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ONE HUNDRED TENTH CONGRESS

**U.S. House of Representatives**
# Committee on Energy and Commerce
**Washington, DC 20515–6115**

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March 27, 2007

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Michael J. Astrue
Commissioner
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Secretary Leavitt and Commissioner Astrue:

As you know, I have a keen interest in the implementation of the Medicare Part D benefit, which first took effect last year, and I am increasingly concerned that many who are eligible have not realized its full benefit. While some problems are caused by structural flaws in the benefit itself, other flaws and barriers to care seem to have been needlessly created through the implementation of Part D.

One of the most troubling failures of Part D pertains to the lack of enrollment in the low-income subsidy (LIS) program. Currently about nine million Medicare Part D enrollees receive the subsidy, representing nearly 40 percent of all enrollees. According to Department of Health and Human Services's (HHS) estimates, however, between three and five million additional Medicare beneficiaries qualify for, but are not receiving, the low-income subsidy. In addition, hundreds of thousands of those who received the subsidy in 2006 were removed from the program for 2007 even though they may still qualify, due to a flawed process for renewing eligibility.

Fortunately, I believe that your Departments can administratively correct many of the programmatic problems that have kept low-income Medicare beneficiaries from receiving the assistance they need and form a barrier to accessing needed medications.

Attached to this letter is a list of policies or practices that I believe the Department of Health and Human Services (HHS) and the Social Security Administration (SSA) could modify without a change in the law to improve both enrollment in Part D and access to medicines under the LIS program.

With respect to the attached list, please specify:

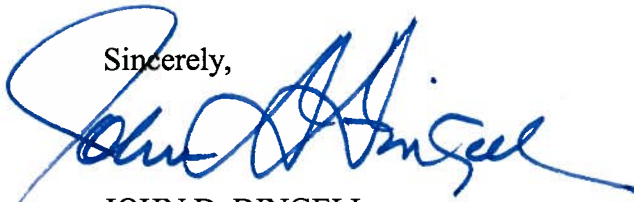
(1) The actions to be taken by HHS and/or SSA to eliminate the existing administrative barrier to either LIS enrollment or LIS beneficiary access to needed medicines, including the timetable for action;

(2) How the agencies plan to inform beneficiaries (and other stakeholders) of the new policy; and

(3) Any additional funding necessary to implement these policy improvements.

I would appreciate your response by close of business two weeks from the date of this letter, so that we can begin a dialogue to address these matters to better serve Medicare beneficiaries under Part D. Once I have a preliminary understanding of how HHS and SSA intends to address these important questions, I would ask that briefings be scheduled with the Committee and Department staff on a regular basis to receive updates on progress in facilitating program improvements. If you have any questions, please have your staff contact Bridgett Taylor or Amy Hall with the Committee on Energy and Commerce staff at (202) 225-2927.

Sincerely,



JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

## ATTACHMENT

### Low Income Subsidy Application

The application for the Low Income Subsidy (LIS) could be improved to make it less cumbersome and daunting for Medicare beneficiaries. Field workers who assist Medicare beneficiaries with LIS applications have noted the following four instances where action by your agencies could improve this process:

1. The application currently has large print notifying Medicare beneficiaries that any incorrect information provided will be considered perjury, a Federal penalty potentially punishable by prison sentence. Given the complex nature of the financial information requested on the form, inadvertent errors could occur. In my State of Michigan, our *Medicaid* application makes no mention of prison sentence and makes clear that it is only the *intentional* giving of false information that is punishable. I hope you will adopt a similar, more reasonable policy. The application should also indicate that individuals may still submit the application if they do not have all the answers and the Social Security Administration (SSA) will follow up to help them get that information.

2. Applications for LIS are available only in English or Spanish, both in the print version and in the on-line application on the SSA website. Thus, current policies do not facilitate enrollment for many beneficiaries who speak other languages. Although samples of the LIS form are available in 15 languages, they can only be completed on-line in English or Spanish. The Department of Health and Human Services (HHS) should allow internet submission of forms in other languages and provide additional assistance in various languages. For example, SSA retirement claims are also frequently requested in Chinese, Russian, and Vietnamese. SSA should quickly adapt the LIS process to accommodate these languages and develop capacity for on-line submittal of applications in other languages as well.

3. A number of elements of eligibility that are currently required make the application more burdensome. One is the consideration of the cash surrender value of life insurance; questions about this require applicants to understand both the face and cash values of their life insurance and create a barrier to completion of the application. I believe the SSA has authority under existing law to eliminate this requirement. This is bolstered by the fact that SSA has chosen not to count non-liquid resources, which indicates SSA believes it has flexibility in interpreting eligibility requirements.

4. Similarly, questions about in-kind support and maintenance (ISM) as income are extremely confusing; advocates report that beneficiaries typically are confused about what is being asked in this question and may give incorrect answers to their detriment. Eliminating consideration of ISM will promote greater ease in completing the application. Again, I believe SSA has authority to do so.

5. SSA assumes up to $1,500 of a Medicare beneficiary's assets are for burial expenses. Yet, the LIS application still separately asks for information on any money set aside for a burial plot. This is confusing for beneficiaries, made worse by inconsistent materials describing the policy. This question should be dropped from the application.

6. SSA currently has no timeframes for processing LIS applications. Medicare beneficiaries have no idea when to expect a response from SSA on their LIS application and thus when to follow up in the event a response is not received. HHS should immediately work with SSA to develop and promulgate guidelines in this area. If beneficiaries are expected to digest plan information and select a Part D plan in about 45 days, SSA and HHS surely should be held to the same standard.

7. Although the Medicare Modernization Act requires that both the SSA and State Medicaid agencies accept and process LIS applications, in practice, the SSA process is used except in very rare instances. Unfortunately, using the SSA process can leave low-income Medicare beneficiaries with less assistance than if they had applied at the State Medicaid agency. State Medicaid agencies should be encouraged to review the applicant's eligibility for other Medicaid programs, including the Medicare Savings Programs (MSP), which assists beneficiaries with uncovered costs for Part A and B of Medicare. In addition, some State Medicaid programs offer less restrictive income and resource limits for the MSP, so beneficiaries who may not have been found eligible for LIS by SSA may well be found eligible for MSP in their State Medicaid office and thus deemed LIS eligible. HHS and SSA should take steps to better incorporate individual State criteria into their approval process in order to ensure the maximum number of eligible beneficiaries are enrolled in LIS.

8. The application itself could do more to encourage beneficiaries to apply for the other Medicare Savings Programs (MSP) that provide assistance with Medicare Part A and B expenses. For example, allowing beneficiaries to waive privacy requirements would allow SSA to share LIS information with States that could determination MSP eligibility, without the beneficiary resubmitting another application. Rather than requiring beneficiaries who call 1-800-MEDICARE to make a separate call to SSA to apply for LIS, the 1-800 number should facilitate a direct transfer to SSA to make this process seamless. HHS and SSA could also do more to prompt beneficiaries to apply for these programs through their phone operators and phone recordings that play while on hold.

**Flawed Process for Renewal Notices**

In the fall of 2006, about 600,000 beneficiaries who were previously enrolled in low-income assistance by virtue of receiving Medicaid, Medicare Savings Program or SSI benefits were informed by CMS that they needed to reapply in order to continue receiving extra help with the cost of their premiums and medicines. This process has been fraught with problems. Notices were not received or were incomprehensible or were inapplicable to the beneficiary who received it. Again, a few simple administrative actions could remedy this situation and improve it for the following year.

1. It is our understanding that in these circumstances neither HHS nor SSA reviewed LIS beneficiaries' income and resources to see if eligibility should continue, but simply terminated the benefit based on loss of Medicaid eligibility. HHS should develop a process to independently review LIS eligibility of those who lose deemed status to prevent termination or renewal notices being sent to beneficiaries who continue to qualify for the LIS benefit. Moreover, all those receiving notice of LIS termination should be given an opportunity for a hearing to challenge the determination.

2. SSA has implemented an entirely different process for redetermining LIS eligibility than it uses for initial eligibility determinations, adding to the confusion surrounding the application and renewal process. HHS and SSA must coordinate and consolidate the application and redetermination process into one location to best and most efficiently serve beneficiaries.

**Proper Appeals and Process Rights for Beneficiaries Under Part D**

Many Medicare beneficiaries have a high school education or less. The information provided under Part D is complicated, not well communicated, and is not very transparent, making it nearly impossible for beneficiaries to appeal plan denials of needed medicine. This is particularly true for the low-income population.

1. When beneficiaries arrive at the pharmacy and find their drug is not covered, they are not given a written notice of a denial or information on how to file an appeal to seek coverage of their medication. Without an actual notice of a denial of coverage, it is nearly impossible to file an appeal to access the needed medicine. HHS should require that written notice, which would constitute a plan coverage determination, be provided at the pharmacy counter in the event a beneficiary is denied access to a medicine, along with the reasons for the denial and information about right to appeal the denial. This should include instances where a beneficiary is not being provided the drug at the preferred price or is not being charged appropriate coinsurance.

2. Each Part D plan has a different process and criteria for exceptions and appeals. Lack of a standardized process and criteria is confusing for seniors and people with disabilities who must switch plans, as well as the pharmacies and physicians who serve them. HHS should standardize the exceptions and appeals processes as well as the criteria that Part D plans use for adjudicating them.

**Flaws in Data Systems to Enroll Low Income Medicare Beneficiaries**

Low-income beneficiaries have experienced delays in coverage or access to needed medicines because the systems used to transmit the necessary data and information are not working as they should. HHS's time lines allow Part D plans more than two months to enroll a new dual eligible in a plan and get the necessary information about both plan and subsidy level to the pharmacy delivering the patient's medicine.

Both HHS and SSA need to improve data systems to expedite transmission of necessary information. In today's computer age, it is commonplace for different entities to have "real time" electronic communication with each other. Part D should also operate in this fashion.

1. HHS must develop a real time data system where plan enrollment and disenrollment and status of subsidy eligibility can be transmitted between CMS, SSA, states, and pharmacies instantaneously. This should be implemented at least by the next open enrollment period, if not sooner.

2. HHS should increase the frequency with which it double-checks the accuracy of enrollment, subsidy and billing in its own systems, its contractors' systems, and the Part D plans. In addition, beneficiaries who are trying to untangle problems should have access to the maximum amount of information from their pharmacist or a 1-800-MEDICARE representative. Currently, Medicare customer service representatives and pharmacists who serve Medicare beneficiaries lack access to data that explain reasons for disenrollment and subsidy status.

3. In late 2005, HHS developed a "Point of Sale" (POS) system intended to keep beneficiaries eligible for both Medicare and Medicaid from falling through the cracks. Unfortunately, as currently configured, this POS system helps few beneficiaries because it only applies when the pharmacist cannot find *any record* of a beneficiary's enrollment in a Part D plan. The POS system does not apply in the instances where the pharmacy cannot bill the correct Part D plan or cannot calculate the correct subsidy level. And, in spite of the fact these problems can occur at any time during the year, the POS system is only available for a short time during the initial enrollment window. The POS system should be available to any low-income Medicare beneficiary until enrollment in the correct plan is achieved *and* the correct cost sharing is being charged. As LIS beneficiaries are being added to the program daily, this should be implemented as soon as possible, and certainly no later than the next open enrollment period. Additionally, the POS system must be required for all pharmacies, pharmacists must be well educated in its use and pharmacies must be held harmless for incorrect billings to the system.

4. Errors continue to plague the system for automatic withholding of Medicare Part D and Medicare Advantage premiums from Social Security payments. After-the-fact extra deductions and refunds cause confusion and anxiety for fixed-income Medicare beneficiaries. For 2007, HHS and SSA should have a plan to isolate and fix premium withholding problems before they happen, and should institute and interagency task force as well as an ombudsman or consumer advocacy organization with resources and authority to resolve problems.

**Unclear and Inadequate Communication to Low-Income Beneficiaries**

Although they are 40 percent of current Part D enrollees (and projected to reach at least 50 percent), LIS beneficiaries are often ignored in the design of program materials. For example, in the model Annual Notice of Change (ANOC) developed for stand alone PDPs, information on costs and rights of LIS beneficiaries is buried among pages of information relating to costs, benefits, and rights of non-LIS beneficiaries, instead of being prominently displayed.

Tailored communications from Part D plans, HHS, and SSA to LIS recipients should be the norm. HHS should develop separate clear model notices specifically geared to LIS beneficiaries. This should be implemented as soon as possible, but no later than the next open enrollment period.

**"Unintelligent Assignment" of Low Income Medicare Beneficiaries to Part D Plans**

HHS has adopted a random approach to automatically assigning low-income beneficiaries to Part D plans. Given the enormous variation across plans in terms of covered drugs, cost sharing, and deductibles, this process has resulted in many beneficiaries being assigned to a plan that does not meet their prescription drug needs. Poor matching of Medicare beneficiaries to Part D plans also winds up costing low-income beneficiaries substantially more out of pocket than if they had been matched to the plan that best met their prescription drug needs. HHS should implement an "intelligent assignment process" in which "random" would mean a random choice of plans *among those that meet a beneficiaries needs*. Similar arrangements have already been approved for certain State Prescription Drug Assistance Programs (SPAPs). Such a process should also be extended to the rest of the low-income subsidy population.