State Solutions
An Initiative to Improve Enrollment in Medicare Savings Programs

Impact of Medicare Part D on Medicare Savings Program Enrollment

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Introduction

Medicare's expansion to include a prescription drug benefit through the Medicare Part D benefit in 2006 was expected to significantly expand access to prescription drugs for the elderly and disabled, particularly for those who previously had no drug coverage and those eligible for the generous Part D low-income subsidies (LIS). Specific provisions in the statute and regulations related to the Part D LIS eligibility determination process were also expected to increase enrollment in other low-income benefits for Medicare beneficiaries including the Medicare Savings Programs (MSPs) that provide subsidies for Part B premiums and cost-sharing through state Medicaid programs.[1]

This brief examines whether MSP enrollment has increased as a result of Part D based on aggregate state data reported to the Centers for Medicare and Medicaid Services (CMS). We first describe the specific requirements under Part D that were expected to increase MSP enrollment and federal estimates of anticipated MSP enrollment increases. We then compare these estimates with aggregate state enrollment reported through two different data sources. We discuss the methodological challenges of determining the impact on MSP enrollment using aggregate state data. We conclude with a discussion of potential reasons why MSP enrollment has not increased as expected and the implications for future policy and research.

Background – How Part D Was Expected to Increase MSP Enrollment

The Medicare Savings Programs are federally mandated programs, administered through state Medicaid programs, that were established in the late 1980s and early 1990s to help Medicare beneficiaries with limited incomes pay for Medicare Part B premiums and cost-sharing. While some progress has been made to increase MSP enrollment, these programs have historically been chronically underenrolled.

The passage of Medicare Part D and its generous low-income subsidies (LIS) presented potential new opportunities to increase MSP enrollment through Part D LIS outreach, education and enrollment efforts that were targeted to similar low-income Medicare beneficiaries (Table 1).

Table 1: Federal Eligibility Criteria for Medicare Savings Programs and Part D LIS

Program	Income Limit	Asset Limit (individual/couple)	Covered costs/ Benefit
Qualified Medicare Beneficiary (QMB)	< 100% of federal poverty level	$4,000/$6,000	Pays all Part B premiums and cost-sharing obligations. Deemed full LIS eligible.
Specified Low-Income Medicare Beneficiary (SLMB)	100 - 120% of federal poverty level	$4,000/ $6,000	Pays Part B premiums. Deemed full LIS eligible.
Qualified Individual 1 (QI-1)	120 - 135% of federal poverty level	$4,000/$6,000	Pays Part B premiums. Deemed full LIS eligible.
Full Part D Low Income Subsidy (LIS)	< 135% of federal poverty level	$6,000/$9,000	Pays Part D premium, no deductible, no coverage gap; Copays $2 generic;$5-brand.
Partial Part D Low Income Subsidy (LIS)	Below 150% of federal poverty level	$10,000/ $20,000	Sliding scale Part D premium, $50 deductible, no coverage gap, 15% coinsurance.

Source: Section 1905(p) and Section 1902(a)(10)(E) (iii) and (iv) of the Social Security Act; Federal Register 42 CFR Parts 403, 411, 417, and 423: Medicare Program; Medicare Prescription Drug Benefit; Proposed Rule. Department of Health and Human Services. August 3, 2004. Page 46731. For QMB, SLMB, and QI1, states have the flexibility to adjust countable income and assets.

In its assessment of Part D's impact on state budgets, CMS assumed that the availability of LIS through Part D and new state responsibilities in LIS eligibility determination would raise awareness of other low-income benefits available to Medicare beneficiaries through Medicaid, including the MSP programs.[2] Specifically, the incentive to enroll in MSP to be 'deemed eligible' for LIS without application combined with the requirement that states screen all LIS applicants applying through the Medicaid agency for MSP, Medicaid and other low-income benefits was expected to increase enrollment.[3] In addition, CMS's plan to share the Social Security Administration's (SSA) LIS 'leads' data – specific information on LIS applicants that had applied through SSA – with states, was also intended to help states identify and reach out to beneficiaries who might qualify for MSP and get them enrolled.[4,5]

These new Part D requirements placed on states, along with the 'woodworking' effect resulting from Part D LIS outreach activities, were expected to increase MSP enrollment. However, the magnitude of predicted MSP enrollment increases varied significantly across governmental sources (Table 2). While

CMS expected 1.1 million more Medicare beneficiaries to enroll in Medicaid and/or MSPs as a result of Part D in 2006 alone, the Congressional Budget Office estimated 1.3 million more would enroll in Medicaid and/or MSPs over the next seven years as a result of Part D or approximately 186,000 in 2006. The vast majority of these new enrollees (172,000) were expected to enroll in MSPs.

While these estimates vary widely in terms of estimated timeframes, they both assume significant MSP enrollment increases as a result of Part D, above and beyond current MSP enrollment trends. In addition, both estimates anticipated that the largest enrollment increases would be in the Medicare Savings Programs, rather than in the full Medicaid program where it was assumed that most of those eligible were already enrolled.

Table 2: Estimated MSP Enrollment Increases

	Total Medicaid enrollees (Full Medicaid, QMB, SLMB, QI1)		Full Medicaid Benefits	QMB (Part B Premiums and Cost-share)	SLMB/QI1 (Part B Premiums Only)	Total Medicare Savings Programs*
CBO	1.3 million by 2013		100,000	550,000	650,000	1,200,000 (or @172,000 per year)
DHHS	1.1 million in 2006		231,000	220,000	649,000	869,000

Sources: Congressional Budget Office, A detailed description of CBO's cost estimate for the Medicare prescription drug benefit, July 2004; and DHHS, 42 CFR Parts 400, 403, 411, 417 and 423 Medicare Program; Medicare Prescription Drug Benefit; Final Rule, January 28, 2005, p 4486.
* Total Medicare Savings Program estimates were not specifically provided by CBO or DHHS, but were calculated by adding the QMB and SLMB/QI1 estimates. This total only includes persons receiving Medicare cost-sharing benefits through Medicaid, not QMB or SLMB enrollees in states where the state has also extended full Medicaid benefits to QMB and/or SLMB enrollees – known as QMB-Plus and SLMB-Plus programs. These individuals are included in the full Medicaid estimate.

Methods and Data Sources

Accurately assessing current enrollment in the Medicare Savings Programs is more difficult than one might expect. Often Medicaid program enrollment data do not identify the specific MSP program in which beneficiaries are participating or distinguish between those who receive full Medicaid benefits with Medicare premium and/or cost sharing or those who receive only Medicare premium assistance or cost-sharing.[6] In part this is due to the complex interplay between Medicare Savings Programs and the Medicaid program, movement of individuals between programs, and state-specific variations in program eligibility and types of buy-in programs available. These state-specific variations can result in different definitions of who should be counted as a Medicare Savings Program enrollee in different federal databases. For example, some states that have Qualified Medicare Beneficiary (QMB) Plus or Specified Low-Income Beneficiary (SLMB) Plus programs extend full Medicaid benefits to individuals eligible for

QMB or SLMB in addition to Medicare premiums and/or cost-sharing. In these states, QMB and SLMB enrollees are full dual eligibles. However, because their full dual status was established by their eligibility for QMB or SLMB, they may be counted in some data sources as Medicare Savings Program enrollees but as full duals in other data sources.

Accessibility to current Medicaid and Medicare Savings Program enrollment data is also relatively limited. There is often a significant time lag from when Medicaid eligibility data is reported and validated and made available to the public.

For this analysis of the impact of Part D on MSP enrollment, we relied on three data sources that provide national and state-specific enrollment estimates. The first two sources provide data that is relatively current, but each captures slightly different information. The third source is only available for 1999-2003 but is used to compare trends from earlier periods. The data sources used in this analysis and described below include:

- Third party buy-in data reported by state from 2003 to 2007 and
- Partial duals reported on monthly Medicare Modernization Act (MMA) file submitted by states to CMS since November 2005 as part of their reporting requirements under Part D.
- Partial duals reported on the Medicaid Statistical Information System (MSIS). [7]

Third party buy-in reports provide aggregated counts of the total number of Medicare beneficiaries for whom state Medicaid programs (the 'third party') have agreed to pay Medicare Part B premiums to 'buy-in' to Medicare. Total Part B Buy-in enrollees include full dual eligibles, on whose behalf all states have elected to pay Medicare premiums in order to reduce costs to the Medicaid program, and partial duals, that only receive Medicare cost-sharing through Medicare Savings Programs. The aggregate reports are drawn from monthly data submitted by states to CMS in the TP Earth data file. This data is used by CMS to bill state Medicaid programs for the state portion of Medicare Part B premiums.[8] States report the number of Part B and Part A buy-ins in the aggregate as well as by the specific program in which they are participating. Aggregate monthly billing reports reflect enrollment from two months previous to the billing period. CMS has made the aggregate monthly tables available to the State Solutions national program office as a mechanism for assessing program enrollment in grantee states since 2002. Thus we are able to use this data to assess MSP enrollment trends both before and after Medicare Part D.

The third party buy-in data has some limitations. While states are required to submit Part B buy-in enrollment, there is less focus on the program-specific eligibility distinctions. CMS provides little guidance to states on what should be reported in each category and thus what is reported in each category is subject to state interpretation. Thus, the definitions of who is included as a QMB, SLMB, QI1, may vary by state. CMS has indicated that program-level estimates from this file are not validated and may not be reliable for comparing across states.[9] States have also identified discrepancies between what is reported in third party billing data and state eligibility and enrollment data.[10] However, as the only source of MSP program-specific level data at the national level that is currently available for the study period (i.e. pre and post Part D), we have utilized it for this analysis. Even if states are defining program

enrollment differently (e.g. including both QMB Plus and QMB-only or only including QMB-only in QMB enrollment counts), we have no evidence that states have modified eligibility or reporting definitions during the study period.

In addition to examining the third party billing data, we also examined partial dual eligibles reported on the Medicare Modernization Act (MMA) file. Partial duals are individuals for whom the state only pays Medicare cost-sharing (i.e. QMB only, SLMB only, and QI1), not full Medicaid benefits (e.g. full duals, QMB Plus or SLMB Plus). The MMA file is a monthly file submitted by the states to CMS since the Fall 2005 to meet new MMA state reporting requirements. The file includes all Medicare and Medicaid full and partial dual eligibles in the state. The MMA file data is used by CMS to count the number of enrollees to calculate the state contribution for Medicare drug coverage for the dual-eligibles (also known as the "state clawback"),[11] to establish the low-income subsidy status of dual eligibles, to perform auto-assignment of individuals into Medicare Part D plans, and for states to convey information to CMS on any Part D low income subsidy enrollment determinations made by the states.[12] Given its purpose and application, the data is subject to considerable scrutiny and validation by CMS and is available on a more timely basis than existing Medicaid data.

State Solutions acquired aggregated validated MMA monthly reports by state from CMS for this analysis. Partial dual enrollment by state is available through the MMA file from the first month states were required to submit it (November 2005) to July 2007. We use this data as a second source for assessing the impact of Part D on MSP enrollment across programs. While a reliable source of overall partial dual enrollment, the MMA file does not distinguish between the specific Medicare Savings Programs for which they are eligible. It also was not collected prior to November 2005, and thus has more limited use in assessing MSP enrollment trends before and after Part D.

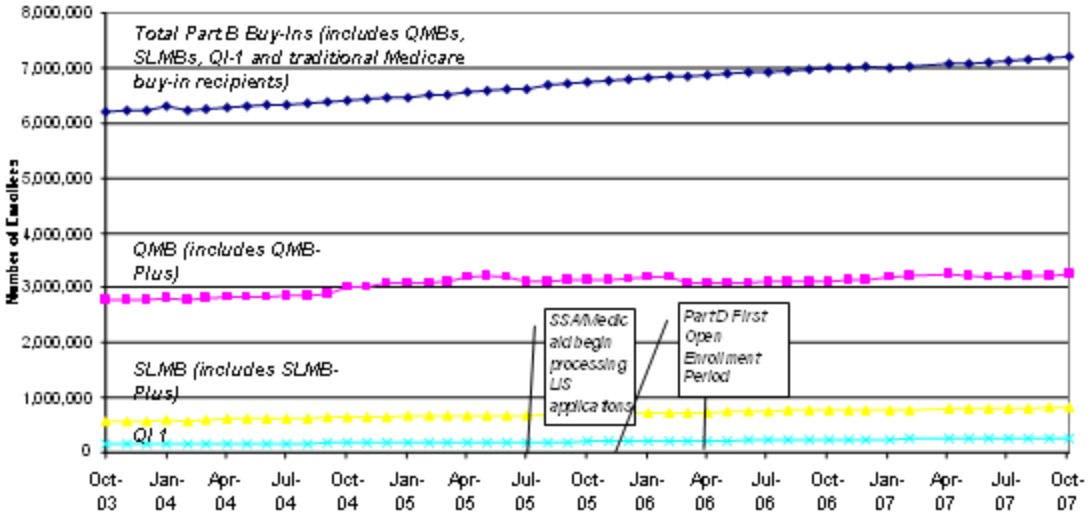
To assist in interpreting partial dual enrollment trends reported in the MMA file relative to historical trends, we also analyzed state-specific data reported on the Medicaid Statistical Information System (MSIS) data. MSIS data have been collected from each state since 1999 and contain enrollee eligibility information and Medicaid claims in each quarter of the federal fiscal year. Data from 1999-2003 are available by calendar year through the Medicaid Analytic Extract (MAX). We also utilized aggregated monthly MSIS data provided to State Solutions by CMS for 2003 to 2004.

Results

MSP Enrollment Trends Constant Before and After Part D

Prior to Medicare Part D, total enrollment in state Medicare Part B buy-in programs (including Part B buy-in for full dual eligibles, as well as buy-in for enrollees in Medicare Savings Programs only) had already been increasing steadily (Chart 1).[13] On average, overall enrollment in these programs has been increasing approximately 4 percent per year.

Chart 1: Part B Buy-In Enrollment Trends by Program, Oct 2003-Oct 2007

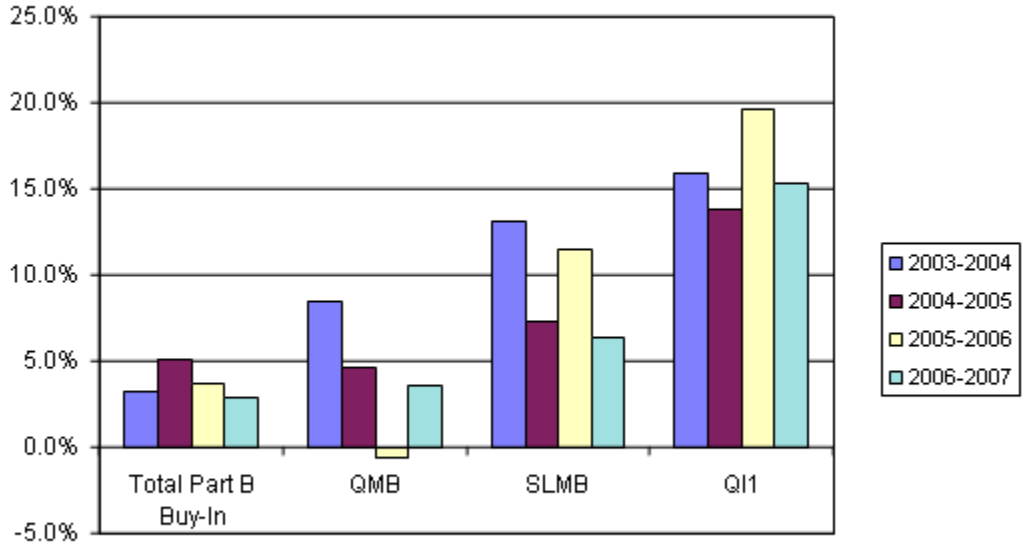


Source: CMS Third Party Billing Reports, Part A and Part B Buy-Ins by State and Selected Eligibility Categories, Billing Cycles Dec 2003-Dec 2007. Only includes 50 states and the District of Columbia; excludes U.S. territories.
Boxes indicate the start of LIS application processing (July 2005) and the Part D open enrollment period in the first year (Nov 2005 to April 2006). LIS applications may be completed at any time and do not have time-limited open enrollment.

Like overall Part B buy-in programs, MSP enrollment in QMB, SLMB and QI1 has also increased from 2003 to 2007. The rate of MSP enrollment increases has been higher than for overall Part B buy-ins particularly in the Q-1 and SLMB programs where enrollment has increased an average of 16.2% and 9.6% per year, respectively since 2003 (Chart 2).

In July 2005, SSA began processing Part D LIS applications and many organizations initiated outreach efforts for both LIS and Part D. State Health Insurance Assistance Programs (SHIPs) received additional funding for LIS and Part D outreach and states with State Pharmacy Assistance Programs (SPAPs) were also provided transitional grant funds for outreach and enrollment of their members into Part D. Since MSP enrollment was increasing prior to the implementation of Part D, we would assume higher increases would occur after Part D's implementation in late 2005 and early 2006. However, from 2005 to 2006, QMB enrollment actually declined slightly, and SLMB enrollment increased but at a lower rate than two years earlier (Chart 2). Only QI1 enrollment from 2005 to 2006 increased at a greater rate than prior years. By 2007, QI1 enrollment increases returned to rates comparable to before Part D.

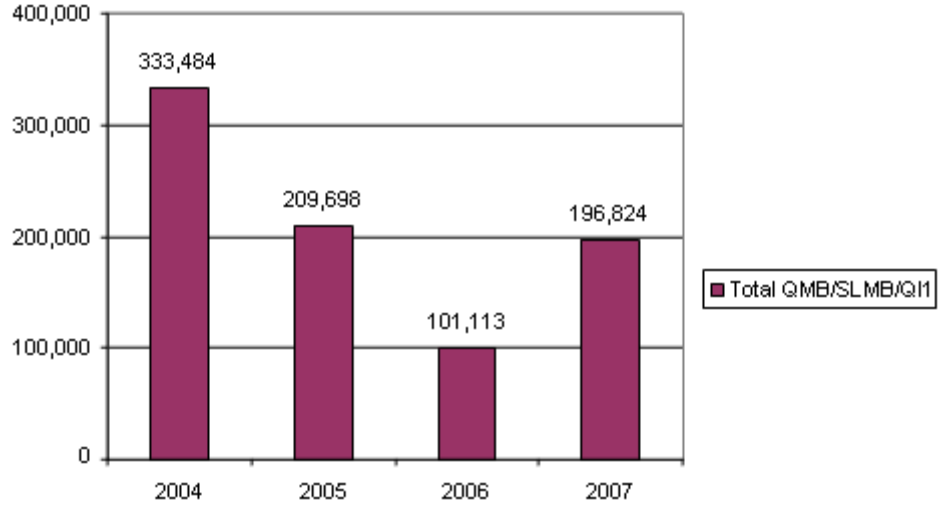
Chart 2: Annual Percent Change in Part B Buy-In Enrollment by Program, 2003-2007



Source: CMS Third Party Billing Reports, Part A and Part B Buy-Ins by State and Selected Eligibility Categories, Billing Cycles Dec 2003-Dec 2007.

Despite additional resources and intense Part D outreach efforts, enrollment in total state Part B buy-in programs and specific MSP programs did not change dramatically during this period. In fact, the number of additional enrollees in the three MSP programs combined in 2006 (approximately 101,000) was significantly lower than additional enrollment reported in the previous two years (@333,000 and 210,000 respectively as shown in Chart 3). It was also significantly lower than CMS's estimate of new enrollment resulting from Part D (1.1 million) and lower than the more conservative CBO estimate of 172,000 new MSP enrollees resulting from Part D per year.

Chart 3: Additional Medicare Savings Program Enrollees per Year, 2004-2007



Source: CMS Third Party Billing Reports, Part A and Part B Buy-Ins by State and Selected Eligibility Categories, Billing Cycles Dec 2003-Dec 2007. Calculated by subtracting total enrollees in December billing cycle in all three programs combined from the prior year.

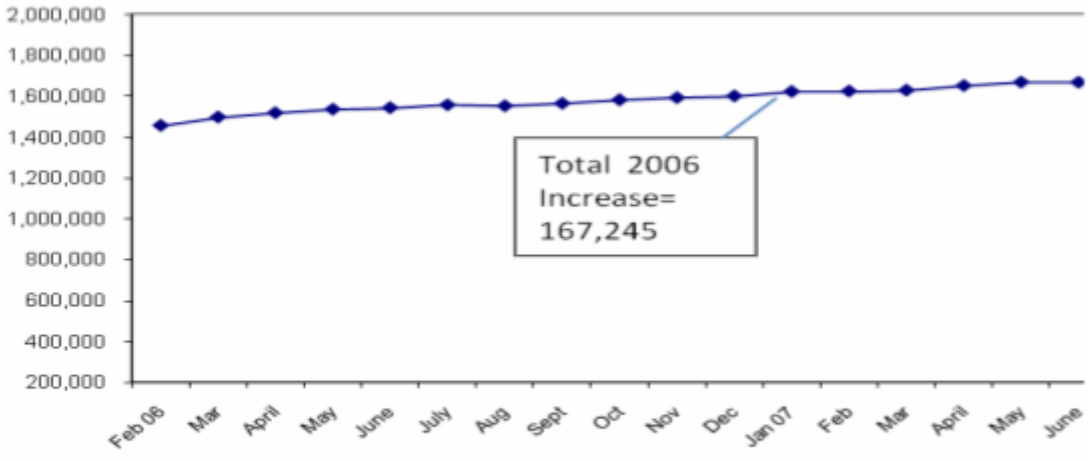
Enrollment of partial duals (QMB-only, SLMB-only, QI1) may be higher since Part D

Third party billing data suggests that MSP enrollment in total has increased only marginally and for some programs, may have even decreased since Part D. To confirm these findings, we also examined partial dual enrollment as reported on the MMA file. Unlike third party billing data which may include full duals in its counts of MSP enrollees, partial duals reported on the MMA file only include persons enrolled in the QMB-only, SLMB-only, QI-1 and other MSP programs that only receive assistance with Medicare cost-sharing, not full Medicaid benefits. As a result, the total number of partial duals reported on the MMA file is significantly lower than the combined MSP enrollees reported on third party billing data.[14]

Based on MMA file data, partial dual enrollment increased by 11% from 2005 to 2006. By the end of 2006, 167,123 more partial duals were enrolled than in the prior year (Chart 4).[15] This is slightly less than the anticipated additional enrollment that CBO expected as a result of Part D and much lower than CMS estimates.[16] While MMA file data are not available prior to 2005, to determine if this trend was comparable to prior years, we compared this data with partial dual enrollment reported on Medicaid Statistical Information System (MSIS) between 2003 and 2004, the most recent years available. In the years preceding Part D, partial dual enrollment increased by only 5 percent, suggesting that, at least for programs that provide only Medicare cost-sharing, Part D may have helped increase MSP program enrollment beyond existing trends, but still below estimated levels.

It is important to note that increases in partial dual enrollment may reflect both enrollment of newly identified eligible persons that were not previously enrolled ***and*** shifts of individuals from full to partial dual status. Full dual-eligible enrollees reported on the MMA file increased by .5 percent from 2005 to 2006. This was a lower rate of increase than two years prior reported on MSIS, when full dual enrollment increased by 1.2 percent between 2003 and 2004.[17]

Chart 4: Partial Dual Total Monthly Enrollment, Feb 2006 - Jun 2007



Source: CMS MMA Data Files, Feb 2006-Jun2007. Partial dual total excludes QMB Plus and SLMB Plus that are eligible for full Medicaid benefits. Total 2006 increase calculated by subtracting total partial dual enrollees in Jan 2007 from total partial dual enrollees in Feb 2006, the earliest date MMA data were available.

While not shown here,[18] partial dual enrollment reported during 2006 varied significantly across states – ranging from a 118 percent increase to a 42 percent decline over the course of the year. This suggests that further research may be needed to determine if these differences are due to exemplary state MSP outreach or policy changes (e.g. elimination of MSP asset test), movement between full dual and partial dual status, and/or inaccuracies in reporting.

Conclusion and Discussion

Based on current data available, Medicare Savings Program enrollment has not increased as a result of the implementation of Part D to the degree that was estimated. State Part B buy-in enrollment overall and enrollment in the specific MSP programs had been increasing prior to Part D – potentially due to other federal policies instituted in the late 1990's to increase MSP participation levels in response to program underenrollment.[19] After Part D was implemented, enrollment continued to increase in these programs, but at or below rates of increase in previous years, suggesting that Part D has had limited to no impact.

Enrollment in those MSP programs that only pay for Medicare premiums and cost-sharing (i.e. QMB-only, SLMB-only and QI-1) may have increased more than MSPs that are also eligible for full Medicaid benefits (QMB-Plus, SLMB-Plus), but even these increases were slightly lower than more conservative estimates of MSP increases. Also, given limitations in the data, analysis at the program level should be interpreted with caution.

Reasons for lower than expected MSP enrollment after Part D may include:

1) The vast majority of LIS applications submitted have been processed through the SSA, which is not currently required to screen for MSP eligibility.[20]
2) State Medicaid agencies that are required to determine LIS eligibility and also screen for MSP eligibility have largely met their LIS responsibilities by referring inquiring individuals to SSA or helping them complete the SSA LIS application.[21] It is unknown whether individuals that inquire about LIS at Medicaid agencies and are referred to SSA are also screened for MSP as required. Because states are not obligated to track these individuals and SSA does not track referral sources, there is no record of their number to allow CMS to monitor or enforce the state's "screen and enroll" rule; and
3) SSA LIS leads data that was intended to assist states in targeting MSP outreach was not provided to states until December 2007.

In general, while the LIS and MSP programs target similar populations, outreach and enrollment efforts have generally not been aligned or coordinated. LIS 2006 outreach information largely did not mention the availability of the MSP benefit, due to SSA concerns that information on two programs would increase beneficiary confusion.[22] Other mechanisms for more closely coordinating application and enrollment demonstrated to be successful in other efforts and recommended by State Solutions and other national organizations– e.g. developing or piloting a joint MSP/LIS model application, and autoenrolling

LIS enrollees into MSP in states with more liberal MSP eligibility rules – have not been implemented. Generally, the implementation of Part D has overshadowed previous federal commitments to maximizing MSP enrollment.

Recently proposed amendments to Part D LIS and MSP, if adopted, may help to streamline and simplify the LIS/MSP application process and could boost MSP enrollment to the levels originally estimated.[23] However, it is unclear whether these proposals have sufficient political support to be implemented. Even with these changes, there needs to be a renewed focus on MSP enrollment by federal agencies and a commitment to maintaining previous enrollment targets.

This analysis of existing MSP enrollment data raises some fundamental questions about the ability to accurately assess program participation rates in the specific MSP programs to target future interventions. For the past decade, MSP programs have been described as chronically underenrolled and reports from credible sources cite participation rates in these programs at between 13-33%.[24] However, in order to assess program participation rates, you need reliable data on both the number of people that are potentially eligible and the number that are currently enrolled. Concerns have previously been raised about the accuracy of estimates of persons potentially eligible for MSP given the lack of data on Medicare beneficiaries' assets. This analysis also raises concerns about the validity and accuracy of the number of people enrolled in these programs given the lack of concordance across federal data sources on MSP program enrollment and lack of clarity in who should be reported by program. Our findings suggest the need for clearer directions to states on what to report, and greater validation and oversight of data reported, in order to fully assess the impact of these programs going forward.

Endnotes

[1] Medicare Savings Programs refer to programs that provide premium and/or cost-sharing assistance for Medicare Part B for persons who otherwise would not be Medicaid eligible. These include Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals -1 (QI1).

[2] DHHS, 42 CFR Parts 400, 403, 411, 417 and 423 Medicare Program; Medicare Prescription Drug Benefit; Final Rule, January 28, 2005, p 4486.

[3] 42 U.S.C. 1396u-5(a)(3)

[4] DHHS, 42 CFR, January 28, 2005. p 4419 and p 4381. According to CMS guidance, states are expected to use this data for outreach purposes to screen and apply for MSP, but are not required to do so.

[5] As of the spring 2007, states had not yet received SSA leads data. CMS indicated at a State Solutions meeting that the data should be available by November 2007. *Finding an Easier Way: Public/Private Solutions for Increasing Medicare Savings Programs and Part D Low-Income Subsidy Enrollment.* Summary of State Solutions Summit March 2007 Proceedings, Rutgers Center for State Health Policy, New Brunswick, NJ, November 2007.

[6] Baugh, David K. "Estimates of dual and full Medicaid benefit dual enrollees, 1999" *Health Care Financing* Review (26)2: 133-139. 2005.

[7] The Medicaid Statistical Information System (MSIS) data, which have been collected from each state since 1999 contain enrollee eligibility information and Medicaid claims in each quarter of the federal fiscal year. They are available by calendar year through the Medicaid Analytic Extract (MAX). As of November 7, 2007, MAX data for

all states and the District of Columbia were available for 1999-2003. CMS, The Medicaid Analytic eXtract Chartbook, 2007. Current dates available downloaded from http://www.resdac.umn.edu/Medicaid/medicaidFAQ.asp#3 on 11/21/07.

[8] Haber, S et al, Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs, Volume 1, prepared for the Centers for Medicare and Medicaid Services, October 1, 2003.

[9] Conference call with Sharon Donovan and Bob Walkey of CMS and staff from Office of Financial Management and Office of Information Services, January 11, 2007.

[10] In seeking to measure the impact of new outreach and or administrative simplification efforts funded with State Solutions grant funds, several states uncovered significant discrepancies between data provided by the state and the data reported on 3rd party billing data, which were subsequently largely resolved.

[11] Effective Jan 1, 2006, outpatient prescription drug coverage for persons dually-eligible for Medicare and Medicaid is provided through Medicare. To help finance the new Medicare benefit for dual-eligibles, states pay monthly payments to the Medicare program based on a formula set in statute.

[12] Centers for Medicare and Medicaid Services, *Technical Instructions for Submitting State Data for Medicare Modernization Act (MMA) Provisions*, June 20, 2006.

[13] Third Party billing data were examined over a four year period from the month of the most recent data available at the writing of this brief – December 2007 billing data reflecting October 2007 enrollment.

[14] Partial duals reported on the MMA file only include those enrolled in the QMB, SLMB, QI1 or other MSP program that are not eligible for full Medicaid benefits. In contrast, states may count QMB Plus and SLMB Plus, who are eligible for full Medicaid benefits in the third party billing reports.

[15] The number of partial duals reported on the MMA increased more than the number of QMB, SLMB and QI1 reported in third party billing data. This may be due to aggregating across programs in the third party billing data and that QMB enrollment (which includes QMB-Plus in third party billing, but not in the MMA) declined in 2006.

[16] Based on analysis of state-level MSIS 2004 monthly files provided to State Solutions by CMS.

[17] Ibid

[18] CMS shared MMA file data with the stipulation that State Solutions not release state-level data.

[19] Government Performance Results Act of 1993, http://www.whitehouse.gov/omb/mgmt-gpra/gplaw2m.html Accessed December 12, 2007.

[20] LIS application rates reported by SSA on Kaiser State Health Facts at http://www.statehealthfacts.org/comparetable.jsp?ind=312&cat=6, downloaded December 2007. Also see Lipson et al, 2007.

[21] Lipson D, Barrett A, Merrill A, Denny-Brown N, *Doors to Extra Help: Boosting Enrollment in the Medicare Part D Low-Income Subsidy*, AARP Public Policy Institute, September 2007.

[22] In 2007, SSA modified its 1144 outreach letters to have targeted messages based on programs for which individuals were eligible including those not enrolled and qualifying for both MSP and LIS, those enrolled in LIS and qualifying for MSP. Donovan, S. *Sharing the Right Data with the Right People: the Federal Perspective*, presentation at State Solutions summit, Washington, DC, March 21, 2007.

[23] H.R. 3162, 110th Congress, The Children's Health and Medicare Protection Act (CHAMP Act) Bill Summary, downloaded at thomas.loc.gov December, 2007; Medicare Payment Advisory Commission, *Increasing participation in the Medicare savings programs and the low-income drug subsidy.* Meeting brief and draft recommendations, Nov/Dec 2007.

[24]Ebeler, Jack, Paul N. Van de Water, and Cyanne Demchak (eds.) 2006. *Improving the Medicare Savings Programs.* Washington: National Academy of Social Insurance.

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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.

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.