

**MEDICARE PRESCRIPTION DRUG BENEFIT:  
REVIEW AND OVERSIGHT**

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**HEARING**  
BEFORE THE  
**COMMITTEE ON FINANCE**  
**UNITED STATES SENATE**  
ONE HUNDRED TENTH CONGRESS  
FIRST SESSION

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MAY 8, 2007  
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## **MEDICARE PRESCRIPTION DRUG BENEFIT: REVIEW AND OVERSIGHT**

**TUESDAY, MAY 8, 2007**

U.S. SENATE,  
COMMITTEE ON FINANCE,  
*Washington, DC.*

The hearing was convened, pursuant to notice, at 10:07 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Bingaman, Lincoln, Wyden, Schumer, Cantwell, Salazar, Grassley, Thomas, and Bunning.

### **OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. The committee will come to order.

The book of Leviticus instructs, "Rise in the presence of the aged. Show respect for the elderly and revere your God."

Today we continue our examination into whether Medicare's prescription drug program is rising to the needs of its beneficiaries and showing sufficient respect for America's seniors.

Last week, we heard from beneficiary advocates and pharmacists. They confirmed that America's seniors need Medicare's prescription drug program to get affordable drug coverage. We have heard that the program has enrolled more than 22 million seniors. Before the program, many of these seniors did not have coverage, and now surveys show that 80 percent of seniors are satisfied with the program. By these measures, the program has been a success.

But last week, we also heard some troubling reports. We heard about a pattern we have been hearing about since the program started: it is a pattern of poor administrative planning, it is a pattern of weak oversight of plans, and it is a pattern of failure to respond to seniors whom Congress intended the program to serve.

We heard again about the problems that agencies and private plans have sharing data; the left hand is not talking to the right. We heard of administrative mix-ups that have led the government to withhold the wrong amount from millions of Social Security checks, mix-ups that have led low-income seniors not to get the benefits for which they are eligible. These seniors have, thus, not been able to afford their prescriptions. These mix-ups have meant uncertainty and hardship for many.

Last week, we heard about the confusion caused by rampant marketing. We heard how seniors who only want prescription drug coverage are ending up enrolled in Medicare Advantage plans that

they do not understand. We heard that private plans are being allowed to operate without sufficient control.

Tobey Schule, a pharmacist from my home State of Montana, told us that seniors there have to choose among 50 plans. He told us how confusing that is. He told how many of his patients have ended up in a plan that is not the best for them based on the drugs that they need.

Tobey also described how a senior may pick a plan because it covers a certain drug, but then the plan can remove that drug from its formulary. This causes seniors to change medications. Plans are overruling the doctors' medical decisions and the patient's choice in search of savings.

Last week, we heard how seniors who had a problem with the program cannot get answers. One witness described how seniors are "shunted" from one place to another. They get passed around among agencies and private plans, and they never get their problems solved.

We are aided in our oversight efforts today by the Government Accountability Office. Today, they will unveil their report on challenges in enrolling dual eligible beneficiaries, a particularly vulnerable population.

We are not here today to place blame, but this committee will hold administrators responsible. We are here today to find out why problems are occurring. We are here today to hear what plans are doing to fix them, and we are here today to determine what the committee needs to do to ensure that the benefit is serving all seniors.

I expect two things from those entrusted to run our programs: responsibility and honesty. As to responsibility, we all need to remember that Congress created this program to serve America's seniors. We are the hired hands; they are our bosses. And by "we" I mean the executive branch, HHS, CMS, as well as members of the Congress. We are here to work for the people. We are just employees. The seniors are our employers. They are our bosses, and we are here to serve them.

They deserve careful planning that considers their needs. They deserve regulators who keep a watchful eye over their private plans. They deserve administrators who respond to their concerns. In short, they deserve respect.

Congress set up the program, and plans are a very important part of that. But the bottom line is, many plans seem to operate based on a profit motive more than they do to the public, more than they do to seniors. We are here today, frankly, to help seniors, help the public, because that is who we are here to serve. It is our responsibility to make sure that we put the interests of seniors first.

As for honesty, I have said it from the very beginning of this program, that I expect administrators to be forthcoming. If there is a problem, tell us about it, and tell us how you plan to fix it. If an immediate solution is not possible, then we can find another way, even if it requires legislation.

So let us make this hearing the first step toward making honest and responsible improvements to Medicare's prescription drug program. Let us make sure that the program is showing sufficient re-

spect for America's seniors. Let us ensure that the benefit is doing what it was designed to do: improve the health and well-being of America's seniors.

Senator Grassley?

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,  
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Yes. Senator Baucus and I wrote this program, so you should not be surprised that we are having oversight hearings because we want to make sure that it works according to the way we intended. So, we have agencies responsible for the administration before us today.

I think we owe a debt of gratitude to the Centers for Medicare and Medicaid Services and to Social Security for putting a very complicated program into operation after we passed it for the benefit of millions of beneficiaries across the Nation. But there have also been some unfortunate glitches.

Most of the early problems seem to have been resolved and they were resolved quickly, and we commend the agencies for that. But there are some persistent problems that should have been fixed by now. I have been fairly vocal that, while much good work has been done, there is room for improvement.

When this bill was written by the two of us, we took great pains to make sure that plans wanting to serve Medicare beneficiaries would have to meet strict requirements. Pharmacy availability and formulary rules are just a couple examples of those requirements.

What I am particularly interested in learning more about today is how the agencies are enforcing requirements spelled out in regulations and rules. We know, for example, that the agency requires that if a plan wants to change its formulary it must allow enrollees to continue to take the drug that they are already taking until the end of the year.

We know that CMS has told plans that they are responsible for claims for new dual eligibles back to their retroactive enrollment dates. This is important because Medicaid provided retroactive drug coverage.

Not long ago I heard from a pharmacy in Iowa about problems affecting dual eligible beneficiaries. The director of billing for the pharmacy informed me that it had not received any payments for claims for Medicare beneficiaries who did not choose a Part D plan, but who were later found Medicaid-eligible and retroactively enrolled. The plans are obligated to pay those claims, yet there had not been any payments made to this pharmacist.

Senator Baucus, as well as Senators Hatch, Rockefeller, and myself requested that the Government Accountability Office study these issues. I am pleased that it was completed in time for this hearing.

Now I would like to comment on the Social Security Administration and its work on the low-income subsidy. We all know that it is not easy to get people enrolled in assistance programs that they are eligible for. We have seen that with Medicaid, SCHIP, and the Medicare savings program.

The Social Security Administration seemingly pulled out all stops to find beneficiaries and get them signed up for the extra financial

help. The results were impressive, but, despite their resource-intensive effort, millions of beneficiaries eligible for the extra help still do not receive it.

I am looking forward to hearing from the Social Security Administration today about its work to re-tool the application and its outreach strategies, and from the Government Accountability Office, which is looking into the low-income subsidy application process as well.

Finally, I cannot help but bring up an issue that we—meaning CMS, the Social Security Administration, and this committee—have talked about at length, and that is the Social Security withhold option that some beneficiaries have chosen to pay their Part D premium.

It has worked well for many beneficiaries, but, as one advocate put it at the hearing just last week before this committee, it has been a nightmare for other beneficiaries. Last fall, we held a member meeting on this topic. While I do not question that progress has been made, it is clearly not enough, as we have heard in testimony before this committee. We need to know when it will be fixed once and for all.

At last week's hearing, I said this committee is ultimately responsible for the drug benefit's operation. On many fronts, the benefit has been a resounding success, but it's not perfect. This hearing and last week's hearing not only continue the committee's commitment to strong oversight, they also will provide a solid foundation for the committee's consideration of improvements to the drug benefit.

One area that I am particularly interested in is the pharmacy issue. Last week, we heard again that some plans' practices have made it difficult for pharmacists to fully gauge the terms and conditions of the contract. That, to me, just does not seem fair, particularly considering that there is not one of these plans that does not have to be approved by the Secretary of HHS before it goes into effect.

You would think that approval of those plans would take a look at the contracts and make sure that the contracts are fair to the one class of people that we were intending to make sure was preserved in our communities, and that is the community pharmacist. I think this and other areas deserve more attention.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Now I would like to welcome our panel. First, we will hear from Abby Block, the Director of the Center for Beneficiary Choices at the Centers for Medicare and Medicaid Services. Ms. Block was responsible for the implementation of the prescription drug benefit.

The second witness is Bea Disman from the Social Security Administration. Ms. Disman is the Regional Commissioner of Social Security for the New York Region, and also serves as the chair of the Medicare Planning and Implementation Task Force.

Third is Kathy King. She is the Director of Health Care at the Government Accountability Office. Ms. King is the lead author of a GAO report being released today on the dual eligible beneficiaries in the Medicare drug benefit.



Finally, we will hear from Barbara Bovbjerg, also from the Government Accountability Office. Ms. Bovbjerg is Director of Education, Workforce, and Income Security.

A reminder to all of you: 5 minutes in your oral presentation. Your statements will automatically be included in the record.

Ms. Block, why don't you proceed?

**STATEMENT OF ABBY L. BLOCK, M.A., M.S.W., M.B.A, DIRECTOR, CENTER FOR BENEFICIARY CHOICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Ms. BLOCK. Good morning, Chairman Baucus, Senator Grassley, and distinguished members of the committee. I am pleased to be here today to discuss the Medicare prescription drug benefit and, in particular, plan oversight and review. First, it is important to review where beneficiaries are today following enactment of Part D just 3 years ago. Nearly 24 million beneficiaries are enrolled in Part D. Not only do 90 percent of eligible beneficiaries have prescription drug coverage through Part D or other sources, but recent surveys tell us that 80 percent of Medicare beneficiaries are satisfied with current coverage and drug plans.

In addition to beneficiary participation and satisfaction, the program also excelled in beneficiary savings and reduced costs to taxpayers. In fact, beneficiaries are saving an average of \$1,200 a year, with estimated premiums 42 percent lower than originally estimated.

One year ago, CMS was resolving a number of systems and processes issues that impacted some Part D enrollees' ability to access covered drugs. The high priority that CMS has placed on working hard to find and fix the problems to avoid similar issues in 2007 has paid off. We work with plans, pharmacists, and States to improve data systems impacting beneficiary access. For example, we facilitated better communication between plans and pharmacies which resulted in upgrades to pharmacy software systems that will improve messaging between pharmacies and plans for better customer service. Also, throughout the year CMS made a series of systems and processes changes and enhancements to improve our file and data exchanges with plans, my fellow witness, the Social Security Administration, and the States to improve performance and accuracy in enrollment and processing. While these efforts have yielded positive results, we understand that we still have a long way to go.

The oversight of Part D plans is a continuous effort. I want to talk today about some of the ways that CMS is building upon lessons learned and information gathered during 2006. One important example is an improved method of identifying companies for compliance audits, making more efficient use of resources available. In addition, CMS has developed a contractor risk assessment methodology that identifies organizations and program areas representing the greatest compliance risks to Medicare beneficiaries and the government.

In that vein, we envision an approach to oversight that will include a mostly centralized data-driven program, fueled by data provided by contractors and beneficiaries. While receipt and analysis

of data is central to this oversight strategy, regularly scheduled and focused targeted program compliance and program integrity audits will be necessary to ensure program compliance. CMS anticipates the risk assessment tool to be ready for implementation and use in January of 2008.

Further, CMS is now working with a contractor to augment the internal agency resources available for Part D compliance audits. Among other things, the contractor is conducting "secret shopping" of sales events across the country to enable CMS to learn firsthand about what is happening in the sales marketplace and to identify organizations in need of compliance intervention.

In addition, strengthened relationships with State regulators are a key to help freely share compliance and enforcement information we jointly regulate about marketing agent conduct.

Specifically, CMS worked cooperatively with the National Association of Insurance Commissioners and State departments of insurance to develop a model Compliance and Enforcement Memorandum of Understanding (MOU).

More fundamentally, before a plan sponsor is allowed to participate in the Part D program, it must submit an application and secure CMS approval. CMS performs a comprehensive review of the application to determine if the plan meets CMS requirements.

CMS has established baseline measures for the performance data and has been tracking results over time. Plans not meeting the baseline measures are contacted by CMS and compliance actions are initiated. Actions range from warning letters all the way through civil monetary penalties and removal from the program, depending on the extent to which plans have violated program requirements. All violations are taken very seriously by CMS, with beneficiary protection the foremost concern.

In my written testimony I have outlined more specific information related to the recently released 2008 Call Letter to plans that serves as central guidance to help plans implement new CMS policies and procedures. As an example of what is included in the Call Letter, CMS expects that sponsors must assign preferred cost-sharing amounts in alignment with preferred formulary tiers. Plans whose cost-sharing amounts fall above the mean will be rigorously examined under the discrimination review. The Call Letter also highlights important reporting requirements, transparency in data exchange between CMS and Part D plan sponsors, and puts significant emphasis on marketing compliance.

CMS continues to make significant progress in overseeing and promoting quality Part D prescription drug coverage. With ongoing effort and vigilance, I am confident we will see continued high levels of plan compliance with program requirements, along with significant improvements where necessary on this critical front. Thank you again for the opportunity to speak with you today. I look forward to answering your questions.

The CHAIRMAN. Thank you, Ms. Block.

[The prepared statement of Ms. Block appears in the appendix.]

The CHAIRMAN. Ms. Disman, you are next.

**STATEMENT OF BEATRICE M. DISMAN, M.A., M.B.A., REGIONAL COMMISSIONER OF SOCIAL SECURITY, NEW YORK REGION; AND CHAIR, MEDICARE PLANNING AND IMPLEMENTATION TASK FORCE, SOCIAL SECURITY ADMINISTRATION, NEW YORK, NY**

Ms. DISMAN. Mr. Chairman, 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 ongoing efforts to sign up eligible Medicare beneficiaries for the low-income subsidy, or "extra help," as it is commonly known.

In my role as Regional Commissioner and as chair of the Task Force, I have seen the truly tireless and dedicated efforts of many Social Security employees as they reach out to those individuals who could benefit from "extra help."

Also, every day our Social Security employees in our field offices and on our 800-number lines deal on a one-on-one basis with Medicare beneficiaries to assist them in filing for the "extra help." I am pleased to provide you with an update of our story.

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, in senior citizen centers, pharmacies, public housing, churches, any place in which we feel 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 clinics, prescription drug plans, and others to identify people with limited income and resources who might be eligible for "extra help."

Throughout these efforts, Social Security has attempted to reach every potentially eligible Medicare beneficiary multiple times, in a variety of ways. Whether there are 300 or 3 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 reach and inform low-income Medicare beneficiaries about "extra help," for example, the multiple targeted mailings, telephone calls, and targeted events, I refer you to our written testimony.

Today, however, I would like to focus on a new initiative. I am pleased to talk about a new strategy in our continuing efforts to inform the public about "extra help."

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

By specifically focusing on these caregivers, Social Security hopes to reach even more individuals who could be assisted through the "extra help" program. At the end of April, the Commissioner met with the advocacy organizations that SSA has been engaged with as partners over the last 3 years to ask their assistance in this new strategy. I have already seen this strategy on a number of their websites.

We are launching the strategy this week, around Mother's Day, as we celebrate some of the special people in our lives. This year, we are asking that people show someone they love how much they care by learning about "extra help" that is available with Medicare prescription drug costs. We are asking them to take a further step to help those loved ones apply.

This week, Social Security employees around the country will be visiting flower shops, restaurants, and places of worship to make information about "extra help" available. I personally will be visiting one of the largest African American churches in Jamaica, New York on Mother's Day, and I have filmed TV spots publicizing "extra help" for NBC's local consumer reporter.

I have seen the activities from around the Nation. My colleagues and their staffs are actively engaged. Social Security also intends to publish related articles in the media and be on local TV throughout the Nation.

Outreach efforts also include distribution of a special pamphlet entitled "This Mother's Day Show Someone You Love How Much You Care," and we made this pamphlet available to all the congressional staff as well.

The campaign will continue throughout the year with a second series of targeted events scheduled for Father's Day. Your offices should be receiving these pamphlets. We are very excited about this new initiative, its timing on Older Americans Month, and its prospects for assisting low-income Medicare beneficiaries.

In addition, Social Security has made a special effort with CMS to reach those beneficiaries who lost their deemed status in January, 2007, and to have them file for the "extra help."

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 that the States have re-deemed.

Social Security is currently personally calling 188,000 of those beneficiaries who have not yet filed for the "extra help." Almost 850,000 beneficiaries have filed for "extra help" this fiscal year. About 200,000 of those filings were unnecessary because the applicant was automatically eligible or they had filed more than once. Based on these filings, about 350,000 individuals are eligible for the "extra help." We continue to receive about 30,000 applications every week, or over 100,000 a month.

In conclusion, I want to express to this committee my personal thanks 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, not only in administering the "extra help" program, but also in providing our very important traditional services to the American public.

We realize that our job is not complete, and we continue to look for ways in which we can reach those in need. We look forward to our continuing dialogue with organizations, advocacy groups, and, of course, this committee.

Thank you. I am glad to answer any questions that you may have.

The CHAIRMAN. Thanks, Ms. Disman.

[The prepared statement of Ms. Disman appears in the appendix.]

The CHAIRMAN. Ms. King?

**STATEMENT OF KATHLEEN M. KING, M.A., DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC**

Ms. KING. Mr. Chairman, Ranking Member Grassley, and members of the committee, thank you for inviting us here to testify today.

As you know, the Medicare Modernization Act moved the drug benefits of dually eligible Medicare and Medicaid beneficiaries from Medicaid to Medicare, effective January 1, 2006.

The CHAIRMAN. Ms. King, do you have a copy of that slide in your materials here?

Ms. KING. I do. It is on page 5 of my testimony.

The CHAIRMAN. All right. Thank you.

Ms. KING. You asked us to do some work on this, and we focused on the continuing challenges of enrolling new dual eligible beneficiaries into the Medicare Part D drug benefit.

My remarks here today are going to focus on a couple of the excerpts from my report. Specifically, I am going to focus on the process of enrolling new dual eligible beneficiaries and the effects of the retroactive coverage policy.

As you know, dual eligible beneficiaries are a vulnerable group because they are poorer, sicker, and have higher health care expenses than other Medicare beneficiaries. In recognition of this, the Congress, in transferring drug benefits from Medicaid to Medicare, required CMS to auto-enroll dual eligible beneficiaries into a Medicare Part D drug plan if they had not enrolled themselves.

Here is where it gets a little complicated, because I want to talk about two different types of dual eligible beneficiaries. The first group is people who are Medicare-eligible first and then they become eligible for Medicaid as a result of incurring high health care expenses or spending down their income. They constitute about two-thirds of the new dual eligible beneficiaries.

The one-third group is people who are eligible for Medicaid first and then they become eligible for Medicare by virtue of turning 65, or ending the waiting period for Medicare benefits through disability. I am going to come back to that.

This chart that I show you here, I am not going to spend a lot of time on this, but I wanted to show it to you because it shows you the complexity of what is involved in the enrollment process for a dual eligible beneficiary.

It involves multiple partners. It involves SSA, all the State Medicaid agencies, CMS, and the prescription drug plans. So, it is quite complicated, with steps going back and forth. It is explained in more detail in our report.

The process involves many steps. I am going to show you another chart now, equally complicated.

The CHAIRMAN. I hope this is not a trend. [Laughter.]

Ms. KING. No, this is it. This is on page 7 of my testimony. I wanted to show you the effect of that on a hypothetical beneficiary. We estimated that it takes about 5 weeks for the enrollment process to be completed because of all the drug interchanges. This proc-

ess has different effects depending on how you became a dual eligible.

For the two-thirds of people who were Medicare-eligible first and then became eligible for Medicaid, they are likely to experience some problems in accessing their drug coverage because not all the parties are informed about their enrollment and what their drug coverage is.

For the one-third who were Medicaid-eligible first and became eligible for Medicare, CMS instituted a process during 2006 to complete their enrollment process before they became Medicare-eligible. The key point about this is, these beneficiaries are Medicare-eligible, as known in advance, because we know when they are going to turn 65 or when they become Medicaid-eligible. So those people's enrollment process is smooth.

The other thing I want to talk about, and I do not have a chart on it even though it is complicated, is the retroactive coverage policy. CMS decided, for new dual eligible beneficiaries, to set the retroactive coverage policy effective the first date of Medicaid eligibility.

So you have the approximate 5-week gap of the enrollment process and then, under State law, most beneficiaries are entitled to an additional 3 months of retroactive coverage. So you have, give or take, 5 months when people are eligible for coverage and they do not know that they have it.

We have estimated that CMS paid approximately \$100 million to PDPs for people in this group, but we do not know how many people took advantage of this coverage because, in order to do so, you would have to know after the fact that you were eligible and have to have saved your receipts, or in some other way claim reimbursement for it. During 2006, CMS did not inform beneficiaries of their right to this retroactive reimbursement.

In March of 2007, they sent out the notice telling people of it. So they have taken steps to do that, but it still requires beneficiaries to know about it and to take active steps to claim reimbursement for those funds.

We have made recommendations to the agency on parts of this, and they have adopted one of our recommendations, which was to inform beneficiaries of their right to reimburse. We have also recommended that they track the number of people who are eligible for retroactive coverage and track the reimbursements.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions.

The CHAIRMAN. Thank you, Ms. King.

[The prepared statement of Ms. King appears in the appendix.]

The CHAIRMAN. Ms. Bovbjerg?

**STATEMENT OF BARBARA D. BOVBJERG, M.A., DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC**

Ms. BOVBJERG. Thank you, Mr. Chairman. Mr. Chairman, Senators, I appreciate being invited to speak today about SSA's progress in signing up individuals for the Medicare Part D low-income subsidy.

SSA is charged with publicizing the subsidy, taking and evaluating applications, and determining participants' continuing eligibility. Although my written statement includes information on SSA's processing of the subsidy applications, due to your interest in outreach, I will focus orally on their progress in identifying eligible individuals and soliciting applications. My statement today represents work still in progress for this committee.

SSA began its outreach in May, 2005. It sent targeted mailings, which included an application form, to almost 19 million individuals identified as potentially eligible. SSA contractors then made phone calls to more than 9 million of those individuals who did not respond to the initial mailing.

SSA also conducted other follow-up efforts, including sending notices to individuals they could not contact by phone, as well as contacting members of specific subgroups, such as non-English speaking individuals and those over 79 living in high poverty areas.

Also, in partnership with other government agencies and with advocacy groups, SSA conducted more than 76,000 events at senior centers, churches, and other community centers. As of March, 2007, SSA's efforts had resulted in approximately 6 million subsidy applications, of which more than 2 million were approved.

Whether this result represents success has been questioned; there are no reliable data on the number of people who would qualify for this subsidy in the aggregate, so it is difficult to know whether the number of approved applications represents most of those who are eligible or a relatively smaller part of that group.

We collected estimates that ranged from 5.6 to 6.9 million individuals who might be eligible for the subsidy, suggesting that the current number of approved applications covers between 30 and 40 percent of that eligible population and that roughly 3.4 to 4.7 million individuals remain eligible but did not apply.

If we assume that these estimates of the eligible population are in the ballpark, this record compared somewhat favorably to the first 2 years of the Food Stamp program, another means-tested program requiring outreach.

However, multiple barriers impede effective outreach. Even though SSA's original mailings to 19 million people were an overestimate of the eligibles and likely went to every individual who could possibly be eligible, why did relatively few apply?

In the course of our work, we heard that many of these individuals may have been confused by the application and did not understand that the subsidy application and the Part D enrollment application were two different things. Also, some individuals may have been reluctant to apply because they did not want to share their personal financial information.

For the future, targeting the remaining eligible individuals for effective outreach will be difficult. Resources are not available to provide direct and personal contact to the 12 million people who received letters and did not apply, and millions of these individuals are not, in fact, eligible anyway.

But SSA cannot target the subset of that population who are likely to be eligible because data to identify them more specifically are not available. SSA believes that tax data held by the IRS could help. Even if many lower-income individuals do not, in fact, file tax

returns, SSA believes that it could at least use asset information from the Form 1099 to eliminate some ineligible from their list.

However, by law, IRS cannot provide such information without specific authorization from Congress. Further, IRS staff expressed doubts that tax information would provide meaningful targeting help.

Those who suggest that SSA go door-to-door to reach potentially eligible individuals are seeking activity that may be unrealistic for them to carry out, with other important responsibilities and limited resources, especially if they cannot target their outreach more precisely.

To conclude, SSA has made a creditable start in encouraging eligible Americans to apply for the Part D low-income subsidy. While it is not clear how best to reach the remaining eligible individuals, the momentum of the initial outreach campaign should not be lost.

Better information on who is or who is not eligible could help, and we encourage SSA and IRS to work together to evaluate the true utility of tax data for targeting outreach efforts. Knowing whether, and to what extent, the tax data would be useful would both settle the inter-agency argument and would inform a decision on whether to provide SSA with access to tax records.

Until we know for sure that the use of such data will not help, we will continue to wonder if we could have reached more individuals more quickly if such information were available. The subsidy program, and those eligible to receive it, really deserve no less.

That concludes my statement. I am happy to answer questions about any of that, and my written testimony.

[The prepared statement of Ms. Bovbjerg appears in the appendix.]

The CHAIRMAN. Sure. I deeply appreciate that, Ms. Bovbjerg, and also the statements of all four of you.

I would like to begin with you, Ms. Block. The question really is what CMS is or is not doing about marketing abuses by private plans.

I am sure you saw today's *New York Times*, the lead editorial, a very stinging rebuke basically against your agency about not doing a proper job in protecting against marketing abuses by some of the plans, and, I would guess, especially, private fee-for-service.

Obviously, it is your agency's responsibility to make sure that the plans engage in proper practices. It is your job to make sure that beneficiaries know their rights when they are the subject of all of these marketing practices, know their rights in appealing, whether a plan does or does not contain the right prescriptions, and so forth. So, I would like you to tell me what you are doing about all this.

But, first, I want to ask you a series of questions. How many plans are there under your purview? The number of plans.

Ms. BLOCK. Well, it depends on how you count.

The CHAIRMAN. The number of plans that basically, in one way or another, provide prescriptions under Part D.

Ms. BLOCK. There are, I would say, about 400 sponsors.

The CHAIRMAN. About 400.

Ms. BLOCK. Yes.



The CHAIRMAN. The next question is, how many of those did you approve and how many have been disapproved?

Ms. BLOCK. Well, all of them were approved or they would not be participating in the programs.

The CHAIRMAN. Did you disapprove any?

Ms. BLOCK. In the initial application.

The CHAIRMAN. During the year since the law has been in effect, has CMS disapproved any plans?

Ms. BLOCK. We have, so far as I know, not disapproved any application.

The CHAIRMAN. And why would that be?

Ms. BLOCK. We have provided, in some cases, notices of intent not to renew certain plans.

The CHAIRMAN. But have there been any instances where you considered not to approve a plan?

Ms. BLOCK. Well, in any instance where there has been an issue, we have been absolutely assured that the plan met all of our requirements before they were approved for participation.

The CHAIRMAN. But you have not disapproved any plans?

Ms. BLOCK. I need to go back and verify that.

The CHAIRMAN. But you are the Director.

Ms. BLOCK. I want to ensure that I give you an accurate answer.

The CHAIRMAN. And you, who oversee this program, have to go back to check to see whether any were disapproved?

Ms. BLOCK. It is not typical that we would disapprove plans in the application process. We go through a rigorous process. If a plan does not appear to be meeting our requirements, we notify them of all of their deficiencies and make very, very sure that, before they receive final approval, they have cured any deficiencies that we have identified. So we have gone through that process, certainly, with some applications.

The CHAIRMAN. Right. I understand that. What about once the plan has been approved? What oversight and regulatory actions do you take with respect to plans that have been approved to see whether or not they are conducting or not conducting abusive marketing practices?

Ms. BLOCK. There are numerous processes in place, including audit processes. But in terms of marketing abuse, in addition to the secret shopper program that I just mentioned—

The CHAIRMAN. Which you just have done recently. That is not an ongoing practice, is it? You have just started that.

Ms. BLOCK. Well, we have been doing it for the last several months—

The CHAIRMAN. How long has this program been in effect?

Ms. BLOCK [continuing]. And would hope to continue it as time goes on, since it has proven to be very useful and the results have been very helpful.

The CHAIRMAN. Have you taken any disciplinary action against any plans?

Ms. BLOCK. We have taken action in terms of working with plans to provide us with corrective action plans where we find that they are not meeting requirements. There are numerous cases under investigation through the Program Integrity program where the MEDICs that we contract with—

The CHAIRMAN. Just give me a rough sense of how many plans have you taken disciplinary action against, and if you can be more precise in describing to us what those disciplinary actions are.

Ms. BLOCK. Well, disciplinary actions range from warning letters, to corrective action plans, to civil monetary penalties.

The CHAIRMAN. And then roughly how many would that be over the course of the program?

Ms. BLOCK. Over the course of the program there have been hundreds and hundreds of actions taken. Most are resolved at the warning letter stage. There are a number of plans under corrective plans at the moment, and we are monitoring those very closely.

We are working very closely with the States in terms of alleged marketing violations. We have worked with plans to ensure that they have, in fact, terminated their contracts with brokers or agents who are in violation of the contract.

The CHAIRMAN. You raise a very good point about States, because the law took regulation away from insurance commissioners and put it in your lap. You have lots of insurance commissioners who would chomp at the bit to clamp down on abusive marketing practices.

So, that raises several questions. One, should the law be changed? Why shouldn't the States that would like to have the traditional role of overseeing insurance plans not go back and take a little closer look at them? And short of that, what can you do in the interim with States to assure that seniors are not being taken advantage of?

Ms. BLOCK. Well, the States still have jurisdiction over the licensed agents, and we require all plans to use only State-licensed agents. So the States do have jurisdiction.

What we have done is established this policy of signing memoranda of understanding and we have, I believe at this point, about 19 States that have already signed that memorandum, and we are looking forward to more of them signing the memorandum so that we can have a free interchange of information with the States about allegations of non-compliance. And where those allegations rise to the level of fraud or abuse, they are then referred to appropriate law enforcement.

The CHAIRMAN. All right. My time is expiring. But as you know, under State law, the States can only look at the agents. They have no jurisdiction over the plans themselves. That is a huge problem. Frankly, I think plans, like private fee-for-service, are taking advantage of that.

My main point is, I just do not get the feeling that CMS is rigorously protecting seniors. I do not get that feeling at all. This hearing is an oversight hearing to see what is or is not working with the program, and frankly there is a very deep sense that CMS is not sufficiently scrutinizing private plans who get a pretty big bump in income, in reimbursement, and especially private fee-for-service.

But the number of private fee-for-service plans has gone up 40 percent—40 percent—since the inception of the plans. As you know, there is less control over them, fewer obligations for them, that there is compared with, say, HMOs or other plans. They are basically renegade plans. I am surprised CMS is not doing some-

thing about that. I am very surprised, frankly, because it is your job to oversee this.

Senator Grassley?

Ms. BLOCK. I would like to assure you we are doing everything we possibly can.

The CHAIRMAN. Well, my personal view is—

Ms. BLOCK. And will continue to do more.

The CHAIRMAN. My personal view is, more needs to be done.

Senator GRASSLEY. Along the lines of what the Chairman just said, I would just simply add that when we set up that the government is going to approve these plans before they can solicit membership from seniors, that the government, and specifically the Department of Health and Human Services, ought to be seen as kind of a good-housekeeping seal of approval in every respect, that not only does a plan meet the basic requirements of what the law does, but that plans are going to operate in a business, ethical, good procedure way so that bad marketing practices do not happen, so that when pharmacists are owed money by plans that they see that they get their money. That is why we got the government involved in that. Now, I am not going to go down that road any further, because I think the Chairman has done a good job.

Ms. Block, I want to ask about the \$100 million that GAO referred to in 2006. Plans have been told that they must pay claims back to those effective dates. From what I have heard, that has not happened. A pharmacy in Iowa said that they have not received any payments for some of their dual eligible beneficiaries, even though the plan should pay them. That is bad for the program, and bad for dual eligibles.

It is one of these things that we ought to be able to take for granted, because a plan has had the government's approval to operate, along the lines of what Chairman Baucus has been spending his time on today.

Now, how are beneficiaries and pharmacies notified that Medicare covers these claims and how to submit them for payment? How does CMS make sure that prescription drug plans pay these claims?

Ms. BLOCK. Well, as GAO just reported, formal notification was added to the letter that informs the beneficiary that they have now become eligible in March. Prior to that, however, that information was readily available through the various support groups and advocacy groups that work with beneficiaries, and the plans have known, and know very clearly, that they have responsibility for paying those claims.

So, if there are situations where pharmacists have not been paid, I would like to hear the specifics, and we will absolutely look into it and make sure that all payment that is due and owed will be properly paid.

In terms of the inherent situation, there are really two choices. The GAO report does not make a recommendation that we change our procedures and policy in that regard because the choices are, you either have this retroactive situation or you have a gap in coverage, and a gap in coverage is simply not acceptable. So, we have chosen to have the retroactive coverage situation.

What we have committed to do, once all of the claims are in for the year, is to go through those claims and see, in fact, whether the retroactive claims are being paid when people had eligibility retroactively.

But I do want to say that it is not unusual in the Medicaid program for coverage to be allotted retroactively, and so we really do believe that Medicaid beneficiaries understand that they have this eligibility, that they are entitled to coverage, and we will do everything in our power to make sure that the plans are, in fact, paying properly.

Senator GRASSLEY. In the first instance, do the plans have the responsibility to notify these beneficiaries about that?

Ms. BLOCK. Yes, they do.

Senator GRASSLEY. They have that responsibility?

Ms. BLOCK. They have that responsibility. They are required to notify them, and we are now notifying them as well.

Senator GRASSLEY. All right.

Ms. King, along the lines of the discussion we have just had, since it is your study that brought this out, can you discuss any recommendations that the GAO may have to make sure that plans pay claims that they are responsible for?

Ms. KING. Senator Grassley, we have recommendations in the report along the lines of notifying beneficiaries of their right to reimbursement. We would like to see a little bit more in terms of what steps you have to go through in order to claim reimbursement, and we recommend that CMS track the number of people, the number of months, and the payments.

Senator GRASSLEY. All right.

The CHAIRMAN. I will give Senator Grassley more time here. Does CMS have within its power the authority to say to a plan that, first, we want evidence that you have actually paid this subsidy, the retroactive subsidy, to the beneficiary, and then we, CMS, will reimburse you, the plan? Why can the burden not be more on the plan rather than the burden on the bureaucracy of the Federal Government?

Ms. BLOCK. Well, the plan can only pay when they know that there is a claim due. Unless they know there is a claim due, there is no way they can pay.

The CHAIRMAN. If they know there is a claim due, then CMS will reimburse the plan once the plan knows the claim is due and the plan then makes the payment to the beneficiary.

Ms. BLOCK. The plan should know before CMS knows, because the only way that a claim can occur is for the beneficiary to go to a pharmacy and fill a prescription. When they do that, a claim is submitted to the plan, so the plan would know well before CMS could possibly know that there is a claim.

The CHAIRMAN. We are talking about retroactively. They already know about the drugs because we are talking about retroactive payments. We are not talking about initial, we are talking about retroactive. I am just curious.

Ms. BLOCK. The only way that either the pharmacist, CMS, or the plan could know about a retroactive claim is if the beneficiary submits that claim.

The CHAIRMAN. I am just suggesting you put the burden on somebody else to get the job done.

Go ahead, Senator.

Senator GRASSLEY. This is going to be my last question. It is a follow-up on the first series of questions that Senator Baucus asked.

CMS said that it is considering a number of additional requirements for the marketing of private fee-for-service plans. What are those requirements, and why did CMS not just adopt those requirements? In other words, why the waiting period?

Ms. BLOCK. Actually, Senator, there is no waiting period. We have adopted those requirements and we will be issuing follow-up guidance that makes very clear what the requirements are.

The reason it was worded that way in the Call Letter is that we did not intend that list to be all-inclusive and we wanted to leave open the possibility that, in addition to the requirements that we spelled out in the Call Letter, we might, in fact, add requirements.

The requirements are very specific. They are that plans will have to document clearly the education process that they have put their brokers and agents through to ensure that they understand all of the requirements of the Medicare program, in addition to the particular aspects of the product that they are selling.

The CHAIRMAN. All right. Thanks, Ms. Block. Thank you.

Senator Bunning, you are next.

Senator BUNNING. Thank you, Mr. Chairman.

Senator Grassley, in your opening statement—there were more than two votes for this program when it went past the committee.

Senator GRASSLEY. As I made the statement, I sensed your grumbling about saying that Senator Baucus and I wrote the bill. What I should have said is, we were the chief negotiators of it.

Senator BUNNING. The chief negotiators.

Senator GRASSLEY. Sorry I offended you.

Senator BUNNING. No, no. That is all right, Senator Grassley. But there were a lot of us advocating this bill when it went past the committee, and I want the witnesses to realize that.

I have some questions for Social Security and CMS. The Medicare drug benefit has been a success, and we all know it has been a success. Ninety percent of beneficiaries at least have coverage of some kind, most—80 percent—are satisfied, and seniors are saving money each month.

However, it is troubling to me the continuing problem some beneficiaries are having when they try to have their drug payments withheld from Social Security checks. The caseworker who works my cases in Kentucky said it took 8 to 9 months to finally get one case solved, and she has cases open since last December that still cannot get fixed.

Do you understand what I am saying now about the payments that either Social Security is withholding and they are not paying the benefit and someone is not getting paid in the process? That is unacceptable, that time frame. Would you like to comment, Social Security or CMS, on this issue?

Ms. DISMAN. Well, let me start talking about it. We share your concern. As a Regional Commissioner, I deal daily with beneficiaries who are experiencing some of the problems that you have

outlined. We take it very, very seriously, the adjustment of people's benefit checks. As a matter of fact, I have brought a staff person with me into Baltimore who is doing the same type of casework that you talk about.

But Social Security is really at the end of receiving all the data. The data starts with the PDP, it goes to CMS, and then has to come to Social Security. When we get data, we do give CMS the response within 2 days. I think the issue that you are talking about right now, I can talk about 2007 data.

When we are looking at the data that we are receiving for 2007, the problems we had identified in 2006 really do not exist with the data in 2007. But I would have to turn it to my colleague at CMS who is in the midst of a reconciliation for 2006. They are currently looking at that, and I would have to turn it to her to talk about that.

Ms. BLOCK. Well, I would like to say, first, that we not only share your concern, but we at CMS feel as strongly as SSA that this is a problem that we have to solve and that we have to solve quickly. So the concern is real, and I have dedicated staff who spend all of their working hours, all of their waking hours, on this problem.

Senator BUNNING. What I would really like for you to do is give us an update on where the problem is and where we are in solving it.

Ms. BLOCK. I would be happy to do that.

Senator BUNNING. All right.

Ms. BLOCK. We are, at this point, almost at the end of the first step in solving the problem, which is to go through enrollment reconciliation so that we can be 100-percent certain that we have every beneficiary in the correct plan. Because of some of the start-up problems in 2006, we had situations where beneficiaries are not, in the record, necessarily in the plan in which they should be enrolled.

Senator BUNNING. Thank you. I want to ask some more questions because I am very limited in time.

For Social Security, it sounds like Social Security is making every effort to find people who are eligible for low-income assistance and get them to apply. That is certainly a great goal.

However, according to your testimony, it looks like there are quite a few who have applied but are not eligible. Is there a fear that having to deny so many individuals might cause frustration with the program?

Ms. DISMAN. Well, the question that we are looking at is, because many States require people to file—the States that have State Pharmaceutical Programs—to have a decision from Social Security that they are not eligible before they get the State program. You have a variety of reasons why people are filing. But as GAO has indicated, we keep reaching people multiple times, multiple ways. People are in the communities and in the streets to really reach people.

Now, it is very interesting. We have done a number of surveys talking to people, because we have actually made some personal phone calls on a number of things that we have done. For example, when we had people who were eligible for the \$600 credit for the

discount card, we actually followed up with that population because we thought that population would be a very, very important population that might really be eligible for the low-income subsidy.

It is very, very interesting. Thirty-one percent of the people we spoke to said they had too much income or resources or they just were not interested.

Senator BUNNING. They are not qualified?

Ms. DISMAN. They are not qualified. And we have done a number of these, so that is why our focus is to try to identify those, again, that could be potentially eligible and to keep reaching out in a variety of ways.

That is why we really have the campaign now, which we have done before, but very specifically, to go to the caregivers and have the sons, the daughters, the grandchildren, to try to reach out. And one of the reasons we are doing it around Mother's Day is because places of worship are one of the biggest places where mothers go on Mother's Day. So, that is why many of us are doing this particular outreach at this time.

Senator BUNNING. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Bingaman?

Senator BINGAMAN. Thank you all for being here. I appreciate it very much.

Let me ask a few questions also about this low-income subsidy program. The two big problems, as I see it, are that, first, we need to change the assets test. I think it is too low. I have been getting opinions on that. But even without changing it, it seems to me there ought to be ways that we can get more people who are eligible to qualify or to participate in the program.

First, let me ask on the first question that I raised there about possibly needing to change the system, Ms. Disman, as I understand it, SSA has evaluated the asset levels of a sample of low-income subsidy applicants who were ineligible because their assets exceeded the statutory limit.

Could you give us any information about what percentage of those applicants were over the statutory asset limit, and if so, how much they were over it?

Ms. DISMAN. Yes. We had conducted a number of studies because we, too, were interested in determining why individuals were not eligible for the "extra help," so we actually did some sampling at various periods of time.

And if you looked at the samples that we conducted, we basically found that when you looked at denials for what I call just assets or resources, that alone was about 42 percent of the samples that we conducted. There was an additional 6 percent that were ineligible for income and resources.

Now, it is very, very interesting, when you look at our application, and when we developed this application, because of the need for mandatory filing for a lot of States and for other purposes, we actually have a screen-out question.

So when you look at the resources themselves, there's a question that says: Do you have more than the amount for an individual and for a couple that might not make you eligible, and we give the resource limits there as well.

And basically, 65 percent of the people who were denied for resources answered that question that they themselves had too much in resources and they wanted a decision. When they do that, we do not get data on the very specific amount of resources. So in looking at that type of thing, we have checked, at that point, some of IRS's records to say, do you really know that these people know what they are talking about?

And I have to tell you, when we did the sampling of the records, it was evident that people really had the resources that they indicated, because we were able to impute interest income and other kinds of assets to determine it. I do not have the exact amount with me, and I can provide that for the record, but we did have the exact amount that they exceeded the asset test.

Senator BINGAMAN. All right.

[The information appears in the appendix on p. 88.]

Senator BINGAMAN. Let me ask on this second point about, even if we are not able to change the assets test, the assets test essentially says that, if you have anything significantly over \$10,000 as an individual in total assets, excepting your house and your car, you are ineligible for the low-income subsidy. It is about \$20,000, a little over \$20,000, for a couple, as I understand it.

Even if we are not able to change that, Ms. Bovbjerg, you have talked about the problems that you have encountered in signing some of these people up or getting people who are otherwise eligible.

The figures that I have are, there are between 3.2 and 4.2 million individuals who remain eligible, but unenrolled, in the low-income subsidy. Or, stated differently, only between 35 and 42 percent of low-income subsidy-eligible individuals who had to affirmatively apply for the benefit are actually receiving the benefit.

Do you really think that getting this thing fixed with the IRS would be a substantial step forward so that they would give you the information they have about people's incomes?

Ms. BOVBJERG. We do not know. The concern that we have at GAO is that this is an unacceptable situation where SSA believes that these data would help, and certainly SSA cannot go door-to-door finding 12 million people, they need to be able to narrow that down. IRS thinks that it will not help.

We think: so take a look. Figure out to what extent the use of these kinds of data might assist Social Security's effort. Just to rule out data sharing because informed staff at the IRS think it might not help did not seem to us to be very conclusive.

Senator BINGAMAN. So you think we should lean on the IRS to at least look at the issue and try to make a more informed determination as to whether this would help?

Ms. BOVBJERG. Yes. We have not completely finished our report, but we are considering a recommendation that IRS work with SSA on this to make sure that they are approaching it in a way that would be helpful to SSA, to see whether it would assist. We thought, at the very least, it might help with these estimates of the total population as well.

Senator BINGAMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Salazar, you are next.



Senator SALAZAR. Thank you very much, Chairman Baucus and Ranking Member Grassley, for holding this hearing.

I have a question for Ms. Block to begin with, and that has to do with rural pharmacies and the timeliness and adequacy of reimbursement for rural pharmacies. At the beginning of the implementation of this program, Senators Baucus, Grassley, and a number of us on this committee, as well as a whole host of other Senators, wrote a letter to CMS about what was happening with rural pharmacies and the timeliness of the reimbursement rate.

Me, I come from what is one of the four poorest counties in the United States of America, and I have seen what has happened at some of these rural pharmacies as they have had to close up for a number of different reasons.

But one of the reasons that I hear from some of these pharmacies out in rural America is that there has been a lack of timeliness in terms of the compensation that is required.

So my question to you is, why has CMS not moved to essentially direct the providers here to provide the reimbursement in a timeline that is less than 30 days, and to do it electronically so that these pharmacies are getting the reimbursement that they are entitled to?

Ms. BLOCK. Well, I think, Senator, that we have, in fact, shared the concern of rural pharmacists and have addressed every situation that has been brought to our attention.

Wherever a pharmacist believes that they have not been paid in accordance with the provisions of their contract with the plan, we have investigated the situation, and where we find that the complaint is justified, we have taken appropriate action with the plan to ensure that they are, in fact, complying with all of their contractual obligations.

Senator SALAZAR. Let me ask you this question. The reality of it is, if CMS had a directive in terms of a requirement that reimbursement be done electronically within, say, 15 days, whatever the appropriate timeline would be, it probably would be much more effective in terms of getting the result as opposed to just dealing with the grievances that come up from a pharmacist who is not getting paid on a particular basis. So does CMS have the authority to do that now?

Ms. BLOCK. Well, in terms of our relationship contractually, we contract with, as you know, the plans that participate in the program. The contracts with pharmacists are subcontracts of those prime contractors. It is not typical in my experience, both in the commercial world, in the FEHB world where I used to work, or in the Medicare world, for a government agency to have that kind of influence or direct involvement in subcontracts with a prime contractor.

What we do say, however, is we do have very specific requirements that the provisions of the contract, including the payment provisions and the timely payment provisions, have to be clear, that pharmacists have to know what they are, and that plans must meet their contractual requirements. So wherever they do not—

Senator SALAZAR. But let me just say this, Ms. Block. I do not think that the rural pharmacists who are complaining to me in the little towns of La Jara, Oak Creek, and a whole host of other places

in my State feel that they are being dealt with adequately by the government.

At the end of the day, these are government taxpayer dollars that are going to reimbursing these pharmacies. So essentially escaping the way you are by saying, well, this is a matter between the provider and the pharmacist, is not good enough for me.

One of the things I want to work on with this committee is to make sure that this program is also working for these local pharmacists who are way out in the rural areas.

Let me ask both you, and if I can, Ms. King, a question. Frankly, I think there is a lot of confusion still with Medicare Part D. It is something that I think we are going to have to deal with over a long period of time. But the morass that you showed us in the two charts with respect to the dual eligibles, Ms. King, I think, is one example of this.

So what would be, in a very summary form, your recommendation in terms of at least how we try to create a clear picture from the morass that you described in the two charts that you testified on?

Ms. KING. Senator, I wish I had an easy answer. But part of the problem that comes with the process is, it is more complicated because it involves so many partners: SSA, State Medicaid agencies, CMS. The plans all have to participate in it. And because of the short length of time between enactment and implementation, CMS had to use its existing systems to piece together this thing, and they do not operate in real time. So, that is what is causing some of the delays, the number of people and the complexity. In terms of that, we did not identify a quick fix to that.

Senator SALAZAR. I appreciate that comment. Let me just make one quick comment, if I may, Mr. Chairman. If I am a senior and I look at Medicare Part D, we have information coming back that says we are at a higher degree of satisfaction, obviously, than we were a year ago. If I look at my State, I think we have 55 plans that are out there under Medicare Part D.

If I sat down for a few days maybe I could try to figure that out, but I wonder how it is that the half million or so seniors whom I have in my State can honestly understand the complexity of what we are providing them with, and how they sort through the plans and figure out which one makes the most sense. So I think, whatever we end up doing in terms of trying to simplify this program that this committee worked on so hard, is something that is very important for all of us.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator. I appreciate that.

Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. I, too, appreciate you and Senator Grassley bringing us together on this really critical issue. I would like to associate myself with Senator Salazar, because, representing States that are rural, oftentimes our pharmacists are the only means of contact that some of our constituency has with a health care provider, in many instances. So, he made some very, very good points.

I know I joined Chairman Baucus last session in introducing a bill on that, and we are working on another one, to make sure that our pharmacists out there who really are doing yeoman's work are getting fair treatment out of these plans, because we have to keep them going.

Just, several questions. Ms. Bovbjerg, I was interested in your conversation in what Senator Bingaman was bringing up in terms of the asset test, and other things. Are there not other Federal programs—I mean, I think about food stamps. Is there not a way to streamline some of this in a greater way if the complication is really the sharing of information between the IRS and the Social Security Administration? Have we attempted to look at the other streamlined processes for other Federal programs?

Ms. BOVBJERG. Well, of course, the problem here is that tax law prevents IRS from sharing this information. For this purpose, it would have to be in law. They would have to have the authorization of Congress.

Senator LINCOLN. That is to share the information. But we do not use IRS records for food stamps.

Ms. BOVBJERG. But in this case, my understanding is that the 1099 forms, which provide information on other non-wage sources of income, which would be income from assets in some cases, from pension assets, from bank accounts, might provide a way to derive which people in this large group are, in fact, not eligible, so SSA could reduce outreach to people who would apply and then be found ineligible for the program.

We really think that it is something worth looking at. Our concern was that it was being rejected out of hand because IRS staff just do not believe that this would help SSA. We did not see evidence one way or the other. We would like to see some.

Senator LINCOLN. Yes. Well, it just seems like there are other means out there that we might look at that would help us facilitate that. I mean, obviously there are other Federal programs that we might go to to at least bring about a hybrid of some type of ability to get a better response.

I mean, we have had people in the field in Arkansas who have gone back and actually interviewed the people who were determined before that they were eligible for the low-income subsidy, and then asked, why did you not, and they said it was just too complicated, there was just too much there.

Ms. BOVBJERG. While it is a complicated application, I know that SSA has made changes to the application to try to make it more accessible to people. One of the reasons that SSA was tasked with taking applications was that it was thought that their network—their online application capability, the nationwide 800 number, 1,300 field offices—would really have the infrastructure in place to reach out to people, and there would not be the stigma that might be associated with getting “extra help” if you go into an SSA office, a place people are very familiar with.

Senator LINCOLN. Well, I do applaud, and I know that when we passed the bill I went and did a large number of meetings across my State, and our regional Social Security administrator from the Dallas office came and went through all those dog-and-pony shows with me. They worked very hard in getting that information out

and looking at non-traditional ways of getting that information out. I think your pamphlet is a great idea. I mean, I do think that there is a lot that they are doing, and I do want to applaud them for that. So, I guess we will just keep working at it and try to figure out what works and what does not.

Ms. Block, it is my understanding that the MMA contained language that specifically said a beneficiary could obtain a 90-day supply of medication from their retail pharmacist if they wanted to, even if the beneficiary had to pay more.

How is CMS interpreting this policy regarding the level playing field, and can pharmacies dispense a 90-day supply if they want to?

Ms. BLOCK. Yes, they can. It is very, very clear that plans need to have pharmacies, retail pharmacies, that will, and do, dispense a 90-day—

Senator LINCOLN. You are just saying they do not all have to. You are saying that they have to have some that will?

Ms. BLOCK. They must have some that will.

Senator LINCOLN. Well, what if they are not accessible to the patients?

Ms. BLOCK. Well, what we have done is made very clear that, if we hear of any access problem, we will deal with that problem. I have to tell you that we have not heard of any such situation to date, but if you know of any or if anybody—

Senator LINCOLN. We have had some complaints. I have to be honest with you, the chronic conditions like hypertension and diabetes, we have had some beneficiaries that have had some definite troubles.

I agree with Senator Salazar. My pharmacies have told me they are still having problems knowing exactly how much they are going to get paid by these Part D plans, for generic drugs, particularly, in their dispensing. What has CMS done to address that issue?

Ms. BLOCK. Well, I have heard the concern. I am not sure specifically why that would be an issue.

Senator LINCOLN. The plans do not tell them. They do not tell them what they are going to get reimbursed.

Ms. BLOCK. I believe they do. I think the question may be, are they telling them timely. That is something that I have heard about and that we are certainly discussing.

Senator LINCOLN. Well, if you have a small pharmacist and they have invested their own capital in that, not getting it in a timely way or not understanding what they are going to get is a real problem.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. Thank you very much.

Senator Schumer, you are next.

Senator SCHUMER. Thank you, Mr. Chairman, for having this hearing. I will thank all of our witnesses.

Let me just say overall that, while we are getting fewer complaints at my office on Medicare, we are still getting plenty. The number of plans is greater than ever. For those who had to switch in 2006, if anything, it was more difficult than in 2005.

Second, long-term care residents face significant challenges in obtaining their medications. Third, the 1-800 number does not seem

to be working very well. I am not going to talk about those three, but I guess I am getting “amens” from the chorus here about that.

I want to talk about pharmacists as well, because one of the problems is that pharmacists have been asked to shoulder a tremendous load here. In a certain way, they are a little like the people in 9/11. They rushed forward early on when there was a big mess, and often helped out not only with time and advice, but even giving people medication without reimbursement.

Now what we hear is, there are all kinds of problems from our pharmacies. In New York, we have had a large number of pharmacies go out of business, and many of them attribute it to the problems they have had here. I put in a bill to deal with this, or co-sponsored a bill, to relieve some of these, including having this 24-hour toll number, a special one, available to pharmacists to work out problems, and I hope we will implement that.

But I have a couple of questions about it. These are to Ms. Block. First, you conducted a survey that found that the vast majority of Medicare drug plans surveyed paid pharmacies within 30 days.

The American Pharmacists Association testified that, in their study of 59 pharmacists, the pharmacists indicated, on the average, almost 20 percent of the plans took longer than 30 days to reimburse their pharmacies. So the first question is, how do you account for that discrepancy?

Second—I am going to ask them all at once, there are just three of them, so you can answer them all—community pharmacists especially rely on prompt and fair payments from the Medicare drug plans for their livelihood.

The National Community Pharmacists Association says 90 percent of independent pharmacists report their overall cash flow is worse now than when Part D began, and 33 percent have said they have considered closing their pharmacy as a result. In the last year alone, as I mentioned, in my State, 221 independent pharmacies closed their doors. Does CMS recognize this concern, and what steps are you taking to alleviate that?

And then a general question: What more can be done to alleviate our local pharmacies from bearing the brunt of Medicare Part D, often doing the job that maybe somebody in the government should be doing? Thank you.

Ms. BLOCK. Well, first, I would like to say that we very much appreciate and understand the work that pharmacists have done and their contribution to the success of the Part D program. The program could not be where it is today without their contribution, and we at CMS very much understand and recognize that, so I would like that to be on the record, first.

In terms of the study you have referenced, sir, I have not seen it, so I cannot account for it. If I can have a copy made available, we will absolutely look at it.

Senator SCHUMER. I will get it to you. Do you still believe, though, that most pharmacists, the vast majority, overwhelmingly are getting reimbursed within 30 days?

Ms. BLOCK. I do. In every case where there is an assertion that that is not happening, we investigate it. Any instances where we have found, in fact, that it was not happening, we have dealt with it promptly with the plan and will continue to do that.

Senator SCHUMER. All right.

Now, what about the general question? Do you recognize that pharmacies are bearing the brunt here? Do you believe it is a problem that independent pharmacies are closing? What do you think you can do to help alleviate the general burden on pharmacies with Part D?

Ms. BLOCK. Well, I have to say that the Medicare prescription drug program was established as a market-based competitive program, and that is the way it is operating. The arrangements that pharmacists make with the plans, they make with a clear understanding of the payment provisions, that those provisions may be different. Certainly I understand that many Medicare beneficiaries, before Part D, paid cash at retail prices.

Senator SCHUMER. Sorry to interrupt. My time is limited. Do you see this as a problem, yes or no?

Ms. BLOCK. Well, I mean, this is an economic issue which I do not believe is specifically a Part D Medicare issue. I think we are operating in a competitive market.

Senator SCHUMER. All right. I am disappointed to hear that you do not regard it as the problem that many of us do.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

A question for you, Ms. Block. A growing number of seniors are getting their Part D benefits through Medicare Advantage plans, and I have come to feel that not all Medicare Advantage plans are created equal.

We have some very good ones in my part of the country that have been out there for years and years—Kaiser would be an example—and then we have some that we have had reports of very troubling practices, these private fee-for-service plans in particular.

My question to you is, when Medicare started providing private choices—and it was done with demonstration projects back in the early 1980s—even then there were a lot of reports that, with these new approaches, there were going to be people who would try to rip seniors off and try to take advantage and would perpetrate fraud.

So it is now 2007. Medicare has had 20 years' worth of experience in looking at private choices in Medicare. Why is the Center not doing a better job of anticipating the kinds of problems that we would see in these new products?

Ms. BLOCK. Well, I want to start by saying we have zero tolerance for ripping seniors off. We have anticipated everything we possibly can. In our marketing guidelines we have very strict requirements that tell plans absolutely what is acceptable and what is not acceptable. When plans violate those guidelines, we take action immediately to ensure that they come into compliance. That is an ongoing process.

I am as concerned and disturbed as you are about some of the allegations, and to the degree that we can enforce our regulations and our guidance, we are doing that every day and will continue to.

We are ever-vigilant that this does not occur, that seniors get appropriate information, that they are not in any way misled, that they understand what they are enrolling in and what their benefits are, and that they get all the benefits that they are entitled to.

Senator WYDEN. My understanding is, a lot of doctors are confused about these new plans as well. What has been done to help doctors sort through these? Because in a lot of parts of the country where doctors do not get particularly well reimbursed under Medicare now, the last thing you need is another headache for doctors with respect to taking patients. So what has been done to try to help doctors sort through these private fee-for-service plans and help seniors?

Ms. BLOCK. I absolutely agree that that is a concern, and it is something that we are dealing with. We have been working with provider groups and with hospital associations. We have been putting material and information up on our website so that doctors understand exactly how these products work and what their reimbursement provisions are.

We have, in addition, required plans to make sure that they are also providing accurate information to providers so that they understand the provisions of that type of product.

Senator WYDEN. I think what troubles me, Ms. Block—and you have had a long and distinguished career in government service, and I respect that work—is a lot of this seems to me to be after the fact, and it could have been anticipated earlier, particularly these problems with doctors.

After 20 years of understanding this—I mean, I go back to the Medigap law. I was the principal author of that. We had shoeboxes full of insurance policies because people were ripping them off. I think, number one, the government has been slow to deal with these rip-offs in private fee-for-service plans. I think it has done harm to the cause of private choices, which I happen to be supportive of, and I want to see it corrected. I hope that there will be faster movement now to deal with the problems.

I am curious how you are going to do this program of calling people who are going to be new enrollees. My understanding is that now, with the reports of the abuses flowing in, you are going to take some additional steps, and that is good. But how are you going to run this calling program for new enrollees? Is this going to be after they make their purchase, or is it going to be some other arrangement? Tell me how that would work.

Ms. BLOCK. Well, it will be before the enrollment takes effect. If a beneficiary decides to enroll in a private fee-for-service plan, before the plan will be permitted to submit that enrollment to CMS, before that enrollment ever occurs, the plan is absolutely required to contact that beneficiary and make 100-percent certain that they really, first of all, signed the application form, because I have seen some of the allegations that those forms are actually being forged, and that of course is criminal and totally unacceptable.

So the beneficiary will have to assure the plan that they have, in fact, signed the form; that they understand the provisions of the product; and that this is, in fact, the kind of coverage that they have chosen.

In terms of how that is working now, we have one plan under a corrective action plan that is already doing this. The requirement across the board will start in 2008.

But the plan that is already doing this is finding that 50 percent of those applications are not being submitted because, when that call is made, they find out that the beneficiary, in fact, either did not intend to enroll in that plan or did not understand the provisions of the plan.

Senator WYDEN. My time is up. Just one last question on this point. How long do you anticipate running this program for? I mean, obviously it is designed to make sure that, in this new and burgeoning field, that people are more aware. Do you anticipate running this from 2008 to 2010, or indefinitely? How long do you see it running?

Ms. BLOCK. At this point, indefinitely.

Senator WYDEN. All right. Thank you.

Thank you, Mr. Chairman, for the extra time.

The CHAIRMAN. Thank you. Thank you, Senator, very much.

Clearly, Ms. Block, we want to make this program work, and there are a lot of questions about it not working as well as it should.

Here is a question that has come up often. I know you have heard about it, and I would like your response. That is, seniors signed up for the plan. They have to stick with it for a year. The plan, mid-term, changes its formulary. They can change, seniors cannot, causing confusion, at the very least, for doctors, for seniors. Off the top, that seems unfair to seniors.

Clearly, I can see why a plan may want to change. They, mid-year, find a cheaper substitute, maybe generic. It saves money, but it is confusing, again, to the beneficiary and to doctors, and perhaps hospitals and pharmacists. Is that fair that seniors cannot change, but plans can change their formularies within the year?

Ms. BLOCK. Well, I would like to say, first of all, that we limit the kinds of changes that plans can make mid-year, and those changes are not all that frequent.

In the case that a plan does make a change, the beneficiary is grandfathered in. So if they are already using that particular medication, that beneficiary can continue to use that medication for the remainder of the year.

The CHAIRMAN. I hear what you are saying. I hear you saying that. That may be what you honestly believe and think. But you kind of sit here in, I guess, DC. I do not know where your office is. At that table, in the spot where Ms. King is sitting, there was a pharmacist named Tobey Schule who told over and over again how much confusion that causes people who come to his pharmacy.

You may think it is working, but according to the people on the front line, they do not think it is working. I encourage you to look much more deeply and aggressively at this question and find out the degree to which it is or is not working. People out in the field do not think it is working. You, in DC, may think it is working, but the people on the ground do not think that it is working.

The basic problem is, seniors do not know about the exceptions process to the formulary. They do not know about it. They do not know they can be "grandfathered," if that is what is meant by the



exceptions process. People just do not know. This is a very, very complicated program all the way along, as you well know, perhaps better than most in the room here. But the problem is, it is extremely complicated, and the persons that it is supposed to help, that is, seniors, we should not make it complicated for them.

This should be a little bit like the proverbial duck swimming in the pond, gliding along effortlessly: seniors getting their benefits right off the top, while underneath people are paddling furiously, that is, you, the plans, the pharmacists, others, to make sure the seniors get their benefits. The sense is that that is not happening.

Another question is, automatic enrollment for dual eligibles. It is my understanding that non-dual eligibles get special treatment. That is, you have a website. I am a non-dual eligible. I go to the site, I can match my needs, my drug needs, with plans. Whereas, with dual eligibles, there is no such matching, it is just automatic.

You are dual eligible, you are a senior, this is what you get, whether or not it matches your drug needs, or whatnot. I understand there are some States who are a little more sensitive in this program than is Uncle Sam, than is CMS. Some States—and I think Maine is one example—have an intelligent system of some kind. Some other States do, too.

Why is CMS not doing a better job matching dual eligibles' drug needs with their plans?

Ms. BLOCK. Well, I think there are several points. First of all, of course, the statute, as I know you know, specifically says that we will assign dual eligibles randomly. So, number one, there is a statutory provision. Number two, we do not know—

The CHAIRMAN. Does that prohibit you, though, from taking steps like Maine is doing?

Ms. BLOCK. Well, it does not prohibit us in that sense, but, even assuming we could selectively assign people, we do not know what their medication regime is at the time that we assign them. Some of the States do and can use that information.

But thirdly, and I think really an important point that needs to be made, is the medication regime that an individual is on is not necessarily the best or most effective regime for them. So it is not a given that just having somebody—

The CHAIRMAN. You are saying a random selection is better?

Ms. BLOCK. No, I am not suggesting that a random selection is better. I am suggesting that once a person is in a plan they have various options. They can opt out of that plan, they can—

The CHAIRMAN. We are talking about dual eligibles here, Ms. Block.

Ms. BLOCK. Dual eligibles can opt out.

The CHAIRMAN. People that are very vulnerable. People where it is very hard to know what is going on here. This is a very complex program that they are faced with.

Ms. BLOCK. I understand that. But there is the opportunity for their providers to examine their medication regime in accordance with the formulary of the plan they are in and see if, in fact, that formulary can work for that beneficiary.

The CHAIRMAN. Can you address this question, Ms. King, about automatic enrollment and lack of matching drugs?

Ms. KING. Yes. We did look, Senator, in the case of Maine. They found that approximately one-third of their beneficiaries had about a 100-percent match under the random assignment, but 20 percent had less than a 20-percent match.

They decided, in consultation with CMS, to give beneficiaries who had less than an 80-percent match an opportunity to see if they could get a better match, and at the end of that process they found a 99.8-percent match for those beneficiaries.

The CHAIRMAN. And could CMS do that with other States or encourage a similar kind of program with those States?

Ms. KING. One of our recommendations is that CMS work with the States that wish to facilitate this kind of thing to have the plans provide them the medication data they would need to provide these kinds of intelligent assignments.

The CHAIRMAN. My time has expired.

Ms. BLOCK. And we do, indeed, work with the States to do that where the States request that they be able to do that.

The CHAIRMAN. All States? You see, the problem here is the sense that you are being pretty passive. The agency is passive. Whatever the plan contracts say, that is what the contract says, end of analysis. That is the sense here. We are trying to get you to move beyond that.

Senator Lincoln?

Senator LINCOLN. Thanks, Mr. Chairman.

Just a few last, quick questions, a lot to what the Chairman was talking about, particularly when we talk about grandfathering and coverage determination, and quantity limits, and the prior authorization.

I just do not understand, Ms. Block, why it would not make more sense for the plans to be barred from dropping the drugs at a mid-stream point. Instead of requiring the seniors to go back through all of these processes when those things are dropped from the formularies, why would you not just initiate from the beginning?

That question, as well as the 1-800 number on the outreach for information for seniors. I am still getting a tremendous amount of calls in my State. They are getting inaccurate information. The person they speak to transfers the caller to someone else, and they have to wait again after they have waited for hours already, with that indication.

I just wanted to know if your records indicate a reduction in the wait time or improvement in the resolution of problems, because we are not seeing a tremendous amount of that in the State in terms of those problems being resolved and the wait times being eliminated.

One other thing. We have talked about marketing tactics. I know for us in our State, Medicare Advantage, there was a lot of misinformation, or maybe lack of information being offered. A lot of seniors got into Medicare Advantage thinking that was a prescription drug component. It ended up taking it out of traditional Medicare fee-for-service.

I know there is a lot you are doing in trying to make sure that information is greater, but could we not solve those that are unhappy and have been treated unfairly by minimizing the time it takes us to put it back into the traditional Medicare fee-for-service

that they want to go back to? We have had a huge amount of problem in our office.

Our casework, in trying to work with our constituencies, have discovered that they, for lack of information, signed up for a plan, Medicare Advantage, that put them out of their traditional Medicare fee-for-service. It is taking us forever to help them get back into it. It seems to me that CMS could do a better job at opening up some kind of help lines or some kind of process that could minimize that time.

Those three questions, on top of one more. Senator Schumer did not bring it up, but I certainly will. Given the high percentage of nursing home residents who are cognitively impaired, after CMS imposed a gag order on the nursing home staff and barred them from assisting the residents in the Part D selection, is it realistic to expect that some of these individuals are going to educate themselves and choose another Part D plan without some assistance? Have you explored options for helping seniors find the plan that is right for them?

I would just be interested to hear what you have to say on that, as well as maybe, perhaps, our GAO witness, if you have any input on the problems that we are seeing with the nursing home residents.

Ms. BLOCK. Well, Senator, I am truly sorry that you think that we have imposed a barrier to nursing home staff assisting beneficiaries. They absolutely can, and should, assist beneficiaries. They simply cannot steer them to a particular single plan in which the advisor has a financial interest. That is the bar, and it is a very legitimate one.

But we absolutely understand that seniors need help, and there is no barrier to nursing home staff working with seniors or their family members in giving them a range of choices that would be particularly suitable for that particular beneficiary.

Senator LINCOLN. How about the other ones in terms of—

Ms. BLOCK. I am concerned to hear that there is a time lag, and it is something that I will absolutely look into. It is our policy that anybody who has enrolled in a plan based on misleading or erroneous information who wants to go back to original Medicare can do that, and we give them a special enrollment period to enable them to do that.

Senator LINCOLN. Maybe you could give me a person over at CMS who could help us expedite that, because we are having some trouble with that.

Ms. BLOCK. I would be very happy to talk with someone in your office to do that.

Senator LINCOLN. All right. Great. Thank you.

And what about just barring them from dropping the formulary drugs midstream?

Ms. BLOCK. There is a statutory provision that says that plans can change their formularies mid-year, and we are abiding by the statute. Nevertheless, we have very rigorous requirements in place in terms of what changes plan can actually make. Staff at CMS reviews those requests and denies any of those requests that we feel are inappropriate.

Senator LINCOLN. Thank you.

Ms. KING. Senator, if I might.

Senator LINCOLN. Yes?

Ms. KING. We do have some work under way that is not finished yet, which should be ready later this year, that actually looks at the coverage determination and appeals process and how well that is working and how well CMS is overseeing that, so we should be able to report on that later this year.

Senator LINCOLN. Great.

Ms. KING. And on the nursing home issue, that was not a specific focus of our work, but our understanding is that a lot of nursing homes worked with a single long-term care pharmacy, so when the dual eligibles were randomly assigned to different plans, they were assigned to a lot of different plans that served one nursing home. So that, I think, was the genesis of the problem.

Senator LINCOLN. Thank you.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Let me ask an open-ended question here. A lot of you have a lot of experience one way or another with this Part D provision. Just stepping back a little bit, forget your assigned roles, just stepping back a little bit, where should this committee consider changing the law? I am not saying we will or should, but at least consider?

Ms. Block, you said the law allows plans to change midstream, and we cannot do a lot about that. There were other areas where you said, well, that is the law. I am asking all four of you, life is short. Say what you think. We do not want to be too short for you, at least in your jobs. [Laughter.] But say what you think. Our job here is to serve seniors. That is our job.

So, where might we at least look at and consider making some changes? I am just going to go down the list here. First, I am going to ask, anybody want to raise your hand? I am going to ask each of you. Who wants to start?

Ms. KING. Senator, I will start.

The CHAIRMAN. All right. You are bold. Good for you.

Ms. KING. I think that one thing that the Congress ought to look at at this point is how well their retroactive policy is being implemented, because it is likely that funds were paid for situations in which beneficiaries did not know they were eligible. I think one thing that you could do is keep a close eye on that in the next years.

The CHAIRMAN. And how can we do so? We asked questions along those lines here today. What else can we do in addition to the questions asked?

Ms. KING. I think that CMS could monitor that more carefully and provide information to you on that.

The CHAIRMAN. All right. And what kind of monitoring comes to mind?

Ms. KING. If they looked at the number of people who were in that category, how many months of retroactive coverage, and more specifically, data from the pharmacies about what kinds of reimbursements were paid during that period.

The CHAIRMAN. All right. Thank you.

Who else wants to step up here? Ms. Disman?

Ms. DISMAN. We have spent a lot of time talking about “extra help” and our outreach efforts and our multiple ways, and certainly I have spent a lot of time talking to the Government Accountability Office and IRS. I think the recommendation initially that we do a study with IRS to see if there is a way to identify individuals—

The CHAIRMAN. SSA.

Ms. DISMAN. SSA, with IRS, to take a look at it. As Regional Commissioner of New York, I have had a lot of experience with the SSI program.

The CHAIRMAN. Right.

Ms. DISMAN. So I know what 1099s have, I know other kinds of data that we get for SSI as a verification. I think it is worth the time to spend to look at it to see if we can narrow this population. The approach would still be the same at SSA: we will conduct mailings, we will call people, we will see them in our field offices, and speak to them on our 800 number.

But it is a lot different if you really have a smaller population that you are dealing with than the one that is identified now. So, we are very supportive of that. I have already spoken to IRS about the potential for us to conduct a study.

The CHAIRMAN. Well, maybe we can play a role here and encourage or commission that study to take place, as well as the suggestions that Ms. King had.

Ms. Block?

Ms. BLOCK. Well, I would say that, given the admittedly bumpy start of the program in the early months of 2006, we are seeing lots of improvement as time goes on. I think it is early to be talking about specific legislative changes. We are looking at the program. We are looking at our experience.

We are learning from our experience every day. We are making changes in our guidance, as you know. At this point in time I think we probably would like a little more time to see how things work and to determine what, in fact, is working well and what possibly might need to be changed.

The CHAIRMAN. We are in our second year already. It has been a long time.

Ms. BLOCK. Two years is relatively early in a program of this magnitude.

The CHAIRMAN. And I was a little concerned at your response to one of the Senators’ questions about payments to pharmacists. You basically said, well, that is what the plans say, so that is it. If plans say we pay within 30 days, no more questions asked.

You also heard one of the Senators say that is not pharmacists’ experience. Their experience is, it takes more than 30 days. I hear you say, well, we will stop. Whatever the plans say, that is it. What if the plan said 90 days? Would you do anything about it?

Ms. BLOCK. We have a specific requirement that 30 days is the maximum.

The CHAIRMAN. Why not make it 15 days?

Ms. BLOCK. That, as I understand it, is not a typical industry practice, sir.

The CHAIRMAN. Well, that is not the issue. That is not the question. There are a lot of practices that perhaps should be changed,

perhaps should be looked at, examined. We do not just automatically accept whatever anybody says, do we?

Ms. BLOCK. I think that the Medicare program needs to be run as a market-based competitive program and, given those parameters, I do not think that it necessarily should step outside—

The CHAIRMAN. But the problem here is, you heard the pharmacists. The pharmacists are on the front lines. They are the ones bearing the brunt of a lot of this. Clearly, it is to a plan's interest to keep it afloat and delay payment as long as they possibly can, to earn interest on it, delay the payments. It is in their economic interests to do so.

You said earlier, well, it is the pharmacists' economic problem. The trouble is, they are at the end of the line. They do not have any leverage. The plans have leverage, pharmacists do not. So if you are talking about competition, one of our goals is to make sure competition is fair, not lopsided.

Ms. BLOCK. By the way, pharmacists do have leverage. We have very strong GAO access standards, and a plan must meet those standards. So if they cannot find pharmacists to contract with them in sufficient numbers to meet our GAO access standards, they cannot participate in the program. That is real leverage for pharmacists.

The CHAIRMAN. Well, not really. Because, if I am a pharmacist in a small town, I am the only pharmacist there is; I have no choice. I have to sign up for the plan. The plans do the same things, maybe, with respect to delaying payment, if they can, to pharmacists. And low dispensing fees, in addition.

Pharmacists do not have a lot of leverage. Plans have a lot more leverage than pharmacists do. So again, if we are talking about competition, if it is fair, we have to look at a lot of different factors here.

This has been helpful. Thank you very much. We will keep looking very closely at the Part D benefit, because our job is to make it work.

To be honest with you, Ms. Block, I just urge you to be a little more aggressive, get out in the field more. Go out and go see some pharmacists and talk to them, and rural pharmacists. I spent a day working in a pharmacy. A whole day working there. I have this plan where, once a month, I work at some job back home. Eight o'clock, sack lunch, all day long. I encourage you to go work at a pharmacy, very rural. I will stop at this point.

But there is a difference between rural and *rural*. [Laughter.] Rural in New York is not very rural, with all due respect to both Senators from New York. If you go further out where I am from, rural is really rural. I would encourage you to go to a really rural pharmacy and spend a day there.

Thank you all very much. The hearing is adjourned.

[Whereupon, at 12 p.m., the hearing was concluded.]

# APPENDIX

## ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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Testimony of  
Abby L. Block, Director  
Center for Beneficiary Choices  
Centers for Medicare & Medicaid Services  
Before the  
Senate Finance Committee  
On  
The Medicare Prescription Drug Benefit: Review and Oversight  
May 8, 2007

Good afternoon Chairman Baucus, Senator Grassley and distinguished members of the Committee. I am pleased to be here today to discuss the Medicare prescription drug benefit (Part D) and in particular, plan oversight. Following the enactment of Part D with the Medicare Prescription Drug, Improvement and Modernization act of 2003 (MMA), CMS undertook an unprecedented outreach campaign, resulting in more than 90 percent of eligible beneficiaries having creditable coverage for prescription drugs through Part D or other sources by the end of the initial enrollment period (May 15, 2006). CMS has worked equally hard to ensure that once enrolled, people with Medicare are able to take advantage of their prescription drug coverage without difficulty.

### **Part D in 2007: Lower Costs and Improved Satisfaction**

In many respects, Part D is the single most important benefit addition in the history of the Medicare program. Nearly 24 million beneficiaries are enrolled in Part D. More importantly, according to recent surveys, over 80 percent of Medicare beneficiaries are satisfied with their current coverage and drug plans, including beneficiaries eligible for both Medicare and Medicaid, who receive the low income subsidy (LIS).<sup>1</sup> Additionally,

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<sup>1</sup> Results are based on a telephone survey of 802 seniors ages 65+ enrolled in Medicare, conducted September 1-7, 2006, by KRC Research for the Medicare Rx Education Network. Of those surveyed, 82

the recent surveys report that 87 percent of dual-eligibles feel “peace of mind” now that they are enrolled in Part D and more than 9 out of 10 dual-eligibles are satisfied. Almost half of the people who reported skipping or splitting dosages of medication prior to Medicare’s prescription drug coverage say they no longer have to under Part D.<sup>2</sup>

In addition to beneficiary participation and satisfaction, the program also has resulted in significant savings for beneficiaries and lower-than-projected costs for taxpayers. Beneficiaries are saving an average of \$1,200 a year, with estimated premiums for 2007 expected to average \$22 a month, down from an average of \$23 a month in 2006 and 42 percent lower than the original estimates of \$37 a month.

The latest cost projections for Part D through 2015, released on April 23 with the 2007 Medicare Trustees Report, are 13 percent lower than estimated in the 2006 Trustees Report (and substantially lower than the original estimates from 2003). Plan bids for 2007 were 10 percent lower than in 2006, as a result of intense competition among plans to attract and retain enrollees and plans’ expectations to further increase use of inexpensive generic drugs, rather than more costly brand-name equivalents. In addition, overall prescription drug costs have increased much more slowly during 2004-2006 than in prior years. Together, these developments reduce projected Part D costs significantly compared to the estimates in the 2006 Trustees Report.

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percent are somewhat (29 percent) or very (53 percent) satisfied with their coverage. The margin of error for the full sample is  $\pm 3.5$  percentage points.

<sup>2</sup> KRC Research survey for the Medicare Rx Education Network, conducted September 1-7, 2006.



**What a Difference a Year Makes: Lessons Learned**

One year ago, CMS was resolving a number of systems and process issues that impacted some Part D enrollees' ability to access covered drugs. CMS worked hard to find and fix the problems, and took significant steps early to avoid similar issues in 2007. We worked with plans, pharmacists and States to improve data systems impacting beneficiary access. For example, we facilitated better communication between plans and pharmacies, which resulted in upgrades to pharmacy software systems that will improve messaging between pharmacies and plans for better customer service. Also, throughout the year, CMS made a series of systems and process changes and enhancements to improve our file and data exchanges with plans, SSA and the states to improve performance and accuracy in beneficiary enrollment and benefits processing.

In September 2006, CMS published a "Readiness Checklist" for all prescription drug plans, reminding them of their obligations, key dates, and vital tasks to ensure a smooth annual enrollment season and transition to the 2007 benefit year. The Readiness Checklist included elements related to call center requirements, complaint resolution, systems testing and connectivity, data submission and file processing, enrollment procedures, beneficiary marketing and communication strategies, beneficiary and pharmacy customer service, and timely payment to pharmacies.

In early November 2006, CMS asked all plans to report back to CMS on their successes and any problems encountered in accomplishing the tasks on the Readiness Checklist. The results from this exercise served two important functions: First, it reassured CMS

that the vast majority of plans were fully prepared for annual enrollment and the new benefit year, and that they had successfully implemented our guidance and requirements. Second, it identified areas where some plans indeed were having problems – for example, some plans reported that they were not able to issue the Annual Notices of Change (ANOCs) within the timeframe specified by CMS. Using this information from the Readiness Checklist, CMS was able to quickly implement a strategy to ensure that beneficiaries who did not receive an ANOC in a timely manner would be granted a special election period to extend the period of time they had to make a decision about their 2007 plan choice.

#### **CMS Oversight of Part D Plans**

Building upon lessons learned and information gathered during 2006, CMS has strengthened its oversight of Part D plans. For example, CMS has improved its method for identifying companies for compliance audits, making more efficient use of the resources available for ensuring compliance, and developing a closer relationship with State regulators.

CMS has developed a contractor risk assessment methodology that identifies organizations and program areas representing the greatest compliance risks to Medicare beneficiaries and the government. CMS will direct its resources to those high risk contracts. We envision that this approach to oversight will include a mostly centralized data-driven program, fueled by data provided by contractors and beneficiaries. While receipt and analysis of data is central to this oversight strategy, regularly scheduled and

focused/targeted program compliance and program integrity audits will be necessary to ensure program compliance and document the Agency's program oversight responsibilities. CMS anticipates the risk assessment tool to be ready for implementation and use in January 2008.

Further, CMS is now working with a contractor to augment the internal agency resources available for Part D compliance audits. Among other things, the contractor is conducting "secret shopping" of sales events across the country; such information enables CMS to learn firsthand what is happening in the sales marketplace and to identify organizations for compliance intervention that are not meeting CMS marketing and enrollment requirements.

CMS also has strengthened relationships with State regulators that oversee the market conduct of health insurers. Specifically, CMS worked cooperatively with the National Association of Insurance Commissioners (NAIC) and State Departments of Insurance to develop a model Compliance and Enforcement memorandum of Understanding (MOU). This MOU enables CMS and State Departments of Insurance to freely share compliance and enforcement information, to better oversee the operations and market conduct of companies we jointly regulate and to facilitate the sharing of specific information about marketing agent conduct.

More fundamentally, before a plan sponsor is allowed to even participate in the Part D program, it must submit an application and secure CMS approval. CMS performs a

comprehensive review of the application to determine if the plan meets CMS requirements. Annually, plans also must submit formulary and benefit information for CMS review prior to being accepted for the following contract year. For each plan sponsor, CMS establishes a single point of contact (Account Manager) for all communications with the plan. The Account Managers work with plans to resolve any plan problems, including compliance issues.

CMS continually collects and analyzes performance data submitted by Part D plans, internal systems, and beneficiaries. CMS has established baseline measures for the performance data and has been tracking results over time. Plans not meeting the baseline measures are contacted by CMS and compliance actions are initiated. Actions range from warning letters all the way through civil monetary penalties and removal from the program depending on the extent to which plans have violated Part D program requirements. All violations are taken very seriously by CMS, with beneficiary protection the foremost concern.

**Looking Ahead: The 2008 Plan Call Letter**

The recently-released 2008 Call Letter to plans serves as a central guidance document to help plans implement new CMS policies and procedures and improve compliance with critical program requirements. Highlights from the Call Letter include:

***Ensuring Accountability.*** CMS strives to provide organizations with the guidance and information they need to meet the requirements of our programs and, in most cases,

organizations are meeting or exceeding those standards. Complying with the Part D program requirements is critical to meeting the needs of people with Medicare; consequently, we may take actions, including sanctions and civil money penalties, when organizations do not comply. If an organization thinks it will be unable to meet a requirement, it must notify CMS immediately. Often we can work with an organization to resolve issues and avoid delays. However, CMS *will* take action against organizations that do not meet critical deadlines or exhibit a pattern of missed deadlines. In order to help organizations meet the requirements of the Part D programs, a calendar of key dates and deadlines that organizations must meet was included with the Call Letter.

CMS also is improving ways of collecting performance data and refining our performance measures for the development of comparative materials such as plan report cards, so that people with Medicare can better evaluate their health care options. As CMS expands web-based and other resources, we expect organizations to provide comparative, in-depth plan information so people can choose the prescription drug benefits that best meet their needs. Looking forward, new areas for measurement may include, but are not limited to: medication therapy management (MTM) services, prescription drug utilization, patient safety, disenrollment, and member satisfaction. The measures to be included as part of the report card will come from multiple data sources, most of which are already currently collected by CMS.

***Fostering Transparency.*** The Health Plan Management System (HPMS) facilitates data exchanges between CMS and Part D plan sponsors. HPMS plays an important role in our

efforts to provide people with Medicare with the information they need to make confident and informed decisions about their health care needs. Data submitted by organizations via HPMS is integral to the Medicare Prescription Drug Plan Finder and the Medicare Options Compare website tools, the plan-specific portion of Medicare and You, and the standardized Summary of Benefits. CMS continually strives to enhance HPMS system and software functionality in support of our outreach efforts and to further streamline the bid and formulary submission processes. While streamlining, we want to make sure we are conveying accurate information. Prior to the publication of plan data, CMS provides organizations ample opportunity to preview the data, and expect them to ensure that all plan data is accurate. As has been done in the past, in cases where the data of a particular plan is inaccurate, CMS will suppress the data to avoid misleading people with Medicare.

***Protecting Beneficiaries.*** To ensure a non-discriminatory benefit, CMS expects that sponsors must assign preferred cost-sharing amounts in alignment with preferred formulary tiers. To this point, cost-sharing amounts for a preferred tier must be lower than cost-sharing amounts for a non-preferred tier. In addition, plans whose cost-sharing amounts fall above the mean will be rigorously examined under the discrimination review.

***Requiring Reporting.*** To ensure that Part D sponsors continue to provide beneficiaries high value health care, sponsors are required to submit data according to our reporting requirements document. They are also expected to comply with any other requests by

CMS for additional data necessary to support payment, program integrity, program management, and quality improvement activities under Part D.

***Focusing on Marketing.*** CMS uses several mechanisms to ensure that MA organizations conduct marketing activities that are compliant with the regulations and marketing guidelines. Organizations are responsible for the actions of sales agents/brokers whether they are employed or contracted. They must ensure agents/brokers are properly trained in both Medicare requirements and the details of the products being offered. Part D sponsors must provide strong oversight and training for all marketing activities. Employees of an organization or independent agents or brokers acting on behalf of an organization may not solicit Medicare beneficiaries door-to-door for health-related or non-health-related services or benefits. Employees, brokers and independent agents must first ask for a beneficiary's permission before providing assistance in the beneficiary's residence, prior to conducting any sales presentations or accepting an enrollment form in person.

### **Conclusion**

CMS continues to make significant progress in overseeing and promoting quality Part D prescription drug coverage. With ongoing effort and vigilance, I am confident we will see continued high levels of plan compliance with program requirements, along with significant improvements where necessary on this critical front. Thank you again for the opportunity to speak with you today. I look forward to answering your questions.

**United States Senate Committee on Finance**  
**Public Hearing**  
**The Medicare Prescription Drug Benefit: Review and Oversight”**  
**May 8, 2007**  
**Questions Submitted for the Record From Abby Block**

**Chairman Baucus:**

1. Beneficiaries have the right to an appeal if their drug claim is denied. I am concerned that beneficiaries are not aware of their rights and that plans are using arbitrary, financial rather than medical, criteria to reject claims. What is CMS doing to ensure beneficiaries are aware of their right to appeal when a drug is rejected at the pharmacy?

**Answer:** If a Part D plan enrollee can't get a prescription filled at the pharmacy, the pharmacy must provide the enrollee with a standardized notice that explains the enrollees' right to ask the Medicare Drug Plan for a coverage determination. CMS regulations require Part D plans to arrange with their network pharmacies for the distribution or posting of this standardized notice. The regulatory cite relating to pharmacies requirements can be found at CFR 423.562(a)(3). CMS also have been working with the American Medical Association and the American College of Physicians to encourage physicians to provide a copy of the notice to their patients whenever they write prescriptions and to post the notice in their offices. If an enrollee is dissatisfied with his/her plans' coverage termination, he/she has the right to appeal the decision.

CMS informs Medicare beneficiaries of their appeal rights in a number of publications, including the *Medicare and You Handbook*, *Your Medicare Rights and Protection* and a CMS Publication entitled "Medicare Prescription Drug Coverage: How to File a Complaint, Coverage Determination, or Appeal." These publications explain how a beneficiary or their representative can request a coverage determination (including an exception) or an appeal. This information is also provided through plan materials based on a model evidence of coverage (EOC) develop by CMS. Coverage determination and appeal information is also available on [www.medicare.gov](http://www.medicare.gov). This site gives beneficiaries information about the appeals process and provides links to additional information and model forms. Appeals information can also be accessed through 1-800-MEDICARE.

1a. How many claims did plans reject in 2006? How many appeals were filed? How many rejections were overturned by independent review? What actions does CMS take against plans with a high rate of rejections?

**Answer:** CMS has no data on the number of rejected claims, that is, prescriptions that were not filled. With respect to appeals, Part D enrollees filed a total of 72,586 redetermination requests (1<sup>st</sup> level appeals to plans) and 13,239 reconsideration requests (2<sup>nd</sup> level appeals to our independent review entity, MAXIMUS) during calendar year 2006. During this timeframe, there was a 53% reversal rate by the Part D IRE of adverse decisions issued by plans (excluding



procedural actions, such as dismissals, and excluding cases involving requests for non-Part D drugs).

Although a high reversal rate at the IRE level does not in and of itself indicate a problem with a plan's decision making process, CMS has been evaluating plan reversal rates and conducting individual reviews of plans with the highest reversal rates. These reviews involve looking at samples of adverse decisions appealed to MAXIMUS and evaluating the criteria used to make the decisions, their compliance with the regulations, and the overall quality of the decisions. To date, CMS has completed two such reviews, and a third review is in progress. These reviews have shown that reversals by the IRE occur most often because cases involving requests for prior authorization also get evaluated as exceptions requests by MAXIMUS if the enrollee does not/cannot satisfy the prior authorization criteria.

2. How many formulary changes were requested for plan year 2006? How many were approved? On what basis were any proposed changes rejected? What was the nature of the changes requested?

**Answer:** CMS has not tracked the number of new drugs that were added to formularies within contract year 2006. Analysis of the number of drugs on formularies between Contract Year 2006 and 2007 has found an approximate 15% average increase in the number of drugs contained on 2007 formularies over 2006 formularies. The most frequent type of non-maintenance or "other" change request was the addition of quantity limits (35%), which are commonly assigned by a Part D sponsor to ensure appropriate dosing of a drug.

CMS approved the vast majority of maintenance changes and approved about two-thirds of non-maintenance changes. Maintenance changes, for example, include the deletion of the brand name medication when an equivalent generic was added to a formulary or removal of a drug due to a Food and Drug Administration (FDA) "black box" warning. Non-maintenance changes, for example, include removal of a medication or dosage form from a formulary or the addition of drug utilization management controls to a drug on a Part D sponsor's formulary.

The decision about the approval of non-maintenance changes requested by a Part D sponsor would generally depend upon whether or not the sponsor's formulary would continue to meet CMS' requirements (e.g., that the formulary continued to have two drugs per class and category). For these non-maintenance changes, beneficiaries currently receiving the medications that are removed from the formulary are "grandfathered" and continue to receive the medication through the end of the contract year.

During the period of December 2005 through September 2006, approximately 63% of all requested changes were attributable to formulary maintenance changes and 37% were attributable to non-maintenance changes. The most frequent type of formulary maintenance change request was a change in the formulary status of a brand name drug (67%) due to the availability and addition of an equivalent generic drug. Our analysis reveals that approximately 6% of the total formulary change requests received involved removal of a drug following an FDA safety warning or manufacturer withdrawal from the market.

**Senator Grassley:**

3. In a letter to CMS last year, I encouraged the Agency to require plans to offer an electronic funds transfer option, and I know that the Agency did that. I also expressed my view that promoting electronic funds transfer is the responsibility of the Agency, not a trade association. Pharmacists should be paid on time and the plans should not consider them to be their bankers. Could you please inform the Committee about steps CMS is taking to promote electronic funds transfer?

**Answer:** CMS supports encouraging plans to adopt the Electronic Funds Transfer payment option. We believe our advocacy is directly responsible for moving the industry towards adopting this payment methodology, as evidenced by one of the larger trade organization's endorsement.

4. Last year, CMS took a number of steps to address a number of start-up issues. One of those steps was to work out a standardized prior authorization form. A witness who testified before the Committee on May 2<sup>nd</sup> suggested that the standardized form is not widely used. Why not require that plans use the standard form?

**Answer:** Enrollees and their prescribing physicians can use the standardized forms or any other written instrument to request coverage determinations (including requesting prior authorization or an exception). Part D plans are required to accept any written request for a coverage determination made using the standardized form or any other written instrument. However, many Part D plans also make available drug-specific forms for requesting coverage determinations. These forms help facilitate obtaining drug/disease specific information needed by a Part D plan to make a coverage determination for a particular drug. In these situations, the standardized form may not be appropriate and use of the standardized form could delay the coverage determination process because the requester might not provide sufficient drug/disease specific information for the Part D plan to make the coverage determination.

**Senator Cantwell:**

5. RE: Sales and marketing practices—Ms. Block, over the past week, as we prepared for this hearing, we talked to various people in our state, including our state health insurance assistance program and our Area Agencies on Aging, about their experiences helping beneficiaries with Part D.

What we heard time and again were concerns about the sales and marketing practices of agents and brokers. We heard complaints about people being solicited at home and about agents using strong-arm tactics to get people to sign-up for their product. We heard that people are confused and dissatisfied because they didn't fully understand what they were being sold. Your testimony outlines some of the rules plans are supposed to follow with respect to overseeing their brokers,

but I'm interested in what you are doing to enforce those rules. As the regulatory agency charged with overseeing the Part D benefit, what specifically is CMS doing to address the practices of brokers?

**Answer:** With the significant expansion of MA and PDP enrollment we remind organization that they are responsible for actions of sales agents/brokers whether they are employed or contracted. Organizations must ensure agents/brokers are properly trained in both Medicare requirements and the details of the products being offered. Part D sponsors must provide strong oversight and training for all marketing activities. Employees of an organization or independent agents or brokers acting on behalf of an organization may not solicit Medicare beneficiaries door-to-door for health-related or non-health-related services or benefits. Medicare Advantage organizations must provide strong oversight and training for all marketing activities. This is especially critical for the marketing of private fee-for-service (PFFS) plans which are unfamiliar to many beneficiaries and providers.

CMS has established policies for PDPs and MA plans to follow in order to protect beneficiaries from inappropriate sales tactics. For example, CMS requires that PDPs and MA plans use only State-licensed marketing representatives in states that have licensing requirements, monitor marketing representative activities to ensure compliance with applicable laws and policies, ensure that the identity and other information of a marketing representative is reported to a State when required, and ensure that terminations for cause are reported to the appropriate State agency, if a State has such a requirement.

Because organizations are required to use only a state licensed, registered, or certified individual to market a plan, if a state has such a requirement, CMS expects an organization to comply with a reasonable request from a state insurance department, or other state department that licenses individuals for the purpose of marketing insurance plans, which is investigating a person that is marketing on behalf of a organization, if the investigation is based on a complaint filed with the state insurance or other department. CMS also encourages an organization to report a person that markets on the plan's behalf to the appropriate state entity, if an organization believes that the person is violating a state's licensing, registration, certification, insurance or other law.

6. How are you holding plans accountable for the actions of the contractors who sell their products?

**Answer:** CMS has unquestioned authority to regulate the marketing activities of MA plans, including the activities of marketing representatives directly employed by a plan. We have comprehensive guidelines in place, we expect plans to follow them, and we strive to ensure that they do through a variety of oversight and complaint tracking activities. As recently announced in our Call Letter to plans for 2008, we are stepping up our vigilance in this area – particularly with respect to private fee-for-service plans, which have generated the vast majority of marketing-related complaints in recent months.

In the case of independent brokers and agents, States have the primary responsibility for overseeing the professional conduct of individuals licensed in their state. CMS has a Memorandum of Understanding (MOU) in place with 26 states and territories currently, which

allows us to share information and better coordinate our oversight efforts to ensure people with Medicare are protected and not misled. We look forward to working with other states to expand our MOU and collaborative efforts to combat marketing abuses.

7. Have you penalized any plans for inappropriate actions by their agents or brokers?

**Answer:** CMS has imposed a number of Corrective Action Plans (CAPs) in response to agent/broker complaints. The CAPs require plan sponsor's to respond to the problems and address how they intend to correct them. The CAPs are an ongoing process that allows for continued follow-up of the issues noted.

**Question for Ms. Disman and Ms. Block:**

8. RE: Social Security withholds—Ms. Disman and Ms. Block, one of the things that your agencies have been charged to work together on, with respect to Part D, is allowing beneficiaries to pay their Part D premium through their Social Security checks. But that process has been a bureaucratic nightmare for many beneficiaries.

We have seen everything from premiums being inadvertently refunded to beneficiaries who were later forced to repay them to premiums being withheld but not paid to plans – which has left beneficiaries with unpaid bills they thought were being paid.

We have heard a lot about CMS and SSA data systems not talking to each other and a variety of other explanations for why this doesn't work better. I am interested in your honest assessment of whether or not Social Security withholding of Part D premiums can work effectively. At a practical level, do CMS and SSA have the capacity to make the withhold option work?

**Answer:** Premium withholding continues to work for the vast majority of the 4.7 million beneficiaries who requested withholding in 2006. While many beneficiaries have experienced some issues with their withholding, CMS is committed to addressing and resolving these issues as soon as possible. The majority of issues were caused by CMS and Social Security Administration (SSA) systems having mismatching data on certain beneficiaries.

CMS, working with the Social Security Administration and key stakeholders (plans, pharmacies, etc.), has made tremendous strides to resolve premium withhold issues encountered in the first year of the program and to lay the groundwork for continued improvements in 2007 and beyond. Those steps have clearly paid off, with a 97% acceptance rate for transactions between CMS and SSA in 2007.

9. What is not happening that should be happening to protect beneficiaries from getting bills for months of back premiums?

**Answer:** Given the issues that occurred in 2006, there will be beneficiaries who will receive bills for outstanding premiums. CMS has informed the Part D plans that they must assist beneficiaries in setting up payment plans that meet beneficiaries' needs. CMS, working with the Social Security Administration and key stakeholders (plans, pharmacies, etc.), has made

tremendous strides to resolve premium withhold issues encountered in the first year of the program and to lay the groundwork for continued improvements in 2007 and beyond. As a result, CMS expects that in the future the likelihood of beneficiaries receiving bills for months of unpaid premiums due to premium withholding issues will be greatly minimized.

**Senator Smith:**

10. Plans responsive to “all or substantially all policy”—In 2005, in response to a number of conversations I had with Dr. McClellan, CMS created guidance that encouraged prescription drug plans to cover “all or substantially all” drugs in six protected classes. I was pleased with the implementation of that policy as it helped promote access to innovative therapies to treat mental illness, HIV/AIDS and cancer. To ensure the integrity of the “all or substantially all” policy, I intend to file legislation in the coming weeks that would make it permanent.

Because the “all or substantially all” policy is merely guidance, I have heard that many plans do not follow it. Instead, beneficiaries often must go through lengthy appeals processes to get the drugs they need. What percentage of plans are currently abiding by the “all or substantially all” policy?

**Answer:** Adherence to CMS’s “all or substantially all” formulary guidance must be demonstrated as part of each plan’s yearly formulary review. Any proposed plan formulary that does not follow this guidance is returned to the plans for modification. Plans must resubmit an updated formulary that adheres to this policy before their bid is approved.

11. Advocates report that the most vulnerable beneficiaries generally receive the medication they need if their plan does not cover it, but they have to go through a lengthy appeals process to gain access to it. How many resources could beneficiaries and the federal government save if CMS simply required plans to cover all the drugs in the six protected classes instead of having them go through an appeals process?

**Answer:** CMS’s “all or substantially all” policy was created to protect the most vulnerable populations and ensures that all drug active ingredients for the six categories and classes of clinical concern are covered on all plan formularies. CMS permits but does not require the inclusion of the following drug types:

- multi-source brands of the identical molecular structure
- extended release products when the immediate-release product is included
- products that have the same active ingredient or moiety
- dosage forms that do not provide a unique route of administration (e.g. tablets and capsules)

The intent of these exclusions is to prevent redundancy in formulary offerings through limiting the inclusion of clinically equivalent medications. These exclusions to the “all or substantially all” policy do not significantly reduce the overall number of unique pharmacological treatment

options in the six classes of medication, and thus rarely lead to situations where beneficiaries need to go through the appeals process in order to acquire necessary medications in these classes. In addition to these exclusions, drugs released on April 16<sup>th</sup> or later preceding the start of the 2008 contract year are subject to an expedited review of 90 days.

In the few instances where appeals may be required for medications in these classes, the process may be expedited when either the plan determines or the beneficiary's doctor notifies the plan that waiting to receive the standard decision could seriously jeopardize the life or health of the individual. Under expedited review at the initial coverage determination, plans must notify the beneficiary of their decision within 24 hours. In the case of an expedited first level appeal (redetermination), the plan must notify the enrollee (and physician, as appropriate) of the decision within 72 hours.

12. Future of the "all or substantially all" policy—The "all or substantially all" policy is merely guidance for prescription drug plans. Unfortunately, it was weakened in 2006 and I am concerned that additional changes could be made in the future that could potentially harm beneficiaries' access to vital prescription drug therapies. What does CMS intend to do with the "all or substantially all" formulary guidance for the 2008 plan year?

**Answer:** For the 2008 plan year, all formularies must include all or substantially all drugs in these six categories that are available on April 16, 2007. The previous response provides all relevant exclusions to 2008 guidance concerning this policy. Plans may not implement prior authorization or step therapy requirements for enrollees that are currently taking a drug in any of these classes. New prescriptions in these classes may be subject to prior authorization or step therapy requirements.

CMS reviews these management procedures as part of its bid review process to ensure that any management procedures in place for these medications are consistent with currently accepted best medical practice and to verify that these restrictions do not steer beneficiaries with certain conditions away from the plan. Any changes to the formulary or to management practices during the plan year must be approved by CMS. These change requests must sufficiently demonstrate that the change is needed in order to address either new knowledge concerning the safety and efficacy of the medication or to account for new products as they enter the market (e.g., new generic forms of drugs).

13. When will Congress be notified of any proposed changes to the existing guidance?

**Answer:** We have no plans to make changes to the existing guidance.

14. Copays for dual-eligible beneficiaries—A recent study published in the *American Journal of Psychiatry* found that 24 percent of dual eligible beneficiaries reported being unable to access their medication because of the copays charged by their prescription drug plan.

It's fair to say that at least some of these beneficiaries receive care through a home or community-based long term care program. Under current law, most low-income beneficiaries receiving long term care in nursing homes are exempted from copays, yet those in home and

community-based programs are not. I believe this is a problem and have filed legislation—along with my colleagues on the Committee, Senators Bingaman, Lincoln and Kerry—to correct it. Until Congress can enact a solution, what type of assistance is available to the beneficiaries receiving care in home and community-based long term care programs who are unable to afford their prescription drug copays?

**Answer:** We understand your concerns regarding the imposition of cost sharing on the full benefit dual eligible population enrolled in home and community-based waiver programs. However, based on the specific statutory language, we do not believe we have latitude to treat home and community-based recipients as institutionalized for the purpose of the cost sharing exemption.

Section 1860D-14(a)(1)(D)(i) eliminates copayments for full-benefit dual eligible individuals who are institutionalized (as defined in section 1902(q)(1)(B)) under the Medicare prescription drug benefit. Section 1902(q)(1)(B) of the statute defines an institutionalized individual as someone who is an inpatient in a medical institution or nursing facility for which payments are made under the Medicaid program throughout a month, and who is determined to be eligible for medical assistance under the State plan. An inpatient is someone who is physically in a medical institution or nursing facility. Beneficiaries living in the community, assisted living facilities, boarding homes, residential care homes, etc do not meet the general definition of an institutionalized individual as defined in section 1902(q)(1)(B). This includes individuals receiving services under the waiver authority provided by section 1915(c) of the Act. We have reviewed this issue and because the definition is written into statute, we are unable to expand it to include individuals receiving care in community-based settings.

Many organizations like State pharmaceutical assistance programs, manufacturer patient assistance programs and other supplemental drug programs may offer cost sharing assistance to those in need, including beneficiaries receiving care in home and community-based long term care programs who are unable to afford their prescription drug copay .

***Part D Premium Withhold***

Last fall, I conducted extensive oversight of a number of problems CMS and SSA experienced correctly withholding Medicare Part D premiums from beneficiaries' Social Security checks. Throughout that process, I was given a number of assurances from both agencies that all outstanding problems would be resolved by year's end without placing an undue financial hardship on beneficiaries. Additionally, I was told that improvements were being made to the existing withholding process so that no additional problems occurred in the future. I am troubled by reports that problems with premium withholding continue to occur, and that pending cases from 2006 have yet to be resolved.

15. What specific plan does CMS have to close out premium withhold cases pending from 2006?

**Answer:** Issues with the Premium Withholding System (PWS) resulted in the following categories of withholding errors: 1) the withholding amount was correct, but plan payment was not; 2) too little was withheld (including zero withholding); or 3) too much was withheld.

To resolve these discrepancies CMS must conduct a premium withhold reconciliation (PWR) to compare the expected withholding data from the CMS payment system known as MARx, the actual withholding data from the Social Security Administration (SSA), and data on the actual payments to plans. CMS is currently examining options for finalizing the premium withhold reconciliation process, which is expected to result in a number of beneficiaries who either are owed refunds or who owe additional money.

16. What specific policy changes and system improvements are SSA and CMS implementing to ensure that beneficiaries no longer experience problems with premium withholding?

**Answer:** CMS and SSA are working very closely to improve the effectiveness of the premium withholding system for the future. For 2007, CMS has implemented new policies that we believe will limit the likelihood of such problems occurring again. These policies include sending fewer files to SSA each month and analyzing and simplifying the data exchange between SSA and CMS.

**Senator Cantwell:**

17. Is there any mandatory training required of brokers and agents who sell MA and drug plans?

**Answer:** With the significant expansion of MA and PDP enrollment we remind organization that they are responsible for actions of sales agents/brokers whether they are employed or contracted. Organizations must ensure agents/brokers are properly trained in both Medicare requirements and the details of the products being offered. Part D sponsors must provide strong oversight and training for all marketing activities. Medicare Advantage organizations must provide strong oversight and training for all marketing activities. This is especially critical for the marketing of private fee-for-service (PFFS) plans which are unfamiliar to many beneficiaries and providers. For example, organizations should be sure that brokers/agents explain to prospective enrollees that while they can see any provider who agrees to accept the plan terms and conditions, providers may decline to accept the PFFS terms and conditions. Employees of an organization or independent agents or brokers acting on behalf of an organization may not solicit Medicare beneficiaries door-to-door for health-related or non-health-related services or benefits.

18. In your testimony, you mentioned a Medicare Advantage plan that was under a corrective action plan for violations of CMS marketing guidelines.

Please provide the names of all MA plans subject to corrective action plans for marketing violations, descriptions of the violations that prompted those corrective actions and the terms of those corrective action plans.



**Answer:** We will be making information regarding corrective action plans publicly available on the CMS website later this fall.

19. What evidence do you have that the corrective action plans have been effective?

**Answer:** Corrective Action Plans (CAPs) have a long-standing role as a way to address violations as they relate to plan sponsors. CAPs, along with other approaches, are an important part of a larger process to identify problems and work to correct them on a broader basis. For example, a CAP focusing on beneficiary enrollment complaints lead to a call-back requirement in which the plan sponsor must call each beneficiary who submitted an application to change plans. The results of this demand as part of this CAP prompted CMS to institute the call-back requirement for all plan sponsors.

20. Please provide the following information so that the Committee can assess the scope and prevalence of marketing abuses:

- The number of beneficiary complaints related to MA marketing;
- The number of requests for disenrollment within three months of MA enrollment;
- The number of warning letters from CMS to MA plans related to marketing violations;
- The number, size of civil monetary penalties imposed on plans related to marketing, if any, and the names of the plans subject to such penalties.

**Answer:**

- The number of beneficiary complaints related to MA marketing: *approximately 2700 since December 2006.*
- The number of requests for disenrollment within three months of MA enrollment: *CMS no longer tracks rapid disenrollment. By statute, beneficiaries are locked in for one calendar year. However, we have a standard operation procedure in place to provide a special enrollment period for beneficiaries who believe they joined a plan based on misleading and erroneous information.*
- The number of warning letters from CMS to MA plans related to marketing violations: *Four.*
- The number, size of civil monetary penalties imposed on plans related to marketing, if any, and the names of the plans subject to such penalties: *Zero.*

21. Many dual eligible nursing home residents remain randomly autoenrolled in drug plans that do not meet their individual medication needs. Given their limitations, is it realistic to expect nursing home residents to educate themselves about their choices under Part D? Since a high percentage are cognitively impaired, who can assist them?

**Answer:** The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that Medicare beneficiaries in long-term care (LTC) facilities receive the medications and pharmacy services they need under the Medicare Prescription Drug Benefit.

As you know, Section 1860D-1(b) (1) (C) of the Social Security Act requires that any full benefit dual eligible that fails to enroll in a PDP or an MA-PD be auto-enrolled on a random basis

among all PDPs in a given PDP region that have premiums at or below the low-income benchmark. All prescription drug plans participating in the Medicare Part D program have comprehensive formularies that are reviewed by CMS to ensure that they meet the prescription drug needs of their enrollees. Additionally, full-benefit dual eligible individuals have the opportunity to change plans at any time, should they decide that another plan best suits their individual needs. Nursing homes are encouraged to provide information and education to residents on all available Part D plans

As you mentioned, many nursing home residents have cognitive and/or other impairments which make communication a challenge. To address this issue, CMS worked with the nursing home industry and related advocacy associations to get information to their members and caregivers about the Medicare Prescription Drug benefit. CMS communicated directly to the staffs of the more than 16,800 nursing homes throughout the nation. Further, since January 2006, CMS has kept nursing homes up-to-date on policy clarifications and recommendations that directly impact nursing home patient care and participation in Part D.

22. CMS' Marketing Guidelines currently prohibit nursing home staff from assisting their residents in plan selection and enrollment. Should those guidelines be modified?

**Answer:** Parts C and D plan sponsors may allow their contracted providers to play an active role in assisting beneficiaries, as long as the contracted providers give objective advice and otherwise comply with the Medicare Marketing Guidelines. The Medicare Marketing Guidelines state the following:

**1. Provider Activities and Materials in the Health Care Setting**—Beneficiaries often look to their health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, eligibility requirements for Special Needs Plans). To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options. Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates (including PDP enrollment applications, but not MA or MA-PD enrollment applications) and display posters or other materials announcing plan contractual relationships. However, providers cannot accept enrollment applications or offer inducements to persuade beneficiaries to join plans. Providers also cannot direct, urge or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their provider.

Providers should also inform prospective enrollees where they may obtain information on the full range of plan options. Because providers are usually not fully aware of all Medicare plan benefits and costs, they are advised to additionally refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, <http://www.medicare.gov/>, or 1-800-MEDICARE.

The “Medicare and You” Handbook or “Medicare Compare Information” (from <http://www.medicare.gov>), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. This includes CMS Plan Finder information via a computer terminal for access by beneficiaries. Plans should advise contracted providers of the provisions of these rules.

See pgs 123-124 of the Medicare Marketing Guidelines (July 25, 2006 version). Furthermore, the Medicare Marketing Guidelines set out a sample list of activities that plan sponsors may allow contracted providers to perform.

Providers contracted with plans (and their subcontractors) can:

- Provide the names of plans with which they contract and/or participate.
- Provide information and assistance in applying for the low income subsidy.
- Provide objective information on specific plan formularies, based on a particular patient’s medications and health care needs.
- Provide objective information regarding specific plans, such as covered benefits, cost sharing, and utilization management tools.
- Distribute PDP marketing materials, including enrollment application forms.

*NOTE: Providers must inform individuals where they can obtain information on all available options within the service area (i.e., 1-800-MEDICARE or [medicare.gov](http://www.medicare.gov)).*

- Distribute MA and/or MA-PD marketing materials, excluding enrollment application forms.
- NOTE: Providers must inform individuals where they can obtain information on all available options within the service area (i.e., 1-800-MEDICARE or [medicare.gov](http://www.medicare.gov)).
- Refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, CMS’s Web site at <http://www.medicare.gov/>, or calling 1-800-MEDICARE.28.
- Print out and share information with patients from CMS’s Web site.
- Use comparative marketing materials comparing plan information created by a non-benefit/service providing third-party (See section See section 10 under Marketing of Multiple Lines of Business, Non-Benefit/Service-Providing Third Party Marketing Materials).

See pg 127-128 of the Medicare Marketing Guidelines (July 25, 2006 version). Finally, nothing in the Marketing Guidelines prohibits a contracted provider from assisting in enrollment or education, as the terms are defined in the Marketing Guidelines. Because the Medicare Marketing Guidelines are targeted to protecting beneficiaries by ensuring that they enroll in a plan best suited for the beneficiaries’ needs, not a plan that may meet the provider’s needs to the beneficiaries’ detriment, the Marketing Guidelines should not be modified.

Anyone may assist a beneficiary with selecting and enrolling in a plan. The beneficiary or his/her legal representatives are the only people who can actually request enrollment.

23. What is CMS doing to ensure that plans and formularies reflect known needs for people with chronic diseases? For example, while sleep disturbance is common for people with Parkinson's disease, at least some plans require a special appeal for coverage of sleep-aids for Parkinson's patients.

**Answer:** Medicare prescription drug plans are required to have formularies that ensure access to a broad range of medically necessary drugs to treat all disease states, and that may not discriminate against certain beneficiaries. Formularies must include at least two drugs in each category and class, as defined by the United States Pharmacopeia (USP) or by the organization sponsoring the plan. CMS also requires plans to cover all or substantially all drugs in six categories classes of clinical concern. If a sleep aid indication for Parkinson's disease is found in any of the statutory compendia (AHFS, DrugDex, USPDI) the sleep aid could be covered as a Part D Drug. While plans cannot require enrollees to use a special appeals process to obtain these drugs, they may attach prior authorization requirements that are in line with the FDA label processes. CMS also reviews the plans drug utilization management processes with MAXIMUS to ensure they are within standard practice.

In addition, CMS has in place a monitoring policy, including a weekly "forum" with the Maximus (Part D QIC) medical directors, where we discuss appeals trends to help us identify and address potential systemic issues.

24. Despite recent decisions by the larger national plans to remove Prior Authorization requirements for Alzheimer drugs, some participating Part D plans are still using inappropriate criteria to determine whether they will cover FDA approved medications to treat Alzheimer's disease. What is CMS doing to ensure that the prior authorization provisions imposed by the participating prescription drug plans are not inappropriately restricting access to needed medications for vulnerable older persons, especially those with Alzheimer's disease?

**Answer:** We allow plans to have prior authorization requirements that are in line with the FDA label processes. The indications for most Alzheimer products depend on the diagnosis and severity of the disease. We would therefore allow a plan to require some measure of severity in line with the label indications as a prior authorization requirement. As with any medication, an exception to a prior authorization requirement can be requested for Alzheimer's medication.

As part of each plans formulary review, we review all proposed treatment management procedures to ensure that these procedures follow the currently accepted best practice and that they adhere to standard industry procedures that are used in most available commercial prescription drug plans. We analyze each plan's treatment management for outlier treatment policies and require that plans resolve any outlier policies prior to bid approval.

**25. What does CMS do with the complaints it receives regarding:**

• *LIS (low-income subsidy) not showing on a beneficiary's record?*

The first step Regional Office caseworkers do in completing this task is to assess the situation. The Medicare Beneficiary Database (MBD) is queried to identify at what point in the process is

the LIS information either inaccurate or missing and if it is a plan, state, SSA or CMS issue. If MDB and MARx are correct and in sync, the plan is contacted on the issue. The plan is asked to manually verify the information in their MARx system and make necessary corrections internally, i.e., enrollment and pharmacy processing systems. This results in pharmacy claims adjudicating correctly. The case is closed

In the event that MBD is showing incorrect or no LIS information on a beneficiary then further intervention and investigation is required. If the beneficiary is dually eligible, LIS information is coming from the beneficiary's respective state Medicaid reporting system. The RO caseworker will contact an agent from the state's Medicaid office in an effort to ascertain accurate information. When information is provided placing the beneficiary at a more favorable LIS level, the RO caseworker is to obtain the supporting evidence. That information can now be forwarded to the plans. As part of the BAE policy, plans are required to use that information to effectuate LIS level changes in their internal systems. This results in pharmacy claims adjudicating correctly. The case is closed.

If the beneficiary is not dually eligible but qualifies for "extra help", the RO caseworker will contact SSA and follow the process outlined above.

In addition to the above process, caseworkers are now required to adhere deeming request process outlined in the June 27, 2007 HPMS memorandum, "Part D Guidance—Low-Income Subsidy (LIS) Status Corrections Based on Best Available Evidence."

• ***LIS showing incorrectly on a beneficiary's record?***

See above.

• ***Erroneous premium withholds?***

Complaints from beneficiaries or their representatives relating to erroneous premium withholds are reviewed by regional office casework staff for investigation. Typically, erroneous premium withholds are caused by differences between what is reflected in CMS' systems and SSA's systems. After caseworkers validate the issue, the caseworker will make an entry into CMS' Priority Entry Tracking System (PETS) so that a corrected transaction can be sent to SSA. It can take 2-4 weeks to issue a refund to a beneficiary that is owed monies after an entry has been made into PETS. Should the corrected transaction reject, it could take additional weeks to achieve a resolution.

• ***Erroneous plan enrollments (LIS beneficiary enrolled in a non-LIS plan despite efforts to enroll in the standard product, beneficiary enrolled in an MA-PD when they wanted a PDP)?***

Beneficiaries seeking retroactive or prospective enrollment changes due to erroneous plan enrollments call 1-800-Medicare and a CSR will effect the change. If a change needs to be made quickly, CMS caseworkers will take the necessary actions and make the necessary updates to CMS systems in real-time.

**Specifically, what are the processes and time frames to fix these errors? In particular, what is the timeframe and process for reimbursing erroneous premium withholdings to the beneficiary?**

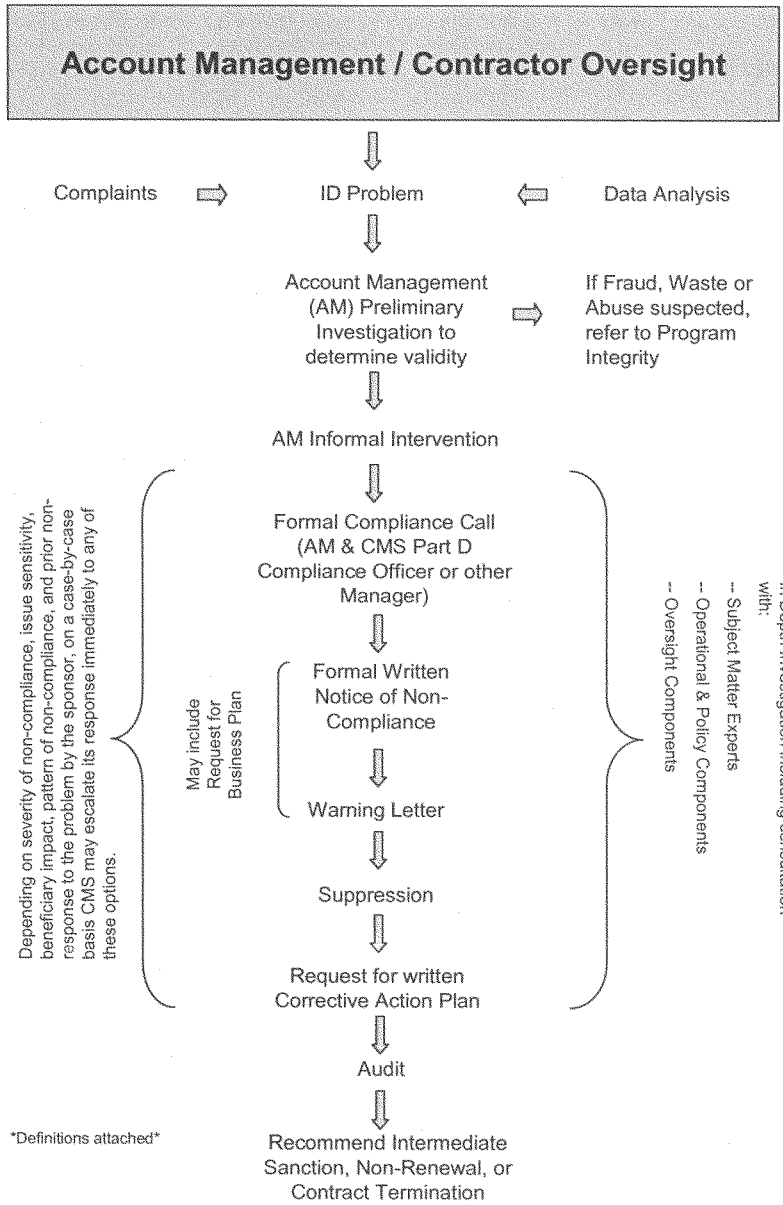
See above.

**What oversight actions does CMS take for any errors originating at the plan level? What are the accountability procedures for ensuring that the current processes work at a higher level of efficiency and in the best interest of Medicare beneficiaries? Were these procedures, if any, implemented in the 2008 call letter that recently went out to plans?**

CMS has a comprehensive plan oversight strategy. The process begins with complaint tracking and follows errors or other problems through to their resolution. This strategy is multi-functional, involving account management, data analysis and performance metrics, targeted audits, compliance monitoring, and program integrity. These elements are carried out through the collaboration of CMS Central Office staff in the Center for Beneficiary Choices and the Office of Financial Management, in addition to staff from CMS Regional Offices through the country.

The attached diagram details the oversight process for the Part D program. At each level, CMS works in the interest of Medicare beneficiaries by promptly addressing errors, identifying trends, and devising and implementing the necessary policy changes. Many of the oversight functions in the attached diagram were included in the 2008 Call Letter sent to plans April 19, 2007.

Compliance Flow Chart and Definitions



### **CMS Part D Compliance Definitions**

*Depending on severity of non-compliance, issue sensitivity, beneficiary impact, pattern of non-compliance, and prior non-response to the problem by the sponsor, on a case-by-case basis CMS may escalate its response immediately to any of the options described below.*

- A **notice of non-compliance** is typically a letter that notifies the sponsor it is out of compliance in a specific way and alerts the sponsor to fix the problem, but does not include strong warning language or require a specific plan of action.
- A **business plan** requires Part D sponsors to submit a written acknowledgement of the problem and a simple outline of the sponsor's process for improving or fixing the problem
- **Warning letters** put sponsors on formal notice that one or more specific areas of performance are unacceptable and further non-compliance will lead to more stringent compliance actions by CMS. These letters typically cite the regulatory basis for requiring a certain level of performance or action and describe potential subsequent compliance actions.
- **Suppression** refers to CMS actions to remove sponsor data relating to formularies and pricing from appearing on the CMS website when there are errors in the information appearing, as this data frequently forms the basis of a beneficiary's decision to choose a particular plan.
- For multiple offenders or as a starting point for egregious violations, CMS may place the sponsor under a formal **Corrective Action Plan (CAP)** and/or may impose **intermediate sanctions**.

**CAPs** are formalized action plans whereby a specific set of actions that will bring the sponsor into compliance are described and agreed to by both CMS and the sponsor. The Part D account manager must monitor the performance of the sponsor under the CAP, and the CAP is generally in place until lifted by CMS.

**Intermediate sanctions** include freezing marketing and enrollment.

- Ultimately, CMS has the authority to **terminate or nonrenew** its contract with a plan for violating our rules and regulations.



**United States Senate Committee on Finance**  
**Public Hearing**  
**“The Medicare Prescription Drug Benefit: Review and Oversight”**  
**May 8, 2007**

*This is the answer for the record to a question asked during this hearing.*

**Lead in:**

**Chairman BAUCUS.** During the year since the law has been in effect, has CMS disapproved any plans?

**Ms. BLOCK.** We have, so far as I know, not disapproved any application.

**Chairman BAUCUS.** And why would that be?

**Ms. BLOCK.** We have provided, in some cases, notices of intent not to renew certain plans.

**Chairman BAUCUS.** But have there been any instances where you considered not to approve a plan?

**Ms. BLOCK.** Well, in any instance where there has been an issue, we have absolutely assured that the plan met all of our requirements before they were approved for participation.

**Question:**

**Chairman BAUCUS.** But you have not disapproved any plans?

**Ms. BLOCK.** There were 34 PDP applicants for the 2007 contract year. Eighteen were initial applicants and 13 were service area expansions (SAE). Three applicants withdrew during the process. Thirteen received intent to deny letters (7 initial applicants and 6 SAE applicants). Of the 13 intents to deny, 5 initial applicants cured during the 10-day period. The other 2 initial applicants received denial letters, but cured prior to reconsideration proceedings. Of the 6 SAE applicants, 5 cured during the 10-day period and the remaining contracts cured during reconsideration.

United States Government Accountability Office

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GAO

Testimony before the Senate Committee  
on Finance

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For Release on Delivery  
Expected at 10:00 a.m. EDT  
Tuesday, May 8, 2007

## MEDICARE PART D LOW-INCOME SUBSIDY

### Progress Made in Approving Applications, but Ability to Identify Remaining Individuals Is Limited

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



May 8, 2007

## MEDICARE PART D LOW-INCOME SUBSIDY

### Progress Made in Approving Applications, but Ability to Identify Remaining Individuals Is Limited

#### What GAO Found

SSA approved approximately 2.2 million Medicare beneficiaries for the low-income subsidy as of March 2007, despite barriers that limited its ability to identify individuals who were eligible for the subsidy and solicit applications from them. However, the success of SSA's outreach efforts is uncertain because there are no reliable data to identify the eligible population. SSA officials had hoped to use Internal Revenue Service (IRS) tax data to identify the eligible population, but the law prohibits the use of such data unless an individual has already applied for the subsidy. Even if SSA could use the data, IRS officials question its usefulness. Instead, SSA used income records and other government data to identify 18.6 million Medicare beneficiaries who might qualify for the subsidy, which was considered an overestimate of the eligible population. SSA mailed low-income subsidy information and applications to these Medicare beneficiaries and conducted an outreach campaign of 76,000 events nationwide. However, since the initial campaign ended, SSA has not developed a comprehensive plan to distinctly identify its continuing outreach efforts apart from other agency activities. SSA's efforts were hindered by beneficiaries' confusion about the distinction between applying for the subsidy and signing up for the prescription drug benefit, and the reluctance of some potential applicants to share personal financial information, among other factors.

SSA has collected data and established some goals to monitor its progress in administering the subsidy, but still lacks data and measurable goals in some key areas. While SSA tracks various subsidy application processes through its Medicare database, it has not established goals to monitor its performance for all application processes. For example, SSA tracks the time for resolving appeals and the outcomes of its initial redeterminations of subsidy eligibility, but does not measure the amount of time it takes to process individual redetermination decisions. According to SSA officials, implementing the low-income subsidy was manageable overall due to increased funding for the outreach and application processes and did not significantly affect the agency's workload and operations.

GAO is considering recommendations for SSA to work with IRS to assess the extent to which taxpayer data could help identify individuals who might qualify for the subsidy, and help improve estimates of the eligible population; and for SSA to develop a plan to guide its continuing outreach efforts and develop key management tools to measure the results of its subsidy application processes.



Highlights of GAO-07-858T, a testimony before the Senate Committee on Finance

#### Why GAO Did This Study

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

To assess Social Security Administration's (SSA) implementation of the Medicare Part D low-income subsidy, GAO was asked to review (1) the progress that SSA has made in identifying and soliciting applications from individuals potentially eligible for the low-income subsidy, and (2) the processes that SSA uses to track its progress in administering the subsidy.

This statement is drawn from GAO's ongoing study for the committee on the Medicare Part D low-income subsidy, which is expected to be published at the end of May. To conduct this work, GAO reviewed the law, assessed subsidy data, and interviewed officials from SSA, the Centers for Medicare and Medicaid Services, the Internal Revenue Service, state Medicaid agencies, and advocacy groups.

[www.gao.gov/cgi-bin/getrpt?GAO-07-858T](http://www.gao.gov/cgi-bin/getrpt?GAO-07-858T)

To view the full product, including the scope and methodology, click on the link above. For more information, contact Barbara Bovbjerg at (202) 512-7215 or [bovjergb@gao.gov](mailto:bovjergb@gao.gov).

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May 8, 2007

Mr. Chairman and Members of the Committee:

I am pleased to be here to discuss the Social Security Administration's (SSA) progress in approving individuals for the Medicare Part D low-income subsidy. High prescription drug costs can have a detrimental effect on low-income seniors and the disabled, who are more likely than others to suffer from chronic medical problems requiring prescription drugs. Such high costs may cause some elderly patients to forgo or restrict their use of prescription drugs. To help the elderly and disabled with these costs, the Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.<sup>1</sup> MMA enabled Medicare beneficiaries to enroll voluntarily in drug plans sponsored by private companies. The benefit includes a low-income subsidy, or "extra help," to assist Medicare beneficiaries with limited income and resources in paying their premiums and other out-of-pocket costs.

The Department of Health and Human Services (HHS) and its Centers for Medicare and Medicaid Services (CMS) is largely responsible for implementing the new drug benefit, called Medicare Part D, and SSA is responsible for administering the low-income subsidy. Accordingly, SSA is responsible for notifying individuals of the subsidy's availability, taking applications, making subsidy eligibility determinations, resolving appeals, and ensuring continued subsidy eligibility. SSA also withholds Part D premiums from Social Security benefits for beneficiaries who select this option. To assess SSA's implementation of the Part D low-income subsidy, you asked us to review (1) the progress that SSA has made in identifying and soliciting applications from individuals potentially eligible for the low-income subsidy and (2) the processes that SSA uses to track its progress in administering the subsidy benefit.

My written statement is drawn from our ongoing work for the committee on the Part D low-income subsidy, for which we expect to provide you a report at the end of May. We have provided SSA and the Internal Revenue Service (IRS) with a draft copy of our report, and agency officials are in the process of preparing their comments. To conduct our work, we interviewed and obtained documentation from officials responsible for implementing the subsidy at SSA headquarters and at eight SSA field

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<sup>1</sup>Pub. L. 108-173.

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offices in Maryland, Virginia, Pennsylvania, and Texas. We also obtained and discussed relevant documentation on SSA's outreach efforts to target the low-income population and methods for obtaining input from state Medicaid agencies. We reviewed available data on SSA's processes for making eligibility determinations, resolving appeals, and making redeterminations, but were unable to verify the reliability of the data. We interviewed CMS officials and obtained documentation on the agency's involvement with SSA's outreach efforts. We interviewed officials at the IRS concerning legal restrictions on its ability to release tax data to SSA. We met with various advocacy groups that represent low-income and disabled beneficiaries to obtain their perspectives on SSA's implementation of the low-income subsidy. We conducted our work from May 2006 through April 2007 in accordance with generally accepted government auditing standards.

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## Summary

In summary, SSA approved approximately 2.2 million Medicare beneficiaries for the low-income subsidy as of March 2007, despite barriers that limited its ability to identify individuals who were eligible for the subsidy and solicit applications. However, the success of SSA's outreach efforts is uncertain because there are no reliable data to identify the eligible population. SSA officials had hoped to use IRS tax data to identify the eligible population, but there are legal limits on IRS's ability to release such data to SSA unless an individual has already applied for the subsidy. Even if SSA could use the data, IRS officials question their usefulness. Instead, SSA used income records and other government data to identify 18.6 million Medicare beneficiaries who might qualify for the subsidy, which was considered an overestimate of the eligible population. SSA mailed low-income subsidy information and applications to the Medicare beneficiaries it identified, and conducted an outreach campaign of 76,000 events nationwide. However, since the initial campaign ended, SSA has not developed a comprehensive plan specific to its low-income subsidy outreach activities to guide its continuing efforts. SSA's efforts were hindered by beneficiaries' confusion about the distinction between applying for subsidy and signing up for the Medicare prescription drug benefit, and the reluctance of some potential applicants to share personal financial information, among other factors.

SSA has collected data and established some goals to monitor its progress in administering the subsidy, but still lacks data and measurable goals in some key areas. While SSA tracks various subsidy application processes through its Medicare database, it has not established goals to monitor its performance in all application processes. For example, SSA tracks the

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time for resolving appeals and the outcomes of its initial redeterminations of subsidy eligibility, but does not measure the amount of time it takes to process individual redetermination decisions. According to SSA officials, implementing the low-income subsidy was manageable overall, due to increased funding for its MMA start up costs, and did not significantly affect the agency's workload and operations.

We are considering recommendations for SSA to work with IRS to assess the extent to which taxpayer data could help identify individuals who might qualify for the subsidy, and help improve estimates of the eligible population; and for SSA to develop a plan to guide its continuing outreach efforts and develop key management tools to measure the results of its subsidy application processes.

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## Background

All Medicare beneficiaries entitled to benefits under Medicare Part A or enrolled in Part B are eligible to enroll in Medicare Part D.<sup>2</sup> Medicare beneficiaries who qualify for full coverage under their state's Medicaid program,<sup>3</sup> as well as Medicare beneficiaries who qualify for more limited Medicaid coverage, Supplemental Security Income (SSI), or state Medicare Savings Programs<sup>4</sup> are automatically enrolled in a prescription drug plan by CMS,<sup>5</sup> automatically qualify for the full subsidy of their premium and deductible, and do not need to file an application. They are referred to as "deemed."

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<sup>2</sup>Individuals who are eligible for Medicare automatically receive Hospital Insurance, known as Part A, which helps pay for hospital stays, related post-hospital care, home health services, and hospice care, and typically does not require a monthly premium. Medicare also offers optional insurance under Supplementary Medical Insurance (Part B) to cover doctor's services and outpatient care, and requires a premium.

<sup>3</sup>Medicaid is a federal and state program that helps pay medical costs for certain low-income people, such as those who are 65 and older, the blind, the disabled, and members of families with dependent children or qualified pregnant women or children. Prior to the effective date of Part D, Medicaid provided coverage for outpatient prescription drug costs for persons eligible for that program.

<sup>4</sup>Medicare Savings Programs are offered by state Medicaid agencies to assist people with limited income and resources with their Medicare premiums and, in some cases, may also pay Part A and Part B deductibles and coinsurance.

<sup>5</sup>The automatic enrollment in the Part D prescription drug benefit only applies if beneficiaries do not enroll on their own.

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Other Medicare beneficiaries who do not automatically qualify for the subsidy (i.e., who are not deemed) must apply and meet the income and resource requirements. These beneficiaries generally qualify if they have incomes below 150 percent of the federal poverty level and have limited resources. Generally, in 2007, individuals qualify if they have an income of less than \$15,315 and have resources of less than \$11,710; couples qualify if they have a combined income of \$20,535 and resources of \$23,410.<sup>9</sup> The amount of the subsidy for premiums, deductibles, copayments, and catastrophic coverage varies, depending on income and resources. Subsidy benefits are provided to these individuals on a sliding scale, depending on their income and resources.

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

Under the MMA, the Congress provided SSA with a \$500 million appropriation from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to pay for the initiation of SSA's Part D responsibilities, and the activities for other MMA responsibilities for fiscal years 2004 and 2005, but later extended the appropriation to fiscal year 2006. Since January 2006, SSA officials told us

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<sup>9</sup>The resource limits are based on three times the resource limit of the SSI program for subsidy beneficiaries that qualify for the full subsidy in 2006, with subsequent limits updated each year based on the Consumer Price Index (CPI); for beneficiaries that qualify for less than the full subsidy, the resource limits are based on specific dollar amounts set in the MMA, which are updated each year based on the CPI. Countable resources include such things as savings, investments, and real estate (other than an individual's primary residence). Countable resources do not include such things as a car, a burial plot or limited funds set aside for burial expenses, or certain other personal possessions.

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that the agency has had to draw on its overall administrative appropriation to support its Part D activities.

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**Progress Has Been Made in Approving Subsidy Applicants, despite Barriers, but Measuring Success Is Difficult**

SSA has approved 2.2 million applicants for the subsidy as of March 2007, despite some barriers, but measuring their success is difficult because no reliable data are available to identify the eligible population. SSA officials told us that their outreach goal was to inform all individuals potentially eligible for the subsidy and provide them an opportunity to apply for the benefit. Because the agency lacked access to reliable data that might help target their outreach efforts more narrowly, SSA used income records and other government data to identify a broad group of potentially eligible individuals. Outreach efforts were further limited by several barriers to soliciting applications. Since its initial outreach campaign, SSA has not developed a comprehensive plan to identify its continued outreach efforts apart from other activities.

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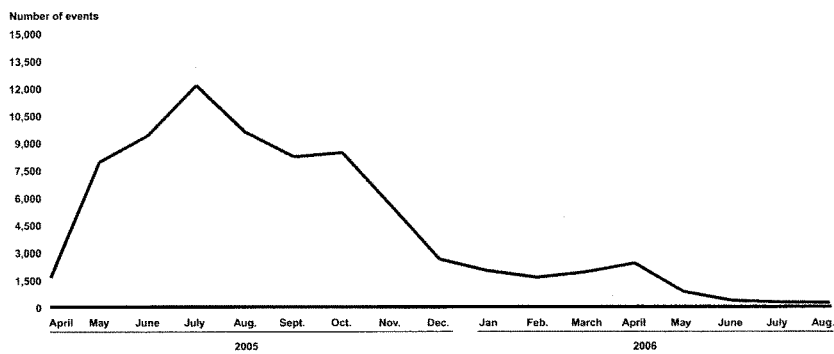
**SSA's Initial Outreach Efforts Were Extensive, but Outreach Has since Decreased**

SSA conducted its initial outreach campaign from May 2005 to August 2006, but has decreased its efforts since then. SSA sent targeted mailings, which included an application for the subsidy and instructions on how to apply, to the 18.6 million individuals it had identified as potentially eligible. After the subsidy applications were mailed, a contractor then made phone calls to 9.1 million beneficiaries who had not responded to the initial mailing. SSA also conducted other follow up efforts, including sending notices to individuals whom the contractor was unable to contact and to specific subgroups that it identified as having a high likelihood of qualifying for the subsidy, such as the disabled; individuals 79 years of age and older living in high-poverty areas; and individuals in Spanish-speaking, Asian-American, and African-American households.

The outreach efforts also included over 76,000 events conducted in collaboration with federal, state, and local partners, such as CMS, state Medicaid agencies, state health insurance programs, and advocacy groups for Medicare beneficiaries. Events were held at senior citizen centers, public housing authorities, churches, and other venues. As figure 1 shows, the number of outreach events has declined significantly, from a high of 12,150 in July 2005 to 230 at the completion of the campaign in August 2006.



Figure 1: Total Number of SSA Outreach Events from May 2005 to August 2006



Source: GAO analysis of SSA data.

Although the initial campaign has ended, SSA is continuing to solicit applications. For example, SSA has conducted various activities to inform individuals in rural and homeless communities about the subsidy, and is planning to launch a new strategy this week for Mother's Day to inform relatives and caregivers—the sons, daughters, grandchildren and family friends—about the subsidy. SSA has incorporated its strategy for continuing outreach efforts for the subsidy into its National Communications Plan. However, it has not developed a comprehensive plan that specifically identifies those efforts separate from other agency activities. As a result, SSA has a limited basis for assessing its progress and identifying areas that require improvement.

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### Multiple Barriers Impeded SSA's Outreach Efforts

#### Data Issues Limited SSA's Efforts to Identify the Eligible Population

SSA did not have access to data that might have helped to narrowly target the eligible population. Because of the lack of reliable data for identifying the entire population, SSA broadly targeted 18.6 million individuals who might be eligible for the subsidy. SSA identified the target population by using income data from various government sources to screen out Medicare beneficiaries whose income made them ineligible for the Part D subsidy.<sup>7</sup> SSA realized that using these data sources would result in an overestimate of the number of individuals who might qualify for the subsidy, because the data provided limited information on individuals' resources or nonwage income. SSA officials said they took this approach to ensure that all Medicare beneficiaries who were identified as potentially eligible for the subsidy were made aware of the benefit and had an opportunity to apply for it.

SSA officials said that they would have preferred to specifically target Medicare beneficiaries who were likely to be eligible for the subsidy by using tax data from IRS on individuals' wage, interest, and pension income. Current law permits SSA to obtain income and resource data from IRS to assist in verifying income and resource data provided on subsidy applications.<sup>8</sup> The law, however, prohibits IRS from sharing such data with SSA to assist with outreach efforts. According to SSA officials, such data would allow SSA to identify individuals to target for more direct outreach and to estimate how many individuals qualify for the subsidy. In November 2006, the HHS Office of Inspector General reported that legislation is needed to provide SSA and CMS access to income tax data to help the

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<sup>7</sup>SSA obtained income data from its earnings records, as well as data from the Office of Personnel Management, the Department of Veterans Affairs, the Railroad Retirement Board, and the Office of Child Support Enforcement of the Department of Health and Human Services.

<sup>8</sup>Under 26 U.S.C. § 6103 (1) (7) (C), IRS may only provide tax return information to SSA for purposes of, and to the extent necessary in, determining the eligibility for or the correct amount of benefits provided through the subsidy program. In signing the application form, individuals acknowledge that SSA will compare the information reported by them on the form to information supplied by federal, state, and local government agencies, including the IRS.

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agencies more effectively identify beneficiaries potentially eligible for the subsidy.<sup>9</sup>

SSA officials believe IRS income tax data could provide access to information on individuals' income and resources. However, IRS officials told us that its data have many limitations. For example, IRS officials said that they have limited data on resources for individuals whose income is less than \$20,000, because these individuals do not typically have interest income, private pensions, or dividend income from stocks that could assist SSA in estimating an individual's potential resource level. Also, the officials said that many people with low incomes do not have incomes high enough to require them to file taxes, and therefore, IRS might not have information on them.<sup>10</sup> IRS also explained that its tax data would most likely identify individuals that would not qualify for the subsidy, rather than individuals that would qualify. Moreover, the IRS officials said that the data it would provide to SSA to determine eligibility could be almost 2 years old. For example, for subsidy applications filed in early 2007, the last full year of tax data the IRS could provide would be for 2005. Given these factors, IRS officials stated that summarily sharing private taxpayer data to identify individuals who could qualify for the subsidy, and the potential cost of systems changes, would have to be weighed against the added value of the data. No effort has been undertaken to determine the extent to which IRS data could help SSA or improve estimates of the eligible population. Legislation is currently pending before the Congress to permit IRS to share taxpayer data with SSA to assist the agency in better identifying individuals who might be eligible for the subsidy.

Other Barriers Have Limited  
SSA's Solicitation Efforts

SSA's efforts to solicit applications were hindered by beneficiaries' confusion about applying for subsidy and the drug benefit. According to SSA field office staff and state Medicaid and advocacy group officials, many individuals were confused about the difference between the prescription drug benefit and the subsidy, and did not understand that they involved separate application processes. Consequently, some individuals thought that once they were approved for the subsidy, they

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<sup>9</sup>Department of Health and Human Services, Office of Inspector General, *Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy*, OEI-03-06-00120, Washington, D.C., Nov. 17, 2006.

<sup>10</sup>Individuals' income, filing status, and age generally determine whether they must file an income tax return. For example, in 2006, single individuals 65 or older were not required to file tax returns if their income was less than \$9,700, and married couples 65 or older filing jointly were not required to file tax returns if their combined income was less than \$18,900.

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were also automatically enrolled in a prescription drug plan. Additionally, some individuals were reluctant to apply because they did not want to share their personal financial information for fear that an inadvertent error on the application could subject them to prosecution under the application's perjury clause.<sup>11</sup>

Though individuals have become more educated about the subsidy, concerns remain about eligibility requirements and the overall complexity of the application. SSA field office staff and advocacy group officials have concerns that the eligibility requirements set by the MMA may be a barrier. For example, they said that the subsidy's resource test may render some low-income individuals ineligible because of retirement savings or the value of other resources. Legislation has been proposed to increase the resource limit. Advocacy group officials have also said that the application may be too complex for many elderly and disabled beneficiaries to understand and complete without the assistance of a third party. SSA headquarters officials told us they worked with various focus groups to develop the subsidy application and that they have revised the application several times to address such concerns, but that much of the information that applicants may view as complex is required by the MMA.

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#### Measuring the Success of SSA's Outreach Efforts is Difficult

The success of SSA's efforts is uncertain because no reliable data exist on the total number of individuals potentially eligible for the subsidy. Using available estimates of the potentially eligible population, SSA approved 32 to 39 percent of the eligible population who were not automatically deemed by CMS for the subsidy. According to these estimates by CMS, the Congressional Budget Office, and other entities, about 3.4 million to 4.7 million individuals are eligible for the subsidy, but have not yet enrolled (See table 1.) In developing these estimates, however, these entities faced the same data limitations as SSA in identifying potentially eligible individuals.

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<sup>11</sup>The perjury clause states that an individual could face imprisonment or other penalties for making a false or misleading statement about information provided on the subsidy application.

**Table 1: Medicare Part D Low-Income Subsidy Estimates of the Eligible Population Who Must Apply to Receive the Subsidy (Numbers in millions)**

Source of estimate	Eligible but not automatically enrolled* (Column A)	SSA subsidy approvals as of as of March 2007 (Column B)	Eligible but not yet enrolled/current participation rate (Column A minus B)
Congressional Budget Office <sup>b</sup>	6.6	2.2(33%)	4.4
Access to Benefits Coalition <sup>c</sup>	6.8	2.2(32%)	4.6
Rice and Desmond <sup>d</sup>	6.9	2.2(32%)	4.7
Centers for Medicare and Medicaid Services <sup>e</sup>	5.6	2.2(39%)	3.4

Sources:

<sup>a</sup>We derived these numbers by subtracting the 7.6 million beneficiaries that CMS estimated in January 2007 were deemed for the subsidy, or had comparable coverage from other federal programs, from the sources' original estimates of all eligible beneficiaries (except for the Rice and Desmond estimate, which included only undeemed beneficiaries).

<sup>b</sup>Congressional Budget Office (CBO), *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, table 8, July 2004, Washington, D.C. CBO estimated that an overall total of 14.2 million beneficiaries would be eligible for the subsidy in 2006.

<sup>c</sup>The Access to Benefits Coalition (*Pathways to Success*, page 1), 2005, Washington, D.C. The coalition estimated that an overall total of 14.4 million beneficiaries would be eligible for the subsidy in 2006.

<sup>d</sup>Rice, T. and Desmond, K. January 2006. "Who Will Be Denied Medicare Prescription Drug Subsidies Because of the Asset Test?" *The American Journal of Managed Care*, 12 (1), pp.46-54, January 2006. The authors estimated that a total of approximately 6.9 million eligible individuals would not be dual eligible beneficiaries, as of January 2006.

<sup>e</sup>Reported in CMS Press release, "Medicare Drug Plans Strong and Growing: Beneficiaries Compared Plans and Continued to Sign Up for Prescription Drug Coverage," January 30, 2007, Washington, D.C. CMS estimated that an overall total of 13.2 million beneficiaries were eligible in 2006.

SSA officials said that it is unfair to judge the success of its outreach efforts for the subsidy in relation to the estimates of the total eligible population, given the limitations in identifying it. SSA officials stated that their efforts have been successful in meeting their outreach goals. In fact, after almost 2 years of implementation efforts, SSA's participation rate compares favorably to that of the Food Stamp Program, which had a participation rate of 31 percent after its second year of implementation. The low-income subsidy participation rate compares less favorably, however, to that of the Supplemental Security Income program, which had a participation rate of approximately 50 percent among the aged a year after the program began. SSA officials noted that the SSI participation rate included individuals who were automatically transferred from state government programs to SSI, which is somewhat similar to the "deemed" population that was automatically transferred to the low-income subsidy.

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### Some of SSA's Application Processes and Operations Lack Key Tools for Monitoring Performance

SSA has collected data and established some goals to monitor its progress in implementing and administering the subsidy benefit, but still lacks data and measurable goals in some key areas. To enable agencies to identify areas in need of improvement, GAO internal control standards state that agencies should establish and monitor performance measures and indicators.<sup>12</sup> Accordingly, agencies should compare actual performance data against expected goals and analyze the differences.

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### SSA Monitors Performance on Applications Processes, but Lacks Data and Goals on Others

#### Determinations

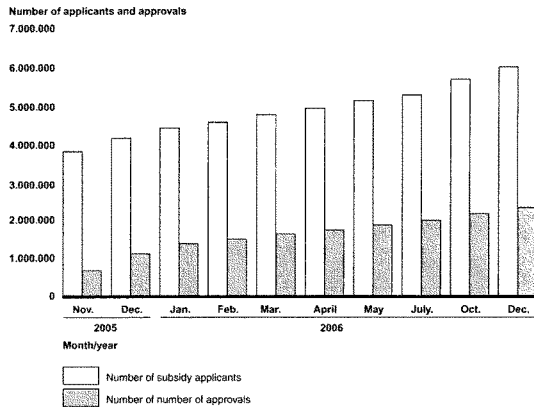
SSA monitors various aspects of its determination process, such as the number of applications received and their outcomes and length of processing, but did not establish a performance goal for processing times until March 2007. SSA largely relies on an automated process to determine individuals' eligibility for the subsidy. Income and resource data provided by the applicant are electronically compared to income data provided by IRS and other agencies to determine if the individual meets income and resource requirements. SSA field office staff follow up with individuals in cases where there are conflicting data or questions. SSA tracks the number of eligibility determinations, the outcome of those determinations, and the length of time for completing the determinations. SSA also tracks denials and periodically samples denied claims to examine the reasons for such actions.

As of March 2007, approximately 6.2 million individuals had applied for the subsidy. SSA received the heaviest volume of applications when the public outreach campaign was the most active. Figure 2 provides data on the cumulative number of subsidy applicants and approvals from November 2005, when SSA began tracking the data, to December 2006.

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<sup>12</sup>GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

**Figure 2: Cumulative Number of Subsidy Applicants and Approvals, November 2005 to December 2006**



Source: GAO analysis of SSA data.

Note: SSA did not have data available for the months of June, August, September, and November of 2006.

While SSA has captured data on the length of time it takes to make eligibility determinations, it did not develop the capability to report the data, and did not establish a performance goal for processing times until March 2007. SSA has now established a goal of processing 75 percent of subsidy applications in 60 days.<sup>13</sup> Of the approximately 6.2 million individuals who had applied for the subsidy as of March 2007, SSA approved 2.2 million, denied 2.6 million, and had decisions pending for 80,000 applicants. SSA officials determined that no decision was required for 1.4 million because they were duplicate applications, applications from individuals automatically qualified for the subsidy, or canceled

<sup>13</sup>The processing time includes a built-in 20-day delay as part of the predecisional process and the 10-14 days that it takes to receive verification data from IRS.

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	<p>applications.<sup>14</sup> To identify reasons for subsidy denials, SSA conducted three separate studies that sampled a total of 1,326 denied claims. These studies showed that 47 percent of applicants were denied due to resources and 44 percent because of income that exceeded allowable limits set by the MMA. SSA officials stated that they plan to conduct a longitudinal study to examine the reasons for all denied claims.</p>
Appeals	<p>SSA tracks data on the total number of appeals, the reason for appeals, the time it takes to process them, the method used to resolve them, and their final disposition. Individuals may appeal denied claims, as well as the level of the subsidy, by calling SSA's national toll-free number, submitting the request in writing, or visiting any Social Security field office. Individuals may also complete an appeals form available on SSA's Web site and mail it to SSA. Individuals have the choice of having their appeal conducted through a telephone hearing or a case file review. According to SSA, about 79,000, or 3 percent of denied subsidy applications were appealed from August 2005 to February 2007. SSA completed about 76,000 appeals in that time frame. On the basis of an SSA sample of 781 appeals, SSA reversed its decision for 57 percent of the cases and upheld its decision for the remaining 43 percent.</p> <p>SSA data show that the overall volume of appeals received was the highest between November 2005 and July 2006, declined between August and November 2006, and rose again between December 2006 and February 2007. During the decline, SSA closed all but one of its six Special Appeals Units by October 2006. Further, the time it took SSA to process appeals varied widely, and did not necessarily decrease when the caseloads grew smaller.</p>
Redeterminations	<p>SSA tracks various results from the redeterminations process, such as the number of decisions made, and number and level of continued subsidies. However, SSA does not track processing time for redetermination decisions and has not established a performance time target for processing such actions. According to the MMA and SSA regulations, all recipients of the subsidy are required to have their eligibility redetermined within 1 year</p>

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<sup>14</sup>Canceled applications included applications that were withdrawn by the applicant or applications that were canceled by SSA because the applicant was not eligible for Medicare, as required to qualify for the subsidy.



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after SSA first determines their eligibility.<sup>15</sup> Future redeterminations are required to be conducted at intervals determined by the Commissioner. SSA's regulations provide that these periodic redeterminations be based on the likelihood that an individual's situation may change in a way that affects subsidy eligibility. Additionally, SSA's regulations provide that unscheduled redeterminations may take place at any time for individuals who report a change in their circumstances, such as marriage or divorce. SSA officials stated that since the redeterminations process is conducted within a certain period of time, it is unnecessary to track the processing time for individual redetermination decisions.

SSA initiated its first cycle of redeterminations in August 2006, which including all of the approximately 1.7 million individuals who were determined to be eligible for the subsidy prior to April 30, 2006. SSA excluded from the redeterminations process about 562,000 individuals who were either deceased, automatically deemed eligible for the benefit by CMS, or whose subsidy benefit had been terminated. SSA data show that as of February 2007, SSA had completed approximately 237,000 redeterminations. About 69,000 individuals remained at the same subsidy level, another 69,000 had a change in their subsidy level, and 98,000 individuals had their subsidies terminated, based on a change in their circumstances.

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**SSA Has Monitored Some Aspects of the Subsidy Program's Impact on SSA's Workload, and Increased Funding Helped SSA Manage the Increased Workload**

SSA has monitored some aspects of the increased workload and found that implementing the low-income subsidy was manageable overall, due to increased funding for its MMA startup costs. Although the subsidy program affected SSA's workload and operations, SSA officials told us that implementing the subsidy did not significantly affect the agency's workload and operations. SSA hired a total of 2,200 field office staff to assist with subsidy applications, as well as an additional 500 headquarters staff to support its MMA activities. SSA officials attribute the light impact of the subsidy program to various factors, including the automation of the subsidy application process and the \$500 million appropriation it received for administrative startup costs to implement its MMA responsibilities. SSA officials pointed out that as they implemented the subsidy, the processing times for other workloads improved. Officials explained that

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<sup>15</sup>This does not include individuals who continue to be deemed or automatically eligible for the subsidy. Individuals who report changes to SSA regarding their benefit status are also excluded from the initial redetermination process since they are redetermined as a result of the change.

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they were able to manage the other workloads because the peak increases in subsidy applications and inquiries were short-lived, allowing SSA's operations to return to a more normal operating level after handling these peak work volumes. SSA officials stated that they expect small increases in its low-income subsidy workload during future prescription drug plan open seasons, which are typically held from November to December.

Although SSA can track expenditures for implementing its various MMA responsibilities overall, it cannot track expenditures related specifically to low-income subsidy activities. For example, SSA cannot calculate how much of the \$500 million appropriation it received for MMA startup costs was spent on the subsidy program versus its other MMA responsibilities. Although SSA could not provide documentation of the total amount of its subsidy-related expenditures, it estimates that its costs related to administering the subsidy are about \$175 million annually, based on workload samples. However, SSA is planning to develop a tracking mechanism to more accurately capture the data.

Recent increases in SSA's administrative resources may have also been a factor in limiting the impact of the subsidy program workload. The amount of SSA's administrative costs covered by the Medicare Trust Funds is projected to increase by about 37 percent between fiscal year 2003 and fiscal year 2008. This increase occurred despite the transfer of the Medicare appeals processing function from SSA to CMS in 2005. While this increase has helped SSA to carry out its various Medicare responsibilities (such as taking applications for Medicare benefits and withholding Medicare premiums, among others), it may have also helped to cushion the impact of the subsidy program.

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## Conclusions

Reaching the millions of people who are forgoing the government's help in paying for their prescription drug benefit remains a significant challenge. Using the \$500 million appropriation for its MMA start up costs, SSA was able to initiate the Part D subsidy and sign up 2 million people for the subsidy without adversely affecting SSA's overall operations. However, while it is not clear how to reach the remaining eligible people, the momentum of the initial outreach campaign should not be lost. The barriers to identifying eligible people and convincing them to sign up remain. For some, the subsidy application is complicated, which is due in part to the low-income subsidy eligibility requirements. Further, no one has yet studied whether or not IRS data can help identification efforts. While advocacy groups have called for a more personalized outreach approach to encourage additional enrollments, it may be unrealistic to

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expect SSA to conduct such efforts, given its resource limitations. Both a better understanding of who is eligible and a plan for continued outreach could help SSA make efficient use of limited staff resources by targeting outreach more narrowly to the eligible population.

Further, a timely and reliable process for deciding initial determinations, hearing appeals, and making redeterminations is essential to effective management of the subsidy. SSA has focused on developing and improving the processes for serving its customers in a timely manner. As SSA moves forward, it may need better information to ensure that the subsidy program serves its target population as efficiently and effectively as possible.

We are considering recommendations for SSA to work with IRS to assess the extent to which taxpayer data could help identify individuals who might qualify for the subsidy, and help improve estimates of the eligible population; and for SSA to develop a plan to guide its continuing outreach efforts and develop key management tools to measure the results of its subsidy application processes.

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

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**GAO Contacts and  
Staff  
Acknowledgments**

For further information regarding this testimony, please contact Barbara D. Bovbjerg, Director, Education, Workforce, and Income Security Issues, on (202) 512-7215. Blake Ainsworth, Jeff Bernstein, Mary Crenshaw, Lara L. Laufer, Sheila McCoy, Kate France Smiles, Charles Willson, and Paul Wright, also contributed to this statement.

**Statement of Beatrice Disman  
Regional Commissioner of Social Security  
New York Region, and  
Chair of the SSA Medicare Planning and Implementation  
Task Force**

**Testimony before the Senate Finance Committee  
May 8, 2007**

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.

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 includes 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**

As you know, extensive research and review 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.

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.

SSA used a number of strategies to follow-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 reentitlement 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 25<sup>th</sup> 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**

I am also pleased to talk about 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. Within the past two weeks, the Commissioner 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 are launching the strategy this week - 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 are 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 is also publishing 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 several days, along with an announcement letter explaining the outreach. We are excited about this new initiative, and its prospects of assisting low-income Medicare beneficiaries.

**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 for your continuing support for the Agency. I can tell you from my own experience that the dedicated employees of SSA will continue to do our very best, not only in administering the “extra help” program, but also in providing our very important traditional services to the American public.

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.

**Response of Beatrice Disman to a Question From Senator Bingaman  
Hearing of May 8, 2007**

Regarding the question of resources reported in low-income subsidy denials, SSA is currently performing a longitudinal study of all denial cases, and hopes to have extensive data available in the near future.

SSA's current knowledge on such denials stems from two earlier studies performed during 2006, with a total case sample of 1,000 denials. Information derived from these studies is limited, because the low-income subsidy application allows individuals to screen themselves out. While the "screen-out" question was strongly supported by advocates, it reduces the amount of information available regarding the specific resources (or resource amounts) that led to ineligibility.

The following data is based on the 181 itemized cases where resources were specified. It also excludes applicants with resources over \$100,000 and one claim from Hawaii.

**Singles**

Average Resources Over the Resource Limit: \$18,768

Median Resources Over the Resource Limit: \$11,061

**Couples**

Average Resources Over the Resource Limit: \$19,147

Median Resources Over the Resource Limit: \$12,215

United States Government Accountability Office

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**GAO**

Testimony  
Before the Committee on Finance, U.S.  
Senate

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For Release on Delivery  
Expected at 10:00 a.m. EDT  
Tuesday, May 8, 2007

## MEDICARE PART D

# Enrolling New Dual-Eligible Beneficiaries in Prescription Drug Plans

Statement of Kathleen M. King  
Director, Health Care



May 6, 2007

## MEDICARE PART D

### Enrolling New Dual-Eligible Beneficiaries in Prescription Drug Plans



Highlights of GAO-07-824T, a testimony before the Committee on Finance, U.S. Senate

#### Why GAO Did This Study

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), dual-eligible beneficiaries—individuals with both Medicare and Medicaid coverage—have their drug costs covered under Medicare Part D rather than under state Medicaid programs. The MMA requires the Centers for Medicare & Medicaid Services (CMS) to enroll these beneficiaries in a Medicare prescription drug plan (PDP) if they do not select a plan on their own. CMS enrolled about 5.5 million dual-eligible beneficiaries in late 2005 and about 634,000 beneficiaries who became dually eligible during 2006.

GAO was asked to testify on (1) CMS's process for enrolling new dual-eligible beneficiaries into PDPs and its effect on access to drugs and (2) how CMS set the effective coverage date for certain dual-eligible beneficiaries and its implementation of this policy. This testimony is based on a GAO report that is being released today, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries* (GAO-07-272).

#### What GAO Recommends

GAO's report contains several recommendations, including that CMS require PDPs to modify beneficiary notices and that CMS monitor the implementation of its payment policy. CMS did not agree with all of the recommendations, but it has taken steps to implement some.

[www.gao.gov/cgi-bin/gettrp?GAO-07-824T](http://www.gao.gov/cgi-bin/gettrp?GAO-07-824T).

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathleen M. King at (202) 512-7119 or [kingk@gao.gov](mailto:kingk@gao.gov).

#### What GAO Found

CMS's process for enrolling new dual-eligible beneficiaries who have not yet signed up for a PDP involves many parties, information systems and administrative steps, and takes a minimum of 5 weeks to complete. For about two-thirds of these individuals—generally Medicare beneficiaries who subsequently qualify for Medicaid—pharmacies may not have up-to-date PDP enrollment information needed to bill PDPs appropriately until the beneficiaries' data are completely processed. As a result, these beneficiaries may have difficulty obtaining their Part D-covered prescription drugs during this interval. CMS has created contingency measures to help individuals obtain their new Medicare benefit, but these measures have not always worked effectively. For the other one-third of new dual-eligible beneficiaries—Medicaid enrollees who become Medicare-eligible because of age or disability—CMS eliminated the impact of processing time by enrolling them in PDPs just prior to their attaining Medicare eligibility. This prospective enrollment, implemented in late 2006, offers these dual-eligible beneficiaries a seamless transition to Medicare Part D coverage.

CMS set the effective Part D coverage date for Medicare-eligible beneficiaries who subsequently become eligible for Medicaid to coincide with the date their Medicaid coverage becomes effective. Under this policy, which was designed to provide drug coverage for dual-eligible beneficiaries as soon as they attain dual-eligible status, the start of their Part D coverage can extend retroactively for several months before the date beneficiaries are notified of their PDP enrollment. GAO found that CMS did not fully implement or monitor the impact of this policy. Although beneficiaries are entitled to reimbursement for covered drug costs incurred during this retroactive period, CMS did not begin informing them of this right until March 2007. Given their vulnerability, it is unlikely that these beneficiaries would have sought reimbursement or retained proof of their drug purchases if they were not informed of their right to do so. Also, CMS made monthly payments to PDPs for providing drug coverage during retroactive periods, but did not monitor PDPs' reimbursements to beneficiaries during that time period. GAO estimated that in 2006, Medicare paid PDPs millions of dollars for coverage during periods for which dual-eligible beneficiaries may not have sought reimbursement for their drug costs.

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Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the Medicare Part D prescription drug benefit. Implementation of this new drug benefit has raised particular concerns for individuals eligible for both Medicare and full Medicaid benefits—known as dual-eligible beneficiaries.<sup>1</sup> These individuals account for about 15 percent of all Medicare beneficiaries and 15 percent of all Medicaid enrollees. As a group, they are generally poorer and tend to have more extensive health care needs than other Medicare beneficiaries. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),<sup>2</sup> dual-eligible beneficiaries—who previously received drug benefits under Medicaid—have had their prescription drug costs paid under Medicare Part D since January 1, 2006. In addition, the MMA requires the Centers for Medicare & Medicaid Services (CMS)<sup>3</sup> to assist dual-eligible beneficiaries by enrolling them in a private Medicare prescription drug plan (PDP) if they do not select a plan on their own. CMS enrolled about 5.5 million dual-eligible beneficiaries in late 2005 for the initial implementation of Part D and about 634,000 beneficiaries who became dual-eligible during 2006.

My testimony today will summarize selected findings from the GAO report that is being released today, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries*.<sup>4</sup> Specifically, my remarks today will focus on (1) CMS's process for enrolling new dual-eligible beneficiaries into PDPs and its effect on beneficiary access to drugs and (2) how CMS set the effective Part D coverage date for certain dual-eligible beneficiaries and its implementation of this policy.

To address these issues, we conducted site visits in six states—California, Maine, Maryland, Michigan, New Jersey, and Texas—to learn about dual-eligible beneficiaries' enrollment in Part D from the perspective of state Medicaid agencies, pharmacies, and long-term care providers. We also

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<sup>1</sup>We use the term dual-eligible beneficiaries to refer to individuals who qualify for a state's full package of Medicaid benefits.

<sup>2</sup>MMA, Pub. L. No. 108-173, tit. I, § 101, et seq., 117 stat. 2066, 2071-2152 (2003) (to be codified at 42 U.S.C. § 1395w-101, et seq. and 42 U.S.C. § 1396a-5).

<sup>3</sup>CMS is the agency that administers the Medicare program on behalf of the Secretary of Health and Human Services.

<sup>4</sup>GAO, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries*, GAO-07-272 (Washington, D.C.: May 4, 2007).

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interviewed officials from CMS and representatives of PDPs about issues that pertain to dual-eligible beneficiaries. We conducted the work for our report from March 2006 through April 2007 in accordance with generally accepted government auditing standards.

In summary, we found that CMS's process for enrolling new dual-eligible beneficiaries involves many parties, information systems, and administrative steps, and takes a minimum of 5 weeks to complete. For the majority of these individuals—generally Medicare beneficiaries not yet enrolled in Part D who subsequently qualify for Medicaid—this processing interval can create difficulties in obtaining Part D-covered drugs at their pharmacies. For other new dual-eligible beneficiaries—Medicaid enrollees who become Medicare eligible because of age or disability—CMS took steps to eliminate the impact of the processing interval by enrolling them in PDPs just prior to their attaining Medicare eligibility. In addition, for the Medicare first, Medicaid second group of new dual-eligible beneficiaries, CMS set the effective date of Part D coverage to coincide with the first date of their Medicaid eligibility. Under this policy, which was designed to provide drug coverage for dual-eligible beneficiaries as soon as they attain dual-eligible status, the start of their Part D coverage can be retroactively set to several months before the date of their actual PDP enrollment. We found that CMS did not fully implement or monitor the impact of this coverage date policy. Although beneficiaries are entitled to reimbursement for covered drug costs incurred during this retroactive period, CMS and PDPs did not begin informing them of this right until March 2007. Also, CMS did not track Medicare payments made to PDPs to provide retroactive coverage or monitor PDPs' reimbursements to beneficiaries for that time period. We estimate that in 2006, Medicare paid PDPs about \$100 million for coverage during periods for which dual-eligible beneficiaries may not have sought reimbursement for their drug costs. In the report, we recommend that CMS require PDPs to notify beneficiaries about their right to reimbursement, monitor implementation of its retroactive payment policy, and take other steps to improve the operational efficiency of the program.

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## Background

Dual-eligible beneficiaries are a particularly vulnerable population. These individuals are typically poorer, tend to have far more extensive health care needs, have higher rates of cognitive impairments, and are more likely to be disabled than other Medicare beneficiaries. About three out of four dual-eligible beneficiaries live in the community and typically obtain drugs through retail pharmacies. Other dual-eligible beneficiaries reside in



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long-term care facilities and obtain drugs through pharmacies that specifically serve these facilities.

In general, individuals become dual-eligible beneficiaries in two ways. One way is when Medicare-eligible individuals subsequently become Medicaid eligible. This typically occurs when income and resources of beneficiaries fall below certain levels and they enroll in the Supplemental Security Income (SSI) program,<sup>5</sup> or they incur medical costs that reduce their income below Medicaid eligibility thresholds. If these Medicare beneficiaries did not sign up for a Part D plan on their own, they have no drug coverage until they are enrolled in a PDP by CMS. CMS data show that this group represented about two-thirds of new dual-eligible beneficiaries the agency enrolled in PDPs in 2006. According to CMS, it is not possible for it to predict which Medicare beneficiaries will become Medicaid eligible in any given month because Medicaid eligibility determinations are a state function.

Another way individuals become dually eligible is when Medicaid beneficiaries subsequently become eligible for Medicare by reaching 65 years of age or by completing the 24-month disability waiting period.<sup>6</sup> Once they become dual-eligible beneficiaries, they can no longer receive coverage from state Medicaid agencies for their Part D-covered prescription drugs. In 2006, this group represented approximately one-third of the new dual-eligible beneficiaries enrolled in PDPs by CMS. CMS can generally learn from states when these individuals will become dually eligible.

For dual-eligible beneficiaries, Medicare provides a low-income subsidy that covers most of their out-of-pocket costs for Part D drug coverage. This subsidy covers the full amount of the monthly premium that non-subsidy-eligible beneficiaries normally pay, up to the low-income benchmark premium.<sup>7</sup> The subsidy also covers most or all of a dual-eligible

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<sup>5</sup>In most states, beneficiaries who qualify for cash assistance from SSI—a cash assistance program for aged, blind, and disabled individuals with limited income and resources—automatically qualify for full Medicaid benefits.

<sup>6</sup>Under Social Security Disability Insurance (DI), which assists people who worked but became disabled before their retirement age, individuals are eligible for Medicare coverage after they have received DI cash benefits for 24 months.

<sup>7</sup>The low-income benchmark is the average monthly beneficiary premium for all PDPs in a region, weighted by each plan's enrollment.

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beneficiary's prescription copayments. In 2007, these beneficiaries are responsible for copayments that range from \$1 to \$5.35 per prescription, depending on their income and asset levels, with the exception of those in long-term care facilities, who pay no copayments.

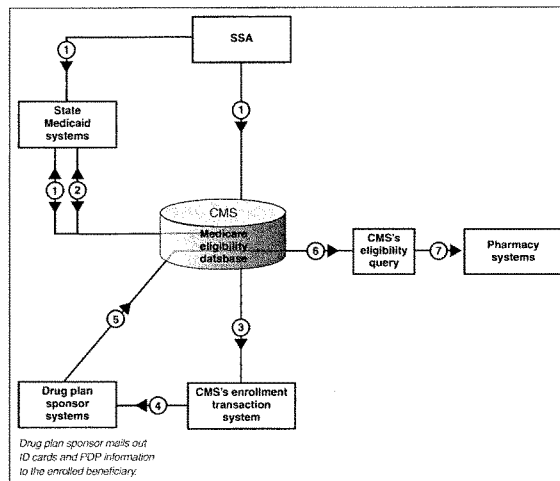
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### **CMS's Enrollment Process Takes Time and Can Create Difficulties for Some Dual-Eligible Beneficiaries**

Given the number of entities, information systems, and administrative steps involved, it takes a minimum of 5 weeks for CMS to identify and enroll a new dual-eligible beneficiary in a PDP. As a result, two out of three new dual-eligible beneficiaries—generally those who are Medicare eligible and then become Medicaid eligible—may experience difficulties obtaining their prescription drugs under Part D during this interval. For other new dual-eligible beneficiaries—those switching from Medicaid to Medicare drug coverage—CMS instituted a prospective enrollment process in late 2006 that enrolls these individuals before their date of Medicare eligibility and offers a seamless transition to Part D coverage.

Multiple parties and information systems are involved in identifying and enrolling dual-eligible beneficiaries in PDPs. As shown in figure 1, CMS, the Social Security Administration (SSA), state Medicaid agencies, and PDP sponsors play key roles in providing information needed to ensure that new dual-eligible beneficiaries are identified and enrolled properly. SSA maintains information on Medicare eligibility that is used by CMS and some states. State Medicaid agencies are responsible for forwarding to CMS lists of beneficiaries whom the state believes to be eligible for both Medicare and Medicaid. CMS is then responsible for making plan assignments and processing enrollments. PDP sponsors maintain information systems that are responsible for exchanging enrollment and billing information with CMS.

**Figure 1: Overview of the Major Systems and Steps Used to Enroll Dual-Eligible Beneficiaries in PDPs**



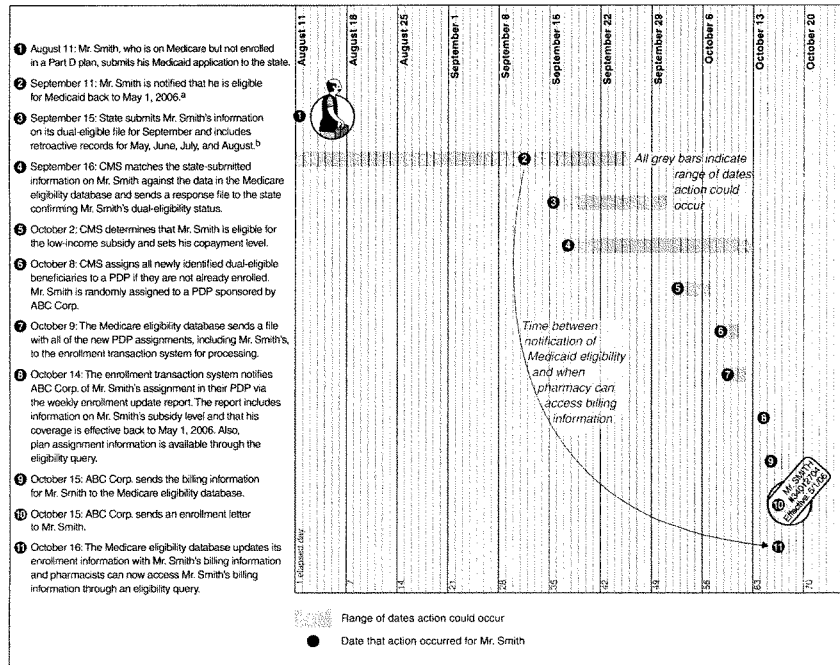
Source: GAO.

Note: CMS adapted existing information systems used in the administration of other parts of the Medicare program to perform specific functions required under Part D. The Medicare eligibility database serves as a repository for Medicare beneficiary entitlement, eligibility, and demographic data. The database is used by CMS to provide up-to-date information to verify the status of dual-eligible beneficiaries, as well as determine subsidy status and make assignments to PDPs. The enrollment transaction system is used to enroll beneficiaries in PDPs. The eligibility query is used by pharmacies to obtain Part D enrollment information from the Medicare eligibility database.

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The process of enrolling dual-eligible beneficiaries requires several steps. It begins when state Medicaid agencies identify new dual-eligible beneficiaries and ends when PDPs make billing information available to pharmacies and send enrollment information to dual-eligible beneficiaries. We estimate that it takes at least 5 weeks to complete the process under current procedures. During this interval, pharmacies may not have up-to-date PDP enrollment information on new dual-eligible individuals. This may result in beneficiaries having difficulty obtaining Part D-covered drugs at their pharmacies. To illustrate why this occurs, we present the hypothetical example of Mr. Smith, who as a Medicare beneficiary did not sign up for the Part D drug benefit and, therefore, upon becoming Medicaid eligible, was enrolled in a PDP by CMS. (Fig. 2 shows the steps in Mr. Smith's enrollment process.)

**Figure 2: Mr. Smith, a Hypothetical Example of the Enrollment Process for a Newly Identified Dual-Eligible Beneficiary Who Was Medicare Eligible but without Previous Part D Coverage**



Source: GAO.

Notes: The dates presented in this example of enrollment for Mr. Smith generally represent the best-case scenario. The range of dates represent the minimum and maximum length of elapsed time allowed for processing and notification, based on information provided by CMS. GAO makes no assurances that the events described would occur on the dates provided for any specific dual-eligible beneficiary.

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<sup>8</sup>The scenario presented reflects an application to Medicaid based on a reason other than disability. State Medicaid agencies have 45 days to make eligibility determinations not based on disability and 90 days for eligibility determinations based on disability, subject to extensions in certain circumstances.

<sup>9</sup>If the state Medicaid agency did not determine that Mr. Smith was eligible for Medicaid before it submitted its September dual-eligible file, his information could not be submitted until October. This scenario is not presented in this figure.

From the time Mr. Smith applies for his state's Medicaid program on August 11, it takes about 1 month for him to receive notification from the state that he is eligible for Medicaid, thus beginning the enrollment process. From there, Mr. Smith's new status is submitted by his state to CMS in a monthly file transmittal. Once CMS receives the lists of dual-eligible beneficiaries from all of the states, it verifies eligibility for Medicare and sets each beneficiary's cost-sharing level. Then, around October 8, CMS assigns Mr. Smith to a PDP randomly, based on the premium level and the geographic area served by the PDP.<sup>9</sup> CMS next notifies the PDP sponsor, which then has to enroll him in its plan and assign the necessary billing information. This billing information, such as a member identification number, is necessary for pharmacies to correctly bill the PDP for Mr. Smith's prescriptions. The PDP also has to inform Mr. Smith of his enrollment information. By the time this process is completed, it is the middle of October.

CMS has developed some contingency measures to help individuals like Mr. Smith during the processing interval. However, we found that these measures have not always worked effectively. For instance, CMS designed an enrollment contingency option to ensure that dual-eligible beneficiaries who were not yet enrolled in a PDP could get their medications covered under Part D, while also providing assurance that the pharmacy would be reimbursed for those medications. However, representatives of pharmacy associations we spoke with reported problems with reimbursements after using this option, which has led some pharmacies to stop using it.

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<sup>9</sup>Some states have assisted dual-eligible beneficiaries by using other methods to select a PDP for enrollment, including methods that also consider drug utilization information. For example, the State of Maine used beneficiary-specific data to reassign nearly half of the state's dual-eligible beneficiaries to PDPs that covered more of their prescriptions. After reassignment, the number of beneficiaries whose PDP covered nearly all of their prescription drugs increased significantly.

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To avoid a gap in coverage for beneficiaries transitioning from Medicaid to Medicare prescription drug coverage, CMS has implemented a prospective enrollment process. Because states can predict and notify CMS which Medicaid beneficiaries will become new dual-eligible beneficiaries and when, CMS begins the enrollment process for these individuals 2 months before their anticipated dual-eligible status is attained. By conducting the processing steps early, the prospective enrollment used for this group of new dual-eligible beneficiaries should ensure a seamless transition from Medicaid drug coverage to Medicare Part D coverage. Fully implemented in November 2006, prospective enrollment applies to about one-third of the new dual-eligible beneficiaries enrolled in PDPs by CMS.

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### **CMS Made Drug Coverage Retroactive, but Did Not Inform Beneficiaries of Their Right to Reimbursement**

For the majority of new dual-eligible beneficiaries, CMS requires PDPs to provide drug coverage retroactively, typically by several months. During 2006, Medicare paid PDPs millions of dollars to provide coverage to dual-eligible beneficiaries for drug costs that may have been incurred during the retroactive coverage period. However, we found that CMS did not fully implement or monitor the impact of this policy.

CMS made the effective date of Part D drug coverage for Medicare beneficiaries who become Medicaid eligible coincide with the effective date of their Medicaid eligibility. Under this policy, Part D coverage for these beneficiaries is effective the first day of the month that Medicaid eligibility is effective, which generally occurs 3 months prior to the date an individual's Medicaid application was submitted to the state, if the individual was eligible for Medicaid during this time. Thus, the Part D coverage period can extend retroactively back several months from when the actual PDP enrollment takes place.

Medicare makes payments to the PDPs for providing drug coverage retroactively. Specifically, PDPs are paid approximately \$90 per month for the retroactive coverage period.<sup>9</sup> PDPs, in turn, are responsible for reimbursing their members (or another payer) for Part D drug costs incurred during the retroactive months. For instance, in the case of Mr. Smith, while he applied for Medicaid in August and learned of his PDP assignment for Part D in October, his coverage was effective May 1. If

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<sup>9</sup>The \$90 per month includes the direct subsidy Medicare pays PDPs for providing the Medicare drug benefit to any Medicare beneficiary and the low-income premium subsidy CMS pays PDPs to cover the cost of premiums dual-eligible beneficiaries would pay if they were not receiving the low-income subsidy.

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Mr. Smith incurred any costs for Part D-covered prescription drugs from May—when he became eligible for Medicaid—through October, he could submit his receipts to his assigned PDP and be reimbursed by the PDP, less the copayments he would pay as a dual-eligible beneficiary.

We found that CMS's implementation of this policy in 2006 was incomplete. While dual-eligible beneficiaries were entitled to reimbursement by their PDPs in 2006, neither CMS nor PDPs notified dual-eligible beneficiaries of this right. The model letters used until March 2007 to inform dual-eligible beneficiaries of their PDP enrollment did not include any language concerning reimbursement of out-of-pocket costs incurred during retroactive coverage periods. In response to a recommendation in our report, CMS modified the model letters that the agency and PDPs use to notify dual-eligible beneficiaries about their PDP enrollment. The revised letters let beneficiaries know that they may be eligible for reimbursement of some prescription costs incurred during retroactive coverage periods.

Given the vulnerability of this population, it seems unlikely that many dual-eligible beneficiaries would have contacted their PDPs for reimbursement if they were not clearly informed of their right to do so and given information about how to file for reimbursement, neither would they likely have retained proof of their drug expenditures. Mr. Smith, for example, would need receipts for drug purchases made during a 5-month period preceding the date he was notified of his PDP enrollment—at a time when he could not foresee the need for doing so.

Further, CMS did not monitor how many months of retroactive coverage PDPs provided, nor did it monitor PDP reimbursements to beneficiaries for costs incurred during retroactive coverage periods. Based on data provided by CMS, we estimate that Medicare paid about \$100 million to PDP sponsors in 2006 for retroactive coverage. CMS does not know what portion of this \$100 million PDPs paid to dual-eligible beneficiaries to reimburse them for drug costs. If Mr. Smith's PDP did not reimburse Mr. Smith for any prescription drugs purchased during the retroactive coverage period, the PDP retained Medicare's payments for that time period.

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## Conclusions

Given the time it takes to complete the enrollment process, CMS has taken action to ensure ready access to Part D for some new dual-eligible beneficiaries, but difficulties remain for others. For the one-third of new dual-eligible beneficiaries whose eligibility can be predicted, CMS's



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decision to implement prospective enrollment should eliminate the coverage gap in transitioning from Medicaid to Medicare drug coverage. However, because of inherent processing lags, most new dual-eligible beneficiaries may continue to experience difficulties obtaining their drugs for at least 5 weeks after being notified of their dual-eligible status. In addition, CMS's incomplete implementation of its retroactive coverage policy in 2006 means that CMS paid PDPs millions of dollars for coverage during periods for which dual-eligible beneficiaries may not have sought reimbursement for their drug costs. Without routine monitoring of this policy, the agency remains unaware of what portion of these funds was subsequently reimbursed to beneficiaries and, therefore, cannot ensure the efficient use of program funds.

Our report contains several recommendations. We recommend that CMS require PDPs to notify beneficiaries of their right to reimbursement and monitor implementation of its retroactive payment policy. We also recommend that CMS take other steps to improve the operational efficiency of the program. Although the agency did not agree with all of them, it has already taken steps to implement some of our recommendations. As of March 2007, CMS has modified its letters to dual-eligible beneficiaries to include language informing them of their right to reimbursement for drug costs incurred during retroactive coverage periods and required PDP sponsors to do the same. In addition, CMS officials told us that they plan to analyze data to determine the magnitude of payments made to PDPs for retroactive coverage and the amounts PDPs have paid to beneficiaries. We hope that CMS will use this information to evaluate the effectiveness of its retroactive coverage policy. If, after conducting the analysis, CMS determines that it is paying PDPs substantial amounts of money and dual-eligible beneficiaries are not requesting reimbursements, the agency may want to rethink its policy in light of pursuing the most efficient use of Medicare funds.

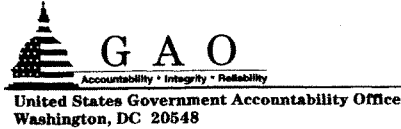
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Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other members of the committee may have at this time.

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## Contact and Acknowledgments

For further information regarding this testimony, please contact Kathleen King at (202) 512-7119 or [kingk@gao.gov](mailto:kingk@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Contributors to this testimony include Rosamond Katz, Assistant Director; Lori Achman; and Samantha Poppe.



June 4, 2007

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate

Subject: Responses to Questions for the Record

Dear Chairman Baucus:

This letter responds to your May 16, 2007, request that we address questions submitted for the record by Members of the Committee related to the May 8, 2007, hearing entitled *The Medicare Prescription Drug Benefit: Review and Oversight*. The responses to these questions are based on work associated with our previously issued report.<sup>1</sup> Your questions, along with our responses, follow.

- 1. In your testimony, you discussed problems with retroactivity of Part D eligibility for Medicare beneficiaries who become full benefit dual eligibles. Some of these beneficiaries, not knowing that their expenses were covered, have not sought reimbursement from the plans that are paid to provide them coverage. This may lead to plans being overpaid. It concerns me that low-income beneficiaries paid out-of-pocket for drugs that could have been covered by the Medicare prescription drug benefit. How extensive do you think the problem is?*

Based on information provided by CMS, we estimated that roughly 256,000 Medicare beneficiaries became eligible for Medicaid and were subsequently enrolled by CMS from April through December 2006. In early 2007, the number of beneficiaries retrospectively enrolled by CMS averaged about 31,000 per month. We estimated that most of these beneficiaries received up to 5 months of retroactive coverage, during which they may have paid out of pocket for prescription drugs. We do not know how many of these beneficiaries actually incurred out-of-pocket drug costs, nor do we know how many subsequently sought and received reimbursements from their assigned prescription drug plan (PDP). However, it seems unlikely that many of these dual-eligible beneficiaries would have requested and received reimbursement given that they were not notified of their right to do so. In March 2007, CMS began including language about the right to reimbursement for retroactive coverage periods in their notifications sent to new dual-eligible beneficiaries. We do not have any

<sup>1</sup>GAO, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries*, GAO-07-272 (Washington, D.C.: May 4, 2007).

information on the number of dual-eligible beneficiaries who have filed claims and received reimbursement from their PDP since March 2007.

2. *You suggested that Congress look at how well CMS is implementing the retroactivity policy. What would it take for CMS to better implement the policy? What information could CMS provide to Congress so that we can conduct better oversight in this area?*

In response to recommendations in our draft report, CMS has taken steps to more fully implement their retroactive enrollment policy. In March 2007, the agency added language to its notification letters to dual-eligible beneficiaries about their right to reimbursement for Part D-covered drugs they purchased during retroactive eligibility periods. Additionally, CMS told us they plan to analyze prescription drug utilization data to determine the extent to which drug plans have reimbursed beneficiaries or those that paid on their behalf in 2006.

CMS could take further action to better implement its coverage policy. While CMS added some language about the right of reimbursement to the notification letter the agency sends to new dual-eligible beneficiaries (and required PDP sponsors to do the same), the letter lacks specific details to help dual-eligible beneficiaries make effective claims. The added language states that the beneficiary or anyone who paid on their behalf "may be eligible for reimbursement" for some costs if they filled a prescription since their effective enrollment date and they should call their plan for more information. However, the letter does not include information about the kind of documentation needed to support their claims, or how to go about compiling and submitting such documentation.

In our report, we recommended that CMS track data on Medicare payments made to PDPs for providing coverage retroactively to dual-eligible beneficiaries. We also recommended that CMS examine PDP-reported data to monitor reimbursements made to these beneficiaries or to pharmacies, for example, which paid on their behalf. A comparative analysis of this information will allow CMS to assess the extent to which beneficiaries are availing themselves of their right to reimbursement. Congress may want to receive a copy of this analysis periodically to consider whether the retroactive coverage policy makes the most efficient use of Medicare funds.

If you have any questions or would like to discuss the responses, please contact me at (202) 512-7119 or [kingk@gao.gov](mailto:kingk@gao.gov).

Sincerely yours,



Kathleen King  
Director, Health Care



COMMUNICATIONS

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STATEMENT  
*of*  
**DAVID KYLLO**  
Executive Director  
National Center for Assisted Living

Senate Finance Committee Hearing  
*on*  
"The Medicare Prescription Drug Benefit:  
Review & Oversight"

May 8, 2007

Congress Should Waive Medicare Part D Co-Payments for Dual Eligible  
Beneficiaries Receiving Long Term Care Services in Home and  
Community-Based Settings,  
including Assisted Living/Residential Care Facilities

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The National Center for Assisted Living (NCAL) is the assisted living voice of the American Health Care Association (AHCA). On behalf of NCAL and AHCA, I would like to thank the Committee for this opportunity to raise an issue of vital importance to America's seniors, and particularly important for frail elderly people with very low incomes. AHCA/NCAL is a non-profit federation of affiliated state health care organizations, together representing nearly 11,000 non-profit and for-profit nursing facilities, assisted living residences, sub-acute centers, and homes for persons with developmental disabilities. NCAL represents more than 2,400 assisted living facilities providing long term care services to about 108,000 residents.

With Medicare Part D now in its second year, it is clear that the program has helped millions of seniors and people with disabilities gain access to needed medications. However, Medicare Part D needs to be modified so that frailest dual eligibles are treated equally. We believe that an existing gap in Medicare Part D coverage may well have been a mistake of omission made as policymakers put together this complex legislation.

Recognizing the vulnerability and special needs of very low-income people living in long term care facilities, the *Medicare Modernization Act of 2003* exempted dual eligible beneficiaries (those covered by both Medicare and Medicaid) living in "long term care facilities" from any cost-sharing for Part D prescription drugs. Technically, under the Medicare Part D program, the Centers for Medicare & Medicaid Services (CMS) defines

a long term care facility as a nursing facility, an intermediate care facility for people with mental retardation and developmental disabilities, or an inpatient psychiatric hospital.

Unfortunately, the *MMA* legislation did not extend the waiver of co-payments for prescriptions to dual eligible residents of assisted living/residential care (AL/RC) facilities and others in home and community-based settings (HCBS), despite the fact that this population may be eligible for nursing home care and has similar needs, vulnerabilities, and income limitations. Under the Part D program, dual eligible assisted living residents and others in HCBS must make co-payments of \$1.00 - \$5.35 in 2007, with the exact amount depending on a person's income and whether a medication is generic. Because of their very low income (often just a few dollars in a personal needs allowance), these co-payments can present financial hardships for dual eligible residents and can impede them from receiving necessary medications. Requiring these co-payments is also inconsistent with efforts to expand Medicaid-covered long term care options – including HCBS – for our nation's most vulnerable citizens who had historically only received care in nursing homes. Under current law, these dual eligible residents automatically receive reduced Part D benefits by choosing to live at home or in an AL/RC facility rather than in a nursing home.

AHCA/NCAL thanks Senator Gordon Smith (R-OR) and the seven co-sponsors, Senators Jeff Bingaman (D-NM), Barbara Boxer (D-CA), Hillary Clinton (D-NY), Susan Collins (R-ME), Blanche Lincoln (D-AR), Bill Nelson (D-FL), and John Kerry (D-MA), who have introduced bipartisan legislation that would provide relief to this group of frail elderly individuals. *The Home and Community-Based Services Copayment Equity Act of 2007 (S. 1107)* would eliminate Medicare Part D co-payments for more than one million low-income Americans, including dual eligible residents of AL/RC facilities and other licensed facilities such as group homes for people with developmental disabilities, psychiatric health facilities, and mental health rehabilitation centers. Dual eligible beneficiaries receiving services in a home setting under HCBS waivers also would be relieved of Part D co-payments. This legislation is supported by a growing coalition of more than 35 national organizations representing a wide range of interests—consumers, health care and long-term care providers, geriatric care professionals, pharmacists, and state officials.

Currently, approximately 15% of the nearly one million Americans in assisted living residences are dually eligible for Medicaid and Medicare coverage. Under HCBS waivers, residents placed in AL/RC facilities must be eligible for placement in nursing homes. Like nursing home residents who rely on Medicaid, more than 120,000 dual eligible residents living in AL/RC facilities have very limited financial resources, often just a few dollars a month from a personal needs allowance. These residents, like those in nursing homes, often require multiple prescription medications – about 8 – 10 prescriptions – according to recent studies. So, in some instances, the amount of their combined Medicare Part D co-pays exceeds their monthly personal needs allowances. In addition, because their Part D co-pays are indexed for inflation while their limited resources grow less rapidly, if at all, there is an even greater burden placed on these individuals.

On January 1, 2006, dual eligible beneficiaries who previously received medications under Medicaid programs were automatically enrolled in Medicare Part D drug plans. Under Part D, pharmacies and Part D Plans are not required to dispense medications if a beneficiary does not pay co-payments. Unless the law is changed, dual eligible residents of AL/RC facilities and others receiving services under Medicaid waivers who cannot afford these co-payments may be at risk for not receiving essential medications.

Another reason we support the elimination of Medicare Part D co-payments for this population is to maintain a level playing field between institutional and community-based services under Medicaid. For many years, policymakers and the public have supported expanding options for people to receive long-term care services at home and in community-based settings under the Medicaid program. AHCA/NCAL supports the principle of Medicaid providing the appropriate services in the setting that best meets each individual's needs and preferences. According to an analysis of the Medicare Part D co-payment legislation, which was conducted for AHCA/NCAL by the Lewin Group, by next year, the number of dual eligible beneficiaries in home and community based settings that would be impacted by this legislation will be larger than the number of dual eligible beneficiaries living in nursing homes and other institutions.

For a small investment in covering Medicare Part D co-pays, Congress would remove an impediment that could prevent some people from remaining at home or in an assisted living facility, thereby saving state and federal dollars as these care settings can be less expensive than the care provided in America's nursing homes. Still, the most important reason to pass this legislation is to help frail, elderly seniors afford much-needed medications.

Thank you for this opportunity to bring this important issue to the attention of the Committee.

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**Statement By The Long Term Care Pharmacy Alliance  
Submitted To The Senate Committee On Finance  
Hearing On *The Medicare Prescription Drug Benefit: Review And Oversight*  
May 8, 2007**

**INTRODUCTION**

Chairman Baucus, Ranking Member Grassley, and Members of the Committee, the Long Term Care Pharmacy Alliance (LTCPA)<sup>1</sup> appreciates the opportunity to share the experiences and perspectives of its member pharmacies as the Committee reviews the initial implementation of the new Medicare drug benefit.

More than 1.6 million Medicare beneficiaries reside in long-term care (LTC) facilities nationwide. These patients, who can no longer care for themselves, are among the most vulnerable individuals served by the new Medicare drug benefit program. They are typically older, may suffer multiple chronic conditions, and are frequently cognitively impaired.

LTCPA's member pharmacies dispense medications and provide specialized services tailored to the needs of patients in nursing homes, assisted living facilities, hospice programs, and similar institutional sites of care. Since passage of the 2003 Medicare Modernization Act (MMA), LTC pharmacies have been working with health care professionals, patient advocates, private plans and the Centers for Medicare and Medicaid Services (CMS) to make the new Medicare drug benefit responsive to the needs of this frail elderly population.

Congress largely tasked CMS with defining the details of this benefit for the LTC segment of the Medicare population. The Agency has made considerable strides, operating within its understanding of its existing authorities, to make the Medicare Part D program "work" for beneficiaries residing in LTC facilities. However, LTC residents continue to face significant challenges in obtaining full access to medically necessary drugs under Part D.

**To strengthen Medicare Part D in the LTC setting, LTCPA respectfully submits the following recommendations for consideration. We look forward to working closely with the Finance Committee as it reviews this important program and considers ways to improve the Medicare drug benefit.**

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<sup>1</sup> *The Long Term Care Pharmacy Alliance (LTCPA) represents the nation's major long-term care pharmacy providers. Together, LTCPA's members serve more than 1.5 million people – including more than two-thirds of all nursing facility residents – through networks of nearly 500 pharmacies nationwide.*



## RECOMMENDATIONS

### I. LTC Standards For Part D Plans

In implementing the new drug benefit, CMS has relied heavily on subregulatory guidance to encourage plans to comply with its stated policies. In March 2005, the Agency released two guidance documents designed to make Part D more responsive to the particular needs of enrollees residing in LTC settings:

- *Long-Term Care Guidance* – Established ten core service and performance criteria for LTC pharmacies participating in plans' networks, and encouraged plans to incorporate these criteria into their contracts with LTC pharmacies.
- *Transition Guidance* – Established appropriate procedures for plans to ensure patients have access to needed medications upon entering a LTC facility.

These guidance documents include important protections for patients, however, they do not have the force of regulation or law. Plans' compliance may lessen as the program matures and Part D payments change or the guidance becomes "lost to history" over time.

**Recommendation:** LTCPA urges the Committee to codify CMS guidance documents as enforceable standards for Part D plans serving LTC residents.

### II. Assistance For LTC Residents In Plan Selection

More than 70 percent of LTC residents are dually eligible for Medicare and Medicaid. These dual-eligible beneficiaries were randomly auto-enrolled into Part D benchmark plans if they did not select a plan on their own.

However, Part D benchmark plans in each region vary widely in their coverage of drugs commonly dispensed to nursing home residents. In every region, there are benchmark plans that either do not have several common drugs on formulary or that subject them to drug utilization management controls, including prior authorization.

While LTC residents are eligible for a special enrollment period (SEP) to change plans, most do not know about this provision. Many also lack the cognitive ability or knowledge to evaluate complex plan offerings, but do not have a guardian or family member nearby to help.

Unfortunately, CMS Marketing Guidelines currently bar health care professionals (including physicians, nurses and pharmacists) from providing advice to nursing home residents in selecting a specific Part D plan. Further, CMS defines nursing homes as "non-benefit providing third parties" and prohibits nursing home administrators and staff from discussing specific plans with their residents.

This rule simply defies common sense. Nursing home staff are most likely to know which Part D plans in a given region offer appropriate coverage for their residents. Absent an effective "gag order" from CMS, professional caregivers in nursing homes are well equipped to provide objective information about coverage options to residents who enter the facility, become eligible for Medicare, or desire to change plans.

**Recommendation:** LTCPA urges the Committee to authorize nursing facility administrators and staff to assist their residents in Part D plan selection and enrollment.

### III. Immediate Enrollment for LTC Residents

Current CMS regulations treats LTC residents identically to other beneficiaries for enrollment purposes under Part D. That is, if a beneficiary enrolls in a new Part D plan, the new enrollment is effective the first of the following month. Prior to the Part D program, however, Medicaid drug coverage for dual eligibles residing in nursing facilities took effect on the date of application.

The CMS rule for is highly problematic for LTC residents, because medication needs significantly change between the ambulatory and nursing home setting. A beneficiary will frequently change plans in that situation, forcing both the LTC facility and the LTC pharmacy to deal with a variety of different formularies and different drug utilization management procedures during the course of a single month.

These administrative hurdles put nursing facilities at risk for citations for failure to provide all necessary medications. LTC pharmacies also are at risk for failing to undertake their contractual obligations to provide prescription medications to residents in a timely fashion.

**Recommendation:** LTCPA urges the Committee to establish a process for Medicare Part D coverage to begin immediately upon plan enrollment for beneficiaries entering a LTC facility and for LTC residents who change their plan enrollment.

### IV. Protections For Assisted Living Residents

In its regulations implementing Part D, CMS incorporated a preexisting definition of “long-term care facility.” This definition did not include assisted living facilities, and citing a lack of statutory authority, the Agency did not expand its scope.

As a result, assisted living residents lack the same protections extended to nursing home residents under Part D. Yet dual-eligible residents of assisted living facilities are also low-income and lack the resources to make copayments under Part D. While they may be able to function in a less restrictive care setting, many assisted living residents nonetheless require specialized pharmacy services to meet their complex medication needs.

CMS has correctly recognized that many residents of assisted living facilities require the same core service and performance standards reflected in its Long-Term Care Guidance. Likewise, the Agency and federal policy-makers have actively promoted home and community-based services as an alternative to care in nursing facilities.

**Recommendation:** LTCPA urges the Committee to extend Part D’s protections for LTC facility residents to include Medicare beneficiaries residing in assisted living.

### V. LTC Pharmacy Access

Part D plans are not currently required to demonstrate that they have an adequate LTC pharmacy network with the experience, capacity, and contractual access to beneficiaries to fully serve all LTC residents in a given region. While CMS used the TriCare standards to establish network adequacy criteria for retail pharmacies serving ambulatory beneficiaries, the Agency did not set mandatory, quantifiable standards for plans’ LTC pharmacy networks.

Instead, CMS simply asks that the plans “attest” they have sufficient numbers of pharmacies in their network that could meet certain performance and service criteria. Moreover, the current LTC pharmacy access standard fails to include the Agency’s own definition of a LTC pharmacy as “a pharmacy owned by or under contract with a LTC facility to provide prescription drugs to the facility’s residents” in its regulations.

CMS cannot currently confirm whether the pharmacies in a plan’s LTC network can adequately serve the number of LTC pharmacy beds in the region, or whether those pharmacies have any actual experience providing services to residents of LTC facilities.

**Recommendation:** LTCPA urges the Committee to establish a LTC network adequacy standard to ensure all Part D plans have the capacity to serve at least 90 percent of their enrollees who reside in LTC facilities.

#### VI. Prompt Payment

LTC pharmacies have encountered many of the same payment delays that retail chains and community pharmacies have experienced since the implementation of Part D. These delays were based in part on the failure by CMS to have computer systems in place to accurately track plan enrollment in the early months of the Part D program.

For example, while dual-eligible residents of LTC facilities are exempt from copayments, most of the plans did not factor this exemption into their data systems. CMS also failed to provide the plans with low-income subsidy data to document the exemptions.

In response, most Part D plans improperly assessed copayments against LTC residents and withheld those amounts from reimbursements to LTC pharmacies. Individual pharmacies have been required to negotiate with each plan to recover the improperly withheld copayments. CMS has advised plans that they should take a LTC pharmacy’s “best available evidence” to resolve copayment claims, but the Agency has been unwilling to develop procedures to require plans to resolve the issue.

Typically, best available evidence includes an enrollee’s Medicaid and Medicare numbers, the date the enrollee entered the LTC facility, and an attestation from the LTC pharmacy that it had not collected a co-pay from the enrollee. Despite this evidence, Part D plans are reluctant to pay amounts due to LTC pharmacies without documentation from CMS that these enrollees were exempt from copayments.

One of the largest Part D plans recently announced its intention to send copayment “refund” checks (\$1 or \$3 for every prescription filled in CY 2006) to LTC residents rather than reimburse the LTC pharmacy that is actually due the amount withheld. The rationale for this decision is that all Part D plans are required to close out their first year by May 31, 2007. Without any intervention by CMS, individual LTC pharmacies may be forced to litigate their 2006 co-pay claims with individual Part D plans.

**Recommendation:** LTCPA urges the Committee to direct CMS to develop procedures to identify LTC residents who are exempt from copayments and require prompt payment of LTC pharmacy claims by Part D plans.

#### VII. Part B Drug Coverage

Currently, Medicare beneficiaries enrolled in Part D may have some of their drugs reimbursed under Part B, if those drugs are administered incident to a physician’s services. However, some drugs

previously covered under Part B now fall under Part D, because they were dispensed by the LTC pharmacy directly to the beneficiary in the LTC facility.

The distinctions between Part D and Part B coverage are creating significant confusion for several drugs commonly administered in LTC settings. Clarification is needed to assure that these drugs can be dispensed in a timely fashion to LTC residents.

**Recommendation:** LTCPA urges the Committee to shift coverage of Part B drugs to Part D for beneficiaries residing in LTC facilities.

#### VIII. LTC Plan Quality

CMS collects data from Part D plans on a number of variables (e.g., aggregate counts of the number of exceptions requests, grievances, etc.). The Agency relies on the data to report to Congress on various aspects of the ongoing implementation and operation of the Part D program.

However, the MMA did not require any separate reporting by CMS or the plans regarding Part D services to LTC residents. Neither CMS nor the plans currently report the number of enrollments and disenrollments, the number of LTC residents' exceptions requests that were approved or disapproved, or the number of appeals and grievances filed in the LTC setting.

**Recommendation:** LTCPA urges the Committee to direct CMS to collect data and report annually to Congress on the quality of Part D plans' drug coverage for LTC residents.

#### CONCLUSION

LTCPA makes the following recommendations to strengthen Part D in the LTC setting:

- Codify CMS guidance documents as enforceable standards for Part D plans serving LTC residents;
- Authorize nursing facility administrators and staff to assist their residents in Part D plan selection and enrollment;
- Establish a process for Medicare Part D coverage to begin immediately upon plan enrollment for beneficiaries entering a LTC facility and for LTC residents who change their plan enrollment;
- Extend Part D's protections for LTC facility residents to include Medicare beneficiaries residing in assisted living;
- Establish a LTC network adequacy standard to ensure all Part D plans have the capacity to serve at least 90 percent of their enrollees who reside in LTC facilities;
- Direct CMS to develop procedures to identify LTC residents who are exempt from copayments and require prompt payment of LTC pharmacy claims by Part D plans;
- Shift coverage of Part B drugs to Part D for beneficiaries residing in LTC facilities; and
- Direct CMS to collect data and report annually to Congress on the quality of Part D plans' drug coverage for LTC residents.

The nation's LTC pharmacies are committed to ensuring the safe and timely delivery of necessary medications and specialized pharmacy services to their patients. To that end, LTCPA welcomes the opportunity to work with the Finance Committee to improve Medicare prescription drug coverage for beneficiaries residing in LTC facilities.