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PRESERVING SENIORCARE: AFFORDABLE DRUG COVERAGE THAT WORKS FOR WISCONSIN

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PRESERVING SENIORCARE: AFFORDABLE DRUG COVERAGE THAT WORKS FOR WISCONSIN

WEDNESDAY, MARCH 28, 2007

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:15 a.m., in room 562, Dirksen Senate Office Building, Hon. Herb Kohl (chairman of the committee) presiding.

Present: Senator Kohl.

OPENING STATEMENT OF SENATOR HERB KOHL

The CHAIRMAN. Hello to everybody. We will commence our hearing right now.

This hearing focuses on a program that is very important to me, to most of the witnesses who are here today and, most importantly, to more than 100,000 low-income seniors in the State of Wisconsin.

Since September 1, 2002, more than 103,000 seniors have participated in Wisconsin's SeniorCare prescription drug program. The Federal Medicaid waiver that allows SeniorCare to operate is set to expire on June 30 of this year.

The Bush Administration holds the key to survival of SeniorCare, and we believe that they must act now to renew the waiver. Without it, this popular and very successful program will end, forcing Wisconsin seniors to join Medicare Part D with a higher cost to both seniors and to taxpayers.

SeniorCare is a model for a simple, affordable drug plan, and the Administration, I believe, should embrace it. It has a one-page application, a $30 annual fee, and a copayment of $5 for generic drugs and $15 for brand-name drugs.

It does not have an asset test, a key difference from Medicare Part D, that makes it easier for low-income seniors to get the extra help that they need. In fact, many SeniorCare enrollees would not be eligible for Medicare's low-income subsidy because of its difficult asset test.

SeniorCare has strong bipartisan support in the State of Wisconsin, and among the entire Congressional delegation. To us, it is a no-brainer. It costs less, it covers more, and seniors are happier.

As an AARP study points out, 94 percent of SeniorCare participants are better off than they would be under Medicare Part D. That is why so many seniors have chosen SeniorCare over Medicare Part D. In fact, enrollment in SeniorCare actually increased

after January 2006, demonstrating that aggressive Part D outreach actually resulted in more seniors finding out about SeniorCare and signing up for it instead of Medicare Part D.

Additionally, SeniorCare saves the Federal Government nearly $500 on each beneficiary when compared to Medicare Part D. The SeniorCare waiver has also saved an estimated $669 million in Medicaid funding, because seniors with SeniorCare have stayed healthier longer, avoiding costlier hospital and nursing home care.

Today we will hear from Leslie Norwalk, acting Administrator for the Centers for Medicare and Medicaid Services, CMS, who will give the Administration's perspective on SeniorCare. CMS ultimately has the authority to grant the waiver that would allow SeniorCare to operate through June 30, 2010. We appreciate Ms. Norwalk's willingness to participate in this hearing and to hear the Wisconsin witnesses make their—our—case for SeniorCare.

Next, we will hear from four Wisconsin witnesses who will make a compelling case for the continuation of SeniorCare. We will be pleased to hear from Wisconsin's Governor, Jim Doyle, who has been an outspoken champion of SeniorCare. We will also hear from Bette Linton, who is currently on SeniorCare and is an example of one of the many Wisconsin seniors who would be worse off under Medicare Part D.

Then we will hear from Tom Frazier, the distinguished executive director of the Coalition of Wisconsin Aging Groups, and also Patricia Finder-Stone, the state president at AARP, who will describe the hardships that Wisconsin seniors will face if SeniorCare is forced to end, as well as to the economic consequences to our State and to the Federal Government.

Now, we hope the Administration will listen carefully to what they hear today. We believe it would be a huge mistake for the Administration to pull the plug on SeniorCare. It is a program that works for seniors and taxpayers, and we are committed to fighting to save it, so that Wisconsin seniors get the best and the most affordable drug coverage.

The Ranking Member, Gordon Smith, will not be able to join us this morning because of a conflict with the Finance Committee hearing, and so we will now turn to our first panel and our first witness, the distinguished Leslie Norwalk.

Thank you for being here.

STATEMENT OF LESLIE NORWALK, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. NORWALK. Thank you.

Good morning, Chairman Kohl and distinguished members of the Committee. I appreciate the opportunity to appear before you today to discuss SeniorCare, a program that provides prescription drug coverage to eligible seniors in Wisconsin.

Prescription drugs are integral to the delivery of safe, modern medical care. Accordingly, adding a comprehensive drug benefit to Medicare has been a priority at CMS for more than a decade, culminating in the 2003 enactment, and January 2006 implementation, of Medicare Part D.

More than 90 percent of Medicare beneficiaries have prescription drug coverage through Part D or another creditable source, at a cost significantly lower to both taxpayers and seniors than originally estimated.

Before Part D, many States played a vital role in offering direct pharmaceutical assistance to their residents. Eligible low-income seniors often received drug coverage through Medicaid. For others, States commonly extended drug coverage through State pharmaceutical assistance programs, or SPAPs. On the eve of Part D implementation, 21 States had SPAPs that provided low-income enrollees with subsidies for prescription drugs.

Additionally, prior to Part D, CMS recognized the need to work with States to extend pharmacy coverage to low-income elderly and disabled individuals not otherwise eligible for Medicaid.

In January 2002, HHS and CMS announced a model demonstration called Pharmacy Plus, which allowed States to expand Medicaid coverage for prescription drugs to seniors and other individuals with family incomes up to 200 percent of the Federal poverty level. These Medicaid Section 1115 demonstrations were intended to test how providing a pharmacy benefit to a non-Medicaid-covered population would affect Medicaid costs, utilization and future eligibility trends.

CMS approval for Pharmacy Plus waivers required States to establish budget neutrality, meaning that the services provided under the demonstration could not exceed the costs that Medicaid would otherwise have incurred in the demonstration's absence.

The overarching theory for Pharmacy Plus was that prescription drug programs for seniors would keep them healthier, target scarce resources more effectively, and generate offsetting savings in Medicaid, and that is known as diversion.

In addition to Wisconsin's SeniorCare program, CMS approved Pharmacy Plus demonstrations in Florida, Illinois and South Carolina, but denied waivers in Delaware and Hawaii because they did not meet the budget-neutrality requirements.

Medicare Part D has significantly altered the landscape in which States provide prescription drug coverage to residents age 65 and over, as well as those who are disabled.

Before January 2006, SeniorCare was one of few affordable drug coverage options for most low-income seniors in Wisconsin not qualified for full Medicaid benefits. Today, they and their counterparts across the country have access to comprehensive prescription drug coverage through Medicare.

Individuals duly eligible for Medicare and Medicaid now receive their coverage through the Medicare program. At last count, more than 571,000 Wisconsin seniors are receiving drug coverage through Part D or other creditable sources.

The low-income subsidy, or LIS, in Part D provides eligible Medicare beneficiaries with substantial help in paying premiums. Most LIS-qualified individuals received 100 percent subsidy, and therefore pay no premium for Part D coverage, and small copayments of around $1 to $5.35.

Part D has had a significant impact on the ability of Pharmacy Plus demonstrations to divert seniors from Medicaid and save the requisite dollars to show budget neutrality.

Now the Medicare drug benefit, and not the Medicaid demonstration, is chiefly responsible for diverting individuals from full Medicaid eligibility.

Given the difficulties of establishing and maintaining Medicaid budget neutrality in this new Part D environment, all States, except Wisconsin, have discontinued their Pharmacy Plus programs. With CMS's assistance, Illinois and South Carolina have successfully transitioned their demonstrations into Part D wraparound programs.

CMS has reached out to Wisconsin, and is eager to work with the State to accomplish the same. Several States have worked with CMS to reconfigure or transfer their SPAP coverage or Pharmacy Plus waivers to wrap around the new Medicare drug benefit.

With Part D at its core, States are able to provide beneficiaries the same or better coverage than before at a lower per-beneficiary cost. Currently, 24 States and the U.S. Virgin Islands operate qualified SPAPs to supplement Part D. These SPAPs pay premiums, copayments and deductibles, or fill in the gap for seniors, or some combination thereof.

Wisconsin SeniorCare, the sole remaining Pharmacy Plus waiver, is set to expire at the end of June. The program has helped many individuals. However, it has failed to meet the State's own expectations as a demonstration project.

Enrollment is roughly half of what the State originally projected, and $109 million in State expenditures for 2007 is similarly overstated. In the current fiscal year, Wisconsin will spend only about $35 million on SeniorCare.

Finally, the State's rationale for how SeniorCare would, in fact, accomplish Medicaid diversion appears to have been flawed. More individuals aged 65 and older have enrolled in Medicaid than the State assumed for every year of the demonstration, in spite of the demonstration's generous assumptions of Medicaid enrollment growth for seniors as a comparison point for budget-neutrality calculations.

I greatly appreciate the leadership Wisconsin has demonstrated in providing prescription drug coverage to its most vulnerable citizens at a time when there were no other options.

CMS wants to avoid any interruptions in SeniorCare enrollees' drug coverage, and is committed to partnering with the State to establish an outreach and transition plan in which we can all take confidence, much like we have done in 24 other States.

That being said, we believe the transition to Medicare Part D must be made as quickly as possible. CMS looks forward to working with Wisconsin to transition SeniorCare into a program that wraps around Part D so that Wisconsin seniors experience as little disruption as possible.

I promise to listen, and am happy to answer any questions that you might have.

The CHAIRMAN. Thank you.

Well, as you know, SeniorCare—as I have discussed here this morning—the waiver expires on June 30 of this year. As you know, SeniorCare is a highly, if not wildly, popular program in the State of Wisconsin. Yet, as you have made clear, apparently the intention

on the part of yourself and the Administration is that the waiver will not be renewed.

So we want to know why you would take a program that is so popular, so successful, and clearly not a program that is by any stretch more expensive than Medicare Part D, why would you take a program like this and scuttle it?

Ms. NORWALK. The main reason that we need to change the way that the program is structured is how it is funded.

These individuals, we don't know enough about their assets in terms of whether or not they would qualify for Medicaid or, in fact, whether or not they would qualify for the low-income subsidy under the Medicare program. The State hasn't done any particular analysis around their assets that is specific to the population that has been enrolled.

So, because of that, and because of the increases in the number of individuals or number of seniors who have qualified for Medicaid above what the State assumed, they simply don't meet their budget-neutrality requirements that they had promised to meet in 2002.

In fact, the number of seniors that enrolled in Medicaid far exceeds, by several thousand, the number that they had estimated would be diverted from the program.

Moreover, while I totally appreciate that Pharmacy Plus has been successful in Wisconsin, and I am glad that a program that HHS and CMS began started, the assumptions under which it was made, the GAO has since questioned as being faulty assumptions.

So, one of the things that the GAO said was that, "Neither data from State experience nor other research supports the saving assumptions necessary for budget-neutrality in the Pharmacy Plus demonstrations."

They go on to state that, "Based on conversations with Wisconsin health care financing officials, and a review of documents, we found that the State's demonstration savings estimates were a residual of the budget-negotiating process, derived from determining how much was needed in savings to demonstrate budget-neutrality, rather than from research or data about what was realistic."

As an example of that, the number of people who are eligible for the Medicaid program that are seniors actually declined over the past 4 years. I don't have the number for 2007. Yet, the assumptions that we have put in for meeting budget neutrality show an increase, so we would say that 2 percent more every year would be eligible for Medicaid, and that is how we assumed their budget-neutrality calculations.

But what, in fact, has happened was the opposite. Fewer people were eligible, and yet an increasing number of people actually went on the Medicaid rolls that were seniors.

So the diversion aspect that the State had to meet in order to qualify for this Medicaid demonstration, they failed to meet over the 5 years. That is really the key point.

It is not so much that we don't want to help Medicare beneficiaries in Wisconsin. Of course we do, just like we have done in 24 other States.

But the financing of that help needs to change. The financing of that help needs to come through the Medicare program, and through the State, rather than through Medicaid. These individ-

uals are not likely to qualify for Medicaid if they can't spend down to meet the LIS asset test any more than they would meet the Medicaid asset test.

The CHAIRMAN. The average annual Federal subsidy for a SeniorCare participant is $617, which is about half of what the Federal Government spends to subsidize a Part D participant.

You have talked about some very technical budget-neutrality rules, but isn't it true, Ms. Norwalk, that, at the end of the day, SeniorCare costs the Federal Government less in its current form than it would cost to transfer everyone to Medicare Part D?

Ms. NORWALK. I actually think that analysis is based, if I understand correctly, on an AARP study from May 2005. I would like to point out there are some significant differences that have happened in the past 2 years since the AARP did that study.

To begin with, the Federal budget has saved over $189 billion from its initial estimates of the cost of the program. Moreover, that study is based on a $35 average premium. Well, the average premium now across the country is $22, and in Wisconsin there is a premium for $14.80. So there alone, the costs are overstated for the beneficiary by $240 purely in premiums.

Moreover, the number of plans in Wisconsin that have a $0 deductible are the majority of them. There is even a plan in Wisconsin that doesn't have a coverage gap for a premium under $50.

So I think that there are lots of options that are available for beneficiaries, with or without the SeniorCare program, that the AARP report doesn't take into account when determining savings.

Finally, I think they overstate the amount that it costs the Federal Government, because of the differences in cost that we have seen over the past 2 years. The cost to the Federal Government for a non-LIS beneficiary is actually significantly less than the AARP report recognizes. It is about $892 a year, rather than the—I don't remember the number you just quoted. What is it, like $1,200?

In any event, I appreciate that at the time when the analysis was done, that was the best information that they had. But a significant amount has actually happened under the Medicare Part D program, including satisfaction rates I suspect are very similar to what you are seeing with the SeniorCare program. Every study that we have seen done, every poll, including J.D. Power and Associates, has a satisfaction rating for Medicare of 75 to 80 percent of those who are enrolled.

So we totally appreciate that both programs are critically important to Medicare beneficiaries, and want very much to continue the concept of SeniorCare.

What we have done in States like, say, Pennsylvania, where they have over 200,000 people on their PACE program, which is a similar program to that in Wisconsin, where they can wrap around the Part D program, and people who had PACE before Part D and after Part D see a very similar product.

So, for example, in Wisconsin, you would have a $15 copayment for the brand-name drugs and $5 for generic or perhaps less, depending on the plan that the State worked with.

What I would like to do is move, rather from a discussion about "Gee, SeniorCare has to exist in its current form," is figure out how it is that we can make SeniorCare work with no more cost to the

State by wrapping around the programs that currently exist in Wisconsin to provide seniors with something that looks very similar and is as easy as possible for them, appreciating that a transition can make many people nervous.

But, we have had so much success in the 24 other States we have worked with, we feel that our past experience and that success will bode well for transitioning the Wisconsin program from one that is Medicaid-based to one that is Medicare-based, with some help from the State and the same funds that the State has set aside for this program.

The CHAIRMAN. As you know, Ms. Norwalk, SeniorCare does not have an asset test. If SeniorCare ends, many beneficiaries who move to Medicare Part D will not qualify for the low-income subsidy because of the complicated asset test. They will have higher out-of-pocket costs and could face the dreaded "donut hole," where many seniors will not be able to afford their drugs.

How can you argue that all of Wisconsin's seniors will be better off under Medicare Part D?

Ms. NORWALK. I actually think that what we have seen in other States that have had wraparound programs is that they have seen very similar costs.

Now, every individual is different, and that is one of the reasons that the Part D program has been so successful, is that Medicare beneficiaries have been able to choose a plan that makes the most sense for them: plans that have no deductibles, plans that fill in the coverage gap with both brand and generics, or plans that have very low premiums, like $14.80. Every beneficiary needs something different.

But one of the things that we have found for other States, for the concern about, "How do I choose the right plan?"—even though the Medicare program has provided significant numbers of tools for beneficiaries, including 1–800–MEDICARE, which is available 24–7, and significant help from CMS and our partners across the country—one of the things that many States have done is that the State decided that they would be the authorized representative of the beneficiary.

They said, we will work with these X number of plans that have low premiums or no deductibles, and we will automatically enroll beneficiaries in those plans and work with those particular plans to wrap around their benefits, so that they see the exact same thing that they do now.

They get a card that has "SeniorCare" on it, it has a $15 copayment for brand-name drugs, it has a $5 copayment for generics, or whatever it happens to be, perhaps less depending on the particular plan that the State works with. But we have had such success there that we think the out-of-pocket costs actually may be no more.

Of course, as you know, the SeniorCare program, in many instances, has a deductible that far exceeds the deductible under Medicare. For certain populations, it is $500. For other populations—the higher the income level, of course—it is $850.

Now, most of the plans in Part D in Wisconsin have no deductible. Consequently, there are lots of instances when beneficiaries

have lower drug costs, maybe up to $850, where they would be better off.

Now, I appreciate that the AARP analysis didn't have the benefit of knowing what was going to be offered in 2007. But I think if they took another look at this, they may come out with very different results, as we have done with many other States in working with them to wrap around the Medicare Part D program.

The CHAIRMAN. Well, we are very much appreciative of your willingness to come here and testify and, as I understand, to hang around a little bit to hear some of the subsequent testimony, particularly from the Governor and the panel. It shouldn't take too long, and we hope it will be instructive and that you will find it useful.

Ms. NORWALK. I am sure. Thank you for having me this morning.

The CHAIRMAN. Thank you for being here.

[The prepared statement of Ms. Norwalk follows:]

STATEMENT OF

LESLIE V. NORWALK, ESQ.

ACTING ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

WISCONSIN'S SENIORCARE PROGRAM

BEFORE THE SENATE SPECIAL

COMMITTEE ON AGING

March 28, 2007

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Before the
Senate Special Committee on Aging
On
Wisconsin's SeniorCare Program

March 28, 2007

Thank you Chairman Kohl for inviting me to appear before you and your distinguished colleagues to discuss Wisconsin's SeniorCare Program (SeniorCare), which provides prescription drug coverage to eligible Wisconsin seniors. Prescription drugs are integral to the delivery of safe, modern medical care. For this reason, adding comprehensive prescription drug coverage to Medicare has been among the Centers for Medicare & Medicaid Services' (CMS) highest priorities, culminating with the enactment and successful implementation of the Medicare Part D prescription drug benefit (Part D). The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) made prescription drug coverage available to all Medicare beneficiaries beginning in 2006, the most significant improvement to health care for seniors and people with a disability in 40 years. Currently, more than 90 percent of people with Medicare have coverage for prescription drugs through Part D or another creditable source. Millions of seniors and people with disabilities are using this benefit to save money, stay healthy, and gain peace of mind.

State Initiatives to Provide Drug Coverage Prior to 2006

Prior to the enactment of Medicare Part D, many States played a vital role in offering direct pharmaceutical assistance benefits to their residents. Eligible low-income and medically needy seniors often received prescription drug benefits through Medicaid. States commonly used two other options for extending prescription drug coverage to seniors not eligible for Medicaid: State Pharmaceutical Assistance Programs (SPAPs) and, to a much lesser extent, Medicaid Pharmacy Plus demonstrations under Section 1115 of the Social Security Act.

State Pharmaceutical Assistance Programs: Through SPAPs, many states provided low-income seniors and individuals with disabilities financial assistance for prescription drugs before Part D

was available. These were State-only funded initiatives that varied significantly in terms of eligibility requirements and benefits. Before January 1, 2006, 21 states offered SPAPs that provided subsidies for low-income enrollees to purchase prescription drugs.

Pharmacy Plus Demonstrations: Prior to the establishment of the Medicare prescription drug benefit, CMS worked with States to extend pharmacy coverage to certain low-income elderly and disabled individuals who were not otherwise eligible for Medicaid. Specifically, in January 2002, the Department of Health and Human Services (HHS) and CMS announced a model demonstration called Pharmacy Plus, which allowed states to expand Medicaid coverage for prescription drugs to Medicare beneficiaries and other individuals with family incomes up to 200 percent of the federal poverty level (FPL). These Medicaid Section 1115 demonstrations offer assistance by paying for pharmaceutical products, assisting privately-insured individuals with high premiums and cost sharing, or providing wrap-around pharmaceutical coverage to bring private sources of coverage up to the level of desired demonstration benefit coverage.

The goal of these demonstrations was to test how the provision of a pharmacy benefit to a non-Medicaid-covered low-income population would affect Medicaid costs, utilization, and future eligibility trends. As with other Section 1115 demonstrations, CMS approval for Pharmacy Plus required the State to establish budget neutrality, meaning that the services provided under the demonstration would need to be offset by other savings in the Medicaid program. The overall theory behind Pharmacy Plus was that prescription drug programs for seniors would target scarce resources more effectively because participants would remain healthier, thereby reducing future health care costs that may result in their becoming eligible for Medicaid.

CMS approved Section 1115 demonstrations for Pharmacy Plus in four states -- Florida, Illinois, South Carolina and Wisconsin. Wisconsin's SeniorCare rolled out statewide in September 2002, and provides prescription drug coverage to residents aged 65 and over, with incomes at or below 200 percent of the FPL. Enrollees with incomes up to 160 percent of the FPL pay $5 for generic medications and $15 for brand name medications. Enrollees between 160 and 200 percent of the FPL have $5 generic and $15 brand name co-payments after satisfying a $500 deductible.

Impact of Medicare Part D

The enactment of Medicare Part D has altered the landscape in which states provide prescription drug coverage to the age 65 and over population. Before January 1, 2006, SeniorCare was the only affordable prescription drug coverage option for most lower-income seniors in Wisconsin not qualified for full Medicaid benefits. Today, seniors in Wisconsin and across the country have access to comprehensive prescription drug coverage through Medicare. Individuals eligible for full benefits under both Medicare and Medicaid now receive their prescription drug coverage through Medicare as well. At last count, more than 571,000 Wisconsin seniors, including dual eligibles, are receiving drug coverage through Medicare Part D or another creditable source.

In addition to the standard Part D benefit, many beneficiaries with limited incomes qualify for the Low-Income Subsidy (LIS). Indeed, certain beneficiaries enrolled in Wisconsin's SeniorCare would be eligible for the LIS. The LIS provides substantial help to Medicare beneficiaries with limited incomes, including a generous federal premium subsidy and minimal cost-sharing for covered drugs.[1] Most LIS-qualified beneficiaries receive the 100 percent subsidy, and therefore have no premium for Part D coverage.

CMS was extremely successful in enrolling LIS-eligible individuals into Part D plans in the first year of the program. Of the approximately 13 million beneficiaries CMS estimates were eligible for the LIS in 2006, nearly 10 million now have coverage for prescription drugs. Through ongoing outreach that continues even today, CMS built upon the successes of 2006, enrolling over 300,000 new LIS beneficiaries in advance of the new 2007 benefit year. With the recently extended demonstration and special election period that allows LIS-approved beneficiaries to enroll through the end of 2007 without penalty, we expect that these numbers will continue to grow.

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[1] As required by law, the Low-Income Subsidy is a means-tested public benefit. In order to apply and qualify, Medicare beneficiaries generally must meet both an income and asset test. For 2007, the maximum income to qualify for the LIS is $15,315 for singles with no dependents or $20,535 for married individuals with no dependents. (Individuals with dependents and residents of Alaska and Hawaii have higher income thresholds). Assets may not exceed $11,710 for a single person or $23,410 for a married individual.

Independent surveys show that a large majority (80 percent) of Medicare beneficiaries are satisfied with their Part D coverage, with even higher satisfaction rates among low-income beneficiaries. According to a recent survey, 9 out of 10 dual-eligibles report that their Part D plan works well. Nearly half of the people who reported skipping or splitting dosages prior to Medicare's prescription drug coverage say they no longer have to under Part D.[2]

State Initiatives to Provide Drug Coverage after Part D

With the implementation of Part D, many states faced the question of how to modify existing prescription drug programs for seniors to supplement Part D coverage as authorized by the MMA. Most states chose to reconfigure their SPAP benefits to wrap-around the new Part D benefit. Having Part D as the core benefit for seniors allows many states to provide the same or better coverage as before, at a lower per-beneficiary cost.

CMS has actively worked with a number of states to transition existing SPAPs into Part D wrap-around programs. For example, CMS worked successfully with the Commonwealth of Pennsylvania to allow 300,000 Pennsylvanians in the "PACE" SPAP to continue or enhance their drug coverage at substantial savings to the state. Currently, 24 states and the U.S. Virgin Islands operate "qualified" SPAPs to supplement Part D.

In regulations implementing Part D, CMS also committed to provide a federal matching payment for Pharmacy Plus programs that could continue to demonstrate budget neutrality (as required for Section 1115 demonstrations). For this reason, CMS accepted Wisconsin's request to continue the demonstration until the end of the original five-year term. However, the establishment of a federal Medicare prescription drug benefit had significant impact on the ability of Pharmacy Plus demonstrations to be budget neutral. Specifically, the advent of Part D and the low-income subsidy altered the circumstances under which CMS originally approved SeniorCare because now Medicare Part D, and not the Pharmacy Plus demonstration, is the main source for Medicaid savings by diverting individuals from full Medicaid eligibility. As a result, we believe it would

[2] KRC Research survey for the Medicare Rx Education Network, conducted September 1-7, 2006 and updated January 5-9 2007.

be very difficult for Pharmacy Plus waivers, as they were originally structured, to meet the budget neutrality requirements in light of Part D.

Recognizing this well before the new prescription drug benefit became available, CMS encouraged the four states with Pharmacy Plus waivers (Florida, Illinois, South Carolina and Wisconsin) to determine how the new Part D benefit would impact their programs, to gauge the feasibility of continuing them beyond January 1, 2006, and to determine if they could be transitioned to another type of program to provide assistance to seniors. Given the difficulties in proving budget neutrality after the implementation of Part D, all states except Wisconsin chose to discontinue their Pharmacy Plus demonstrations for dual eligibles. Both Illinois and South Carolina have successfully transitioned their Pharmacy Plus demonstrations to Part D wrap-around programs.

Moving Forward: Wisconsin's SeniorCare Program

The passage of MMA and implementation of Medicare Part D have had a significant impact on state programs like SeniorCare. SeniorCare in Wisconsin is the sole remaining Pharmacy Plus waiver, and is scheduled to expire in July 2007. CMS encouraged states to transition these programs into qualified SPAPs that wrap around Part D coverage as the MMA allows. Illinois and South Carolina have done so successfully. We are eager to work with Wisconsin to effectively implement a similar program for Wisconsin seniors.

I greatly appreciate the leadership Wisconsin has demonstrated in providing prescription drug coverage to Wisconsin's most vulnerable citizens at a time when they had no other options for drug coverage. CMS does not want current SeniorCare beneficiaries to suffer any interruptions in drug coverage, and we are committed to partnering with Wisconsin officials to establish a transition and outreach plan in which we can all take confidence. That being said, we believe the transition must be made as quickly as possible. Wisconsin has deemed SeniorCare as creditable coverage relative to Part D, so individuals transitioning to Part D will not face a late enrollment penalty.

CMS looks forward to working with the state to transition SeniorCare participants into the Medicare Part D program and to develop a wrap-around program that coordinates with Medicare Part D.

Thank you and I would be happy to answer any questions.

The CHAIRMAN. We now move to our second panel, which will be the Governor of Wisconsin, Jim Doyle. Jim Doyle is the former Wisconsin attorney general, and he is now in his second term as our Governor.

Governor Doyle has worked diligently to save and expand the SeniorCare program. He is a very strong proponent of it. His efforts prove how strongly he feels about its very important role in our State's health care system. We certainly do thank him for following that conviction to make this journey here to Washington to testify before this Committee today.

With that, we would like to hear from you, Governor Doyle.

STATEMENT OF JIM DOYLE, GOVERNOR OF WISCONSIN

Governor DOYLE. Good morning, Senator. Let me express my deep thanks to you for this hearing and for the work that you have done for seniors in Wisconsin, and particularly for SeniorCare.

I want to also acknowledge and thank Ms. Norwalk.

We continue to hope that we are going to be able to convince CMS that extending the waiver for SeniorCare for 3 more years is the best thing, not only for seniors in Wisconsin, but also the fact that we can do this in a manner that saves the Federal Government money and saves the State of Wisconsin money.

I am currently here with a cane because I am currently in rehab for a little hip procedure that I had. Yesterday, I was in the pool at the rehab center. I had one of these instances that I know you, Senator, have frequently, where I was there and there was a class of seniors in the warm-water pool who were going through their exercises. They noticed that I was over in the other pool doing my rehab work, and you could tell people were talking with each other.

As they came out of their pool at the end of their class, I would say about three-quarters of the group—I would think it was about 20—about 15 of them came over to me and said, "Please save SeniorCare. Please save SeniorCare." It was only one more instance of what happens to me frequently and, I know, to you as well, Senator, as you go though Wisconsin.

All of us in Government appreciate the fact that there are often programs that work that people are very concerned about, and aren't tremendously favorable toward the Governmental program.

In my experience as Governor, SeniorCare is the singularly most popular program, in which more people come up to me who are either enrolled in it themselves or who are sons and daughters of parents who are enrolled it it, who want to talk about what a positive experience SeniorCare has been.

I don't think I have, in my time—and you could draw on your own experience—I don't think I have had a single negative comment made to me about SeniorCare, and yet hardly a day goes by that I don't have people talking to me in a positive way.

I say this because one of the purposes we often hear talked about in Washington is about how States should be laboratories and how we should be able to develop programs in our States that help lead the Federal Government toward good policy.

While we recognize all of the work that has been done on Part D—and in Wisconsin, we have certainly lived up to our obligations, and we have had senior specialists, and you will hear from some,

who have spent a lot of time working to make sure that people are participating in Part D and are enrolled in the right program. We have done a lot of that work in Wisconsin.

But I also hope that we all recognize that maybe Part D isn't exactly the way we might want it to be in the end. As we work toward furthering, improving nationally, how we provide prescription drug care for seniors, that it is good to have some programs like SeniorCare out there that serve as models and serve as places that policymakers can go and look and think about how they might want to improve Part D as we move forward, and have some options.

In fact, there is really only one left, in SeniorCare. But I hope it is one that the Federal Government recognizes the importance of maintaining for purposes of having some other alternatives and some other places that they can look to for developing policy.

You know, since 2002, Wisconsin has been a National model for providing affordable, comprehensive drug coverage to older citizens through our SeniorCare program, and it has proven to be popular, efficient and cost-effective.

In fact, when the Federal Government started offering its own coverage through Medicare, SeniorCare's enrollment didn't go down, it went up. So today, more than 105,000 seniors trust and rely on this program for lifesaving medicine at prices they can afford.

Again, I really want to acknowledge and thank Ms. Norwalk and people at CMS, who have worked with us.

One of the things that we did as part of our agreement with CMS to continue SeniorCare was to develop a wraparound program. Compared to the other 24 States with wraparound programs, our wraparound programs was developed by working and looking at those States.

But compared to SeniorCare, the wraparound program has such little popularity that we couldn't even get bidders to come in to bid on the wraparound program in Wisconsin.

So, I think that really tells you where the marketplace is on this in Wisconsin. People vastly, vastly prefer SeniorCare. As I say, since Part D came into place, our SeniorCare enrollment has gone up significantly.

As you know, SeniorCare operates under a waiver from the Federal Government that is expiring soon. I want to thank and acknowledge that Secretary Leavitt and I were able to work out an agreement that allowed SeniorCare to continue past January 1, 2006. I thank the Secretary for his consideration and for allowing that and for at least giving us a fighting chance to be in the position that we are right now to have SeniorCare continue.

But without additional action from the Bush Administration, the waiver will end on June 30 and our 105,000 citizens who are on SeniorCare will face a new world. Most of them will be forced into the Medicare Part D program, and we believe that they will face higher payments, they will face more complicated bureaucracy, and some of them will face the donut hole.

I don't think you will find a voice in Wisconsin of either political party that doesn't agree that SeniorCare is the preferable program.

Throughout the past year, as our seniors had to choose between SeniorCare and Part D, they overwhelmingly chose SeniorCare.

During that time, SeniorCare enrollment increased over 26 percent. We believe it is obvious why: An AARP study found that 94 percent of SeniorCare participants are better-served under SeniorCare than they would be under Medicare Part D.

As you do, Senator, and as I mentioned earlier, I talk to seniors all over the State. They love SeniorCare, and they are obviously very concerned about what will happen to them if it is taken away.

I believe the argument for SeniorCare is compelling. While the Medicare drug plan tends to be complex and bureaucratic, SeniorCare is very simple to administer and easy for people to navigate. While the Medicare plan is expensive and comes with the donut hole, SeniorCare has no gaps in coverage and much lower out-of-pocket costs.

While the Medicare plan makes it illegal for the Federal Government to negotiate lower drug prices, in Wisconsin, we use that very negotiating power to be able to get big discounts on the most commonly prescribed drugs. Because of our very low administrative costs and the discounts we negotiate, the program is not only affordable for seniors, but it saves taxpayers money.

The fact is, at the heart of our request for an extended waiver is this fact of lower costs. Both seniors and the Federal Government will spend more by ending SeniorCare than by extending it. In the State fiscal year 2006 alone, SeniorCare reduced drug costs for Wisconsin seniors by almost $200 million. Of the $253 million in drug costs billed to the SeniorCare program in fiscal year 2006, the Federal Government paid only $46 million, or about 18 percent, of those total drug costs after the rebates are taken into account.

In fact, the average annual Federal subsidy for the SeniorCare waiver participant is $617. The Federal Government pays almost twice as much as that under Medicare, or about $1,200 per senior.

The SeniorCare waiver has consistently achieved budget neutrality, which is the requirement for these waivers. Our most recent analysis shows that the program saved about $669 million in Medicaid funding through the fourth year of the waiver.

These savings are the direct result of reduced Medicaid costs for health care services, because seniors with SeniorCare prescription drug coverage have stayed healthy longer and have saved us Medicaid costs.

We are projecting that the savings to Medicaid will continue to be significant under the proposed waiver extension for State fiscal years 2008 through 2010. As shown in our waiver application, there are projected savings of $697 million to the Medicaid program alone during the waiver extension period. These savings translate into $404 million in reduced Federal expenditures.

Last June, I asked the Federal Government to consider continuing the waiver, and in October, we submitted our formal application for our 3-year extension. To date, formally what we have received is a brief letter from the Department acknowledging the receipt of our waiver extension application.

So I thank you for today's hearing, and I hope I can shed some light on this urgent issue, and I hope it can be part of our effort to persuade the Secretary and CMS to extend SeniorCare. With

their approval, we will continue to receive Federal funding for the program. Without their approval, we will lose our Federal match, and this extremely successful and popular program will cease to exist.

Again, I want to emphasize how important it is for the States to be laboratories, and for us, particularly with SeniorCare, where we have demonstrated that without asset qualifications, that we are able to reach seniors and provide them with a very simple, good and effective program.

Of course, we are going to continue to work with you, and we will continue to work with CMS, and we will do whatever ultimately we are required to do.

But I do hope that we continue SeniorCare in Wisconsin and continue it as an example for the Federal Government and for you, Senator, and other Members of Congress to be able to continue to look at as we look for ways to improve providing prescription drug coverage for seniors, not only in Wisconsin but across the United States.

I want to thank you, Mr. Chairman, for your tireless support of SeniorCare and for giving our citizens a strong voice in Washington. I continue to look forward to working with you and other members of our delegation of both political parties to make sure that seniors in our State can continue to get affordable, comprehensive drug coverage.

I know that these budget-neutrality issues can get very complex, but I would hate to see SeniorCare get lost in an argument between Medicaid and Medicare. For most people in Wisconsin, and certainly people on SeniorCare, the argument about whether this is Medicaid or Medicare, which—we all understand or deal with these budgets, but it kind of gets lost. They see it as Federal Government and State Government and a program in which the Federal Government has very successfully partnered with the State Government to provide really meaningful coverage for seniors in Wisconsin.

SeniorCare, to me, is the example of the program we should be looking for, where the State of Wisconsin has stepped up. I want to emphasize that even in very, very difficult budget times—and when I first became Governor, our State faced the worst budget crisis in its history, and there was pressure. We really had to decide what our priorities were, because we had to make very, very deep cuts.

But even in that very, very difficult time, Wisconsin put its money into the SeniorCare program. Even in that time when everything else was getting cut, our priority was the preservation of SeniorCare.

I am very proud that we came through that very difficult time with SeniorCare not only intact, but a growing, strong program. It shows the commitment that the State of Wisconsin has made to this very, very important issue of providing comprehensive prescription drug coverage for our seniors.

It also shows the commitment that the Federal Government—and again, I want to emphasize, of both political parties—that the Federal Government has made to this program as well. Together,

we have developed a very, very strong and a very, very popular program in Wisconsin.

I hope that we are able to persuade CMS and the Secretary that this is a program fully worthy of being continued for 3 more years.

Again, thank you very much, Senator Kohl. I appreciate that you have taken your very valuable time to really explore this issue and to come to an understanding of how important SeniorCare is, I believe not only to the people of Wisconsin, but SeniorCare stands as a model of something that can be very helpful to the entire United States.

Thank you.

The CHAIRMAN. That is a very good statement, Governor Doyle.

The question I want to ask you surrounds the issue of, why is this being done? I mean, you have made a very, very powerful point, and it is clearly a fact, that SeniorCare is enormously successful, wildly popular and, according to every analysis, not expensive compared to Medicare Part D.

So we have over 100,000 people who are enrolled. It is a growing enrollment program. Every one of those 100,000-plus are happy with the program, don't want to see it eliminated.

As you pointed out, States are laboratories, and this is certainly a successful kind of a health care experiment that does work.

The people at CMS—Ms. Norwalk, who is here, and others, Secretary Leavitt—they are smart people. I think they have an awareness and an understanding of this program's success in Wisconsin.

So cutting through all the technicalities, trying to understand in real-life terms what we are talking about here, in your opinion, why are they moving, if not having decided, moving in the direction of scuttling this program?

Governor DOYLE. In my opinion, I believe that there is tremendous pride in Part D and a tremendously strong desire to show that Part D has accomplished everything for everybody. So, I think we are really fighting against very strong momentum to show that Part D can be used in ways to cover all problems and to do it very well.

Now, we all know what we have been through in Wisconsin with Medicare Part D, and you will hear from a panel later, and I don't know to what extent they will touch on this, but this has been a very, very difficult time for seniors.

We have been good partners—I want to really emphasize this—with CMS and the Secretary. Because we didn't just sit back and complain that Part D is a mess, which in many ways it was, but we really did—we increased our number of senior specialists dramatically in the State who were out there working with people.

I know your office and our other Congressional delegation, we worked hard, because it is important. If Part D is the vehicle for getting this done, then we wanted to get as many people enrolled in the right program in Part D.

But I think we all have to understand, there are some very big shortcomings to Part D. To try to sort of jam everybody into this system creates some real difficulties.

So I think, again, I appreciate—and I want to express my thanks to Secretary Leavitt, who did go out of his way to allow SeniorCare to continue after January 1, and to allow it to at least give us a

fighting chance to be here. I want to express my thanks to the Secretary for doing that.

But I think what we are practically up against is a real desire by this Administration to show the world that Part D is a great thing, and yet we have a few—we actually only have one that is left out there, like SeniorCare, which says, "Hey, you know, maybe Part D is or is not a good thing, but there are some other ways to go about doing this." At least in SeniorCare, it is actually an easier, more understandable and a better way to do it.

So I think we are kind of up against the whole big Part D machine here, and that is kind of what we are trying to just say: "Well, let us just be one little voice out there that says that whatever you think of Part D, one way or another, that there is a way that we have found to do this in Wisconsin that actually works better." I hope that that voice prevails.

The CHAIRMAN. That is very good. Well, we appreciate your being here today.

Ms. Norwalk is seated behind you, and of course, she is a fine woman, and probably doesn't agree with your conclusions. I would ask if she wishes to make a response now, because this is a chance to have an informal exchange.

Do you want to say a word or two or three, whatever is on your mind? Then we will go to the next panel. But we thank you for your willingness to come forward once more and make a few remarks.

Ms. NORWALK. Sure. Happy to be here.

We certainly do appreciate all the help that we have had from the State of Wisconsin in terms of Part D.

I appreciate that your perspective, Governor, that this is all about Part D.

It is really about whether the Medicaid program should be paying for individuals that would highly unlikely be able to qualify for Medicaid, either from an asset reason—although I appreciate that you may not have the specifics there, not having surveyed them. But that aside, there is another program, and that other program would, I think, be the reason that people did not qualify for the Medicaid program.

You did mention something about negotiating, and I do want to clarify the negotiation point for Part D, because it is widely misunderstood.

The prescription drug plans negotiate on behalf of Medicare beneficiaries every day to the tune of billions of dollars in price concessions, including things like rebates. So the Part D program, one of the reasons it is much less expensive than originally estimated is because of the large price concessions they have been able to extract from prescription drug manufacturers.

I am glad that the State also has had success in getting rebates for the seniors in Wisconsin for the SeniorCare program, but likewise, the Part D program has had great success in doing that.

That is why you see premiums much lower than the AARP report estimated. That is why I think the AARP report and some of the numbers that we have been discussing today are very overstated both in terms of Federal costs, as well as in terms of beneficiary costs.

I appreciate that whatever happens, it is not so much that we want SeniorCare to go away, we want SeniorCare to be transformed into a different sort of program than it is, still with the State's help so that beneficiaries in Wisconsin are no worse off than they are today.

I think that there are lots of examples of how we can do that in different forms, and look forward to working with the State to end up with just that result.

Thank you.

The CHAIRMAN. Last comment, Governor Doyle?

Governor DOYLE. Well, I know Ms. Norwalk has this argument all the time about the negotiations, and she can debate Members of Congress. But I would say, could you imagine if the Federal Government actually, on behalf of all potential Medicare recipients, was the one out negotiating, what those discounts would be? But that is not our issue before us today.

I do want to talk about the Medicaid-Medicare issue, if I could, for just a moment.

Wisconsin made a decision not to asset-test. CMS has now been asking us to go back, as Ms. Norwalk just mentioned, and to do a survey of people to see how many, if the asset test was applied, would no longer be eligible for Medicaid prescription drug assistance.

We have been very reluctant to do this. I think you can appreciate this, Senator, because even if we go out and start surveying people on this, it really cuts to the very core of what SeniorCare is designed to do.

I also believe, and I believe we have demonstrated this to CMS, that by not having the asset test for SeniorCare and allowing people to get their prescription drugs easier, we keep many people out of Medicaid-funded nursing care and other cares for much longer periods of time.

That is really where we save the Federal Government Medicaid money. Because these people would, if asset-tested, would eventually have to spend down those assets and go into Medicaid.

This is how, in 2002—we are not changing the rules of the game here—this is how in 2002, a prior Administration, and a Republican Administration, in Wisconsin demonstrated budget neutrality in 2002. That is how we are demonstrating again, as we go for our renewal in 2007.

So this is something that we have been trying to engage CMS in. Again, Ms. Norwalk and her team have worked with us in a lot of different ways, and we really want to express our appreciation for that.

But I do think that the non-asset-tested SeniorCare demonstrates that over time, we do keep people who would then spend down those assets and become Medicaid-eligible, we keep them out of Medicaid for a longer period of time, save the State money and, obviously, save the Federal Government a lot of Medicaid money to do it.

That is what we have been working to demonstrate to CMS. That is what was demonstrated back in 2002 with the original budget neutrality of this program for the waiver, and that is the same standard that we are working on now.

The CHAIRMAN. OK, well, in my personal life I have always operated under the principle that it is smart to give a woman the last word. [Laughter.]

Ms. NORWALK. Bless you.

The CHAIRMAN. So this will be the last word. Go ahead.

Ms. NORWALK. Thank you.

Just to address that particular point that the Governor raised, now that we have 5 years of experience with the SeniorCare program, it is not so much that we were suggesting that SeniorCare should have had an asset test all along, but rather that, with that 5 years of experience, if we knew more about who was enrolled in SeniorCare, we could do a number of things.

One, figure out whether or not their assets were such that they would have actually spent down to Medicaid. We are not sure about that, because we don't know. I don't know if they have very expensive homes, or whatever it happens to be. If it is, that is fine from the SeniorCare program perspective.

But when we are looking at a couple of things: both whether or not they would be able to spend down to the Medicaid program for purposes of comparing SeniorCare, with or without the waiver, whether SeniorCare existed or not, what would have happened with Medicaid and the numbers of people who enrolled who were seniors; and then second, for determining—both of you raised this point—in terms of who is better off under the Medicare program, and given that the limited-income subsidy help, you pay no premiums and you pay only very small copayments.

In fact, the copayments you pay under the LIS program in Medicare are significantly less than the copayments that are paid under SeniorCare. Because we don't know the asset information about that, we don't know actually how many of those in SeniorCare might be better off under the Medicare program.

So for both purposes, we thought that asset question was very important and critical for determining, after 5 years of experience, whether or not they were actually budget-neutral in terms of the number of people on Medicaid and who would be better off under the Medicare program, not so much that we expected SeniorCare to have an asset test.

But it was an important piece of information for us to do the analysis to figure out, on a go-forward basis, whether or not they could continue to meet budget-neutrality, now that we aren't starting from scratch in 2002 but have 5 years of experience.

Given the GAO's concern, thought that it would be important for us to find out that information, because the GAO thought that our assumptions were, in fact, significantly more generous than they would have preferred for the State.

The CHAIRMAN. Thank you so much for being here. This testimony has been extremely important, and thanks a lot.

Governor DOYLE. Thank you, Senator.

Ms. NORWALK. Thank you.

[The prepared statement of Governor Doyle follows:]

JIM DOYLE
GOVERNOR
STATE OF WISCONSIN

Testimony of Governor Jim Doyle
Hearing on SeniorCare
United States Senate Special Committee on Aging
March 28, 2007

Let me begin by thanking Chairman Kohl for holding this important hearing. Wisconsin couldn't ask for a stronger advocate in Washington than our senior Senator, and I know Wisconsin's seniors are grateful for everything you're doing to protect this program.

Since 2002, Wisconsin has been a national model for providing affordable, comprehensive drug coverage to older citizens through the SeniorCare program. It has proven popular, efficient, and cost-effective. In fact, when the federal government started offering its own coverage through Medicare, SeniorCare's enrollment didn't go down ... it went up. Today, more than 105,000 seniors trust and rely on this program for lifesaving medicine at prices they can afford.

SeniorCare operates under a waiver from the federal government that is expiring soon. Last year, Secretary Leavitt and I worked out an agreement that allowed SeniorCare to continue to continue past January 1st of 2006. But without additional action from the Bush Administration, the waiver will end on June 30th, and 105,000 of our citizens will lose their coverage. Most of them will be forced into the Medicare Part D program, where they'll face higher payments, more complicated bureaucracy, and of course, the donut hole.

Everyone in Wisconsin agrees that SeniorCare is a very effective program. Throughout the past year, as our seniors had to choose between SeniorCare and Medicare Part D, they overwhelmingly chose SeniorCare. During that time, SeniorCare enrollment increased over 26 percent. And no wonder -- an AARP study found that 94% of SeniorCare participants are better served under SeniorCare than they would be under Medicare Part D. I talk to seniors all over the state who love their coverage, and don't know what they'll do if it's taken away.

The argument for continuing SeniorCare is clear:

- While the Medicare drug plan tends to be complex and bureaucratic, SeniorCare is simple to administer and easy for people to navigate.

- While the Medicare plan is expensive and comes with a donuthole, SeniorCare has no gaps in coverage, and much lower out of pocket costs.

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- While the Medicare plan makes it illegal for the federal government to negotiate lower prices, in Wisconsin we use our buying power to get big discounts on the most commonly prescribed drugs.

- Because of the low administrative costs – and the discounts we negotiate – the program is not only affordable for seniors, but it saves taxpayers money.

That fact is at the heart of our request for an extended waiver. Both seniors and the federal government will spend more by ending SeniorCare than by extending it.

In state fiscal year 2006 alone, SeniorCare reduced drug costs for Wisconsin seniors by almost $200 million.

Of the $253 million in drug costs billed to the SeniorCare program in State Fiscal Year 2006, the federal government paid only $46 million -- or about 18% of total drug costs -- after the rebates from drug companies are taken into account. In fact, the average annual federal subsidy for a SeniorCare waiver participant is $617. The federal government pays almost twice as much under Medicare – nearly $1200 per senior.

The SeniorCare waiver has consistently achieved budget neutrality, which is a requirement for these waivers. Our most recent analysis shows that the program saved $669 million in Medicaid funding through the fourth year of the waiver. These savings are the direct result of reduced Medicaid costs for health care services because seniors with SeniorCare prescription drug coverage have stayed healthier longer.

We are projecting that the savings to Medicaid will continue to be significant under the proposed waiver extension for state fiscal years 2008 through 2010. As shown in our waiver application, there are projected savings of $697 million to the Medicaid program alone during the waiver extension period. These savings include $404 million in reduced federal expenditures.

Last June, I asked the federal government to consider continuing the waiver, and in October, we submitted our formal application for a three year extension. To date, the state has only received a brief letter from the Department acknowledging receipt of the waiver extension application.

I hope today's hearing can shine the spotlight on this urgent issue, and help persuade Secretary Leavitt and Centers for Medicare & Medicaid Services to extend SeniorCare. With their approval, we will continue to receive federal funding for the program. Without their approval, we would lose our federal match and this extremely successful and popular program would cease to exist.

Again, I want to thank you, Mr. Chairman, for your tireless support of SeniorCare, and for giving our citizens a strong voice in Washington. I look forward to continuing to work with you – and other members of our congressional delegation – to make sure that seniors in our state can continue to get affordable, comprehensive drug coverage.

The CHAIRMAN. So we will now move to our third panel.

Our first witness will be Bette Linton, a SeniorCare beneficiary from Fitchburg, who we are fortunate to have in Washington today.

Our second witness will be Tom Frazier, the distinguished executive director of the Coalition of Wisconsin Aging Groups, a Statewide nonprofit, nonpartisan federation of over 600 member organizations. The Coalition is involved in education, training, leadership development and advocacy for Wisconsin's aging network.

Our third witness will be Patricia Finder-Stone, the AARP Wisconsin State president. She is a registered nurse and a Green Bay-area resident for nearly 50 years. Ms. Finder-Stone is familiar with the concerns and challenges facing our aging community in Wisconsin.

So we thank you all for being here.

We will start, Bette, with your testimony.

STATEMENT OF BETTE LINTON, SENIORCARE BENEFICIARY, MADISON, WI

Ms. LINTON. Thank you, Senator Kohl, for inviting me to one of the most beautiful capitals in the world. It is a privilege to be here at this time, when the cherry blossoms are in bloom. I am happy to represent the SeniorCare plan.

Sometimes, we think that good health is simply the absence of illness. If you were asked today, "Are you healthy?", most of us would respond, "I hope so," or "I think so."

Being healthy, in my view, is a way of living that emphasizes taking steps to prevent illness and to prolong our lives. These steps enable us to achieve a state of well-being given our own individual set of circumstances.

Each stage of life has its own challenges. With the development of new drugs, diagnostic and surgical techniques, as well as the advances in medicine, we are offered new ways to prevent illness and to prolong and enjoy our lives. But the downside of this is that the cost of health care is soaring.

So here is my experience.

Prior to a fall that I had last year, I had been taking two prescription drugs routinely, one for acid reflux and the other for an occasional urinary tract infection. The medication for reflux came to about $140 a month, $1,680 per year, which came out of my own pocket. On a monthly Social Security check of just $648, it was a significant expense.

Exactly one year ago last Friday, I dropped an empty laundry basket while I was going upstairs. In trying to retrieve it, I stepped backward three steps and landed on a hard concrete floor. I broke my right femur in three places and lay for 1½ hours before someone came home, called an ambulance and took me to a hospital.

The pain was intense. Today, I have a long steel rod, four screws and a plate in my right leg. Before flying to Washington, I wondered what the security door through the airport was going to sound like. [Laughter.]

While in the hospital and the nursing home for rehab, I was given pain medications as well as pills to help me sleep. Ambulation during the past year has taken me from a wheelchair to a

walker and, finally, my cane. Once at home, the home health agency installed grab bars and benches to ensure my safety.

That summer, last summer, a nurse introduced me to the SeniorCare plan. As I said before, for several years I have been paying significant costs for the medications I mentioned earlier. The SeniorCare plan offered me huge savings.

Someone—because I am not very good at figures—compared the cost of my medication under Medicare Part D with the costs under SeniorCare. Under Medicare Part D, the cost of my medication and premiums would be $684 a year under the least expensive plan. With SeniorCare, the cost would be $180 per year, an impressive savings for me of $504.

So who has helped me pay for these costly expenses? Medicare helped with hospitalization, rehab and some home health assistance. Living on a Social Security check of just $648, I might have had to live in a small rented room with limited options for quality living, but I am one of those very fortunate senior citizens: My son has given me a room in his home 4 days a week, and my daughter cares for me from Friday through Sunday noon.

My daughter was the nurse who introduced me to the SeniorCare plan. But, you know, when I think of the elderly people who have to take many, many medications each day and who must decide whether they can afford medications or buy a preferred meal, I know that I am truly blessed.

Earlier, I stated, "Being healthy is a way of living that emphasizes taking the right steps to prevent illness and to prolong life." I believe that my SeniorCare plan has enabled me to achieve this goal—and I had my card right here, but I can't find it now. Anyway, I value my SeniorCare plan very much.

Thank you for having me this morning.

[The prepared statement of Ms. Linton follows:]

TESTIMONY
OF
BETTE LINTON
BEFORE
THE UNITED STATES SPECIAL COMMITTEE ON AGING
MARCH 28, 2007

Sometimes we think good health is simply the absence of illness.

If you were asked "Are you healthy?' most of us would respond, "I think so, or I hope so!" Being healthy is a way of living that can cause stress. When we take steps to prevent illness and prolong our lives, this enables each of us to achieve a state of well-being.

With the development of new drugs, diagnostic and surgical techniques, as well as advances in medicine, we are offered ways to prevent illnesses, prolong our lives and attempt to live happily ever after.

The downside of this is that the cost of health care is soaring.

Prior to a fall I had last year, I had been taking two prescriptions routinely, one for acid reflux and the other for occasional urinary tract infections. The medication for reflux alone came to about $140 per month, or almost $1700 per year, which came out of my own pocket. On a monthly social security check of just $648.00, it was a significant expense.

Exactly one year ago last Friday I dropped an empty laundry basket, when going upstairs, and in trying to retrieve it stepped backwards down three stairs on to a very hard concrete floor. I broke my right femur in three places and lay there for one hour and 30 minutes before someone could get an ambulance to take me to a nearby hospital. The pain was intense. Today I have a long steel rod, four screws and a plate in my right leg. Now I think, what will it be like going through the security doorway when I fly?

While in the hospital and the nursing home for rehab, I was given pain medications as well as medications to help me sleep. Ambulation during the past year has taken place by way of the wheelchair, walker, and cane. Once in my home, I had the assist of a home health agency to install grab bars and benches to insure my safety.

That summer a nurse introduced me to the Senior Care Plan. For several years I had been paying significant costs for my reflux medication (Aciphex), but I was presented with a plan that could save me huge amounts. I compared the cost of my medication under Medicare Part D with the cost under SeniorCare. Under Medicare Part D, the cost of my medications and premiums would be $684 a year under the least expensive plan. With Senior Care, my monthly cost for this medication is only $15, or about $180 per year - an amazing savings for me of $504 per year!

So who has helped to pay for these costly medical expenses? Medicare helped with the hospitalization, rehab, and some home health assistance. With my small social security check, I might be living in some small rented room, with poor nutrition.

I am one of those very fortunate senior citizens. My son has given me a room in his home, and even though he has included me in his company "family" health insurance plan, there was no coverage for my medications there. I have been blessed to have this support system, but I think about many elderly people who do not have these benefits, or those who are on many, many medications for their illnesses, or those who have to choose between the right foods to buy or what medications they can afford this month.

I'm sure it is absolutely understandable why I value my Senior Care Card.

Bette Linton

The CHAIRMAN. That is a great statement, Bette. Thank you so much for coming here to make it.

Tom, let's hear from you.

STATEMENT OF TOM FRAZIER, EXECUTIVE DIRECTOR, COALITION OF WISCONSIN AGING GROUPS, MADISON, WI

Mr. FRAZIER. Good morning, Senator. I am pleased to be here today. Thank you very much for inviting me.

I want to make the point that thousands of older people in Wisconsin would suffer significant harm if Wisconsin's SeniorCare waiver is not extended.

In preparing for this testimony today, I asked for stories about people, and I would like to just give you three. I have many, but I would like to give you three stories.

The first is a woman on SeniorCare, takes four generic drugs and four brand-name drugs, and her annual cost under SeniorCare is about $990. The cheapest Part D plan would cost over $5,000, a difference of over $4,000. She does not qualify for the extra help due to assets.

A 75-year-old widow takes six medications for high cholesterol, osteoporosis and a heart condition. Her income is actually below the Federal poverty level, but she recently sold her home and moved into an apartment, so she does not qualify for the extra help, again, due to those assets. The least costly Part D plan would cost her over $4,000 a year in out-of-pocket expenses. Under SeniorCare, she would pay $960 a year, a difference of over $3,000.

Another SeniorCare enrollee actually wanted to see if she would actually be better off in Part D. So she and her husband's combined income would require an $850 deductible under the SeniorCare program before she would qualify for the assistance. Under SeniorCare, her costs are about $2,500 a year. Under Part D, her costs would be about $7,300 a year in premiums, copayments and deductibles. Needless to say, she chose to stay in the SeniorCare program.

The worst thing is that the people who can least afford their prescriptions will be the ones hurt the most, and that is the major point I want to make today.

Out of the 104,000 people on the SeniorCare program in Wisconsin, 48,000 of them, nearly half, fall into what we call Level 1, which is an income of $16,000 or less per year. Those people pay a $30 enrollment fee, and then they pay a $5 and a $15 copayment for a generic or a brand-name drug. If they don't qualify for extra help under Part D, they will have a deductible, a copayment, a monthly premium, and no help if they are unfortunate enough to reach the donut hole.

One of the factors in Wisconsin that is somewhat unique, we are the second-worst State in the country in getting our applications for extra help approved. Over two-thirds of our applications are denied, and that is one of the reasons.

We think that is largely due to the asset test for Part D, which is so low—$7,600 for an individual and $12,000 for a couple. It is just extremely low, and for some reason, I guess, older people in Wisconsin have managed to save a little bit of money in their golden years.

The other thing is, as you have already heard, and I don't want to belabor this, but the SeniorCare application and process is simpler. This is the SeniorCare application: one page, back and front. This is the extra-help application for the Social Security Administration. We have a cover letter, we have a page of instructions, we have five pages of actual application. Then, of course, we do have the paperwork reduction notice at the end of it. [Laughter.]

SeniorCare is popular because it costs less, both for individuals and the Government, it is simpler to use, it covers almost every drug that somebody needs to take, and, as you have heard, there is no donut hole.

In summary, thousands of low-income older persons will face much higher out-of-pocket costs, and I think you heard the examples: $3,000, $2,000, almost $5,000. Those people will not be able to afford their prescription drugs, and I don't think the Federal Government, the State Government, or anybody wants that to happen.

I think there are two compelling reasons to continue SeniorCare.

First, it costs less, so why should we change it?

Second, CMS defends Part D on the basis of choice. "We need to give people choice. One plan does not fit everyone." I have heard that time and time again. We have already got 54 Part D plans to choose from in Wisconsin. Why don't we just consider SeniorCare as choice number 55 and let them have one more choice?

A lady from northwestern Wisconsin may have said it best. "Without SeniorCare, I couldn't possibly make it. My monthly income is so low, I can barely get my bills paid." If she is forced off SeniorCare, Senator, I can assure you she will not get her bills paid, and that would be a shame. It would be a shame that our Government has let her down.

Thank you.

[The prepared statement of Mr. Frazier follows:]

Coalition of Wisconsin Aging Groups
Advocacy ▪ Membership ▪ Elder Law

TESTIMONY

OF

Tom Frazier

Before

THE UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

WISCONSIN'S SENOR CARE PROGRAM

Extension of Waiver

March 28, 2007

Good Morning. My name is Tom Frazier and I am the executive director of the Coalition of Wisconsin Aging Groups located in Madison, Wisconsin. CWAG (Coalition of Wisconsin Aging Groups) is a grassroots, nonpartisan elderly advocacy organization whose mission for the past 30 years has been to work on behalf of frail and elderly persons who are unable to speak for themselves on issues affecting their quality of life in Wisconsin.

Thousands of older people will suffer significant harm if Wisconsin's SeniorCare waiver is not extended past June 30, 2007. Similar to the statement that you just heard from Bette Linton, there are more stories just as compelling. For example:

1. *A woman on SeniorCare takes four generic Rxs and four brand name Rxs and her annual costs are $990 (960 in co-pays and the $30 SeniorCare enrollment fee). By comparison the cheapest Part D plan for this woman would cost $5,133, a difference of $4,143. The woman is a diabetic and must have these medications. She would not be eligible for Part D extra help due to assets.*
2. *A seventy-five year old widow takes six medications for high cholesterol, osteoporosis and a heart condition totaling over $6,000 a year. The woman's income is less than the federal poverty level but she recently sold her home so*

would not quality for Part D extra help. Under the least costly Part D plan, she would have out-of-pocket costs exceeding $4,000 per year. Under SeniorCare Level I she would pay $960 a year, for a savings of over $3,000.

3. *Another SeniorCare enrollee wanted to see if she would be better off buying a Part D Rx drug plan. She and her husband's combined income put her in SeniorCare Level 2b which requires an $850 deductible before qualifying for assistance with Rx drug costs. Under SeniorCare her costs were $2,500 a year including the $30 enrollment fee, the $850 deductible and $5 and $15 co-pays for each Rx. Under Part D she would have had to pay $7,300 for premiums, co-payments and deductibles—a savings of $4,800. Needless to say, the lady decided to remain on the SeniorCare program.*

The worst part is that the people that will be hurt the most are the ones who have the lowest incomes and can least afford a huge increase in out-of-pocket costs for their Rx drugs. Out of 104,000 older persons enrolled in SeniorCare, 47% or over 48,000 persons, have incomes below 160% of the Federal Poverty Level (FPL). This is an annual income of only $16,336 for an individual. Under SeniorCare, they have an annual enrollment fee of $30 and then pay $5 co-payment for a generic prescription and $15 for a brand name prescription.

As mentioned in the examples cited above, under Part D (if they are ineligible for the "extra help" or low-income subsidy) they will have a deductible of $265, a monthly premium (that averages $36 in Wisconsin), a 25% co-payment on the cost of the next $2,135 worth of drugs and then no help if they are unfortunate enough to reach the donut hole.

Another relevant factor in Wisconsin is that we have the second worst record in the country in terms of applications for extra help being approved—just over one-third (35.4%) of applications are approved by the Social Security Administration. This means that the vast majority of the lowest income seniors would not be eligible for extra help under Part D and, therefore, would face significantly higher out-of-pocket costs. As you have also heard, many SeniorCare enrollees with incomes over 160% FPL also would face much higher costs.

Cost is not the only concern. SeniorCare requires the completion of a two-page application form and, unlike Part D, does not include an asset test. The application for Part D extra help is five pages, a cover letter, one page of instructions, and, of course, the "Paperwork Reduction Notice." SeniorCare includes all Rx drugs covered under Medicaid (which is almost everything) while Part D requires people to compare 54 different plans and try to find a plan that is affordable and covers all or most of the Rx drugs that the person takes. To adequately compare Part D plans a person really needs a computer and internet access. SeniorCare does not require a computer and internet access.

"If it ain't broke don't fix it." SeniorCare is not broken. It actually costs less (for both individuals and the government), it is much simpler for older persons to use, it does not have a donut hole, and older people love it. I urge you to fix Part D, not SeniorCare. How often can you say of a government program that it is what people want and it costs less. SeniorCare is what older people in Wisconsin want and it costs less.

A lady from northwestern Wisconsin may have said it best - "I pray you do not discontinue the Wisconsin SeniorCare program. Because without it I couldn't possibly make it. My monthly income is so low that I can hardly get my bills paid."

ATTACHMENT 1

Additional SeniorCare Case Examples

1. An eighty-two year old woman called for help in September 2006 when her husband reached the coverage gap under his Medicare Part D plan. Her husband required a number of expensive medications due to Parkinson's Disease and his actual drug costs were $5,400 per year. She and her husband had an annual gross income of $26,400, an income too high to qualify them for a low-income subsidy under Medicare Part D. They had no resources left to draw upon, and the woman was considering the sale of their burial plots in order to generate enough money to pay for her husband's medications next month.

   I strongly recommended that the couple consider enrolling in Wisconsin SeniorCare instead of Medicare Part D for prescription drug coverage in 2007. According to my calculations, SeniorCare would offer them more comprehensive coverage at a lower cost.

   Based upon their income, they would qualify for Level 2b coverage under SeniorCare. Her husband used seven generic medications and two brand name medications. His total actual drug costs were about $450 per month, so it would take about two months for him to meet the $850 deductible. After meeting the deductible, he would pay a total of $65 per month for his prescriptions. According to my estimate, over the course of the year, this gentleman's total out-of-pocket costs under SeniorCare would be about $1,530—over $1,300 less than the lowest estimated cost for a Medicare Part D plan.

2. Mr. and Mrs. E have limited resources and live on Social Security in very rural northern Wisconsin. Mrs. E takes three generic drugs each month. Mr. E does not require any medications on a regular basis. Both of them enrolled in SeniorCare.

   Somehow during the first year of Medicare Part D, this couple was identified as eligible for the Low Income Subsidy. Each was facilitatedly enrolled, without their knowledge or consent, in a Part D plan (PDP). This situation became apparent when Mrs. E tried to fill a prescription and was informed that her SeniorCare was no longer primary. Since Mrs. E had not enrolled in a PDP and had no knowledge of this enrollment she paid the full cost of the drug herself.

   Mr. E discovered his enrollment when he received a bill from a PDP that included $135 in past due premiums. The monthly premium for the PDP designed at assisting the low income was $30.99. Mr. E paid only $30 a year to enroll in SeniorCare.

Through much perseverance a benefit specialist working with the CWAG Elder Law Center was able to disenroll Mr. and Mrs. E from their PDPs. For the three months it took to correct this matter, Mrs. E continued to pay the full cost of her prescription out of her own pocket.

Unfortunately, their saga does not end there. On January 1, 2007 they were again auto-enrolled into new PDPs. Using Special Enrollment Periods, we were able to fairly easily disenroll them in January. But again Mrs. E was unable to use the SeniorCare she was enrolled in because the other plan showed up on her records, another month of paying for the drugs herself. After consulting with a representative at CMS Region V, Mrs. E attempted to contact Medicare to opt out of Part D. She gave up after she was unable to navigate the automated system.

In February each received notice that they had been identified as qualifying for extra help and had been auto enrolled in new PDPs. Again special enrollment periods were used to disenroll the couple and another month passed without any help paying for medications although Mrs. E was enrolled in SeniorCare. (If a PDP shows up in a computer search of a person's record, SeniorCare becomes the secondary payer.) This problem was ultimately resolved through a 30-minute phone call to CMS at the office of the benefit specialist, an 80-mile round trip for this low-income couple. (A previous attempt by the benefit specialist to opt the couple out of Part D failed when the CMS representative stated the couple had to be present at the office. During the second call to CMS the representative did not ask to speak to either Mr. or Mrs. E, although we had been instructed that they had to be present.)

Now that SeniorCare is primary for each of them, Mr. E pays only $30 annually to maintain creditable coverage. Mrs. E pays $30 per year and $15 each month in co-pays, less than just one month's premium in Mr. E's original PDP enrollment.

3. Mr. D was 72 when he applied for extra help to pay for Medicare Part D. His annual income, solely from Social Security was less than $15,000. He had $1,500 in savings. Even though he qualified for a partial subsidy his monthly premium in 2006 was $19.03 per month in the PDP he was auto enrolled with. He had a $50 deductible and according to the materials from his plan his co-payment for "generic preferred multi-source drugs is no more than 15%."

   Under SeniorCare Mr. D paid only $30 annually. There was no deductible and his drug costs were fixed at $5 for generic and $15 for brand name drugs. The savings in premium alone over a one-year period with SeniorCare was nearly $200. For this low-income individual Part D even with extra help was no bargain. As soon as he was able to cut through the red tape of auto enrollment and opting out of Part D he returned to the more affordable easy to understand SeniorCare.

4. Gentleman turning 65 years of age wanting to compare SeniorCare to Medicare Part D. He currently takes eight brand name drugs and 10 generic drugs over the course of a year. His income and assets are over the eligibility requirements for receiving the low-income subsidy provided through Medicare Part D, so he is subject to the normal Medicare Part D coverage—a monthly premium, a deductible (if the plan that he chooses to go with has a deductible), co-payments for his prescriptions and the possibility of falling into the donut hole.

   Medicare Part D: When we ran Medicare Part D's plan comparison, the least expensive plan out of the 54 plans that are available to him, the estimated annual cost was $4,472. And this plan did not have a deductible.

   SeniorCare: When we looked at SeniorCare, based on his income, if he was eligible for:

   Level 1 = no deductible; The estimated annual cost was $2,070.
   Level 2a = $500 deductible: The estimated annual cost was $2,465.
   Level 2b = $850 deductible: The estimated annual cost was $2,735.

5. Gentleman currently on SeniorCare with a $500 deductible. Wanted to compare SeniorCare to Medicare Part D. He currently takes three brand name drugs and two generic drugs over the course of a year. His income and assets are over the eligibility requirements for receiving the low-income subsidy provided through Medicare Part D, so he is subject to the normal Medicare Part D coverage—a monthly premium, a deductible (if the plan that he chooses to go with ha a deductible), co-payments for his prescriptions and the possibility of falling into the donut hole.

   Medicare Part D: When we ran Medicare Part D's plan comparison, the least expensive plan out of the 54 plans that are available to him, the estimated annual cost was $1,973. And this plan did not have a deductible.

   SeniorCare: When we looked at SeniorCare Level 2a with the $500 deductible, the estimated annual cost was $1,095.

6. Gentleman currently on SeniorCare with an $850 deductible. Wants to compare SeniorCare to Medicare Part D. He currently takes three brand name drugs and 1 generic drug over the course of a year. His income and assets are over the eligibility requirements for receiving the low-income subsidy provided through Medicare Part D, so he is subject to the normal Medicare Part D coverage—a monthly premium, a deductible (if the plan that he chooses to go with has a deductible), co-payments for his prescriptions and the possibility of falling into the donut hole.

Medicare Part D: When we ran Medicare Part D's plan comparison, the least expensive plan out of the 54 plans that are available to him, the estimated annual cost was $2,931. And this plan did not have a deductible.

SeniorCare: When we looked at SeniorCare Level 2b with the $850 deductible, the estimated annual cost was $1,400.

7. I have a woman who is enrolled in Humana Enhanced, with an annual cost of $402. She has applied for SeniorCare and will be in Level 1. She takes two medications, which are both generic, so her annual cost with SeniorCare would be $150, which includes the enrollment fee. Her savings with SeniorCare is $252. She is not eligible fore the LIS because of assets. Once she is enrolled in SeniorCare we are going to disenroll her from Humana Enhanced.

8. Client is on SeniorCare Level 1. She is not eligible for LIS due to assets. She is currently taking five generic and two brand name medications. Her SeniorCare costs her $690 per year.

   The cheapest Part D plan for her would be Cignature Rx Value according to Medicare's plan finder. Her cost under Part D would be $915 and she would hit the donut hole. The estimated Part D costs of $915 does include the $265 deductible, 12 months of a $28.60 premium, her prescription co-pays and the $175.58 that she would pay when she hits the coverage gap in the 12th month. This is with a plan where she does not pay anything toward her generic drugs in the deductible period or during her initial coverage period but it does not provide any coverage in the gap. Thus SeniorCare is saving her $225 per year. She is willing to speak about this when her health permits.

9. Kay is 74. She is lucky enough to enjoy good health. She takes no medications on a regular basis. She uses SeniorCare as an affordable means to maintain creditable coverage. If she was to enroll in a Part D plan her cost would be nearly $175 for a plan she would derive absolutely no benefit from.

   Kay still works part time in order to afford those little extras that her Social Security check doesn't cover such as an occasional meal out and a trip out west to visit her grandchildren. When she isn't working she volunteers at a senior center and the local hospice. If she was forced to pay for a more expensive plan she would have to find a different job that offered more hours. This would force her to cut down in the amount of time she gives to others in need.

10. One important aspect of SeniorCare is how easy it is to use the program. My mom who is 78 and has emphysema, among other things, has SeniorCare. She would actually save money by using Medicare Part D, but the emotional toll that the change would have on her would just not be worth the monetary savings. As people age, they do become set in their ways and learning new and

often difficult ways of doing things is a strain on them. Even with me doing all the "work" for my mom, she still wants to stay on SeniorCare. It's an easy to maneuver health care plan and one that is more suited to an aging population who grew up without all of the choices that are being offered in the Part D program. I would say that if you are in SeniorCare now, allow people to stay in SeniorCare—don't make them change. Let Wisconsin set a precedent for advocating for an easier plan for its seniors. Thanks for caring.

The CHAIRMAN. Thank you, Tom. That is a great statement.
Patricia, would you let us hear from you?

STATEMENT OF PATRICIA FINDER-STONE, STATE PRESIDENT, AARP WISCONSIN, MADISON, WI

Ms. FINDER-STONE. Chairman Kohl and distinguished Committee members, who are unable to be with us today, I am Patricia Finder-Stone. I am president of the AARP Wisconsin, and I am a registered nurse. Thank you for inviting AARP to testify on the importance of the Wisconsin SeniorCare prescription drug program.

AARP played a critical role in enacting SeniorCare, and we strongly support renewal of the waiver that helped create it. SeniorCare was tailored to meet the needs of Wisconsin residents with limited incomes, and it provides greater assistance to some individuals than is available under Medicare Part D. AARP also strongly supports and played a critical role in enacting the Medicare Part D benefit.

Part D is helping millions of beneficiaries, including thousands in Wisconsin not eligible for SeniorCare, to afford the drugs they need. However, SeniorCare is able to provide greater coverage for some people with low incomes in Wisconsin, because Wisconsin contributes State funds and it gets millions of dollars in discounts and rebates from drug companies.

Without the waiver, Wisconsin would not be able to use the savings from drug companies. That is because Medicare only counts payments by State programs toward Part D's coverage if the State program does not get savings from drug companies. Without those savings, the State would not be able to provide its current level of coverage if it were to reconfigure SeniorCare to wrap around the Part D benefit. The result would be higher costs for beneficiaries, for the State and for Medicare.

In fact, SeniorCare currently costs the Federal Government less than half of what Part D costs for the average enrollee, $617 for SeniorCare versus $1,331 for Part D.

Unlike Part D's low-income subsidy program, SeniorCare has no asset test. A report that we commissioned in 2005 found that 80 percent of SeniorCare enrollees who meet the Part D low-income subsidy income criteria do not meet its asset test.

I have personally helped Medicare beneficiaries enroll in SeniorCare, and I was touched by how grateful people were and how easy the one-page application is. However, because of the asset test, people applying for the Part D low-income subsidy must fill out a daunting eight-page application form, to which Tom referred.

The extra help Part D offers to those that are least able to afford their drug is one of the most important features and a key factor in our support of Part D. But the asset test is keeping millions of people who need the low-income subsidy from getting it. AARP believes that we should encourage people to save for retirement, not penalize those that do so with an asset test.

We have been working with Senator Smith, along with Senator Bingaman, on legislation that takes a solid first step toward AARP's goal on eliminating the asset test by raising the asset limits and streamlining the application process. We greatly appreciate

their leadership on this issue, and we especially want to thank you, Senator Kohl, for being a cosponsor.

However, SeniorCare has never had an asset test, and this onerous provision has never been imposed on beneficiaries in our State. That is a strong argument for renewing the waiver.

The insurmountable cost of providing equivalent coverage is a strong argument for renewal, and the lower per-capita cost to the Federal Government compared to Part D is yet another powerful argument for renewing the waiver.

We therefore urge CMS to re-authorize the SeniorCare waiver and to help us ensure that no one is worse off under Part D.

Thank you again for inviting us today, and I would be happy to answer questions that you have.

[The prepared statement of Ms. Finder-Stone follows:]

Testimony of

Patricia Finder-Stone

President, AARP Wisconsin

On

Wisconsin SeniorCare

Submitted to the

Senate Special Committee on Aging

March 28, 2007

WASHINGTON, D. C.

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Chairman Kohl, Senator Smith, I am Patricia Finder-Stone, president of AARP Wisconsin. Thank you for inviting AARP to testify on the importance of the Wisconsin SeniorCare prescription drug program to our members and our state.

AARP played a critical role in enacting SeniorCare and we strongly support renewal of the Medicaid waiver that helped create it in 2002. SeniorCare was tailored to meet the needs of Wisconsin residents 65 and older with limited incomes, and provides greater assistance to some individuals in the state than is currently available under the Medicare Part D drug benefit.

AARP also strongly supports and played a critical role in enacting the Medicare Modernization Act, which included the Part D benefit. Part D is helping millions of beneficiaries – including thousands in Wisconsin not eligible for SeniorCare – afford the drugs they need.

SeniorCare uses discounts and rebates from drug companies to save money for both government and beneficiaries. The savings allow Wisconsin to extend affordable drug coverage to thousands of beneficiaries who would not qualify for the Part D low income subsidy (LIS), and thus would have to pay higher copays and premiums if they instead were enrolled in Part D plans. They also would have to pay deductibles and would potentially fall into the Part D "doughnut hole" coverage gap – neither of which exists in SeniorCare.

Failure by the Centers for Medicare and Medicaid Services (CMS) to renew the SeniorCare waiver would be a step backward in our efforts to improve access to affordable drug coverage.

SeniorCare and Lower Drug Prices

The State of Wisconsin deals directly with drug companies on behalf of more than 100,000 SeniorCare enrollees – including both the more than 71,000 covered under the waiver and more than 31,000 additional residents covered with state-only funds.

Wisconsin has been very aggressive in getting savings from drug makers and is using some tools, such as the Medicaid rebate as a floor and a preferred drug list that AARP does not believe would be appropriate for Medicare to use in bargaining on behalf of its beneficiaries nationally. However, the state has used its leverage very effectively to obtain $53 million in discounted prices and $50 million in manufacturer rebates in fiscal 2006. These savings of more than $100 million a year are why the state has been able to provide greater low income assistance than is available under the Part D LIS. Without the waiver, Wisconsin would lose the leverage to obtain such savings.

CMS policy expressly prohibits state pharmacy assistance programs that fill in gaps or "wrap around" Part D coverage from obtaining discounts and rebates from drug companies. If they do, CMS refuses to allow payments they make on behalf of enrollees from counting as "True Out-of-Pocket" (TrOOP) payments that count when tabulating costs for filling in the Part D "doughnut hole" coverage gap and accessing Part D catastrophic coverage.

Without the ability to obtain millions of dollars in discounts and rebates from drug companies, the state would not be able to afford to provide its current level of coverage if it were to reconfigure SeniorCare to wrap around the Part D benefit.

The result would be higher cost for Medicare, beneficiaries and the state, and decreased ability to help Wisconsin residents with limited incomes. Wisconsin would have to cut back on benefits or pick up the full costs for more than 36,000 current enrollees covered by the waiver with limited incomes over 150% of the federal poverty level ($15,315 for an individual or $20,535 for a couple) because they are categorically ineligible for LIS.

Wisconsin would also have to cut benefits or pick up the full cost for many of the more than 38,000 current enrollees covered by the waiver with incomes below 150% of poverty who would not meet the Part D asset test.

Asset Test Barrier

SeniorCare has no asset test because Wisconsin understands the importance of not penalizing people who, despite limited incomes, do the responsible thing of saving to have a small nest egg for retirement. The report we commissioned in 2005 found that 80% of SeniorCare enrollees who meet the Part D LIS income criteria would not meet its onerous asset test. Many more who are now getting needed comprehensive, low-cost coverage from SeniorCare may not be able to access LIS because they would have difficulty filling out the daunting and invasive application form.

I have personally helped AARP members and other Medicare beneficiaries enroll in SeniorCare and was touched by how grateful people were and how easy it was. There is only a one-page application, compared to the 8-page application for LIS, since there is no asset test to complicate the application process.

Under the Part D asset test in 2007, people with limited incomes can have no more than $11,710 as an individual or $23,410 as a couple in assets to qualify for LIS. Such small amounts of savings are hardly enough to get someone through retirement. Yet the asset test is rigidly enforced no matter how low someone's income or how high their other living expenses may be.

The extra help LIS provides to those least able to afford prescription drug costs is one of the Part D program's most important features and a key factor in our support for the Medicare Modernization Act (MMA) that created Part D. But the asset test is proving to be a serious barrier.

The Kaiser Family Foundation has estimated that, nationally, more than 2.3 million Medicare beneficiaries who meet LIS income criteria will not be eligible because of the asset test. Almost half exceed the asset limit by $25,000 or less. In fact, the asset test is the leading reason why people who apply for the subsidy are rejected – even if they are only just above the limits.

For those who are eligible for the LIS, we believe the difficult application process required by the asset test is a key reason why from 3 million to 5 million who would meet both the income and asset test remain unenrolled. The application form is lengthy, confusing and invasive, largely because of the asset test. For example, the application:

• requires people to report not just savings but such obscure details as the current cash value of any life insurance policies – information people simply do not have on hand;

• asks people whether they expect to use savings for funeral or burial expenses, but does not explain that individuals can have up to $1500 ($3000 for couples) in savings above the asset limits for such expenses;

• asks invasive questions, such as whether applicants get help with meals or other household expenses, which can be difficult to estimate; and

• threatens applicants with prison terms if information they provide is incorrect.

Applying for the LIS thus can seem overwhelming and require many hours, extra help from family members or insurance counselors, and often repeated efforts to find all of the required information. SeniorCare wisely does not impose this burden, or penalize Wisconsin seniors who have done the responsible thing of saving for retirement.

AARP has been working with this Committee's Ranking Member, Senator Smith, along with Senator Bingaman, on legislation that takes a first step toward eliminating the asset test by raising the limits and streamlining the application process. We greatly appreciate their leadership on this issue. However, this is only a solid first step toward AARP's goal of eliminating the Part D LIS asset test completely.

The fact that Wisconsin's SeniorCare program has never had an asset test argues strongly for renewing the waiver so this onerous provision is never imposed on residents of our state.

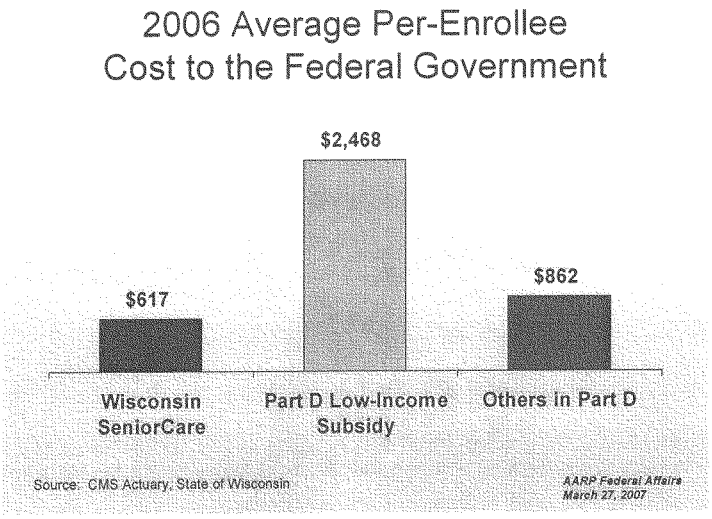
SeniorCare Savings

The report we commissioned in 2005 showed that SeniorCare was costing both beneficiaries and the federal government less than Part D would, based on projected Part D costs. Part D has since proven to cost less than projected, due in large part to LIS under-enrollment. That under-enrollment is due in large part to the asset test, which SeniorCare does not have.

Even with lower-than-projected costs, SeniorCare is a good deal for the federal government, the state, and especially beneficiaries.

For the federal government, SeniorCare costs less than half of what Part D costs per enrollee. According to the CMS Actuary, the current estimate of the average cost to the federal government for each Part D enrollee in 2006 was $1,331 ($2,468 for those with LIS and $862 for others in Part D plans), and in 2007 is $1,345 ($2,573 for those with LIS and $892 for others in Part D plans). However, according to the State of Wisconsin, the average cost to the federal government for each SeniorCare enrollee in 2006 was only $617, and the federal government paid only about $46 million – or 18% of SeniorCare's total $253 million cost.

SeniorCare drug coverage also generates additional savings to Medicaid – $669 million in its first four years, according to the state – by keeping beneficiaries healthier so they need less hospital and nursing home care, which has kept the waiver budget neutral. The state projects an additional $697 million in Medicaid savings if the waiver is renewed, which includes $404 million in federal savings.



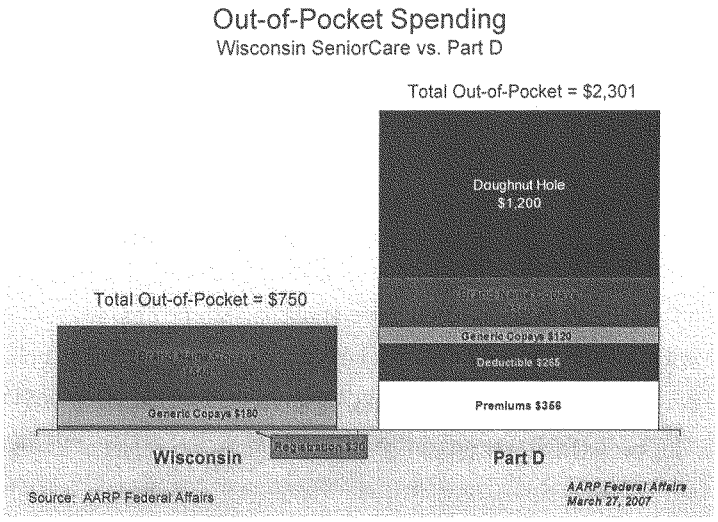
The state's contribution of its own dollars and its ability to leverage drug rebates and discounts is why the cost to the federal government of providing prescription drug benefits through SeniorCare is less than that for a Medicare Part D beneficiary.

For beneficiaries, SeniorCare is also often a much better deal. Take, for example, a Wisconsin senior with income just above the 150% of poverty eligibility cliff for LIS, or income slightly below that cliff with just a few dollars in savings over the assets limits. They may be taking three brand name drugs with an average retail price of $80 each and three generics with an average retail cost of $20, and would have total annual drug costs of $3,600.

Under SeniorCare, annual out-of-pocket costs for such a beneficiary total $750, including the $30 registration fee, $180 for generic copays ($5 per 3 refills 12 times a year), and $540 for brand copays ($15 per 3 refills 12 times a year).

Under a typical Part D plan, they would be required to pay more than three times as much. They would pay $356 in premiums (based on average Part D premium in Wisconsin of $29.67 per month) and $265 for a deductible (which SeniorCare does not have for beneficiaries below 160% of poverty). They would pay $480 in copays for the first eight months of the year ($5 for each of 3 generics each month and $15 for each of 3 brand name refill each month), and then would hit the Part D "doughnut hole" coverage gap.

Once in the coverage gap, which starts when both they and their Part D plan have paid $2400 for drugs, they would be required to pay for 100% of their drug costs, or the entire bill for their remaining $1200 in annual drug cost.



The net result would be $2,301 out-of-pocket. That is not enough to reach the Part D catastrophic limit of $3,850 in out-of-pocket costs, but is $1,551 more than the $750 they would have to pay under SeniorCare.

For Wisconsin seniors between 160% and 200% of the poverty level, who are not eligible for LIS at all, SeniorCare does require a $500 deductible but still provides better coverage than Part D. With the same drug needs as in the example above, annual enrollment and deductible costs would total $530, and the beneficiary would pay $180 for generic copays ($5 per refill) and $540 for brand name copays ($15 per refill). Total out-of-pocket costs would be $1250. That is $1051, or about 46% less than the $2301 they would have to pay under Part D.

Conclusion

Wisconsin could not afford to provide equivalent coverage to SeniorCare by "wrapping around," or filling in gaps in Part D coverage without the waiver. The lost ability to get discounts and rebates from drug makers would create a more than $100 million annual funding shortfall. With so many SeniorCare enrollees ineligible for LIS, the additional costs outlined in the examples above would be insurmountable in our state. That, along with lower per capita cost to the federal government, is a powerful argument for renewing the waiver rather than requiring SeniorCare enrollees to switch to Part D.

SeniorCare also demonstrates the clear advantage of not having an asset test in getting assistance to people with limited incomes. We therefore urge CMS to reauthorize the SeniorCare waiver and help us ensure that no one is worse off under Part D. We look forward to working with CMS and Congress to ensure that this pioneering program continues.

The CHAIRMAN. Thank you.

Tom, briefly, given your experience working with SeniorCare beneficiaries, is there any question in your mind that SeniorCare saves the Federal Government money compared to Medicare Part D?

Mr. FRAZIER. No. There is not.

The CHAIRMAN. Ms. Finder-Stone, in 2005, AARP commissioned a study on SeniorCare and looked at the feasibility of Wisconsin switching to a Medicare Part D wraparound at the same level of coverage that beneficiaries have today.

What factors contribute to your findings that the transition to a wraparound would be more costly to Wisconsin and the Federal Government?

Ms. FINDER-STONE. Well, we feel that Wisconsin is using tools that might not be appropriate for Part D to use in negotiating better drug prices, because we use tools like a preferred drug list.

The waiver is a Medicaid-based program, and those tools are commonly used in Medicaid. However, Part D is a Medicare program, and individual Part D plans already have formularies.

Many people have serious concerns about the Federal Government establishing a single National formulary, because they fear that it might create access problems that AARP would not want to see.

The CHAIRMAN. Thank you.

Well, we want to thank you for your testimony, all three of you. The importance of your coming here is, I think, exemplified by the fact that both the Governor and Ms. Norwalk have stayed to listen to your testimony, which indicates how important your testimony is to this whole process.

I think it has been a great hearing. I think the Governor has been very powerful in his statement. Ms. Norwalk has been very strong in her position, and I know she is an open-minded woman, and I have hope that she will be much impressed by what has transpired here this morning.

With that, I declare the hearing closed.

[Whereupon, at 11:21 a.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF REPRESENTATIVE THOMAS E. PETRI

Chairman Kohl and Ranking Member Smith:

I would like to take this opportunity to thank you for holding this important hearing on SeniorCare and its impact in Wisconsin. I strongly believe that Secretary Leavitt should approve the pending waiver to extend the program through 2010.

Today's hearing will highlight the immense popularity and cost effectiveness of SeniorCare. Over 100,000 senior citizens participate in the program, and receive prescription drugs in a manner that is affordable and easy to understand. Not only are seniors in Wisconsin satisfied with the program, but taxpayers are saving money. The average federal subsidy for a SeniorCare waiver participant is $617, less than half the $1,174 the federal government spends to subsidize a Part D participant.

If SeniorCare is not continued, some of our most vulnerable seniors will face potential breaks in prescription drug coverage, confusion, and needless expense.

Wisconsin has created a program that works well for our seniors and taxpayers. I am encouraged that this Committee will be examining this issue closely, and I will continue to work with my Wisconsin congressional colleagues to support our seniors. This hearing will provide important information for the Department to consider as it evaluates Wisconsin's waiver request, and I again commend Chairman Kohl for calling this hearing.

PREPARED STATEMENT OF STATE REPRESENTATIVE STEVE WIECKERT

Thank you for holding a hearing on Wisconsin's Senior Care program. I am especially concerned about Senior Care's future, as are so many Wisconsin citizens. One reason in particular I am so fond of the Senior Care program is not only because I believe it is helping Wisconsin's citizens, but because I was the author of the Senior Care program in the Wisconsin Assembly.

I ask that the decision on whether to extend the Senior Care waiver be extended for another two years, which would mean the waiver would be extended until at least June 30 of 2009.

While originally 4 states have been granted these waivers for their own prescription drug programs for seniors, only Wisconsin remains as the only state that still has the waiver in effect. The reason I believe that is important for the federal government to continue this waiver and allow Wisconsin's program to remain helpful to our seniors is because of the cost saving nature of the way that the plan was designed. I know that "budget neutrality" is a major review criterion for extending our program.

From the beginning, our early legislative drafts had the participation of private drug companies, which helped pay for our plan. For example, currently about $44 million of Senior Care is paid for through drug rebates in Wisconsin each year. If Senior Care was required to be redesigned through a federal withdrawal of participation, program costs could skyrocket by more than $44 million a year.

It would certainly benefit so many more U.S. Senior Citizens if the federal Medicare Part D plan was modeled after Wisconsin's Senior Care.

I ask the committee do all it can to work toward the extension of the Wisconsin Senior Care program.

Thank you for this opportunity to submit written testimony to your committee.

PREPARED STATEMENT OF STATE REPRESENTATIVE THOMAS NELSON

Thank you Mr. Chair and members of the Special Committee on Aging. I want to offer my thanks to Chairman Herb Kohl for conducting this hearing and for his leadership on SeniorCare. I apologize that I am not able to offer my remarks in person but appreciate the opportunity to enter my comments into the public record.

The SeniorCare program has been tremendously successful in Wisconsin and is far superior to the alternative, federal program, Medicare Part D. Currently, over 103,000 Wisconsin seniors are enrolled in SeniorCare.

The popularity of Senior Care reflects the program's simplicity and cost-efficiency. Where Medicare Part D has been widely criticized for its difficult application process. SeniorCare has a simple one-page enrollment form—and no doughnut hole. The savings to Seniors are clear when you compare SeniorCare's $30 annual fee to the monthly premium and $265 annual deductible of Medicare Part D. Additionally, Seniors and taxpayers enjoy savings from overall lower costs negotiated with drug companies. Not surprisingly, among eligible Seniors, 94% would fare better under SeniorCare than Part D.

For some time, the states have served as laboratories for constructive social policy change. Over the years, Wisconsin has led the way in welfare reform, campaign finance reform, and workers' compensation—just to name a few issues. Often, these successful, new approaches to solving old problems are implemented at the federal level or replicated in other states. It is unfortunate that the Bush Administration has turned this process on its head. Rather than promoting the Wisconsin-born and widely successful SeniorCare program, the administration is seriously considering forcing Wisconsin Seniors into Medicare Part D, or what I call, SeniorCare Lite.

U.S. Health and Human Services Secretary Mike Leavitt has stated that a major constraint in renewing the SeniorCare waiver is ensuring that the program is budget-neutral. SeniorCare costs the federal government half as much as Medicare Part D. Where Part D costs the government $1,174 per participant, SeniorCare costs $617 per enrollee and leverages private and state dollars. The fact that Secretary Leavitt seemingly ignores this fact makes me question his leadership and overall competence as HHS Secretary.

The Secretary's failure to appreciate SeniorCare cost-efficiency follows a long and disturbing pattern of poor performance by key Presidential cabinet members and administrative personnel—notably former U.S. Defense Secretary Donald Rumsfeld and most recently, current U.S. Attorney General Alberto Gonzalez.

While the Bush Administration's resistance to embrace and support SeniorCare might suggest SeniorCare is a partisan issue, to the contrary, Democrats and Republicans alike in Wisconsin are united, four-square behind SeniorCare. To my knowledge, not a single elected official has publicly opposed this program. A big reason why SeniorCare enjoys universal, political support in Wisconsin is because everyone recognizes its positive impact on so many Seniors and their families. At a time when Seniors face rising prescription drug costs, Seniors can turn to a program that offers much needed financial relief. By saving on average $1,629 per year, Seniors have considerably more disposable income to pay home heating costs, groceries, and other expenses.

Last month, I launched a petition drive to save SeniorCare. Many other legislators and organizations across Wisconsin have signed on, generating thousands of e-mails, letters and phone calls in support of SeniorCare. To say the least, public support has been overwhelming. Consider two stories told by a pair of concerned families:

"When reading that Senior care may be discontinued, I was alarmed. I have had my Mother on Senior care since it started and I know how much it has saved her. She is now almost 97 years old and her assets have been depleted a long time. As of now four of us, her children, who are retired are using our funds to pay for her care. Also she lived in a retirement assisted living residence and so many of those elderly people were so very confused regarding the Medicare D program. Many elderly do not have family who can help them fill out the paperwork. I personally told them who to contact for Senior care. I have also been at the pharmacy watching these wonderful Seniors struggle to get their prescriptions. Even the pharmacist tried to explain why some drugs are covered and some not. Senior Care was so simple and cost effective, so please do your best to have it continued."

"I heard that there is word that Senior Care may be discontinued. I hope that you can do all you can to save it as it has helped many like myself who do not have money for medications. My brother died because he could not afford $500 a month for his medication for cancer. He was a Marine veteran, wounded on Iwo Jima about March 8, 1945 much before Senior Care began. Thank you."

These are just two of the countless stories demonstrating SeniorCare's importance and begs leadership from Washington, DC to do the right thing and renew the federal waiver. Please, Mr. Chair, on behalf of the 103,000 Seniors and their families, do whatever you can to save SeniorCare.

Thank you for the opportunity to present testimony on this important issue.