State Solutions

An Initiative to Improve Enrollment in Medicare Savings Programs

# *Why Inreach Makes Good Business Sense: The Case for Medicare Advantage and Part D Plans*

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## Introduction

Enrollment in Medicare subsidy programs – including both the Part D Extra Help/Low-Income Subsidy (LIS) and Medicare Savings Programs (MSP) that provide help for paying Part B premiums and cost-sharing – has been lower than expected. Efforts to get people enrolled in LIS have largely focused on broad-based outreach to Medicare beneficiaries in general, not to those currently enrolled in Part D plans. However, a sizeable number of individuals that are eligible but not enrolled in both LIS and MSP subsidy programs are currently enrolled in Medicare Advantage (MA) and Part D plans.[1] Much less attention has been given to "inreach" to get these individuals enrolled, and to the attendant business advantages for Medicare health and prescription drug plans.

This issue brief discusses the potential societal, marketing, and economic benefits of an investment in inreach to health and drug plans' existing members. Inreach generally includes identifying plan members likely to be eligible for LIS and/or MSP, providing information on the benefits available, and/or providing assistance with applications to get them enrolled. This paper first describes the favorable business case for such an investment in the context of current plan payment methods and marketing guidelines. We then present a case study of a successful joint project between Kaiser Permanente (KP) and the National Council on Aging (NCOA) to assist KP health plan members with applying for LIS and making them aware of their likely eligibility for MSP and other important public benefits. The case study offers evidence of a favorable return on investment both to plans and their members and provides the conceptual justification for inreach to health plan members.

## Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 authorized the largest expansion of Medicare since its inception in 1965, creating

a prescription drug benefit open to all people with Medicare. While Medicare Prescription Drug Coverage (also known as Medicare Part D) is available to all beneficiaries, Part D coverage is most generous for those with limited incomes and resources who qualify for the LIS, which covers between 85 and 100 percent of their prescription drug costs.

The Medicare Savings Programs, which were first established as part of the Medicare Catastrophic Coverage Act in 1988 and expanded throughout the 1990s, help Medicare beneficiaries with limited incomes and assets pay Medicare Part B premiums, and in some cases, other cost-sharing.

While administered separately, there are some linkages between these two Medicare subsidy programs. People enrolled in the Medicare Savings Programs – i.e., Qualified Medicare Beneficiary (QMB), Specified Low-Income Beneficiary (SLMB) or Qualifying Individual (QI) – are "deemed" eligible for the LIS. This means that they are automatically enrolled in the LIS and do not have to apply separately. In addition to help with Part B premiums and in some cases cost-sharing, MSP enrollees also receive the full LIS, which means they have no annual deductible and pay no monthly plan premium for Part D, provided they are enrolled in plans that meet the low-income benchmark for their region. In 2007, they also pay no more than $2.15 for generic drugs or $5.35 for brand-name drugs covered by their plan. The result is an extraordinary reduction in beneficiaries' out-of-pocket costs.[2]

Over 9 million people are currently enrolled in LIS. According to data from the Centers for Medicare & Medicaid Services (CMS), which administers Medicare, and the Social Security Administration (SSA) which is responsible both for finding those who may be eligible for LIS and processing their applications, by January 2007 nearly 6 million people with Medicare had applied for LIS, and about 2.3 million had been found eligible for this important benefit. An additional 6.9 million people have been automatically enrolled in LIS by virtue of their participation in Medicaid, MSP, and/or Supplemental Security Income (SSI).[3]

Despite large scale outreach and enrollment efforts by CMS, SSA, the Administration on Aging, and national and local organizations, there are still millions of people likely eligible, but not yet enrolled in LIS. CMS reported that about three-fourths of those without drug coverage, approximately 3.3 million people, were likely to be LIS eligible; however, a recent GAO report stated that as many as 4.7 million beneficiaries may be eligible for, but not enrolled in, LIS.[4] A recent survey of low-income seniors not receiving LIS, indicated that nearly half are currently in a Part D Plan.[5] Estimates of the number of people with Medicare currently in Part D plans who may be eligible for, but not yet receiving LIS, range up to 1.1 million.[6]

Part D plans were required by CMS to communicate with all of their members about the availability of LIS. This communication was done primarily through plan marketing materials such as letters and other direct mail to members, pre-enrollment packets, telephone scripts used by plan customer service representatives, and plan web sites.[7] Plans were also permitted to conduct specific LIS inreach (either themselves or through a subcontractor) to all or part of their membership and to follow up no more than two times via phone or letter with those who were the target of that initial inreach. Consistent with Part D marketing in general, plans or their subcontractors were not allowed to conduct in-home solicitation or marketing related to LIS, unless invited by a member to do so.[8]

Although expanded outreach efforts and simplified enrollment processes for MSPs have led to increased participation in recent years, many are still not enrolled. Estimates of the number of MSP eligible but not enrolled vary widely, ranging from 3 to 4 million.[9,10,11] It is unknown how many of these are in Medicare Advantage or Part D plans. A conservative estimate presuming an equal number to the percent of Medicare beneficiaries enrolled in MA plans, would suggest as many as 800,000 are MSP eligible but not enrolled in Medicare health plans or nearly 10% of MA plan members.[12]

In contrast to LIS, neither MA or Part D plans are required to inform their members about MSP. However, like LIS, plans are permitted to conduct specific MSP inreach with similar restrictions on the number and form of contacts.

## *Reasons for Private Plans to do MSP/LIS Inreach*

In addition to providing an important benefit to plan members, there are tangible benefits that accrue to plans. The tangible benefits for Medicare Advantage and Part D-only plans differ significantly, so each will be discussed separately.

### *Increased Revenues*

Both Medicare Advantage and Part D-only plans are paid more, all else being equal, when they succeed at inreach.

In Medicare Advantage, plans are paid more for members that are higher risk through “risk adjustment” payment factors.[13] These payments are person-specific and are based on the diseases that they have, on some “status” codes and on demographic variables. Specifically, when a member becomes enrolled in MSP, the Medicaid status code is turned on. This results in a payment increase, as noted in the example below.

**Table 1: Risk Payments with and without Medicare Savings Program Enrollment**

| Risk factors | Example 1: MSP Enrolled | Example 2: MSP Eligible but not Enrolled |
|---|---|---|
| 76-year old female | .468 | .468 |
| Medicaid (including MSP) | **.177** | .000 |
| COPD (lung disease) | .398 | .398 |
| CHF (heart failure) | .395 | .395 |
| Vascular Disease w/ complications | .645 | .645 |
| CHF-COPD interaction | .216 | .216 |
| Total Risk Factor | 2.299 | 2.122 |
| $11,000/year per unit of risk(Los Angeles, 2007) [14] | $25,300 per year | $23,300 per year |

As shown above, a change in MSP status increases CMS payments to the individual's MA or Medicare Advantage Prescription Drug (MAPD) plan by $2,000 per year in the Los Angeles area (2007).[15]

Both Part D-only plans and Medicare Advantage drug plans also receive extra payments for LIS-enrolled members. Specifically, for most LIS enrollees a drug plan receives 8% more than they receive for a non-LIS member.[16] This factor is applied to only the Part D revenues from CMS, which are person-specific and which vary geographically. Given that CMS Part D premium support payments to plans are often less than $1,000 per year (2007), the incremental revenues caused by a member's enrollment in LIS are small.

In summary, all plans, whether MAPD or Part D-only, stand to benefit somewhat from getting their members enrolled in MSP and LIS. Medicare Advantage plans offering Part D stand to benefit from two risk adjustment factors (i.e., for medical care and for drug coverage) when they succeed at inreach. The incremental reimbursement for LIS alone in Part D-only plans is less significant than MSP, but the costs of identifying members are also lower because LIS applications are centrally administered by SSA, can be completed online, and require less documentation.

***Potential Obstacles***

There are three obstacles that weaken the business case for inreach by plans.

First, there is up to a one year lag before the MA payment increment begins. The CMS payment system computes risk factors using the member's Medicaid/MSP status code during the previous calendar year.

For example, if a member's MSP enrollment was effective in March 2007, this health plan's revenues are unaffected until January 2008. Despite this delay, elderly beneficiaries' economic situations rarely improve dramatically. Therefore, the MA plan can reasonably assume that the payment increment will often persist for many years.

Second, plans must factor in the cost, complexity, and low success rates of inreach. The case study below demonstrates that all are significant. If the MSP/LIS processes were easy and straightforward, the innovative approaches used by Kaiser Permanente and others would be unnecessary.

Third, the health plan's inreach investment can be made moot by events in the member's life. A medical crisis, a housing crisis, bankruptcy, or a variety of other life events cause members of this sub-population to become Medicaid-eligible every year. The MA payment increment described above is still payable, but a business case for inreach cannot reasonably take credit for them. Similarly, other entities' beneficiary education efforts would have succeeded eventually for some members.

The business case for inreach by MA and MAPD plans is a calculus which balances all these factors. As amply demonstrated in the case study below, we have strong evidence that this calculus will often indicate a favorable result.

In many ways, the business case for inreach is old news. Several niche specialty vendors have emerged that specifically focus on identifying potential health plan members that might be eligible for public programs – most commonly Medicaid, but also Medicare Savings Programs – and on providing application assistance. Medicare Advantage plans have purchased these services because they believe that the calculus described above is favorable. In fact, in interviewing state officials in Oregon about significant increases in MSP enrollment in 2000, they attribute almost all of the increase to these efforts by a large Medicare Advantage plan and its vendors.[17]

The potential difference with Medicare Part D is that now the Medicare Savings Program is essentially two-benefits-in-one for MAPD plans. Investing in intensive inreach now provides the added benefit of having them automatically deemed eligible for LIS.

Little information is publicly available that delineates the costs of specialized inreach services and application assistance relative to the benefit of enhanced revenues from risk adjustment. The case study that follows provides a glimpse of one plan's experience.

### *Kaiser Permanente Case Study*

In 2005 and 2006, Kaiser Permanente and National Council on Aging (NCOA) teamed up for an initiative designed to increase access to the LIS, MSP and other benefits for eligible KP Medicare members and provide some application assistance for those who needed it.

Kaiser Permanente is the largest nonprofit health-care organization offering a continuum of services in the United States. KP cares for 8.5 million members, and 875,000 Medicare members (through its Medicare Advantage or Medicare Advantage prescription drug plans) in eight geographic regions, nine states and the District of Columbia.[18] NCOA is a national nonprofit advocacy and education organization with a national network of more than 14,000 organizations and leaders dedicated to improving the lives of older Americans.

This joint effort had four overarching objectives:

1. To identify and help to enroll as many qualified KP members into LIS as possible and to inform these same members about their likely eligibility for MSP and other important public benefits.
2. To develop and sustain an infrastructure at KP to respond to future initiatives related to enrollment in LIS and MSP for this segment of its membership.
3. To support local, grassroots LIS outreach and enrollment initiatives.
4. To share with others in the field lessons learned related to getting low-income Medicare beneficiaries into benefits for which they qualify.

To achieve these ends, this joint initiative included a targeted mailing, inbound and outbound calls utilizing a specialized LIS call center, the use of technology to identify eligibility for benefits, and grants to local, community-based organizations to enroll people in these benefits. It also included a more traditional outreach campaign that included posters placed in clinics and pharmacies and use of various KP member communications vehicles. This initiative provided a favorable return on investment both in terms of the broader societal benefit and economically for Kaiser Permanente.

***Overview of the Inreach Initiative***

This campaign targeted both Medicare beneficiaries who directly pay KP to be enrolled in a Medicare Advantage plan and those whose employers or prior employers pay KP to offer supplemental health care coverage to Medicare beneficiaries. To target inreach to KP Medicare plan members that might be eligible for LIS, KP and NCOA used a proprietary predictive modeling tool using various criteria including age, income, gender, marital status, and asset and home value estimates.[19] Based on this predictive modeling, nine percent of KP's Medicare population – nearly 80,000 members – were

identified as potentially eligible. Estimates varied across the eight KP regions, ranging from 6 percent to nearly 15 percent. In addition, over 4,000 members were also referred for LIS inreach services from KP's pharmacies and membership services.

KP members identified as eligible for LIS through the predictive model and by referrals received multiple mailings from the "Kaiser Permanente Extra Help Center" on joint NCOA/KP letterhead. The letters informed members about LIS and their potential eligibility. For further information, members were either referred to a dedicated LIS call center and/or provided a response card with a prepaid envelope to send in a request that someone contact them for assistance. CMS regulations currently prohibit Part D plans from directly contacting beneficiaries without their explicit permission. The LIS call center was also advertised through broader awareness-raising techniques including posters, flyers displayed in KP pharmacies and clinics, and other member communications.

The LIS call center supported KP members that called in by assisting them with the completion and submission of the LIS application to the Social Security Administration. The call center also made outbound calls to all non-responders of the mailings. Because CMS regulations do not allow plans to collect personal information on outbound calls, initial non-responders who were reached and now interested in applying had to call back in to the call center to receive application assistance.

Members who were assisted with the LIS application were also screened to determine if they qualified for a Medicare Savings Program, Medicaid, Supplemental Security Income (SSI), and other Federal and state programs. This was an automated process, known as batch screening, using data collected during the LIS application process. Members then received a customized report about their eligibility, with information on programs that the member appeared eligible for including: a brief description of the benefit, what information would be needed to apply for the program and a local agency address and/or phone number where members could apply for the benefit. This process did not guarantee eligibility in those programs. Rather, it was intended to help members access additional benefits for which they may be eligible, but about which they may not have otherwise known.[20]

As part of its broader public service mission, Kaiser Permanente, through a community grant initiative, also supported local organizations engaged in providing assistance to Medicare beneficiaries that might be eligible for LIS. The grants were made to six non-profit agencies in five KP regions to support LIS enrollment to non-KP members, and to connect KP regions with community-based organizations in their area.

Finally, in order to sustain these efforts and equip itself with the ongoing capability to continue LIS enrollment efforts through its own membership services operators, KP and NCOA developed an online

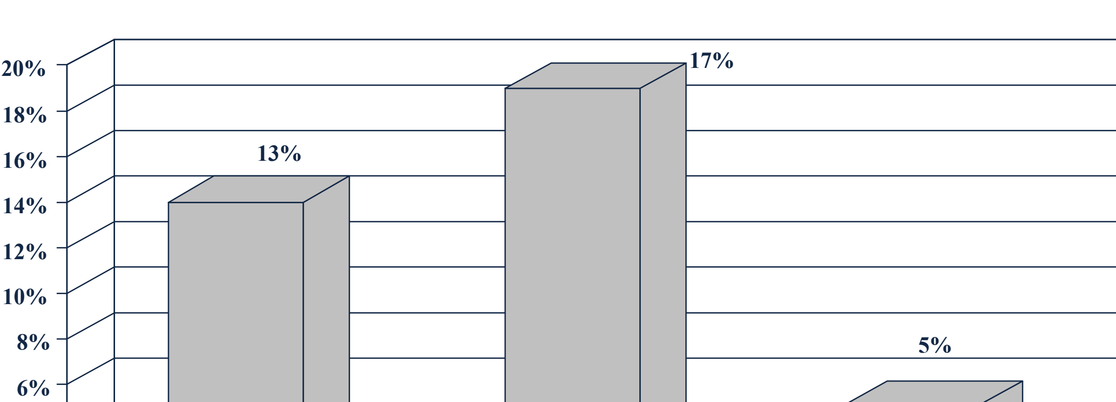
tool to identify member eligibility for benefits. *KaiserPermanenteCheckUp*, a customized version of NCOA's BenefitsCheckUp tool tailored to KP regions' key benefits programs (including its own Charity Care program), was designed to enable KP staff to help members determine their eligibility for LIS and other benefits.[21,22]

***Key Findings***

Of the total Medicare population identified as being likely eligible for the LIS, 23 percent responded to the direct mailing or a follow-up call to them (up to two calls made) with the goal of informing them of their potential eligibility. Ultimately, about 13 percent (or 10,700 members) applied for LIS. Some reasons members did not want to proceed with applications included: 1) they believed themselves to be ineligible; 2) they didn't want to give out financial information; and, 3) they preferred to submit a paper application themselves. Of those whom applied, 25 percent (2,600 people) were found eligible for LIS.[23]

A higher proportion of direct pay (individual) members responded and applied (17% or 9,209 members) compared to the employer group population [5% or 1,464 members) (Figure 1).[24] One explanation for this difference may be that many with employer-sponsored coverage either assumed their coverage was sufficient for their prescription drug needs and/or did not understand the benefits of LIS as compared to their current coverage. These findings illustrate the importance of personalized counseling in order to assist specific populations with understanding benefits and with the overall decision-making process.

**Figure 1: Percentage of Contacts Converted to Applications for KP-NCOA Outreach Program, by Member Type, 2006**



Over 10,200 of the LIS applicants were also screened for potential eligibility for other benefit programs.[25] Of the total screened, 22 percent (or 2,301 members) were found to be eligible for but not currently receiving Medicaid, 7 percent (or 766 members) for MSP (but not full Medicaid),[26] and 16 percent (or 1,643 members) for SSI.

***Lessons Learned***

**Lesson #1: Using a "person-centered" approach to screening and enrollment – in particular, coupling Medicaid, MSP and LIS inreach and enrollment – is critical to ensuring access to benefits for low-income beneficiaries and maximizing value for both the member and the plan.** People who are eligible for one means-tested public benefit are highly likely to also be eligible for, but not receiving, other key public benefits. KP found that as many as 29 percent of LIS eligible members were potentially Medicaid or MSP eligible. Separate research of NCOA's national BenefitsCheckUp data have shown that as many as 65 percent of LIS applicants are also likely to qualify for MSP.[27]

Offering information on additional benefit qualifications at the point of LIS application is effective. Research has shown that approximately 33 percent of those informed of benefit eligibility are likely to follow through with application and ultimately, enrollment.[28] Furthermore, a much larger uptake in follow-through – as much as 50% – has been shown to result when the individual receives assistance with the application process.[28] While the availability of an online application process for LIS certainly enables an easy and cost-effective means of providing such assistance, health plans should consider ways of offering a similar service for other benefits such as MSP. It may not be feasible for the plan itself to assist with the application, but there are several national and regional vendors who provide that service. Three of the KP regions were using such external partners for Medicaid/MSP outreach during the course of the project.

Person-centered screening is efficient whenever an organization assists beneficiaries to identify program eligibility, but it is particularly so in a targeted inreach project. With the KP inreach project, nearly 75 percent of the direct costs associated with application were the process of engaging the individual (compiling target lists, producing and mailing outreach letters, handling in- and outbound calls, etc.). Therefore, there is minimal added cost, but significant incremental value, associated with each additional benefit beyond the first. For example, by just informing the 3,000 members who appeared eligible for MSP or Medicaid, KP significantly increased both the members' and the plan's projected annual value of benefits as a result of the project.

KP maximized the concept of increasing returns in two ways: 1) batch screening through BenefitsCheckUp was performed for all low-income members who had applied for LIS, to address any further benefit eligibility; and 2) a custom version of BenefitsCheckUp was implemented, to enable their staff to screen future low-income members at the point of contact.

Technology that both screens for and allows someone to enroll in LIS, while allowing them to understand other benefits for which they may be eligible and directing them on how to apply for them, is both efficient and effective. Furthermore, coupling this person-centered approach that maximizes the return on investment, with a cost-reducing strategy such as the use of predictive modeling on a health plan's membership list, is a powerful strategy for health plans performing benefits outreach.

**Lesson #2: "Warm" transfers (direct transfers of member phone calls to call center specialists prepared to provide immediate LIS application assistance) seem to be the most promising and cost-effective LIS enrollment strategy.** A portion of the KP inreach project was a more traditional broad-brush educational campaign to inform all members of the LIS opportunity and encourage those who thought they might qualify to contact either their local KP regional office or the LIS call center for further details. Posters and handouts were placed in the pharmacies and clinics throughout the KP system. Articles were also included in member newsletters and on the KP website. KP Member Service departments were also informed of the project and instructed to transfer any member with an inquiry regarding LIS to the call center.

While the majority of the LIS applicants in the project were identified through and contacted as part of the targeted inreach campaign, a portion were reached through the informational campaign and subsequent conversations with a KP Member Services representative. These individuals, who had already "self-identified" as potentially LIS eligible and were often prepared with application information and material on-hand, were then forwarded directly to a LIS call center staff person who was ready to assist them with the application. This provided a seamless process for LIS enrollment by keeping beneficiaries from having to call another number, which often discourages action.

Given that these individuals did not incur expenses associated with targeting, mailing and following up in order to reach them, but rather self-referred into the process, their direct cost per application was substantially less than the outreach group. Additionally, their initiative and preparedness resulted in a much greater contact-to-application conversion rate.

**Table 2: Application Rates and Costs by Inreach Strategy[29]**

| KP Outreach Project | Mail & Calls | Referrals |
|---|---|---|
| Total Members Contacted | 79,761 | 4,520 |
| Total Applications | 7,764 | 2,927 |
| Contact-to-Application Conversion Rate | 9.7% | 64.8% |
| Direct Cost per Application | $143 | $18 |

These warm transfers, or referrals of KP members to the specialized LIS call center, were overall, the most successful strategy for converting contacts into LIS application submissions.

While this finding by no means indicates that a “reactive” approach should replace targeted inreach, it demonstrates the importance of 1) having a mechanism through which individuals not included in the targeted inreach can “raise their hands” for assistance; and 2) having a place to refer people at the very moment when they are looking for information.

**Lesson #3: Overall, inbound calls produced more LIS applications than outbound calls.** Conversion rates, or the percentage of individuals that ultimately submitted an application for LIS, for inbound calls under the KP initiative were 250% greater than those for outbound follow-up calls with non-responders (40% versus 15%, respectively). Members who proactively called the LIS call center phone line were more prepared to apply, given that applications requirements were articulated in the mailings. As a consequence, call center operators, in working with people who willingly called, were able to complete LIS applications more quickly and completely than possible through outbound calls to members. While the outbound calling process netted an additional 2,583 applications, the incremental cost of the process ($59 per application) may not be feasible or practical in an outreach project with a more limited budget.

**Lesson #4: Inbound calls are also more effective than response cards for getting people to apply for benefits.** Members initially targeted with mail outreach were given the option to get more information by making an inbound call to KP’s LIS call center or to submit a response card requesting that someone call them back. The purpose of varying the options was to test response rates – i.e., whether an individual would feel more comfortable requesting a call back from the call center or placing a call to the center directly. The inbound calls led to higher application rates compared to response cards (47% versus 29%, respectively). Response cards required more contact attempts from KP, and over 30 percent of response card responders were unable to be reached. Therefore, while response cards are effective for a portion of the target population, an option for inbound calls should not only be included in any outreach strategy, it should be emphasized as the primary avenue for response.

**Lesson #5: Outbound calls to people likely to be eligible for benefits are generally less effective when inbound call back is required.** Outbound calls to those who sent in a response card asking for a call, and to those who did not respond to the mailing at all were less effective when an inbound call back was required. While 32 percent of those reached on an outbound call expressed interest in the program, more than 50 percent of those interested failed to call back. Individuals were required to call back due to current government guidelines which do not permit health plans to request personal information on an outbound call. Therefore, applications were lost in this two-step process. As noted above, outbound calling did increase penetration, adding 2,583 applications, but at higher cost per application due to fewer applications being submitted using this strategy (i.e., a lower conversion rate).

***Value to Plans and Their Members***

A conservative financial analysis of the return on investment (ROI) for this program shows that both members and the health insurance plan benefited from this large-scale outreach and enrollment effort. Overall, Kaiser Permanente members attained an undiscounted 17:1 ROI on the project and Kaiser Permanente attained a 5:1 return. This translates to $24 million in discounted lifetime benefits for members and almost $5 million in additional discounted revenue for KP.[30] For members, these financial benefits are realized in the form of reduced co-pays and co-insurance, expanded medical coverage, actual increases in their Social Security checks, and Supplemental Security Income. For the health plan, the increased revenue is driven by additional reimbursement from Medicare based on the members' categorization as either LIS or dually eligible (including MSP), with MSP accounting for the majority of the increase.

To arrive at these estimates of return, NCOA and Kaiser Permanente used the following assumptions:

***Benefit Values***

- Valuation of LIS/Medicaid/MSP benefits to KP members included only the incremental value beyond the benefit already provided by KP Medicare Advantage plan. The SSI benefit valuation used an estimated combined average value of state and Federal benefits for low-income seniors.
- LIS/Medicaid/MSP incremental revenues to KP were estimated by the KP finance department in the fashion noted above. The revenues reflected the increased payments from CMS for members in these benefit categories.

***Duration & Discount***

- Member duration was based on internal KP studies, and assumed that each member was at the mid-point of tenure.
- Money flows were discounted at KP's internal standard for present value calculations.

***Base Population***

- Only LIS enrollments that had been confirmed as of September 30, 2006 were counted. To remain conservative, NCOA applied no projections of final application-to-enrollment conversion rates.
- Enrollment estimates for Medicaid/MSP/SSI used the results of the BenefitsCheckUp batch screening. The application-to-enrollment conversion rate was assumed to be 33 percent of those screened positive for benefits, with KP providing no further assistance members and no enrollment follow-up. If KP were to provide additional follow-up assistance enrollment rates could increase from 33% to 50%.[31]

In addition to the financial benefits to both members and plans, there are indirect and difficult-to-quantify benefits and avoided negative consequences attributable to this targeted effort. First, Kaiser Permanente offered an additional "service" to its clients, which is likely to generate increased satisfaction among

members and improved member retention over the long-term. Second, low-income beneficiaries, who have to bear the full cost burden of their prescription drugs or health-care benefits, often defer or reduce required medication use. Therefore, the medical consequences and costs avoided as a result of members being enrolled in the MSP and/or LIS and having these costs covered partially or in full are likely to ultimately decrease costs to health plans in the future, while improving the overall health and well-being of its membership. Third, by screening members for other non-medical benefits (i.e., Food Stamps, energy assistance, low-income housing), KP is helping members potentially improve their quality of life.

## *Conclusions and Implications*

With up to four million LIS-eligible and three to four million MSP-eligible Medicare beneficiaries yet to be found and enrolled in these valuable benefits, there is clearly a long road ahead in terms of outreach, education, and application assistance. As this brief discusses, health plans can play a vital role in this process. As a result of KP/NCOA's initiative, over 10,000 KP Medicare members likely eligible for LIS applied for that benefit, with just over 2,600 enrollments confirmed as of the end of the project. These same members were also screened and sent information about other important public benefits such as MSP, Medicaid, SSI, Food Stamps, energy assistance, and more. With seven percent of these members screening eligible for MSP and 22 percent screening eligible for full Medicaid, it is clear that such a person-centered approach is a sensible strategy. It helps members learn more about, and potentially enroll in, other benefits for which they may be eligible all at once, rather than having to hunt down this information for different programs at different times. In addition, as a result of the infrastructure developed by this effort, KP is also now better equipped to handle LIS and other benefit screening for its members in the future.

While KP's initiative was initially focused on providing LIS application assistance and only screening for MSP, one lesson learned is that the return on investment for health plans is larger if members enroll in both MSP and LIS. Since MSP enrollees are deemed eligible for LIS, providing MSP application assistance to members rather than only LIS application assistance yields two benefits in one with members' only needing to complete one application process. Health plans considering replicating or modifying KP's model may want to make the larger investment in MSP application assistance in order to yield an even larger return on investment.

Even modest enrollment rates resulting from inreach yield significant financial benefits both for members and health plans. KP's initiative resulted in discounted lifetime benefits to their members of approximately $24 million and almost $5 million in additional discounted revenue for KP. These estimates do not factor in the intangible benefits to KP of building brand loyalty among its members and potentially reducing utilization of more costly health-care services. By undertaking similar initiatives to promote MSP and LIS, health plans can "do well by doing good" for their members.

## *Endnotes*

1. "Medicare Advantage" (MA) denotes certain private health plans that serve Medicare beneficiaries, including Special Needs Plans and Regional PPOs. All of these plan types are paid by CMS on a "risk" basis for their members.
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12. Center for Medicare and Medicaid Services, Medicare Advantage in 2007, April 20, 2007 at http://www.cms.hhs.gov/hillnotifications/downloads/MedicareAdvantagein2007.pdf. CMS analyses of Current Medicare Beneficiary Survey (MCBS) data suggests that a disproportionate number of low-income beneficiaries may enroll in MA plans. If so, the number of MSP eligible but not enrolled in MA plans could be higher.
13. Medicare Advantage risk adjustment policy is described by CMS in cumulative annual advance-notice and final-notice documents. The original description of methodological intent can be found at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf
14. Center for Medicare and Medicaid Services, Ratebook at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp
15. The reason for a Medicaid/MSP revenue increment is well-documented in actuarial studies that underpin the CMS payment system. Health status and economic status are strongly related to each other, in an inverse fashion.
16. This 1.08 factor is applied multiplicatively to the sum of an enrollee's other Part D risk-adjustment factors. See CMS risk adjustment documents at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats for further information. A minority of LIS-enrolled beneficiaries generate a smaller 1.05 factor.
17. Tiedemann, A., Fox, K., Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements. State Solutions National Program Office, Rutgers Center for State Health Policy, New Brunswick, NJ. September 2004.
18. The geographic areas that Kaiser Permanente served during the study time period include: California, Colorado, Georgia, Hawaii, Maryland, Virginia, District of Columbia, Oregon/Washington State, and Ohio.

19. The Benefits Data Trust (BDT), a nonprofit organization co-founded by NCOA, developed this predictive modeling tool.
20. In addition to batch screening, many KP regions were already contracting with enrollment brokers to assist KP members with MSP enrollment.
21. BenefitsCheckUp, a service of the National Council on Aging (NCOA), a comprehensive web-based service to screen for benefits programs for seniors with limited income and resources. It includes more than 1,550 public and private benefits programs from all 50 states and the District of Columbia. A consumer version of the BenefitsCheckUp service is publicly available at www.benefitscheckup.org
22. Charity Care is a medical financial assistance program sponsored by Kaiser Permanente that provides temporary financial assistance to financially needy patients who received health-care services from a KP provider at a KP facility.
23. This application approval rate was slightly lower than anticipated for two key reasons: 1) At the time of the analysis, many applications were still pending so the status for many enrollees was unknown; 2) Applications were submitted on behalf of members screened ineligible for the LIS but who wanted to apply regardless in order to fulfill the members' wishes; therefore, these unfavorable enrollment results affected the overall application rate.
24. Those with employer or retiree coverage in plans receiving the retiree drug subsidy were excluded from the targeted inreach. Their current coverage was as good as or better than what they would receive under Part D (i.e., creditable coverage).
25. The difference between the 10,700 total LIS applications and the 10,200 batch screenings conducted is due to the fact that a small portion of the applications were submitted after the batch screening process was initiated.
26. Relatively low rates of MSP-only eligibility may be due to existing MSP inreach activities by enrollment brokers in some KP regions.
27. Analysis of data from the BenefitsCheckUp® database (N = 4,532), February 2007. KP's much lower rate of MSP potential eligibles may be attributable to pre-existing MSP application assistance efforts by enrollment brokers in some KP regions.
28. Firman J.P., Kiefer, K.M., Greenberg, J, Holmes, C.A., and Kopper, M. (forthcoming). *Bridging the Access Divide: How Technology Can Help Low-Income Seniors Get into Benefits*. The Commonwealth Fund: Washington, DC.
29. NCOA, Kaiser Permanente, and Benefits Data Trust presentation to CMS (August 23, 2006), *Kaiser Permanente Part D LIS Outreach Project Preliminary Findings and Implications,*
30. NCOA and KP presentation. (March 21, 2007), *Kaiser Permanente Medicare Prescription Drug Coverage Limited Income Subsidy (LIS) Member Outreach & Benefits Screening Program*, State Solutions' Summit, Washington, D.C.
31. Firman J.P., Kiefer, K.M., Greenberg, J, Holmes, C.A., and Kopper, M. (forthcoming). *Bridging the Access Divide: How Technology Can Help Low-Income Seniors Get into Benefits*. The Commonwealth Fund: Washington, DC.

State Solutions

The Medicare Savings Programs are publicly financed programs that help people pay for costs associated with Medicare, such as premiums, co-payments, and deductibles. It is estimated that 5 million people are eligible to receive financial help through the Medicare Savings Programs, but only half are enrolled. Eligibility is generally granted to Medicare enrollees with low incomes, including people with disabilities and seniors.

State Solutions is a national program working to increase enrollment in and access to the Medicare Savings Programs. Funding for State Solutions is provided by the Robert Wood Johnson Foundation and The Commonwealth Fund.

The National Council on Aging's mission is to improve the lives of older Americans. NCOA programs help older people remain healthy and independent, find jobs and training, increase access to benefits programs, and discover meaningful ways to continue contributing to society. A non-profit organization with a national network of more than 14,000 organizations and leaders, NCOA was founded in 1950 and is based in Washington, DC. For more information about NCOA, please visit www.NCOA.org.