



Medicare Rights Center

**MEDICARE RIGHTS CENTER
TESTIMONY**

**Presented by
Deane Beebe, Public Affairs Director**

Partnership for Coverage Hearing

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**New Yorker Hotel
481 8th Avenue
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Good evening, I am Deane Beebe, Public Affairs Director of the Medicare Rights Center (MRC), the nation's largest independent source of health care information and assistance for people with Medicare. Founded in 1989, MRC is a consumer service organization that helps older adults and people with disabilities get good, affordable health care.

MRC works each day with older and disabled Americans, helping them navigate Medicare and other insurance coverage. Since our inception, much of our work has focused on helping men and women – especially the frailest and poorest people with Medicare – access low-income assistance programs so that they can have the health care benefits to which they are entitled. Through this work, we have seen that again and again, men and women seeking relief – and eligible for such relief – are not able to access it for two reasons: bureaucratic disenfranchisement and unaffordable expense.

Allow me to share a typical Medicare Rights Center case which exemplifies the kind of bureaucratic disenfranchisement problems that prevent our clients from getting the benefits they are entitled to receive.

The Medicare Rights Center helped Ms. C, an 83-year-old woman with some assets, submit a Medicare Savings Program application on February 29, 2006; she received a denial notice on November 17, 2006 because the “Medicare number and Social Security number do not match.” Ms. C is eligible for QI-1, a Medicare Savings Program, which will also automatically entitle her to Extra Help, the federal subsidy to pay for the Medicare drug benefit. She cannot apply directly for Extra Help because her limited assets would disqualify her. The Medicare Rights Center sent the case to New York State on December 7, 2006, and the State, after months of looking into the problem eventually responded, “This application is denied for failure to establish eligibility for benefits.” After reviewing Ms. C’s application, the Medicare Rights Center found this statement to be false. On April 10, 2007, MRC requested a Fair Hearing on behalf of Ms. C and is still awaiting a date.

Bureaucratic Disenfranchisement

Many people with Medicare are denied assistance by a range of “discouragement” practices, also referred to as bureaucratic disenfranchisement. Experts have long recognized that winning rights on paper is, at most, half the battle. The existence of rights – to food, to health care, to shelter – does not guarantee these rights. The “waiting room ethos” is an ethos that pervades social service and health care coverage offices nationwide. Sometimes developed by office staff, sometimes created by government agencies to curb spending, and sometimes the result of outdated application processes and technologies, unnecessary bureaucracy frustrates attempts to apply for benefits or delay receipt of benefits – and put lives on the line.

Bureaucratic disenfranchisement encompasses a broad range of practices, many of which are employed to keep costs down by making it difficult for people to access benefits for which they are eligible. These practices affect people from all walks of life. **For example, as recently as 2005, it was estimated that, of five million older and disabled men and women in this country eligible for low-income Medicare Savings Programs (MSPs) – the programs that minimize the cost-sharing requirements of Medicare -- only one-half, or fewer, are enrolled.**

This MSP example shows bureaucratic disenfranchisement at work, keeping guaranteed rights from the people who need them most. Although federally created, the MSPs are partially funded and completely administered by states or their counties. In order to apply for enrollment, individuals must surmount multiple obstacles, including burdensome income and asset documentation requirements, copious paperwork, travel to often inaccessible Medicaid offices, and long waits for service once they get there. When combined with the perceived stigma of asking for help, these hurdles keep many people with Medicare from applying for the assistance they need and as a result, often going without care.

To help eliminate bureaucratic disenfranchisement, New York should adopt reforms and monitor implementation of reforms that simplify and streamline MSP applications materials, and use technology to limit the amount of documentation individuals need to provide to prove MSP eligibility. Medicaid applications are invariably daunting: in New York, the application is 16 pages, the font is small, and the questions are confusing and intrusive. One step forward is that New York State is considering eliminating the currently required face-to-face interview. This change would make it possible for more New Yorkers to enroll in MSPs.

Similarly taxing documentation requirements for MSPs often deter people from applying or result in incomplete and subsequently voided applications and delayed or denied coverage. Perhaps most frustrating are the stories of those who follow all the rules, jump through all the hoops, and still are turned away – maybe because of a misinformed or overburdened case worker or maybe because of a language barrier or an accessibility issue.

Unaffordable Expense

Similarly, the Medicare drug benefit (Part D) often prevents access to medications because of the very high out-of-pocket costs incurred when Medicare private drug plans fail to cover prescriptions because:

- the drug is not on the Medicare private drug plan's formulary,
- the drug has utilization management restrictions placed on it by the private drug plan, or
- the person with Medicare has hit the coverage gap known as the "doughnut hole" and is responsible for paying 100 percent of the cost on the drug.

New York's state pharmaceutical assistance program, EPIC, helps people with Medicare whose drug plans do not provide the medications they need. For New Yorkers who are 65 and over and meet EPIC's income criteria, the state's pharmaceutical assistance program will fill the Medicare private drug plans' coverage gaps by paying most of the cost of their prescribed medications.

When EPIC members receive Extra Help, the federal program that helps people with low incomes pay for their Medicare drug coverage, EPIC's costs, as well as the members', are reduced significantly. EPIC's income limit criteria are higher than that of the Extra Help program and EPIC, unlike Extra Help, fortunately has no asset test. Therefore, not all EPIC members can qualify automatically for Extra Help.

People enrolled in a MSP are automatically enrolled in Extra Help. To reduce costs for both New York State and elderly residents with Medicare, the state could change eligibility criteria for MSPs to allow

people enrolled in the EPIC Fee program to qualify for a MSP, which would make them automatically eligible for Extra Help.

To accomplish this, New York should apply to CMS for a State Plan Amendment to **remove the asset test for all three Medicare Savings Programs and raise the income eligibility limits for QI to match those of the EPIC fee plan** (\$20,000 a year for individuals; \$26,000 for couples). If MSP eligibility is coordinated with EPIC eligibility, and enrollment in an MSP automatically qualifies you for Extra Help (paid for with 100% federal dollars), aligning the income criteria would greatly reduce EPIC's costs.

These EPIC program savings could be used to expand EPIC to New Yorkers with disabilities who receive SSDI – New Yorkers who have high drugs costs, low incomes, and limited assets. Low-income New Yorkers with disabilities lost access to many of the pharmaceutical patient assistance programs that helped them pay for their prescriptions when Medicare Part D was implemented. New Yorkers with disabilities have never been able to enjoy the lifesaving benefits of EPIC and have seen their safety net erode further.

Several additional reasons for aligning the income criteria of MSPs with that of Extra Help and eliminating the asset test include:

- **Simplified program administration.** Eliminating the need for asset review both at the time of application as well as the time of recertification would significantly decrease time and administrative costs for the state. A 2004 study by The Commonwealth Fund states, “Reviewing asset information is the most time-consuming task in the enrollment process.”
- **Already tested in other states.** The Commonwealth Fund report found that Maine and Vermont have eliminated the asset test for all three programs. The cost to the states of Part B premium assistance was offset by savings to their State Pharmaceutical Assistance Program due to increased enrollment in Extra Help. Alabama, Arizona, Delaware and Mississippi have raised the asset tests or eliminated them for one or more of the programs. Arizona eliminated the asset test for QI after conducting a fiscal impact study. “The study found that savings on administrative costs related to documenting assets roughly equaled the costs of benefits for additional persons who would enroll in the programs.”
- **Savings to the state.** EPIC has recently required that all people with EPIC enroll in Medicare Part D and if they are eligible for Extra Help they must apply for it. EPIC saves an average of \$1,430 a year for every member who has Full Extra Help. This offers New York substantial savings that can be applied to any increases in costs related to QMB and SLMB. In addition, the state can save on the administration of the asset test.

Unnecessary expense, bureaucracy and bureaucratic errors cost lives. Conversely, affordable, streamlined, straight-forward, and cooperative health assistance programs would ensure that promises are kept and health care entitlements are realized. Older and disabled Americans would get access to the health care that is their right. A streamlined system would accomplish this by making it easier to enroll in health assistance programs, while also reducing costs for the state. This is true not just of the Medicare program, but for all health care programs.

I thank you, and Governor Spitzer, for your consideration.