State Solutions
An Initiative to Improve Enrollment in Medicare Savings Programs

Maximizing MSP Enrollment with Part D: Lessons from Three States

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Introduction

The challenges and opportunities presented by ongoing efforts to enroll poor Medicare beneficiaries in the low-income subsidy (LIS) for the Medicare Part D prescription drug benefit provide states with a new impetus to increase participation in Medicare Savings Programs (MSP). MSPs provide important assistance through Part B premiums and Medicare cost-sharing, enabling lower income individuals to afford Medicare coverage and promoting access to necessary health care for lower-income older adults and persons with disabilities.[1] Enrollment in state MSPs also confers eligibility in the LIS, increasing the social value of state efforts to maximize MSP enrollment. Interest and attention in the Part D program and the LIS, popularly referred to as *Extra Help*, should also provide an opportunity for increasing MSP enrollment.

This report examines the efforts of three states to boost enrollment in the MSPs. New York, Arizona, and North Carolina represent three different geographic regions of the country and each of these states have simplified MSP enrollment in some form and/or have recently experienced significant increases in MSP enrollment[2]. New York and North Carolina also have pre-existing state pharmacy assistance programs (SPAPs) for low-income elderly, which could influence how they elect to coordinate MSP enrollment and Part D. Based on interviews with state officials and a review of administrative documents, this report considers the states' previous MSP initiatives and their initial impact on MSP enrollment, and discusses state plans to continue these and other initiatives with the launch of Part D in late 2005 and early 2006 as an opportunity to concurrently expand MSP enrollment.

These states have adopted policies that other states seeking to increase both MSP and LIS enrollment may want to replicate. Similarly, consumer advocates across the country may wish to examine the approaches underway in other jurisdictions as they seek to maximize the opportunity that the launch of the Part D program may provide to improve these programs.

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The policies tested by these states to increase MSP enrollment include:

1) Eliminating the asset test for MSPs. This ensures that each individual below 135 percent of the federal poverty line seeking to enroll in the LIS will be definitively eligible for an MSP. For individuals enrolling in the LIS in a state office, they can be simultaneously registered for an MSP program without any further screening. This will increase the number of residents eligible for the LIS, as all MSP enrollees are "deemed" eligible, even if their assets exceed LIS thresholds.

2) Ensuring criteria used to determine asset and income levels are at least as liberal as those used to determine LIS eligibility. Like the elimination of the asset test, this policy ensures that state offices can sign up individuals for an MSP at the same time as they forward LIS applications to SSA.

3) Eliminating the requirement for in-person interviews for MSP enrollment, allowing simpler mail-in or Internet-based applications.

4) Eliminating documentation requirements, allowing (as the federal LIS application does) the substitution of personal attestation that eligibility requirements are met.

Current MSP Policies

As Medicare Part B premiums rise at historically high rates[3], the premium subsidies available through MSPs have become increasingly important to lower-income people with Medicare. MSPs remain significantly underenrolled. A study using 1999 data suggests 61 percent of the eligible, non-institutionalized population was signed up for an MSP, leaving about 2.75 million eligible but unenrolled.[4] The enrolled population for the QMB program is weighted heavily towards Supplemental Security Income beneficiaries who are automatically enrolled in many states.[5] Studies show that two major factors – lack of awareness of the program and the administrative complexity related to enrollment – stifle enrollment.[6]

In most states, MSP applicants must apply in person at a local welfare office, provide hard-to-locate documentation such as original birth certificates, life insurance or burial policies, endure intrusive questions regarding personal savings and other assets, and complete lengthy and confusing application forms. In recent years, Federal, state and philanthropic sector efforts, including the Robert Wood Johnson Foundation's State Solutions initiative to increase enrollment, have helped to expand outreach efforts, simplify the application process, improve renewal procedures and expand program eligibility. The experiences in Arizona, New York, and North Carolina are instructive of how states can boost MSP enrollment as the Social Security Administration leads enrollment efforts for the LIS.

Arizona

Arizona has moved to simplify the MSP eligibility process, reduce enrollment barriers, and increase the number of enrollees. Toward this end, in 2000 and 2001, Arizona implemented a variety of measures to expand enrollment in their MSP programs.[7]

These changes spurred an initial spike in enrollment, with MSP enrollment growing 14 percent from September 2000 to September 2001.[8] Growth in Arizona's MSPs has slowed somewhat since then.[9] Enrollment in the QI program grew 14 percent between December 2003 and May 2005. The SLMB program grew 8 percent during the same period. The number of QMB enrollees, the overwhelming majority of whom also qualify for full Medicaid benefits, grew by 11 percent.

Changes made to Arizona's MSPs in the past five years include:

- Excluding consideration of all assets in MSP determinations since 2000, making MSP eligibility premised on income alone. This decision was based on a study projecting that the cost of the eligibility expansion would be largely offset by savings on administrative overhead.[10]
- Excluding the consideration of in-kind support and maintenance from income determinations. This decision was based on the administrative burden of calculating in-kind support for eligibility workers, and the burdens associated with in-kind support for consumers, including the intrusive nature of the questions and the difficulty applicants have in understanding the rules and in accurately calculating their assistance from others.
- Excluding Medicare Savings Program and acute care Medicaid expenditures from estate recovery as permitted by federal law. Arizona officials said the practice was not cost-effective. They also acknowledged that estate recovery has been identified as a barrier to Medicare Savings Programs enrollment in other states.
- Increasing the Medicaid income level to the federal poverty level. This change coincided with a 14.3 increase in MSP enrollment over one year. At the time, officials speculated that improving the value of the MSP benefit to allow QMBs to qualify for full Medicaid encouraged more MSP applications.[11]
- Eliminating the requirement for an in-person interview.
- Adopting a streamlined application form for MSPs that only requires documentation of income, other health insurance, and citizenship.
- Implementing a streamlined, annual, mail-in renewal process utilizing pre-printed renewal forms. Officials commented that the earlier standard of bi-annual renewals with burdensome procedures undermined retention. Moreover, many persons who failed to renew often reapplied later engendering unnecessary frustration for consumers and administrative expense for the state.
- Obtaining permission in February 2005, from CMS, to exclude from income determinations the interest and dividends generated by financial accounts that are normally excluded from asset tests, such as crime victim payments or educational assistance. State Medicaid officials favor this

change because counting interest and dividends requires documentation and verification of these accounts, thus negating some of the benefits – including administrative savings – created by elimination of the asset test. A clarification to the federal statute already permitted the state to exclude interest and dividends from financial accounts that are counted by the statute for Medicaid asset tests, even though Arizona itself has eliminated its asset test.[12]

Despite Arizona's progress in liberalizing Medicare Savings Programs requirements, the program remains under-subscribed. State officials believe that consumers' limited awareness about the benefit remains a leading barrier to enrollment. In particular, Arizona has not undertaken significant outreach efforts in the last several years, so ongoing Part D outreach and education activities may provide an additional opportunity for publicizing the MSP programs, either on a stand-alone basis or as an avenue for Part D premium assistance for people with higher assets than the low-income subsidy standard.

New York

Over the last several years, New York has implemented a series of measures to reduce bureaucratic and financial barriers to enrollment and simplify the application process resulting in a steady increase in MSP enrollment. From March 2003 to March 2005, total MSP enrollment has increased from 249,851 to 371,492, An increase of over 48 percent. These totals also include QMB enrollees, the vast majority of whom also receive full Medicaid benefits. The elimination of the asset test for the QI program tripled enrollment during the same period. In particular, New York has:

- Implemented self-attestation of resources for all MSPs and community-based Medicaid;
- Created simplified application forms for SLMB and QI applicants, which can be downloaded from the Internet (QMB applicants must still use the longer Medicaid application, which is not available on-line);
- Eliminated the asset test for the QI program;
- Eliminated the face-to-face interview requirement for SLMB and QI and implemented a "deputization" strategy in selected counties, which permits individuals and community-based organizations to perform the interview function for SLMB and QI applicants, in those counties on behalf of the state;
- Implemented streamlined, mail-in renewals;
- Initiated a Part A buy-in agreement with CMS on behalf of MSP enrollees who are not fully eligible for Medicare Part A.
- Adopted an MSP application based on the CMS model, which does not require MSP applicants to declare in-kind support since this income is regularly considered to be included within reported income on the application. In addition, New York does not pursue estate recovery for MSP enrollees.

New York also runs a state pharmacy assistance program, the Elderly Pharmaceutical Insurance Coverage program (EPIC), which covers many residents with incomes that may also make them eligible for MSP programs. The EPIC program is strictly income-based, so low-income individuals with assets above the MSP threshold still qualify for benefits. In addition, EPIC does not generally require proof of income, enabling it to run a simplified, mail-in application process.

Historically, however, there has been limited coordination between EPIC and the New York MSPs. State officials explain that State regulations prohibit each program from sharing information that does not directly serve program goals. This means that EPIC and New York have not matched their enrollment lists.

Part D implementation should provide an even greater opportunity for collaboration across these two programs, as EPIC seeks to identify enrollees potentially eligible for the LIS, but does not intend its outreach to also expand MSP enrollment. For example, the EPIC program intends to hold LIS outreach events and pursue a range of enrollment efforts, including face-to-face assistance, with the intention of maximizing LIS enrollment among eligible EPIC participants. Since EPIC will provide secondary prescription drug coverage for those enrolled in Part D and since the LIS provides much more generous federal coverage than the basic benefit, EPIC has a strong incentive to ensure that their clients who are eligible enroll not only in the Part D program, but also apply for the LIS. While some of EPIC's outreach and enrollment activities will reach beyond the EPIC client population into the broader community of lower-income older adults, at the time of our interviews, the state does not plan to inform them about MSP. Similarly, although the state is planning to help EPIC enrollees complete LIS applications, they do not intend to provide members with this assistance for MSP applications – even for the MSPs that enjoy a more streamlined application process – nor do they have plans to provide referrals to the MSPs .

If EPIC and the MSP programs were able to share program data and enable the MSPs to conduct "inreach" on the EPIC enrollee population, New York may be able to identify and enroll a significant number of MSP enrollees. In addition, given EPIC's commitment to helping their members apply for LIS, the EPIC program would be able to better target these efforts if they knew which EPIC members are already "deemed eligible" for LIS because they receive MSP support. If these sister agencies – both of which reside in the New York State Department of Health – could work out their data sharing issues, the state could benefit from maximizing LIS enrollment among EPIC members, and simultaneously improve MSP enrollment. Other organizational collaboration, such as referrals to MSPs or assistance with MSP and LIS applications, could also improve MSP enrollment rates.

More importantly, since EPIC will realize significant cost savings by maximizing the number of EPIC enrollees that are enrolled in the LIS, it would benefit New York to eliminate the asset tests for the QMB and SLMB program – the asset test for the QI program has already been dispensed with – and use its outreach to sign members up for MSP programs. Any newly-eligible and newly-enrolled MSP beneficiaries would be deemed eligible for the LIS, and these individuals would also be eligible for – and

may be enrolled in – EPIC. Over half of those applying for the LIS have been disqualified because of financial resources over the asset threshold[13]. Making this population of New Yorkers eligible for the LIS through their enrollment in an MSP would reduce the cost the EPIC program incurs as a secondary payer to Part D plans. However, unlike the QI program, which is federally funded, the cost of the QMB and SLMB is shared by the states. New York would bear part of the cost of Medicare premiums and cost-sharing of QMB and SLMB members made eligible by the elimination of the asset test.

North Carolina

North Carolina assisted approximately 137,000 individuals with their Medicare Part B costs through the MSP in mid-2005, up from some 79,000 served at the end of 2003. [14] The state has implemented limited strategies to simplify the eligibility process and in some cases, these policies serve to expand financial eligibility as well. In particular, North Carolina:

- Accepts self-attestation of citizenship
- Uses automated data matches to verify some types of income; and
- Relies on a streamlined, mail-in process for renewal.

In addition, several of North Carolina's standard eligibility determination practices address application procedures that have proved to be barriers to participation in other states. For example, North Carolina does not pursue estate recovery for MSP beneficiaries.[15]

But unlike other states, North Carolina has not adopted a simplified, MSP-only application that would enable individuals to download applications from the Internet, or mail in the application. North Carolina still uses a single application for all Medicaid-funded health benefits. With few exceptions, individuals must apply in person at the county eligibility office, where eligibility workers screen applicants for all programs they may be eligible for, including full Medicaid benefits and MSPs. Eligibility workers usually help applicants fill out North Carolina's 20-page Medicaid application.

The state has taken only limited steps in easing financial eligibility criteria and in some cases imposes stricter requirements than those used to determine LIS eligibility. The LIS program has higher asset thresholds ($10,000 individuals/ $20,000 couples) than the state's MSPs, which follow the federal MSP limits ($4,000 individuals/$6,000 couples). Also, the LIS uses a more expansive definition of household size in determining income than the North Carolina MSPs. On the other hand, North Carolina excludes the first $10,000 in the cash value of life insurance from asset calculations, while the LIS only exempts the first $1,500 of life insurance cash value. Because of these differences, North Carolina may face challenges if it seeks to closely coordinate LIS and MSP.

The state has experienced a rise in MSP enrollment since 2003, largely but not entirely due to a surge in enrollment in June 2004 that is not entirely explainable. Enrollment in the SLMB program jumped sharply from just under 4,000 in May of 2004 to just over 29,000 a month later.. Participation in the

QMB program spiked 27.5 percent between May and June but also grew steadily before and after. During the year-and-a-half prior to May 2005, enrollment in the QMB program grew 48 percent, to 96,820, the vast majority of whom also receiving full Medicaid benefits. Participation in the QI program has been flat at around 10,000.

The June spike in MSP enrollment coincided with an extensive state outreach effort in its expanded Senior Care program, a pharmaceutical assistance program financed with state-only funds. That effort also illustrates the possible boost to enrollment that can flow from data sharing between the MSPs and LIS program for the new drug benefit.

Intense interest by legislators and the Governor's office in increasing Senior Care enrollment led North Carolina to experiment with several innovative techniques, including data-sharing between the MSPs and Senior Care. To maximize Senior Care enrollment, the North Carolina Medicaid agency examined its MSP enrollee pool and their diagnoses on cross-over claim files to identify people with MSP coverage who were likely to be Senior Care eligible but remained unenrolled and auto-enrolled them. Through this process, the state auto-enrolled 6,000 MSP enrollees into Senior Care in March 2004.

In addition to auto-enrolling MSP participants into Senior Care, the state also expanded eligibility for the pharmaceutical assistance program and conducted extensive outreach in conjunction with the publicity surrounding the transitional assistance provided for low-income seniors under the Medicare drug discount card. The result was an explosion in enrollment in Senior Care, with 80,000 enrollees joining in six months.[16] Many of these new enrollees, like those that are likely to apply for LIS under Medicare Part D in the future, may also be eligible but not enrolled in the MSP.

Using a grant from CMS, North Carolina conducted extensive outreach, including over-the-phone and in-person counseling, to SeniorCare members with incomes that potentially qualified them for the LIS to encourage their application for the subsidy. In addition, SeniorCare sent the state Medicaid department a list of members who are potentially eligible for a MSP but are not enrolled in a program so that the Medicaid could follow up with targeted letters. Because of resource constraints and computer systems issues, the Medicaid department has not followed up on those leads. [17]

Conclusion: Harmonizing Eligibility Criteria and Simplifying Application Processes

As discussed, the LIS and MSPs target similar groups of low-income people with Medicare coverage for significant benefits. Both programs establish eligibility using income levels tied to the Federal poverty level, with income counting methods that are generally based on Supplemental Security Income (SSI) methods, and (in most cases) resource tests that also follow similar methodologies. In spite of these broad similarities, however, the differences between these programs will influence the states' ability to dovetail their MSP enrollment efforts with the LIS outreach and enrollment efforts led by SSA.

State and federal efforts could help align these eligibility rules and reduce confusion for consumers and organizations that are trying to help enroll them in the LIS and MSPs. For example, under current law, additional states[18] could extend the LIS rule for determining family size to the MSP. LIS income determinations take into account family members in addition to the spouse; income determinations for Supplemental Security Income (SSI), and by extension MSP in many states, do not. States have the option, however, through an amendment of their state Medicaid plan, of adopting less restrictive income criteria than are used for the SSI program. They could align their MSP standards with the LIS and benefiting from the administrative simplicity – for eligibility workers as well as consumers -- that would result from this coordination.

For states, elimination of the asset test, as Arizona has done across all MSPs and New York has done for the QI program, is the single most important step to boost MSP, and consequently LIS enrollment by state residents. Since New York's elimination of the QI asset test, however, CMS has informed states they cannot impose different asset criteria for each of the MSPs, effectively precluding states from liberalizing the test only for the QI program, and not MSPs which are funded jointly by states and the federal government.[19]

Short of eliminating the asset test, harmonizing thresholds down to the levels used for the LIS, is a means to aligning eligibility rules of the two programs. Excluding consideration of in-kind income also brings state MSP determinations in line with the income criteria used for the LIS.

Elimination of the in-person interview requirement or its substitution with interviews by community-based volunteers, reduced documentation requirements and the facilitation of mail-in applications – steps taken to varying degrees by all three states – can greatly simplify the application process.

For states with pharmaceutical assistance programs, efforts to combine outreach for MSP enrollment with ongoing efforts to sign members up for the LIS also hold promise.

Endnotes

[1] For a full explanation of the MSP's see Alex D. Federman, Bruce C. Vladeck and Albert L. Siu, "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program," Health Affairs, Volume 24, Number 1. The Medicare Savings Programs (MSPs) pay Medicare premiums and cost-sharing for 3.8 million low-income Medicare beneficiaries. These programs – the Qualified Medicare Beneficiary (QMB) program, Specified Low-Income Beneficiary program (SLMB) and Qualified Individual program (QI) – are administered by the states through the Medicaid program, with the Federal government providing matching funding at the regular Federal Medical Assistance Percentage (FMAP) rate for QMB and SLMB costs, and 100 percent of costs for QI enrollees. These programs cover some or all of the out-of-pocket expenses normally paid by people with Medicare.
[2] CMS Buy-in files, on file with the author.
[3] Fact Sheet, Centers for Medicare and Medicaid Services, Sept. 16, 2005
[4] "Comparing Beneficiaries of the Medicare Savings Programs with Eligible Non-Participants." *Social Security Bulletin.* 64(3): 76-80. 2002.
[5] Barents Group. "A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries." April 7, 1999.
[6] Michael J. Perry, Susan Kannel and Adrianna Dulio, "Barriers to Medicaid Enrollment for Low-Income Seniors," The Kaiser Commission on Medicaid and the Uninsured, January 2002; Laura Summer and Lee Thompson, "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits," The Commonwealth Fund, May 2004.
[7] Kim Glaun, "Medicaid Programs to Assist Low-Income Medicare Beneficiaries: working paper on Medicare Savings Programs in Arizona," The Kaiser Commission on Medicaid and the Uninsured, December 2002.
[8] Glaun, 2002
[9] CMS Buy-in File
[10] Glaun, 2002.
[11] Glaun, 2002.
[12] SSA § 1612(b)(3) and 1612(b)(23), added by the Social Security Protection Act of 2004 (P.L. 108-203).
[13] Social Security Administration, footnote tk
[14] CMS Buy-In File
[15] However, North Carolina eligibility workers do notify MSP applicants at the time they apply for benefits that the state would make efforts to recover nursing home expenditures, if they were ever to receive Medicaid help with long-term care expenses.
[16] Interview with Michael Keough, SeniorCare, May 3, 2005.
[17] Interview with Michael Keough,SeniorCare, February 6,2006.
[18] Arizona and Minnesota are among a handful of states that have adopted less restrictive rules regarding family size.
[19] Amy M. Tiedemann and Kimberley Fox, "Promising Strategies for Medicare Savings Program Enrollment:

Modifying Eligibility Criteria and Documentation Requirements", 2004

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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.

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