Testimony
of
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The Health Assistance Partnership (HAP) is an independently supported intermediary for the nation's State Health Insurance Assistance Program (SHIPs). HAP is a project of Families USA, a national, non-profit organization which promotes high-quality and affordable healthcare for all Americans. HAP's mission is to increase the capacity of SHIPs so that they might become more efficient and effective in educating and counseling Medicare beneficiaries (and their caregivers) about the health insurance benefits to which they are entitled. HAP is committed to stabilizing and increasing federal funding for the SHIP network.

State and local SHIP programs are an extraordinarily valuable— though woefully under-funded— resource to this nation's Medicare population. Created through the Omnibus Reconciliation Act (OBRA) of 1990, they promote understanding of the then newly standardized Medicare supplement insurance (or Medigap) policies. The role of SHIPs has expanded to 1,400 community-based SHIP programs operating within the Area Agencies on Aging or State Departments of Insurance, with 12,000 staff members and volunteers who counsel Medicare beneficiaries about their Medicare, Medicaid, private insurance, and other coverage options.

Each year, the SHIPs provide individual assistance to more than four million Medicare beneficiaries, approximately 27 percent of whom have cognitive impairments; 31 percent have limitations in activities of daily living; almost one-third have not graduated from high school; and 12 percent are over 85 years of age. SHIPs are unique in that they offer one-on-one, in-person counseling to one of this nation's most vulnerable populations. The federal government has depended on the nationwide network of SHIP staff and volunteers to educate beneficiaries about the Medicare drug plans' benefits and costs and to assist with enrollment decisions that involve mind-boggling choices between dozens of plans.

Many of the SHIPs have come to rely on HAP for technical assistance about complex Medicare issues and help with resolving difficult cases. Consequently, HAP is in constant communication with state and local SHIP programs nationwide. Most of these requests for assistance in the past year involve Medicare Drug Coverage and the program's impact on those who are eligible for the low-income subsidy program. HAP would like to take this opportunity on behalf of the entire SHIP network to bring to light the overwhelming issues that SHIP counselors face every day alongside beneficiaries. Many of these issues could affect any Medicare Part D enrollee. But the 6.6 million beneficiaries who fall into the lowest income subsidy category and no longer have

Medicaid coverage for their prescription drugs are particularly vulnerable.[1] They often do not have the means or resources to address the problems that arise. As a result the SHIP network has brought the following concerns and problems to HAP's attention most recently:

The system for real-time data sharing among CMS, SSA, and plans does not work properly; as a result data is being shared untimely, inefficiently, or incorrectly.
This flawed system results in a lack of subsidy status and/or plan data in pharmacy computer systems. It leads to incorrect cost-sharing amounts being charged at the pharmacy. This problem is most significant for beneficiaries who also have Medicaid or Medicare Savings Programs and cannot afford standard cost-sharing amounts. In addition, if no plan enrollment is reflected in the system, CMS enrolls the dual eligible population into randomly selected plans. Thus, when data is not shared in real-time, some beneficiaries have found themselves in a different plan or in more than one plan; they are then unaware of the shift. Several SHIPs have also reported that beneficiaries with the Low-Income Subsidy enrolled in "benchmark plans" are receiving erroneous bills for premium payments, despite their full subsidy status. This is costly to taxpayers and state safety net programs, as well as the lives and wallets of vulnerable beneficiaries who leave the pharmacy counter without their medications.

Confusing plan structure leads to problems accessing appropriate medications at the pharmacy counter.
Restrictions on formularies, commonly called utilization management requirements, have led many pharmacies to bypass the exceptions and appeals process. Resolving a prior authorization or step therapy issue for beneficiaries involves a different process for each plan. Because dozens of plans (with dozens of different formularies and restrictions) are available in most areas in the country, these hurdles to accessing drugs are too burdensome for busy health professionals. In many cases pharmacists and physicians simply will change a prescription to a drug with fewer or no restrictions. While this process may not be a problem for some individuals, adverse medication interactions can occur, especially for beneficiaries who fill prescriptions at multiple pharmacies. This type of resolution also results in the plans not accurately reflecting exceptions or appeals with regard to medications that are formulary "inclusive" but not accessible.

CMS Regional & Central Offices require specific information about client problems one-by-one.
Since the inception of Medicare Drug Coverage, myriad problems have occurred with all aspects of the program—from problems with the Medicare Prescription Drug Plan Finder (www.medicare.gov) to beneficiaries unable to get their medications despite their best efforts and those of the SHIPs, the pharmacists, or the physicians. Throughout the first year of the program and even today, CMS insists on attempting to resolve these problems piecemeal, rather than to address them systemically.

CMS produces misleading media campaigns and correspondence.
CMS issued an ad in Parade magazine in November 2006 that advised beneficiaries to "take no action" if they were satisfied with their plans. The ad failed to inform enrollees that the plans may have significant changes from year to year. A beneficiary's satisfaction with a Part D plan

[1] Medicare Policy Project, Henry J. Kaiser Family Foundation *Medicare Drug Benefit Enrollment Update* (Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2006).

in 2006 is no guaranteed predictor of their satisfaction with a plan in 2007. Furthermore, those beneficiaries who receive the Low-Income Subsidy and accepted CMS's auto-assignment into a Part D plan in 2006 were reassigned to different plans in 2007 if their previous plan would have a monthly premium more than $2.00 above the benchmark for their region.

Customer Service Representatives at 1-800-Medicare and the Part D Plans refer beneficiaries directly to SHIPs.
Throughout the existence of Medicare Part D, the SHIPs have reported consistently that Customer Service Representatives (CSRs) at Medicare and the Part D plans refer beneficiaries to SHIPs for assistance with general programmatic and enrollment issues. This practice led to problems with SHIP hotlines being overwhelmed by questions easily answered by the Medicare hotline. Furthermore, yearly funding for the SHIP network was $31 million in 2006, while the Medicare Contractor, Pearson Government Solutions, received $440 million in 2006 for a two and a half year contract. [2]

Telephone hold times to speak with Part D plan representatives are too long.
Long hold times in many cases have led SHIPs and pharmacies to improvise solutions to problems with Part D rather than wait to address problems with the plan.

CMS Regional Offices are inconsistent when addressing State and Local SHIPs needs.
HAP has received numerous reports about many Regional Offices being unable or unwilling to provide technical assistance to State and Local SHIP staff in dire need of resolution when it comes to specific problems that only CMS is authorized to provide. There is a lack of accountability and/or responsiveness by many Regional Offices; and the SHIPs are left to navigate on their own the differing perspectives of the pharmacies, the Part D plans, and CMS.

There exists a deficiency in considering the specific needs of this vulnerable population.
In many cases CMS materials and correspondence are not available in languages other than English (and sometimes Spanish). Materials often do not address the needs of the visually impaired or the isolated and homebound, among others. Reading levels for many materials is consistently higher than those recommended for this population. Often, the information is vague and does not describe the effects of these changes adequately, yielding more questions than answers after reading CMS publications. It is also well documented that the health literacy levels of this population are also much lower than standard literacy levels.

Explanations of Benefits (EOBs) that are mailed to beneficiaries by the Part D Plans are not clear for Low Income Subsidy recipients.
The EOBs are not tailored to the different needs of the LIS population. Some refer to the coverage gap, while many miscalculate the True Out of Pocket (TrOOP) spending for those with LIS.

All of the plans, particularly Medicare Advantage plans, are employing aggressive marketing tactics to all Medicare beneficiaries, especially the LIS population.
Aggressive marketing tactics are not new when we think back during the summer of 2005 the Medicare Drug Gold Rush event where the brochure read, "Profit from The Biggest New Benefit

[2] http://www.pearson.com/index.cfm?pageid=73&pressid=2035

in the History of Medicare – Part D Drug!!! "[3] SHIPs all across the country are reporting new marketing tactics, particularly when it comes to Private Fee for Service (PFFS) plans. Some of these strategies include the "enroll and migrate" strategy, whereby plans first enroll beneficiaries in stand-alone PDPs, and then target these same beneficiaries later to enroll in a Medicare Advantage plan with Part D (MA-PD). The low-income subsidy population who are also dually eligible (Medicare with either Medicaid or a Medicare Savings Program) are particularly vulnerable to this tactic because of their ongoing special enrollment period.

Furthermore, SHIPs are reporting life-threatening hardship for beneficiaries who find themselves in PFFS plans and whose doctors or hospitals are unwilling to accept plan payments or do not understand what they are. New legislation passed late in 2006 exempts PFFS plans not offering Part D coverage from the enrollment "lock-in" and permits them to continue enrolling beneficiaries throughout the year. SHIPs report that sales representatives use misleading catch phrases to draw parallels between Original Medicare and PFFS plans, including "see any doctor you want" and "no network." While technically not false, these sales representatives do not explain how PFFS plans differ from Original Medicare and that they require each provider to agree to the plan's payment terms per patient and per episode.

SHIPs have reported to HAP other marketing strategies by brokers including uninvited soliciting of plans at beneficiaries' doors. Also, once in residential buildings, the sales representatives find additional Medicare beneficiaries by paying home care workers for referrals; offering $200 drugstore coupons for signing up with a plan; telling beneficiaries they must choose a plan or they will lose their Medicare; enrolling beneficiaries in Medicare Advantage plans through sign-in sheets at senior centers or other venues for prizes and gifts; and downplaying formulary restrictions or making bold claims that their doctor is "in network" without such knowledge.

Pharmacies do not use the WellPoint Point-of-Sale (POS) option; or they are unaware it is available or do not understand how it works.
The POS option is not an effective safety net, as it only exists to serve those dual-eligible beneficiaries who show up in pharmacy systems with no plan whatsoever. However, as data is not being shared in real-time, these computer systems do not necessarily reflect the correct enrollment status of individuals. Additionally, pharmacies do not always use this system even if aware of it, because it is often burdensome and they may be at-risk financially if the data in the system is not accurate.

CMS recommends Patient Assistance Programs (PAPs) as a solution for plans' restrictions on formularies.
PAPs exist as an additional, privately funded safety net for certain low-income individuals to obtain needed medication. Instead of requiring the Part D plans to provide more extensive formularies, CMS recommends for beneficiaries who fulfill the requirements of the PAPs to apply for this coverage drug-by-drug.

[3] http://www.insurancebroadcasting.com/crg051605-2.pdf

In Summary

HAP supports legislation which will address and remedy the above identified ongoing problems experienced by many beneficiaries, including those with the Low-Income Subsidy. We would like to emphasize the value of the SHIP network to Medicare beneficiaries. SHIPs are the only entities that already offer one-on-one assistance with a great depth of knowledge, an objective viewpoint, and an ability to handle complex cases that may require lengthy follow-up. In addition to supporting remedies to existing LIS legislation, we urge this Committee to advocate for increased funding for the SHIP network of at least $1.00 per beneficiary in 2007 and future years.

Overall Recommendations

Coordinate data sharing between states, plans, SSA and CMS in real-time.
There are no mandatory systems in place that ensure dually eligible do not experience gaps in their drug coverage or subsidy. Real-time data sharing between states, Centers for Medicare & Medicaid Services, the Social Security Administration and the plans would allow for pharmacy counter interactions to run more smoothly and accurately.

Return to the original LIS co-pays of $1 & $3 for full status, and $2 & $5 for partial status until the program is operating more smoothly.
Beneficiaries are left to bear the burden of paying increased co-pays for medications they may not be receiving as prescribed, or have been changed due to utilization measures.

Enact a monthly co-pay cap allowing some reprieve for those who take multiple medications per month.
Beneficiaries, who take more than several medications per month, brand or generic, face incredible hardship when it comes to paying multiple co-pays. Enacting a monthly cap allows them to actually receive all of their medications, rather than choosing between paying their rent or food.

Errors that occur by the plans or CMS at the expense of low-income, needy beneficiaries, who have been charged incorrect co-pays, should have the option of opting out of refunding moneys to the plans due to financial hardship.
Where data is incorrect and beneficiaries are charged higher co-pays or asked to pay plan premiums because their LIS status is not reflected at the pharmacy counter, beneficiaries are asked to layout moneys in order to obtain their medications as a result of error beyond their control. Under these circumstances, neither CMS nor the plans are living up to their end of the bargain.

Remove the barriers to applying for LIS by eliminating the asset test and by not allowing the subsidy to adversely affect any other means tested benefits such as food stamps and rental subsidies.
When reductions are made in other needs-based assistance programs such as Section 8 housing, food stamps or TANF benefits, this only serves to discourage LIS enrollment.

Expand the POS option to make it useable in real-life instances of inaccurate or inadequate data transference issues.
Coverage should be available for all LIS beneficiaries that have drug dispensing problems beyond their control at the pharmacy counter. CMS should also require use of the POS option and hold pharmacies harmless for acting in good faith.

Remove any need for determining life insurance or cash value thereof.
The SSA application currently requires applicants to report the cash value of their life insurance policies, however, many beneficiaries do not have this information and paperwork readily available and they do not know how to get the information. Seniors and persons with disabilities often plan to use their life insurance benefit to pay for their final expenses and not cash in their policy now to place additional burden on family members.

Exclude in-kind support as countable income.
In-kind support and maintenance is difficult to estimate due to its fluctuating nature. This discourages beneficiaries from applying for LIS because it also threatens their in-kind support, and is therefore a barrier to enrollment. The unrealistic level of detail involved in calculating the value of in-kind support and maintenance is likely resulting in potentially eligible beneficiaries not filing LIS applications.

Allow SSA access to IRS data in advance to allow for targeted outreach specifically around the Low Income Subsidy, just as they have done with the new Part B premium legislation.
Given that the Part B premiums are now based on income information released by the IRS, the LIS should follow the same protocol for consistency and accuracy.

Authorize the costs of drugs under Part D to count towards medically needy "spend-down" eligibility for Medicaid, as was allowed for low-income people entitled to the "transitional assistance benefit" in the Medicare Discount Drug Card program.
Beneficiaries with Medicare, who also require the use of Medicaid, often met their spend-down or surplus income through medication costs in order to access their Medicaid benefits. Now that they can no longer do so, they are unable to meet their spend-down or access their Medicaid benefit which also covers their doctors, hospitals and rehabilitative needs.

Cover Part D excluded drugs such as benzodiazepines, barbiturates (anti-anxiety, anti-seizure medications), and allergy medications, especially for this population.
It is particularly risky for the overall health of our fellow citizens not to cover mental health medications that keep beneficiaries functional and stable.

Conclusion

While we realize CMS and SSA have been working diligently to resolve some of these problems, all of them still require substantial attention and systemic consideration to improve the Medicare Part D program, especially for our lower income beneficiaries. HAP urges lawmakers to consider these recommendations carefully and strategically, building upon the existing knowledge of the SHIP network that has strived for excellence against all odds.