

The Medicare Rights Center
Questionnaire for 2006 Congressional Candidates

As Representative/Senator, will you:

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| 1. Sponsor legislation to enact a prescription drug benefit delivered through Medicare? | Yes | No |
| 2. Sponsor legislation requiring Medicare to directly negotiate prescription drug prices? | Yes | No |
| 3. Sponsor legislation to eliminate the 24-month waiting period for Americans with disabilities under age 65 to gain Medicare coverage? | Yes | No |
| 4. Sponsor legislation to make Medicare cover outpatient mental health care at 80% of its approved rate, as Medicare does for all other outpatient medical services? | Yes | No |
| 5. Sponsor legislation to fully federalize administration and financing of the Medicare Savings Programs? | Yes | No |
| 6. Sponsor legislation eliminating the asset test for Medicare Part D's low income subsidy, also called the Extra Help program? | Yes | No |

See the following pages for background on each question.

Please return responses no later than
September 15, 2006
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1. Sponsor legislation to enact a prescription drug benefit delivered through Medicare.

A recent survey on the Part D prescription drug benefit found that 77 percent of Americans age 65 and older feel that it would have been better to provide drug insurance automatically as part of Medicare, instead of through an optional program with multiple providers.¹ Only 30 percent think that Part D was well designed.

Administering Part D through Medicare, instead of private insurance companies, would give older adults and people with severe disabilities drug coverage that is reliable and affordable. Instead of gambling that the Part D plan they picked will cover the medicines they need, individuals could simply present their Medicare card at any pharmacy in the country to get the medicines they need.

True Story

Mr. S is a retiree who worked for the railroad industry. When the Part D benefit started, he and his wife enrolled in a plan provided to railroad retirees, at a cost of \$87 per month. They then found out that the insurance company offered a similar plan to the general public for \$31.80 a month. They called the company and asked if they could switch to the other plan, and were told that it was fine, that all they had to do was fill out the enrollment form and send it in. However, the couple then received membership cards for the railroad retiree plan. They spent the next two months trying to correct the situation, speaking on the phone to at least seven different drug plan representatives and three different people at Medicare. On May 18, the couple found out they had been completely disenrolled from Part D, and are now left with no drug coverage. Mr. S takes five prescriptions, and Mrs. S takes three. They have decided to return to buying their medications from Canada, because it's cheaper and it means a lot less stress.

A drug benefit administered by private insurers means these companies' administrative costs and private margins are subsidized by taxpayers. Medicare foregoes the savings it could reap by negotiating lower drug prices and administering the program directly. A Medicare-administered benefit would yield \$38 billion in savings on administrative costs over the next seven years.² A Medicare drug benefit would provide the simplicity and security that has made Medicare one of the country's most popular and successful social programs.

¹ Retirement Perspectives Survey, 2006. See Heiss, McFadden, and Winter, "Who Failed to Enroll in Medicare Part D, And Why? Early Results," *Health Affairs* 25 (2006).

² The costs attributable to private insurers administering the program include the costs associated with marketing and profits. Baker, "The Savings from an Efficient Medicare Prescription Drug Plan," January 2006. See "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit," Congressional Budget Office, July 2004.

2. Sponsor legislation requiring Medicare to directly negotiate prescription drug prices.

Under the law that created the Part D prescription drug benefit, the federal government is prohibited from negotiating lower drug prices with pharmaceutical manufacturers for the 43 million people with Medicare. The insurance companies providing Part D plans are supposed to negotiate lower drug prices but have not been able to match the discounts received by state Medicaid programs³ or to keep prices from rising.⁴

The prohibition on price negotiations means that people with Medicare still pay higher prices for their medicines than our neighbors in Canada. In fact, if Medicare could negotiate the same prices as Canada, and there is no reason it can't, there would be enough savings to fill the doughnut hole in Part D, the coverage gap when people still pay premiums but receive no drug coverage.⁵

True Story

Alice takes medication for acid reflux disease, a condition aggravated by the chemotherapy she undergoes for breast cancer. However, it was not on her Part D plan's formulary. She filed an exception, with a statement from her doctor that she had tried all the medicines on the formulary and none had helped her as much as this medication. Her plan made it a Tier 3, non-preferred drug. She still has to pay 75 percent of the cost, \$284.50 for a three-month supply.

Under her former insurance plan, she only paid \$32 for a three-month supply. But the plan stopped covering prescriptions when Part D went into effect, so she had to enroll in a Part D plan. Now, under this plan, she has to spend \$1,138 a year for the medicine she was paying \$128 for last year.

The American people overwhelmingly agree that direct price negotiations by Medicare would save money,⁶ but the pharmaceutical industry is lobbying hard to prevent Congress from allowing Medicare from using its bargaining power. Taxpayers and people with Medicare deserve to get the most for their dollars through a drug benefit delivered directly by Medicare with the lowest prices the government is able to negotiate.

³ Department of Health and Human Services Office of Inspector General, "Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price," June 2005.

⁴ Since the beginning of the Part D benefit, the changes in prices have risen faster than inflation. "Big Dollars, Little Sense: Rising Medicare Prescription Drug Prices," Families USA, June 2006.

⁵ Anderson, Shea, Hussey, Keyhani, and Zephyrin, "Doughnut Holes and Price Controls," *Health Affairs*, July 21, 2004.

⁶ Kaiser Family Foundation, Health Poll Report Survey, March/April 2005

3. Sponsor legislation to eliminate the 24-month waiting period for Americans with disabilities under age 65 to gain Medicare coverage.

An estimated 1.3 million Americans with disabilities are currently stuck in the “Medicare waiting period.”⁷ Although 1972 legislation extended Medicare coverage to people with significant disabilities, it also imposed a 24-month wait for this coverage from the date a person’s Social Security Disability Insurance (SSDI) begins. When added to the mandatory five-month delay for SSDI benefits to begin, the total waiting period is 29 months.

The wait is devastating. At a time in their lives when their need for health coverage is most dire, close to 400,000 Americans with disabilities are uninsured and many more have inadequate coverage.⁸ The proportion of people in the waiting period who have no health insurance is likely higher today, because health insurance is less accessible and less affordable than it was four years ago. States have tightened up Medicaid eligibility, curtailing access to health benefits for the poor. Employer-sponsored health coverage has been steadily eroding and monthly premiums have been rising steeply. This means the COBRA program, which allows former employees to pay to keep the coverage they had under their last job, is either inaccessible or unaffordable to people forced to leave their job after being struck with a disability.

True Story

Stan White worked in a textile factory until January 2002, when he had a stroke that partially paralyzed him and force him to stop working. A few months later, he had a seizure and was diagnosed with a malignant tumor. He was able to participate in a clinical trial involving an experimental drug, which was successful. His COBRA coverage paid for 80 percent of the cost, and Stan was able to afford the rest. In February 2004, though, his tumor returned. By this time, the factory where he had worked had gone out of business and he no longer had COBRA coverage. Furthermore, his savings account had been drained by the high COBRA premiums and health expenses. Uninsured and still waiting for Medicare, the only treatment Stan was able to afford was an experimental procedure for a clinical trial he was enrolled in. The treatment was not successful. Stan finally had Medicare coverage in July 2004, in time to receive hospice care. He died in September 2004.

While they are waiting for Medicare coverage, people without health insurance go without necessary medical care and skip taking vital medicines. About 4 percent of people in the waiting period die every year. If they survive, they wind up sicker and more expensive to care for when Medicare coverage does begin.⁹ Ending the 24-month waiting

⁷ Dale and Verdier, “Elimination of Medicare’s Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs,” Mathematica Policy Research Inc., The Commonwealth Fund, July 2003.

⁸ Ibid.

⁹ Ibid.

period would also save money for financially pressed states, which cover 40 percent of people waiting for Medicare coverage through their Medicaid programs. Eliminating the waiting period would provide continuity of care to people with disabilities when they need it most.

4. Sponsor legislation to make Medicare cover outpatient mental health care at 80% of its approved rate, as Medicare does for all other outpatient medical services.

Today, limitations in Medicare's mental health coverage prevent many Americans with Medicare from receiving the therapy they need. One in five older adults has a mental health condition,¹⁰ as do over half of the people who qualify for Medicare because of a disability.¹¹ Older adults have the highest suicide rate in the United States.¹² Untreated mental health conditions can lead to poor health and quality of life, a reduction in ability to function, and higher mortality rates.

While Medicare pays 80 percent for most covered Part B services, such as doctor visits, it pays only 50 percent for covered mental health services. As a result, people with Medicare without supplemental coverage must pay out of pocket a larger proportion of the cost for mental health care than for general health care services. This cost prevents many men and women from seeking mental health care.

True Story

Ms. S is a disabled 49-year-old woman from Liverpool, NY with Original Medicare and no supplemental coverage. She has lived with major depression for six years, but has only seen a therapist once to confirm her diagnosis. She did not return for therapy because she could not afford the 50% coinsurance for the visits.

Medicare's discriminatory and limited coverage for mental illness perpetuates the stigma of mental illness as less worthy of treatment than other illnesses. It also causes many patients to forego needed therapy that would improve their quality of life, permit more active and independent involvement in the community, and prevent costly hospitalizations. Putting coverage of mental health treatments on par with other medical services will move Medicare toward providing comprehensive, up-to-date care for all people with Medicare.

¹⁰ Bartels, "Prevention, Treatment and Intervention for Mental Disorders in Older Persons: Priorities for Health Policy and Research," Comments from a Congressional briefing: "Addressing the Unmet Needs of America's Elderly-A Briefing on Mental Health and Aging," June 5, 2001.

¹¹ "The Faces of Medicare: Medicare and the Under-65 Disabled," Kaiser Family Foundation, July 1999.

¹² National Strategy for Suicide Prevention, Department of Health and Human Services.

5. Sponsor legislation to fully federalize administration and financing of the Medicare Savings Programs.

Medicare deductibles, premiums, and coinsurance are becoming an increasing burden for people with low incomes. The Part B premium has almost doubled since 2000, reaching \$89.50 in 2006.¹³ Older Americans with incomes below 135 percent of the poverty line spend one-third of their income on healthcare.¹⁴ Since 1989, Congress has addressed this problem through the Medicare Savings Programs (MSPs) that are designed to help low-income individuals with their out-of-pocket Medicare costs.¹⁵ After 17 years, however, between one-third and one half of eligible individuals are enrolled in these programs.¹⁶

Unnecessarily complicated administration of the MSPs is directly responsible for this marked underenrollment. Although federally created, the MSPs are partially funded and completely administered by states or their counties.¹⁷ In order to apply for enrollment, individuals must surmount multiple obstacles, including burdensome income and asset documentation requirements, Byzantine 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 discourage many people with Medicare from applying for the assistance they need.

True Story

Ms. M, an 82-year-old Manhattan resident, has an annual income of \$8,636 from Social Security. She is eligible for the QMB savings program. To apply, Ms. M had to gather all of her documentation and take a bus to the Medicaid office. She arrived with her completed application already in hand, placed the application in the appropriate basket and took a seat. As time passed, Ms. M grew increasingly anxious. Hours later, a receptionist finally rummaged fruitlessly through a pile of papers only to claim that Ms. M had never submitted an application. Despite her diligent preparation and long wait, Ms. M, sweating and hands shaking, was told to fill out yet another application. Ms. M nearly gave up, overwhelmed by the stress of the application process. Few would have gone as far.

¹³ Medicare Board of Trustees, 2006 Annual Report

¹⁴“Out-of-Pocket Spending on Health Care By Medicare Beneficiaries Age 65 and Older in 2003,” AARP *Data Digest*, September 2004.

¹⁵ The MSPs are: Qualified Medicare Beneficiary (QMB) for individuals with an income below 100% of the federal poverty line, Specified Low-Income Medicare Beneficiary (SLMB) for individuals between 100% and 120% of poverty, and Qualified Individual 1 (QI-1) for those between 120 and 135% of poverty. QMB pays for premiums, deductibles and coinsurance, while SLMB and QI-1 pay for the Part B premium only.

¹⁶ The Congressional Budget Office estimates that only 33% of eligible people are enrolled in QMB and 13% in SLMB. “A Detailed Description of CBO’s Cost Estimate for the Medicare Prescription Drug Benefit,” July 2004. Nationally, only about 145,000 (10%) of the estimated 1.4 million eligible individuals are enrolled in the QI-1 program. 68 Fed. Reg. 50792, August 22, 2003.

¹⁷ An exception is QI-1, which, though completely administered by states and subdivisions, is 100% federally funded. In some states (e.g., NY), counties administer both Medicaid and the MSPs and pay a portion of Medicaid costs.

Federalizing administration (by the Social Security Administration) and funding (from general revenue) of the MSPs would greatly improve enrollment. The Social Security already has extensive information on the assets and income of people with Medicare who have applied for the Part D low-income subsidy that could be used to enroll individuals in MSPs. A federalized MSP program would allow eligibility criteria for MSPs and the Part D low-income subsidy to be harmonized, maximizing enrollment in both programs.

6. Sponsor legislation eliminating the asset test for Medicare Part D's low income subsidy, also called the Extra Help program.

For the poorest members of the Medicare population, the Extra Help program is a valuable resource. It fills in the coverage gap built into Part D and helps pay premiums and coinsurance, allowing many of the most vulnerable people with Medicare to have access to the medicines they need.

According to Social Security Administration officials, 57% of individuals found ineligible for the program actually met the income requirements for enrollment, but were denied eligibility because their financial assets – bank accounts, insurance policies, etc. – disqualify them for the program.¹⁸ The asset test penalizes Americans who have saved up to provide some security for themselves and their families. It requires people to cash out life insurance policies or draw down hard-earned savings to pay for medicine that remains unaffordable even with Part D coverage.

True Story

Violet, a retired resident of Montgomery County, New York, receives \$1006.50 each month from Social Security. Although her income falls below the Extra Help income limit of \$1225 per month, she is not eligible because she has \$13,000 in assets, \$1,500 over the income limit. Because she lives in New York, she can qualify for a Medicare Savings Program (MSP), which will pay her Part B premium and automatically enroll her in the Extra Help program. This is possible because New York has eliminated the asset test for the QI-1 program, the MSP for people with Medicare earning less than 135 percent of the poverty line. Only five other states have eliminated the asset test for any of their MSPs.

The asset test also needlessly complicates the application process for Extra Help, discouraging many eligible individuals from enrolling. The seven-page application is filled with intimidating questions about bank accounts, life insurance policies, in-kind support and living arrangements, which must be completed accurately under pain of fine and/or imprisonment.

Currently, over 5 million of those eligible for Extra Help remain unenrolled in the program.¹⁹ Besides bringing in the roughly 2 million who were disqualified because of

¹⁸ See “Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules,” Kaiser Family Foundation, May 2006.

¹⁹ Families USA, “The Medicare Drug Program Fails to Reach Low-Income Seniors,” May 2006.

their savings, elimination of the asset test would greatly facilitate outreach and enrollment in the program. An income-only standard would enable targeted outreach based on income data the IRS and other federal agencies already have. Eliminating the asset test is a giant step toward giving all low-income people with Medicare access affordable prescription drug coverage.