Good afternoon. My name is Patricia Nemore. I am attorney with the Center for Medicare Advocacy. I am grateful for the opportunity to testify before the Senate Aging Committee today.

Since I understand that the interest of this Committee is implementation of the Medicare drug plan, the testimony I have submitted for the record as well as my oral comments today focus on those areas where the Center for Medicare Advocacy believes the Secretary and Administrator can act to improve the drug benefit for low income beneficiaries. We have not addressed the many areas of the law that we believe require amendment.

We know that low-income Medicare beneficiaries have disproportionately complex health care needs, and that their enrollment in assistance programs is hindered by lack of information and by complicated and burdensome application and enrollment processes. The Medicare prescription drug program and low income subsidy are themselves complex and are likely to create a great deal of confusion among those who most need the coverage. That said, I would like to make five points that are critical to implementation of the law to promote the best possible access to prescription drugs by low-income beneficiaries needing to navigate the extremely complex system created by the law.

1. **The Secretary must address the unique circumstances of dual eligibles.** Dual eligibles—beneficiaries eligible for both Medicare and Medicaid and those with the most complex medical needs and high drug utilization—will lose Medicaid prescription drug coverage effective January 1, 2006. To assure that they have no gap in coverage, dual eligibles will have to choose a Part D plan between November 15 and December 31, 2005. They will need to be identified and provided clear information and one-on-one assistance in order to do so. States, State Health Insurance Counseling Programs (SHIPs) and community-based organizations can be enlisted to help dual eligibles choose Part D plans. As the law authorizes the Secretary to automatically enroll dual eligibles in plans if they do not do so themselves, any automatic enrollment must itself be followed up by information and assistance to individuals, letting them know how to use their plan or how to choose a different one if they wish.
2. The Secretary must act to simplify, streamline and create equity in the eligibility and enrollment processes for low-income subsidies. Possible actions are many and are presented in more detail in my written testimony. They include:

- deeming all Medicare Savings Programs beneficiaries eligible for the low-income subsidy. To do so will eliminate the requirement for application and enrollment of almost 1 million low-income individuals;

- permitting all states to use the more liberal methodologies they use for their Medicare Savings Programs and, to create equity within a state, requiring the Social Security Administration in each state, when it determines eligibility, to use the state’s more liberal methodologies;

- requiring that the simplified application form and process that the law requires the Secretary and the Commissioner of Social Security to create be available to all beneficiaries regardless of whether they apply at the Social Security Administration or at the Medicaid office. The simplified process must minimize documentation requirements concerning the assets test.

3. The Secretary must require that clear, detailed information be provided directly to beneficiaries by Part D plans. The Secretary must assure that both prospective enrollees and enrollees themselves, after they have chosen a plan, are directly provided—not merely told about—the availability of—clear, detailed information they can understand about the specific drugs provided in a plan’s formulary, the formulary design and structure, the cost-sharing structure, including any tiered cost-sharing and which drugs are included in each tier. Beneficiaries need to be directly provided notice when plans add or remove drugs from their formularies or change the tiered co-payment of any given drug. Such notice must include clear information about how the beneficiary can seek coverage of a drug removed from the formulary or review of a change in a drug’s co-payment.

4. The Secretary must clarify the requirements for Part D plans’ processes for determinations, reconsiderations and appeals to assure beneficiaries access to expedited review of coverage for drugs not on the formulary, coverage for drugs removed from the formulary and co-payment requirements. Such clarification should include, as under Medicare Advantage, that the physician can seek expedited review on behalf of the beneficiary.

5. The Secretary must increase substantially resources for outreach, information, counseling and assistance that will assure the availability of the one-on-one assistance that is going to be desperately needed by beneficiaries trying to navigate this very complex system. This should be done by funding the State Health Insurance Counseling Programs (SHIPs) at $41 million per year, or $1/Medicare beneficiary, and by providing additional resources for other non-profit community-based organizations that can meet the particular needs of specific under-served populations of low-income Medicare beneficiaries.

Thank you for this opportunity to share the views of the Center for Medicare Advocacy with members of this Committee. I am happy to answer any questions you have.