000 per Center. [\$2.5 million]
- Conduct pilot projects on list strategies, call centers, and other innovative strategies to test the most cost-effective outreach and enrollment methods. [\$500,000]
- Maintain and update web-based decision support and enrollment tools and integrated, person-centered systems that are available to BECs, the entire aging network and directly to consumers. [\$500,000]
- Train and provide technical assistance to the BECs and to the rest of the aging network, administer the pilot projects and begin to develop an information clearinghouse on cost effective best practices. [\$500,000]

Conclusion

Congress created the MSP and LIS programs to provide needed assistance to low-income Medicare beneficiaries in paying for their health and prescription drug costs. Unfortunately, enrollment in these programs has historically been low. To increase enrollment, needed changes should be made to the programs, including simplifying and aligning them, to increase access for Medicare beneficiaries with limited incomes. Cost-effective best practices should be used in outreach and enrollment efforts for needs-based benefits.

Thank you for the opportunity to submit this statement on behalf of the National Council on Aging. If you have any questions please contact Howard Bedlin, NCOA's vice-president for Public Policy & Advocacy at (202) 479-6685 or howard.bedlin@ncoa.org.

Statement of Senior Citizens League

On behalf of the approximately 1.2 million members of The Senior Citizens League (TSCL), a proud affiliate of The Retired Enlisted Association (TREA), thank you for the opportunity to submit a statement regarding low-income programs available to eligible Medicare beneficiaries. TSCL consists of active senior citizens, many of whom are low income, concerned about the protection of their Social Security, Medicare, and veteran or military retiree benefits.

Some estimates suggest that as many as two-thirds of those eligible for certain low-income programs do not participate—often because they are not aware that such programs exist or believe they will not qualify based on out-of-date information. Frequently, our members contact our office with concerns over having to choose between purchasing prescription medications and paying bills. In some cases, these individuals are eligible for low-income programs but were not aware of the programs' existence.

MEDICARE SAVINGS PROGRAM (MSP)

With three separate programs for Medicare Part B assistance, the first task seems to be determining which one applies for an individual. For individuals with an annual income level of \$10,452 (\$871 per month), or \$13,932 (\$1,161 per month) for couples, the Qualified Medicare Beneficiary (QMB) program exists. Asset levels are set at \$4,000 for individuals and \$6,000 for a couple. Persons in the QMB program have their Part B premiums, deductibles, and all Medicare cost sharing paid by their state Medicaid program. According to a May 2004 report by The Commonwealth Fund, it is estimated that 4 million seniors are eligible, based on income alone, for this program.

Specified Low-Income Medicare Beneficiaries (SLMB) are persons whose annual income is at or below 120% of the federal poverty level, or \$12,492 (\$1,041 per month) for an individual, and \$16,668 (\$1,389 per month) for a couple. SLMB are subject to the same asset limits as QMB. State Medicaid programs pay SLMB's Medicare Part B premiums.

The third MSP grouping is Qualifying Individuals (QI). Individuals with an annual income between 120% and 135% of the federal poverty level fall into this category. To qualify, individuals must have an annual income of no more than \$14,028 (\$1,169 per month), or couples must have an annual income of no more than \$18,720 (\$1,560 per month). Asset levels remain the same for this group as for the SLMB and QMB. The Federal Government, and not the state, pays Medicare Part B premiums for persons designated QI.

The Federal Government sets the income limits for eligibility, application procedures and asset limits. Although income limits are adjusted annually, asset limits, which were set in 1989, have not been indexed since then, according to The Commonwealth Fund, May 2004 issue ("How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits"). The asset limits are burdensome, outdated, and intimidating. Personal disclosure of one's incomes and assets can also be a major hurdle for many elderly individuals. When asked about the cash value of in-kind contributions and the cash value of life insurance policies, applicants either do not know the value or are embarrassed to report such assistance. Counting the "in-kind" value of meals and support supplied through the generosity of others penalizes the neediest of seniors, and disregards the *contributions* of those who kindly supply the most basic of needs. In some instances, applicants do not disclose requested information for fear of incarceration, which is mentioned on the application.

Asset limits vary by state. It should also be noted there are a few states that have eliminated or adjusted asset levels for the QMB and SLMB. States also have the option of using less restrictive measures for income and asset levels when determining Medicaid eligibility. In these instances, an individual who does not meet federal asset levels may be eligible for the MSP assistance.

In the vast majority of cases, low-income seniors are not aware that programs exist to assist with premiums. Indeed, just learning the income limits to prepare this statement for the record proved a difficult challenge. When this statement was prepared, there was no link to Medicare Savings Programs posted on the homepage of www.medicare.gov. Information pulled up by use of the website search engine was more than one year old and the income limits out-of-date. By using the search engine for the 'Frequently Asked Questions,' only one answer even mentioned MSPs, and it directed us to our state Medicaid office, with no income information. The website for the Centers for Medicare and Medicaid Services (CMS) is not designed for seniors or easy to use by the general public. It also failed to readily supply current income information. In fact, in order to prepare this statement, we relied on income information from other Medicare advocates, the Medicare Rights Center.

Improved outreach is obviously needed and could be simply supplied starting with links to information about the program on the homepage of Medicare.gov. In addition, adequate funding must continue for seniors' counseling provided by Area Agency on Aging offices; local organizations that already reach out to low income individuals; and state insurance (Medicaid) offices. In recent years, the need for these services has been rapidly growing, but funding has not kept pace.

LOW INCOME SUBSIDY (LIS) PROGRAM FOR PRESCRIPTION DRUGS

For persons enrolled in a Medicare Part D prescription drug plan, depending on income and asset levels, financial assistance, known as 'Extra Help,' is available. Enrolling in Extra Help, the Federal Government's low income subsidy (LIS), is simpler than MSPs. For instance, applications can be submitted on-line, at the state Medicaid agency office, through a local Social Security Administration (SSA) office, or by deemed status (dual eligible). Persons enrolled in a MSP and who receive SSI, or "Dual Eligibles," are automatically enrolled in a LIS. Of the 9 million seniors enrolled in a LIS, approximately 6 million were enlisted automatically, thus they were considered "dual eligibles." Seniors not automatically enrolled into a LIS must meet the following criteria: annual income is below \$15,315 (\$1,276 per month) single or \$20,535 (\$1,711 per month) for a couple, with assets (bank accounts, stocks, bonds, etc.) of less than \$11,710 (single) or \$23,410 (couple). Assets do not include house or car values.

According to a report by the Medicare Rights Center, the SSA found that 57% of seniors who applied for extra help were denied due to their financial assets, even though they met the income levels. Although the income and asset levels are more reasonable with LIS eligibility than with MSP, a senior should not be penalized because he or she has planned for the future and saved to help pay for unexpected expenses associated with older age. TSCL supports eliminating, or at the very least updating and indexing, asset tests, especially for MSP eligibility.

Similar to the MSP application, the LIS application is also complex and lengthy, which is discouraging to many seniors. Threats of imprisonment, questions surrounding the cash value of life insurance policies, in-kind support, and bank accounts are intimidating. Some estimates suggest there are as many as 5 million seniors eligible for Extra Help who have not yet enrolled. TSCL believes this staggering number to be the result of long and confusing applications, asset testing, and a lack of awareness that Extra Help is even available. The SSA reports a person enrolled in Extra Help could save, on average, \$3,700 annually. This is a huge amount for someone on a limited income.

SOLUTIONS

The first step in increasing enrollment numbers for both the MSP and the LIS is to make the information more readily available and increase outreach. By ensuring the funding for non-federal entities such as state Medicaid offices and local SSA offices, more seniors can be made aware of these programs. Additional federal grants are needed to ensure there are trained Medicare benefits counselors to help seniors apply for financial assistance.

TSCL believes that the asset test should be completely eliminated. Basing an individual's eligibility on annual income is sufficient. Seniors should not be penalized for saving and planning for the future. However, if complete elimination of the asset test is not feasible, then, at the very least, increased asset test limits are necessary.

Another option could be to automatically enroll an MSP beneficiary into the LIS, and vice versa. With federal funding supporting both programs, the government should consider setting uniform standards (including simplified applications) for Medicaid offices to follow when determining the eligibility of seniors for the low income programs. This would help clear up confusion as to what resources are counted for which program and what resources do not need to be disclosed. With federal agencies working together with the same end result in mind, more eligible seniors would benefit.

In addition, the government already screens Medicare beneficiaries for "income related" Part B premiums. TSCL believes many more seniors would be enrolled in low income programs if Medicare beneficiaries were allowed to permit the Internal Revenue Service (IRS) to share low income information with both the SSA and CMS.

Several pieces of legislation are being, or already have been, introduced that offer possible solutions. For example, Rep. Lloyd Doggett (TX-25) introduced H.R. 1536, the Prescription Coverage Now Act, earlier this year. TSCL fully supports this legislation that increases asset test limits from \$11,710 to \$27,500 for individuals and from \$23,410 to \$55,000 for couples. Rep. Doggett's bill also makes the application less intimidating by eliminating questions that ask for cash values of life insurance and in-kind assistance received. Additionally, H.R. 1536 would authorize the Social

Security Administration limited use of IRS data, which is already used to determine Part B eligibility. Finally, the bill also calls for coordination between low income programs in Part B and Part D. TSCL encourages Congress to approve this vital legislation.

TSCL applauds Congress for addressing the low enrollment numbers in Medicare assistance programs. With increased outreach, elimination of asset test limits, and a less intimidating application process, more individuals will be made aware of these programs designed to assist with rising healthcare costs. The end result will undoubtedly be increased enrollment and better financial stability for seniors in the lowest income brackets.

Thank you.

