



**Testimony of Frederic Riccardi**  
President  
Medicare Rights Center

“Legislation to Improve Americans’ Health Care Coverage and Outcomes”

United States House of Representatives  
Committee on Energy & Commerce  
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## Introduction

Chairwoman Eshoo, Dr. Burgess, and members of the House Committee on Energy & Commerce, Subcommittee on Health: I am Fred Riccardi, president of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to nearly three million people with Medicare, family caregivers, and health care professionals each year.

Thank you for the opportunity to speak with you today about two bipartisan bills that would help older adults and people with disabilities access and afford needed care, the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (H.R. 2477) and the Protecting Patients Transportation to Care Act (H.R. 3935).

### **The Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (H.R. 2477)**

#### Medicare Part B Enrollment Challenges and Consequences

Medicare is the federal government program that provides health care coverage if you are over 65, under 65 and receiving Social Security Disability Insurance (SSDI) for a certain amount of time, or under 65 and living with End-Stage Renal Disease (ESRD). As you know, there are four parts of Medicare: Part A, Part B, Part C, and Part D:

- Part A provides inpatient/hospital coverage.
- Part B provides outpatient/medical coverage.
- Part C offers an alternate way to receive your Medicare benefits.
- Part D provides prescription drug coverage.

People with Medicare can choose to receive their Parts A and B benefits from Original Medicare, the traditional fee-for-service program offered directly through the federal government that was enacted in 1965, or from a Medicare Advantage Plan, a type of private insurance offered by companies that contract with the federal government. This option was added in 1996. Regardless of how a beneficiary ultimately chooses to receive coverage, the transition to Medicare can be a daunting task for people who are not yet collecting their Social Security benefits.

The BENES Act would help. It would update the Part B enrollment process for the first time in 50 years, making it easier for beneficiaries to understand and navigate. These modernizations are needed due to significant changes in how people experience their initial Medicare eligibility.

While most beneficiaries are still automatically enrolled in Medicare Parts A and B at age 65 because they are receiving Social Security benefits, a growing number of Americans are not. In 2016, only 60% of Medicare-eligible 65-year-olds were taking Social Security, compared to 92%

in 2002.<sup>1</sup> Several factors are responsible for this shift, including the decoupling of the Medicare and Social Security eligibility ages, changing demographics, and evolving employment patterns. More older adults are working later in life and deferring Social Security, though they may not realize that doing so impacts their Medicare coverage.<sup>2</sup> Others may choose—appropriately or not—to delay signing up for Medicare because they have another source of coverage, such as an employer-based plan.

Unlike those who are auto-enrolled, individuals who defer Social Security until after age 65 must take steps to enroll in Parts A and B. To sign up for Part A, the decision is relatively straightforward: people who qualify for premium-free Part A—the majority of Medicare beneficiaries—are not bound by any enrollment periods; they can sign up any time after they are eligible, without penalty.

Delaying and then enrolling in Part B without penalty is a much more complicated and high-stakes endeavor. It requires beneficiaries to understand and consider specific enrollment periods, existing coverage, and the penalties associated with delayed enrollment. If this process is mismanaged, the consequences can be significant—including lifetime financial penalties, high out-of-pocket costs, and periods of non-coverage.

Unfortunately, many people do make mistakes. Year after year, among the most frequent calls to our National Consumer Helpline are those from or on behalf of people eligible for Medicare who inadvertently and through no fault of their own failed to enroll in Part B on time and are experiencing severe repercussions.<sup>3</sup>

The rules are so confusing that even sophisticated Human Resources (HR) experts can struggle to follow them, and many employers' benefits departments lack the Medicare knowledge to effectively guide their employees and retirees on Medicare enrollment. Further, the federal government provides virtually no notification to people who are nearing Medicare eligibility about their responsibilities, including if they must actively enroll. Instead, only people who already receive or have applied for Social Security benefits before turning 65 are notified by the federal government when they first become eligible for Medicare.

This notification process is chiefly managed by the Social Security Administration (SSA), the federal agency responsible for Medicare enrollment. SSA identifies individuals collecting retirement benefits and sends their records to the Centers for Medicare & Medicaid Services (CMS)—the federal agency that manages the Medicare program—four months before they turn 65.<sup>4</sup> CMS then sends them a “Welcome to Medicare” packet three months before their 65<sup>th</sup>

<sup>1</sup> Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care Delivery System” (June 2019) available at: [http://www.medpac.gov/docs/default-source/reports/jun19\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0).

<sup>2</sup> Johnson, R.W., Urban Institute, “Older Workers: Opportunities and Challenges” (July 2010) available at: <http://www.urban.org/UploadedPDF/412166-older-workers.pdf>.

<sup>3</sup> Medicare Rights Center, “Medicare Trends and Recommendations: An Analysis of 2017 Call Data from the Medicare Rights Center’s National Helpline” (April 2019) available at: <https://www.medicarerights.org/pdf/2017-helpline-trends-report.pdf>.

<sup>4</sup> Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care Delivery System” (June 2019) available at: [http://www.medpac.gov/docs/default-source/reports/jun19\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0).

birthday that includes their new Medicare card, a letter confirming their enrollment and explaining how Medicare works, and information about how to decline automatic enrollment.<sup>5</sup>

Because this Medicare notification process is tied to the collection of Social Security benefits, it is reaching a shrinking subset of beneficiaries.<sup>6</sup> In part, this is due to the gradual two-year increase in the Social Security eligibility age, from 65 to 67.<sup>7</sup>

Historically, the eligibility age for both Medicare and Social Security was 65. This made the linkage between the programs' beneficiary notification systems less problematic than it is now that the ages are no longer aligned. Today, Medicare-eligible individuals who do not begin taking Social Security until they reach the age for full retirement benefits (currently 66) receive nothing from the federal government about their initial Medicare eligibility at age 65. And existing law offers no remedy: there is no requirement that either SSA or CMS notify people if they have not yet applied for Social Security.

As a result, many people bear the full burden of navigating Medicare's complex enrollment process alone, to disastrous effect. We frequently hear from beneficiaries who, in this information vacuum, have made enrollment missteps that have left them functionally uninsured and on the hook for sizable costs.

All too often, there is no easy solution. Under Medicare enrollment rules, these individuals may be unable to get coverage quickly. Absent access to a Special Enrollment Period (SEP) based on qualifying job-based insurance,<sup>8</sup> people who do not enroll in Part B during their Initial Enrollment Period (IEP)—a seven-month around their 65<sup>th</sup> birthday—must wait until the next General Enrollment Period (GEP) to sign up. This can mean gaps in coverage, as the GEP runs from January 1 to March 31 each year but coverage does not begin until July 1.

Consider Medicare Rights' client, Mr. A. He was laid off at age 65. As part of his termination, he was provided two years, through September 2018, of continued enrollment in the company's large employer group health plan. Before the group coverage was due to terminate, Mr. A went to his local Social Security office to enroll in Medicare. There, for the first time, he was told that when he lost his job, it triggered a change in how his group health coverage was treated under Medicare rules. He learned that he was ineligible to enroll in Part B through a SEP and would have to wait until the next GEP in January 2019 to sign up, and until July of that year for coverage to begin—leaving him without adequate health coverage for nearly a year. Mr. A also

<sup>5</sup> Centers for Medicare & Medicaid Services, "Welcome to Medicare booklet and letter" available at: <https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/welcome-to-medicare-booklet-and-letter>.

<sup>6</sup> Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2019) available at: [http://www.medpac.gov/docs/default-source/reports/jun19\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0).

<sup>7</sup> The Social Security Amendments of 1983 gradually raised the full retirement age for Social Security benefits, also known as the Old-Age, Survivors, and Disability Insurance (OASDI) Program, from 65 to 67. The increase in the full retirement age began in 2003 and will be complete in 2027. See: *Ibid*.

<sup>8</sup> The Part B Special Enrollment Period (SEP) is an eight-month period during which an individual can enroll in Medicare Part B after they no longer have coverage from current work (job-based insurance). See: Medicare Rights Center, "Job-based Insurance and Medicare" (2019) available at: <https://www.medicareinteractive.org/get-answers/coordinating-medicare-with-other-types-of-insurance/job-based-insurance-and-medicare>.

learned that he would be required to pay a Part B Late Enrollment Penalty (LEP), which can be a lifelong burden.<sup>9</sup>

The Part B LEP accrues at 10% of the current Part B premium for every year a person should have been—but was not—enrolled in Part B.<sup>10</sup> Because Mr. A delayed enrollment for two years, he must pay 20% more every month, amounting to a lifetime penalty.<sup>11</sup> The Part B LEP is intended to encourage individuals newly eligible for Medicare to enroll in the program and ultimately to ensure that a younger, healthier population balances the Medicare risk pool.<sup>12</sup> But because the rules concerning Medicare enrollment are often unknown or misunderstood, many people end up paying LEPs due solely to honest error. In 2018, roughly 760,000 Medicare beneficiaries were paying a Part B LEP, with the average penalty representing nearly a 30% increase in a beneficiary's monthly premium.<sup>13</sup>

The prevalence, amount, and efficacy of the LEP is concerning, especially given the financial status of many Medicare beneficiaries. Currently, half of all people with Medicare—nearly 30 million seniors and people with disabilities—have annual incomes below \$26,200 and one quarter have less than \$14,550 in savings.<sup>14</sup> At the same time, high and rising health care costs are taking up an increasing share of beneficiaries' limited budgets. In 2016, nearly 30% of Medicare households spent 20% or more of their income on health care, while only 6% of non-Medicare households did so.<sup>15</sup> Most people with Medicare simply cannot afford to pay more for their care.

Another complication is that people like Mr. A, who have other insurance when they become eligible for Medicare, must try to make sense of Medicare's intricate coordination of benefits requirements. These rules govern how other types of insurance works with Medicare, which pays first, or primary, and which pays secondary. This is important because when Medicare is primary, the other insurance may not pay until Medicare does, whether the individual is enrolled in Part B or not. Accordingly, if an individual has secondary insurance—such as COBRA or retiree coverage—and does not enroll in Medicare, it is as if they have no coverage at all.

The rules are different for each type of insurance and are not easily understood, if a beneficiary even knows they exist. Like others not yet collecting Social Security, individuals with other coverage do not get a notice from the federal government explaining these interactions and

<sup>9</sup> Those who are eligible for Medicare as a result of disability and who are not yet 65 have an IEP when they turn 65. During this IEP, a previously assigned late enrollment period for wrongfully delayed enrollment upon becoming eligible for Medicare due to disability may be removed. See: POMS at HI 00805.015.

<sup>10</sup> 42 C.F.R. § 407.15; POMS at HI 00805.025.

<sup>11</sup> 10% multiplied by the number of years delayed. See: Medicare Rights Center, "Medicare Part B Late Enrollment Penalties" (2018) available at: [http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script\\_id=316](http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=316).

<sup>12</sup> Davis, P.A., Congressional Research Service, "Medicare: Part B Premiums" (August 4, 2016) available at: <https://fas.org/sgp/crs/misc/R40082.pdf>.

<sup>13</sup> Congressional Research Service, "Medicare: Part B Premiums" (April 4, 2019) available at: <https://fas.org/sgp/crs/misc/R40082.pdf>.

<sup>14</sup> Jacobson, Gretchen; et al., Kaiser Family Foundation, "Income and Assets of Medicare Beneficiaries, 2016-2035" (April 21, 2017) available at: <https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/>.

<sup>15</sup> Cubanski, Juliette; et al., Kaiser Family Foundation, "The Financial Burden on Health Care Spending: Larger for Medicare Households than for Non-Medicare Households" (March 1, 2018) available at: <https://www.kff.org/medicare/issue-brief/the-financial-burden-of-health-care-spending-larger-for-medicare-households-than-for-non-medicare-households/>.

other considerations when they turn 65. Some employers may know the rules, but many may not, which can result in well-intentioned but incorrect guidance on which employees rely, often to their detriment.

This was the case for Medicare Rights' client Ms. R. She was covered by COBRA and undergoing cancer treatment.<sup>16</sup> She declined to enroll in Part B because her employer told her that COBRA pays primary to Medicare. Unfortunately for Ms. R, it's the other way around—Medicare pays primary to COBRA. While she was receiving needed treatment, the COBRA plan realized she was not enrolled in Part B and should have been. As is allowed in these circumstances, the plan then stopped paying for her care and recouped several months' worth of payments. Because losing COBRA coverage does not trigger a SEP, Ms. R had to wait until the next GEP to enroll in Part B. Consequently, she was left without health insurance for nearly a year, charged thousands of dollars in medical bills, and put at risk of losing needed care, as her providers threatened to cut off her cancer treatment because she lacked outpatient coverage.

### Demographic and Employment Trends

Without immediate solutions, more and more Americans will have experiences like Mr. A and Ms. R. The population is aging rapidly<sup>17</sup> and more older adults are working later in life.<sup>18</sup> At the same time, the gap between Medicare and retirement benefit eligibility continues to grow. As a result, an increasing number of individuals will face critical Part B enrollment decisions, lending an urgency to the need for improvements to the current system.

From 2006 to 2016, the number of Americans age 65 and over rose by 33%—from 37 to 49 million. Over that same time period, the number of Americans aged 45-64 (who will reach age 65 over the next two decades) increased by 12%, and the number of Americans age 60 and over increased by 36%. By 2040, estimates suggest that the U.S. will be home to 82 million older adults, over twice their number in 2000.<sup>19</sup>

Aside from this sheer increase in volume, a growing share of this population is likely to delay taking Social Security benefits at age 65, while the full retirement age raises to 67.<sup>20</sup> Recent data show this shift, illustrating that an increasing number of older adults are working later in

<sup>16</sup> The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law passed in 1986 that lets certain employees, their spouses, and their dependents keep group health plan (GHP) coverage for 18 to 36 months after they leave their job or lose coverage for certain other reasons, as long as they pay the full cost of the premium. See: Medicare Rights Center, "COBRA Basics" (2019) available at: <https://www.medicareinteractive.org/get-answers/coordinating-medicare-with-other-types-of-insurance/cobra-and-medicare/cobra-basics>.

<sup>17</sup> Administration for Community Living, "A Profile of Older Americans: 2018" (April 2018) available at: <https://www.acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans>.

<sup>18</sup> Mitra Toossi and Elka Torpey, Bureau of Labor Statistics, "Older Workers: Labor Force Trends and Career Options" (May 2017) available at: <https://www.bls.gov/careeroutlook/2017/article/older-workers.htm>.

<sup>19</sup> Administration for Community Living (ACL), "A Profile of Older Americans: 2017" (2017) available at: <https://www.acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans>.

<sup>20</sup> Favreault, M.M., Urban Institute, "Raising Social Security's Retirement Age" (July 2010), available at: <http://www.urban.org/UploadedPDF/412167-Raising-Social-Security.pdf>.

life: between 1999 and 2009, the share of workers ages 55 and older increased from 12 to 19%, the largest proportion on record.<sup>21</sup>

Further, the number of employed older Americans rose by nearly 35% just between 2011 and 2016, and this demographic is projected to be the fastest-growing segment of the workforce in the coming years.<sup>22</sup> Over the 2014 to 2024 decade, the labor force growth rate of 65- to 74-year-olds is expected to be about 55%. This number climbs to 86% for those 75-and-older, compared with a 5% increase for the labor force as a whole.<sup>23</sup>

These realities demand that policymakers act now to improve Medicare Part B enrollment. Otherwise, a growing number of newly eligible beneficiaries will struggle to access and afford meaningful health care and coverage.

### The BENES Act

As discussed throughout, Medicare’s rules are complex. The resulting beneficiary confusion is compounded by the lack of federal government outreach and notification to people as they approach Medicare eligibility. Exacerbating these systemic issues is the growing disconnect between the eligibility ages for Medicare and full Social Security benefits, along with changing demographics and employment patterns. As these trends show no sign of abating, the BENES Act’s commonsense solutions are needed now more than ever.

Championed by Reps. Ruiz (D-CA) and Bilirakis (R-FL), as well as Reps. Schneider (D-IL), and Walorski (R-IN), the bipartisan and bicameral BENES Act (H.R. 2477) would take major steps to **(I) Strengthen Education for the Soon-to-Be Eligible; (II) Eliminate Harmful Gaps in Coverage; and (III) Align Medicare Enrollment Periods.**<sup>24</sup>

**I. Strengthen Education for the Soon-to-Be Eligible.** Today, no federal entity is responsible for notifying people about their Medicare eligibility if they are not already collecting Social Security when they first become eligible. As a result, many Americans do not receive the enrollment information they need, when they need it. This is a rapidly intensifying problem. In 2002, 8% of those who were eligible for Medicare at age 65 were not auto-enrolled in the program and did not receive government notification until after their IEP—past the point in time that an individual can always enroll in Medicare without facing any late enrollment penalties. By 2016, this number had risen to 40%.<sup>25</sup>

<sup>21</sup> Johnson, R.W., Urban Institute, “Older Workers: Opportunities and Challenges” (July 2010), available at: <http://www.urban.org/UploadedPDF/412166-older-workers.pdf>.

<sup>22</sup> SeniorLiving, “Elderly Employment: Analyzing Rates of Employment for Older Americans” (December 2017) available at: <https://www.seniorliving.org/research/elderly-employment/>.

<sup>23</sup> Mitra Toossi and Elka Torpey, Bureau of Labor Statistics, “Older Workers: Labor Force Trends and Career Options” (May 2017) available at: <https://www.bls.gov/careeroutlook/2017/article/older-workers.htm>.

<sup>24</sup> The legislation has also been included as Title I of the Beneficiary Education Tools Telehealth & Extenders (BETTER) Act of 2019 (H.R. 3417) and has been introduced in the Senate as S. 1280 by Senators Casey (D-PA) and Young (R-IN). The Senate bill has eight other bipartisan cosponsors.

<sup>25</sup> Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care Delivery System” (June 2019) available at: [http://www.medpac.gov/docs/default-source/reports/jun19\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0).

As noted by MedPAC in its June 2019 report, “the Medicare program should not rely on alternative sources to properly inform potential beneficiaries to sign up for Medicare during their IEP.”<sup>26</sup> We agree with the commissioners that this should be addressed, and that “[i]mprovement in the timeliness of notification to eligible individuals about Medicare enrollment and potential late enrollment penalties is essential.”<sup>27</sup>

The BENES Act offers a logical solution. It would require the federal government to notify people nearing Medicare eligibility about their rights and responsibilities. The notification would be sent to individuals at ages 60 to 65 as part of their annual Social Security statement and to people with disabilities who are in the 24-month Medicare waiting period. It would, in part, clearly explain the individual’s Medicare eligibility, the potential effects of delayed Part B enrollment, and the need for coordination of benefits. With this important reform in place, people approaching Medicare eligibility—including those who are not already receiving Social Security—would, for the first time, get trusted, understandable information from the federal government about how, whether, and when to enroll in Medicare.

This consumer-friendly notice would be developed by the federal government in consultation with relevant stakeholders, including older adults, people with disabilities, low-income individuals, HR professionals, private health plans, and others. The notice would also be posted online in a prominent location on both the SSA and CMS websites.

**II. Eliminate Harmful Gaps in Coverage.** The BENES Act would also modernize the Medicare IEP and GEP to allow coverage to begin more quickly post-enrollment. This significant update would eliminate gaps in coverage that can leave people exposed to high costs and inadequate care.

Currently, if a newly eligible beneficiary enrolls in the fourth through seventh month of their IEP, the initiation of Medicare coverage is needlessly delayed. The BENES Act would restructure the IEP so that Medicare coverage begins on the first of the month or the first of the following month when a person enrolls. Similarly, the annual GEP includes a significant gap between enrollment and the start of an individual’s coverage—up to a seven-month delay. The BENES Act would also restructure the GEP to start coverage as soon as possible.

**III. Align Medicare Enrollment Periods.** Medicare’s annual GEP does not coincide with the program’s annual open enrollment periods for private Medicare plans, including Medicare Advantage and Part D. Nor does it align with commercial insurance open enrollment periods, which also traditionally take place between October and December of each year. This fragmentation is inconsistent with the goals of maximizing coverage continuity and informed beneficiary choice and easing beneficiary transitions to Medicare. The BENES Act would correct this by shifting the three-month GEP from January to October.

<sup>26</sup> Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care Delivery System” (June 2019) available at: [http://www.medpac.gov/docs/default-source/reports/jun19\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0).

<sup>27</sup> *Ibid.*



Taken together, the BENES Act's long overdue, commonsense changes would better empower people who are approaching Medicare eligibility to make optimal, timely coverage decisions that build their health and economic security.

These reforms have been endorsed by eight past CMS Administrators who served in both Democratic and Republican administrations. In an August 2016 letter supporting the BENES Act when it was first introduced, they wrote "...we frequently disagree among ourselves about any number of issues. But we all agree on the importance of treating Medicare beneficiaries fairly, efficiently, and as helpfully as possible. That's why we have come together in support of the bipartisan [BENES Act]."<sup>28</sup> The bill is also strongly supported by the Medicare Rights Center and a diverse array of nearly 100 stakeholder organizations, including consumer advocates, health plans, unions, service providers, and faith-based groups.<sup>29</sup> We reiterate this long-standing support again here, and urge you to pass the BENES Act without delay.

### **The Protecting Patients Transportation to Care Act (H.R. 3935)**

Medicaid is an important source of health care for 12 million people with Medicare, covering needed services that Medicare does not, such as long-term services and supports (LTSS) and some types of nonemergency medical transportation (NEMT) to medically necessary health services. Medicaid also makes Medicare more affordable by helping low-income beneficiaries pay their premiums and cost-sharing amounts.<sup>30</sup>

Individuals who are eligible for both programs, known as dual eligibles, tend to have complex health care needs which can require recurring doctor appointments, strict adherence to prescription medication, and frequent medical tests: 41% of dually eligible individuals have at least one mental health diagnosis, 49% receive LTSS, and 60% have multiple chronic conditions, such as ESRD, diabetes, or heart disease.<sup>31</sup>

For these and other high-need Medicaid enrollees, consistent, reliable transportation to and from their medical appointments is crucial but may not always be readily available. Health and affordability issues may make it impossible for them to drive a car, use public transit, or pay for a ride. Others, such as those who live in rural areas, may have limited public transportation options and face long travel times. In these instances, Medicaid NEMT can be a lifeline. It facilitates access to medical services for low-income beneficiaries who have no other means of

<sup>28</sup> Letter from eight former CMS Administrators to leaders of the House Committee on Energy & Commerce, the House Committee on Ways & Means, and the Senate Committee on Finance (August 22, 2016) available at: <https://www.medicarerights.org/pdf/CMS-Admin-Support-Ltr-BENES-Act-S3236-HR5772-082216.pdf>.

<sup>29</sup> Letter from 85 stakeholder organizations to Chairman Richard Neal and Ranking Member Kevin Brady of the House Committee on Ways & Means (June 25, 2019) available at: <https://www.medicarerights.org/pdf/062619-benes-act-support-letter.pdf>. See also: List of 95 supporting organizations submitted for the hearing record.

<sup>30</sup> Centers for Medicare & Medicaid Services, "People Enrolled in Medicare and Medicaid" (March 2019) available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_Factsheet.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf).

<sup>31</sup> *Ibid.*

transportation—helping them receive the care they need to manage their conditions and improve their outcomes.

Consider Ms. V, a Medicare Rights client who is a dual eligible and lives independently in an apartment building. She has several health challenges and is unable to walk without assistance, much less drive a car or navigate public transportation. Through her Medicaid NEMT benefit, she is able to safely attend her medical appointments. Another client, Ms. L, has ESRD and multiple chronic conditions. She doesn't qualify for a kidney transplant and needs dialysis regularly to stay healthy and independent. Without Medicaid NEMT, she wouldn't be able to access this life-sustaining care while living at home and participating in her community.

Of the less than 10% of Medicaid enrollees who qualify for and use NEMT,<sup>32</sup> many, like Ms. V and Ms. L, rely on the benefit to access services that help them stay healthy—such as dialysis, substance use disorder/behavioral health care, adult day health care, preventive care, specialist visits, and physical therapy/rehabilitation.<sup>33</sup> Assisting individuals in getting to their routine medical appointments allows them to receive preventive care and stick to treatment regimens that help them build and maintain their health—as well as avoid costly medical emergencies, hospitalizations, and institutionalizations.

Multiple studies agree the benefit is cost-effective.<sup>34</sup> One such review found that for the estimated 3.6 million people who miss or delay medical care each year due to lack of transportation, NEMT was a cost-effective or cost-saving way to help them manage their conditions.<sup>35</sup> Another concluded that NEMT yielded impressive returns on investment for dialysis and wound care.<sup>36</sup> And still another found that adults who lack transportation to medical care are more likely to have chronic health conditions that can escalate to require more expensive care if not properly managed.<sup>37</sup>

NEMT can also help people travel to their pharmacies to pick up their prescriptions and medical supplies. In some states, such as Georgia, the benefit covers rides to pharmacies whether or not they are part of a trip to a medically necessary health service. This function—and its potential to improve prescription drug access and adherence—is especially critical for dual eligibles. In part this is due to utilization. Older adults take an average of four to five prescriptions per month, and over two-thirds have multiple chronic conditions that require ongoing medical

<sup>32</sup> Letter from the Congressional Black Caucus to Chairwoman Rosa L. DeLauro and Ranking Member Tom Cole of the House Committee on Appropriations, February 15, 2019.

<sup>33</sup> MaryBeth Musumeci and Robin Rudowitz, Kaiser Family Foundation, “Medicaid Non-Emergency Medical Transportation: Overview of Key Issues in Medicaid Expansion Waivers” (February 2016) available at: <https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/>.

<sup>34</sup> Justice in Aging, “Medicaid Non-Emergency Medical Transportation for Older Adults: A Critical Benefit at Risk” (May 1, 2019) available at: <https://www.justiceinaging.org/fact-sheet-medicaid-non-emergency-medical-transportation-for-older-adults-a-critical-benefit-at-risk/>.

<sup>35</sup> P. Hughes-Cronwick and R. Wallace, et al., Transit Cooperative Research Program, “Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation” (October 2005) available at: [http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp\\_webdoc\\_29.pdf](http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf).

<sup>36</sup> Adelberg, Michael; et al., “Non-Emergency Medical Transportation: Findings from a Return on Investment Study” (July 2018) available at: <https://mtacoalition.org/medical-transportation-101/health-economic-benefits/>.

<sup>37</sup> Richard Wallace, et al., “Access to Health Care and Nonemergency Medical Transportation: Two Missing Links” (2005) available at: [http://www.researchgate.net/publication/39967547\\_Access\\_to\\_Health\\_Care\\_and\\_Nonemergency\\_Medical\\_Transportation\\_Two\\_Missing\\_Links](http://www.researchgate.net/publication/39967547_Access_to_Health_Care_and_Nonemergency_Medical_Transportation_Two_Missing_Links).

treatment.<sup>38</sup> At the same time, many live on fixed or limited incomes, which can make paying for medications or transportation to the pharmacy difficult.<sup>39</sup> Those who cannot purchase or collect their prescriptions may be forced to go without care—leading to worse health outcomes and quality of life. The Medicare and Medicaid programs are also impacted by barriers to enrollee prescription drug access and affordability, as those who forgo medication and experience declining health as a result may need more extreme interventions later.<sup>40</sup>

NEMT has been a mandatory Medicaid benefit by regulation since the Medicaid program's inception in 1966,<sup>41</sup> based on the Department of Health and Human Services' statutory authority to require state Medicaid plans to provide for methods of administration necessary for their proper and efficient operation.<sup>42</sup> Additionally, as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, states are required to offer children from birth to age 21 and their families "necessary assistance with transportation" to and from providers.<sup>43</sup>

As all 53 members of the Congressional Black Caucus noted in a February 15, 2019 letter, "over half of Medicaid transportation services are utilized by patients with the highest burden of chronic diseases, including those diagnosed with cancer, HIV, mental illness, substance abuse, and end-stage renal disease....without this help, they could not access the chemotherapy, dialysis, and other services that allow them to remain at home and out of the hospital."<sup>44</sup> In 2017, members of the Blue Dog Coalition also weighed in to support the benefit, writing "NEMT is an essential component of our nation's health care system, especially in rural areas."<sup>45</sup>

The Protecting Patients Transportation to Care Act (H.R. 3935), introduced by Reps. Carter (R-GA) and Cardenas (D-CA), along with Reps. Graves (R-GA) and Bishop (D-GA), would formally codify this long-standing requirement, ensuring that beneficiaries have meaningful health care coverage. The Medicare Rights Center and nearly 60 other NEMT stakeholders strongly support H.R. 3935 and urge its swift enactment.<sup>46</sup>

## Conclusion

Based on our work with people with Medicare and their families, we know that health care access and affordability are ongoing challenges. Every day on our National Consumer Helpline,

<sup>38</sup> Purvis, Leigh; et al., AARP Public Policy Institute, "Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans: 2017 Year-End Update" (September 2019) available at: <https://www.aarp.org/content/dam/aarp/ppi/2019/09/trends-in-retail-prices-of-prescription-drugs-widely-used-by-older-americans.doi.10.26419-2Fppi.00073.003.pdf>.

<sup>39</sup> Jacobson, Gretchen; et al., Kaiser Family Foundation, "Income and Assets of Medicare Beneficiaries, 2016-2035" (April 21, 2017) available at: <https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/>.

<sup>40</sup> Lee, Shinduk et al., "Attitudes, Beliefs, and Cost-Related Medication Nonadherence Among Adults Aged 65 or Older With Chronic Diseases" (December 6, 2018) available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6292137/#>.

<sup>41</sup> 42 C.F.R. § 431.53.

<sup>42</sup> 42 U.S.C. § 1396a(a)(4)(A).

<sup>43</sup> 42 C.F.R. § 441.62; *see also* 42 U.S.C. § 1396a(a)(43).

<sup>44</sup> Letter from the Congressional Black Caucus to Chairwoman Rosa L. DeLauro and Ranking Member Tom Cole of the House Committee on Appropriations, February 15, 2019.

<sup>45</sup> Letter from Reps. Sanford Bishop, Charlie Crist, Jim Cooper, Henry Cuellar, Vincente Gonzalez, Josh Gottheimer, Daniel Lipinski, Tom O'Halleran, Collin Peterson, David Scott, and Kyrsten Sinema to Chairman Greg Walden and Ranking Member Frank Pallone of the House Committee on Energy & Commerce, October 17, 2017.

<sup>46</sup> *See*: List of 58 supporting organizations submitted for the hearing record

we hear from older adults and people with disabilities who are struggling to cover these costs and obtain services for which they are eligible.

To improve the health and financial well-being of current and future Medicare beneficiaries, I urge you to pass the BENES Act and the Protecting Patients Transportation to Care Act this year. These urgently needed legislative solutions would help an ever-growing number of Americans make informed Medicare enrollment choices and stay healthy in their homes and communities.

Additionally, as you work to strengthen the Medicare and Medicaid programs this year through an extenders package or otherwise, I respectfully ask you to address several programs and policies that require prompt action due to looming expirations or other circumstances. Recently championed by the Medicare Rights Center and 71 other national organizations representing older adults, people with disabilities, consumers, and providers, these time-sensitive matters include relief for Medicare beneficiaries who will face even higher prescription drug out-of-pocket costs this year due to the January 1 increase in Medicare Part D catastrophic coverage eligibility thresholds from \$5,100 to \$6,350; at least five-year extensions of the Medicaid Home and Community-Based Services (HCBS) Money Follows the Person Program (MFP), and Spousal Impoverishment Protections; and permanent, increased funding for Medicare low-income outreach and enrollment efforts.<sup>47</sup>

Again, thank you again for the opportunity to be here today. I look forward to continuing to work together to improve Americans' health care coverage and outcomes.

<sup>47</sup> Letter from 72 stakeholder organizations to Speaker Nancy Pelosi, Minority Leader Kevin McCarthy, Majority Leader Mitch McConnell, and Minority Leader Chuck Schumer (December 16, 2019) available at: <https://d2mkcg26uv91cz.cloudfront.net/wp-content/uploads/Medicare-Medicaid-Extenders-Group-Letter-12-16-19.pdf>.