The Honorable Henry Waxman, Chairman
House Energy and Commerce Committee
United States House of Representatives
Washington, D.C. 20515

The Honorable Charles Rangel, Chairman
House Ways and Means Committee
United States House of Representatives
Washington, D.C. 20515

The Honorable Joe Barton, Ranking Member
House Energy and Commerce Committee
United States House of Representatives
Washington, D.C. 20515

The Honorable Dave Camp, Ranking Member
House Ways and Means Committee
United States House of Representatives
Washington, D.C. 20515

May 28, 2009

Dear Representatives Waxman, Rangel, Barton and Camp:

The undersigned organizations urge you to address the needs of low-income Medicare beneficiaries as Congress considers health care reform. The economic downturn has increased the urgency for fixing the Medicare safety net programs for vulnerable seniors and people with disabilities. This population, typically with incomes below only $20,000, has been hit particularly hard, and tends to be sicker, more isolated and have limited educations. They are high users of medical and other health-related services, and they benefit significantly from financial assistance with growing out-of-pocket costs that, without assistance create barriers to care and in the long run higher costs to taxpayers for preventable complications and institutionalizations. It is also important to bear in mind that addressing the physician payment SGR problem will increase Medicare Part B premiums.

The Congressional Budget Office has estimated more than two-thirds of those eligible for several Medicare Savings Programs (MSPs, which provide assistance with Medicare cost-sharing) do not receive benefits. Additionally, the Centers for Medicare & Medicaid Services state that more than 4 million individuals eligible for the Part D Low-Income Subsidy (LIS, or Extra Help) are not enrolled.

A major barrier to enrollment in the Medicare Savings Programs and the Low-Income Subsidy is the lack of alignment of eligibility rules and application processes between MSP and LIS, even though both programs serve the same general population. Additional barriers include: restrictive income and assets limits, income and asset documentation complexities, lack of sufficient resources for effective outreach, lack of knowledge of the programs, language issues, social and physical isolation, and other daunting application requirements.

The lives of low-income beneficiaries would improve significantly with better access to the financial assistance provided by these important programs. As health care reform moves forward, we urge that you include the following changes to programs serving low-income Medicare beneficiaries:

- *Aligning, simplifying, and increasing income eligibility*: Under current rules, income eligibility for the Medicare Savings Programs is limited to those with incomes up to 135 percent of the poverty level ($1,281/month for an individual). The Part D LIS program provides partial assistance up to 150 percent of the poverty level ($1,353/month for an individual), although full assistance is limited to those with incomes up to 135 percent of poverty. By contrast, we note that the Senate Finance Committee's Coverage Options paper contemplates subsidies for the non-Medicare population up to 400 percent of the poverty level.

Income eligibility rules should be modified in several ways. First, eligibility standards should be increased for all of these programs in order to assist the many seniors and people with disabilities of limited means who continue to struggle with increasing out-of-pocket costs. Second, income eligibility should be aligned across the programs. At most, there should be two levels of benefits: a comprehensive benefit covering costs for Medicare Parts A, B, and D for those with lower incomes, and a partial benefit for those with slightly higher incomes.

- *Eliminating or substantially increasing asset limits:* Even when the improvements included in 2008 MIPPA legislation take effect in 2010, beneficiaries with assets over about $8,000 for an individual and $13,000 for a couple will be disqualified from receiving full Part D assistance or any help under the Medicare Savings Programs. This policy penalizes people who did the right thing in saving for retirement, and creates administrative complications both for beneficiaries and the agencies that must verify eligibility.

  Ideally, the asset test should be eliminated. Very few people who meet the modest income limits have significant savings. Alternatively, the limits should be increased to at least $27,500 for singles and $55,000 for couples so that those with modest nest eggs would not have to deplete their savings completely in order to get help with health care costs.

- *Stabilizing the programs:* Beneficiaries and states, which administer the MSP programs, must be able to rely on their availability. Current instabilities that must be resolved include: the recurring, disruptive short-term reauthorizations of one of the Medicare Savings Programs--the Qualified Individual (QI) program; the need for beneficiaries to be recertified for benefits each year by re-documenting their income and assets; and the loss of eligibility some beneficiaries face due to the effects of receiving other benefits.

- *Administrative simplification:* Outreach and enrollment for low-income Medicare programs could be significantly simplified through use of Internal Revenue Service records to identify potentially eligible beneficiaries (while respecting confidentiality rules); by making more materials available in additional languages; and by further simplification of the application process and elimination of annual recertification.

Thank you for your consideration of these important issues. We look forward to working with you in the coming months on behalf of needy seniors and people with disabilities who rely on Medicare.

Sincerely,

AARP

AFL-CIO
Alliance for Retired Americans.
Alzheimer’s Association
American Postal Workers Union Retirees
American Society of Consultant Pharmacists
Amyloidosis Support Groups
Association for Ambulatory Behavioral Healthcare
Association of BellTel Retirees
Autism Society
Center for Medicare Advocacy
Community Access National Network (TIICANN)
Easter Seals
Ehlers Danlos National Foundation
Families USA
Gray Panthers
Hispanic Senior Action Council
Housing Works
Institute for the Puerto Rican/Hispanic Elderly, Inc
Long Term Care Community Coalition
Lutheran Services in America
Medicare Rights Center
National Academy of Elder Law Attorneys
National Alliance for Caregiving
National Association of Area Agencies on Aging
National Association of State Long-Term Care Ombudsman (NASOP)
National Committee to Preserve Social Security and Medicare
National Council on Aging
National Health Law Program (NHeLP)
National Indian Council on Aging
National Senior Citizens Law Center
National Senior Corps Association
NCCNHR: The National Consumer Voice for Quality Long-Term Care
OWL - The Voice of Midlife and Older Women
Services & Advocacy for GLBT Elders (SAGE)
STARS (syncope trust and reflex anoxic seizures)
The Arc of the United States
The Health Assistance Partnership, A Project of Families USA
United Cerebral Palsy
United Jewish Communities
United Spinal Association
Wider Opportunities for Women