NATIONAL ACADEMY OF SOCIAL INSURANCE

Report of the Study Panel on
Medicare/Medicaid Dual Eligibles

Improving the Medicare Savings Programs

June 2006

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Contents

Summary

In early 2003, the National Academy of Social Insurance (NASI) convened a study panel to identify ways to increase the number of people enrolled in the Medicare Savings Programs (MSPs), which help low-income people pay Medicare's premiums and cost-sharing. After enactment of Medicare prescription drug coverage in December 2003, the panel expanded its focus to consider how the programs can be better coordinated with the low-income prescription drug subsidy.

Participating in the Medicare Savings Programs improves the financial wellbeing of low-income individuals, reduces financial barriers to health care, and can lead to better health outcomes for eligible Medicare beneficiaries. Yet fewer than one in three eligible low-income persons is receiving benefits.

Significantly increasing enrollment in the Medicare Savings Programs, the study panel concluded, will require a stronger federal role in their administration and financing. Increasing participation will require some additional spending. The panel believes that support for low-income individuals should be as uniform as possible across the nation. Because of the financial constraints on states, the needed additional funding should come primarily from the federal government.

What is the Problem?

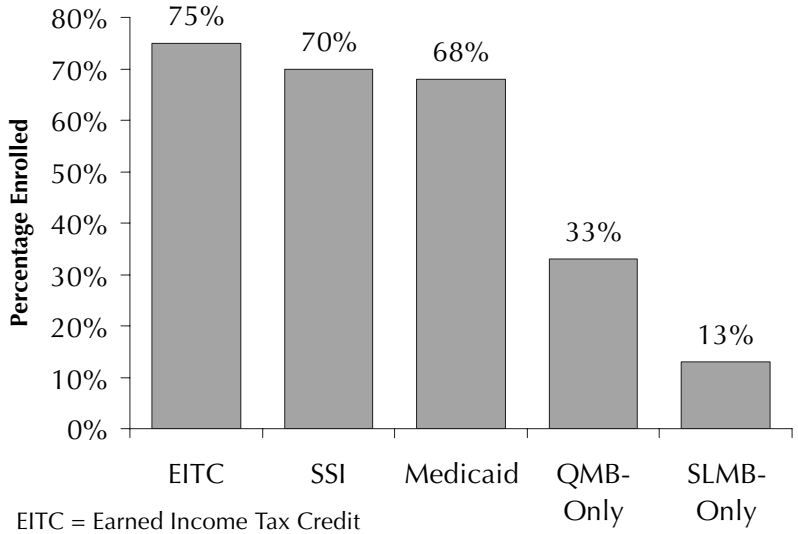
Medicare provides health insurance to 43 million elderly and disabled Americans. It offers hospital insurance (Part A of Medicare), supplementary medical insurance for doctors' bills (Part B), and—starting in January 2006—prescription drug coverage (Part D). Even with the addition of a drug benefit, however, Medicare beneficiaries can still face substantial out-of-pocket costs for health care. Medicare does not cover certain services, such as most eyeglasses, dental care, and long-term care. Beneficiaries must pay monthly premiums for Part B and Part D. All three parts of Medicare require beneficiary cost-sharing through deductibles and co-payments, and there is no annual dollar limit on a beneficiary's financial liability.

The Medicare Savings Programs help low-income people pay for Medicare's premiums and cost-sharing for Parts A and B. Three major programs—the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income

Medicare Beneficiary (SLMB) program, and the Qualifying Individual (QI) program—provide varying degrees of assistance depending on a person's income and assets. In addition, the low-income drug subsidy provides assistance with the premiums and cost sharing for Part D of Medicare. Its eligibility criteria and application process differ from those of the Medicare Savings Programs. To receive all of these benefits, a person may have to deal with as many as four separate organizations: the Social Security Administration (SSA), the Centers for Medicare & Medicaid Services (CMS), the state Medicaid agency, and a Medicare Advantage plan or prescription drug plan.

Rates of enrollment in the Medicare Savings Programs are well below those of other means-tested benefit programs (see Summary Figure). The Congressional Budget Office estimates that only 33 percent of eligible people are participating in the QMB program, and that the participation rate in the SLMB program is only 13 percent. (These figures exclude people who are eligible for full Medicaid benefits.) In comparison, participation rates are estimated to be 75 percent in the earned income tax credit, 66 percent to 73 percent for Supplemental Security Income, and 66 percent to 70 percent for Medicaid.

Summary Figure
Estimated Enrollment Rates in Various Means-Tested Programs



Notes: EITC = Earned Income Tax Credit
SSI = Supplemental Security Income
QMB = Qualified Medicare Beneficiary
SLMB = Specified Low-Income Medicare Beneficiary

Sources: GAO 2005; CBO 2004.

The Congressional Budget Office has projected that participation in the low-income drug subsidy will exceed that for the Medicare Savings Programs, and initial enrollment figures appear to bear out this prediction. Applicants for the subsidy may enroll at Social Security offices, which is easier and entails less stigma than going to a Medicaid office. Also, for many people the value of the drug benefit and low-income subsidy may greatly exceed the value of the Medicare Savings Programs.

What Factors Impede Enrollment?

Why do so many eligible people fail to sign up for the Medicare Savings Programs? The study panel identified several barriers to enrollment:

- *Lack of Awareness*. Not knowing that the Medicare Savings Programs exist is the most significant barrier to enrollment. Seventy-nine percent of non-enrolled eligible people have never heard of the Medicare Savings Programs.

- *Hard-to-Reach Population*. Many eligible individuals are difficult to reach or communicate with because they are old, cannot read or speak English, have difficulty seeing or hearing, or lack transportation.

- *Burdensome Application Process*. In addition to completing a lengthy form, applicants must usually provide substantial documentation. As a result, two-thirds of enrollees need help with the application.

- *Connection to Welfare*. Many people are reluctant to apply for benefits at a Medicaid office—still a requirement in many states.

- *Asset Reporting*. Many potential beneficiaries do not apply because they incorrectly assume that they have too many assets to qualify or fear losing their estate.

The administrative and financing structure of the Medicare Savings Programs exacerbates all of these difficulties. Although established by federal law, the Medicare Savings Programs are administered by the states, eligibility criteria and application processes vary from one state to another, and states bear much of the

cost. This arrangement makes it harder for beneficiaries to enroll and provides little incentive for states to facilitate the enrollment process.

Why Should Enrollment be Expanded?

Increasing enrollment in the Medicare Savings Programs is vital if the programs are to succeed in reducing financial barriers to the use of health care services for low-income Medicare beneficiaries. Compared to all Medicare beneficiaries, those who are eligible for the Medicare Savings Programs are more likely to be old, female, black or Hispanic, and living alone. They are also more likely to be in fair or poor health. Thus, they not only have more limited means than other Medicare beneficiaries but a greater need for medical services.

Enrolling in a Medicare Savings Program confers substantial financial benefits. Premiums for Part B alone are currently $88.50 a month, or $1,062 a year. Those premiums constitute 11 percent of income for a person at the poverty level ($9,800 in 2006) and 8 percent of income for a person at 135 percent of poverty ($13,230). Beneficiaries who are relieved of the responsibility for making copayments save even more.

By reducing or eliminating cost-sharing responsibilities, the Medicare Savings Programs improve access to health care services. Use of all types of medical services is greater for MSP enrollees than for eligible non-enrollees, even when accounting for differences in health status and other characteristics. And for these low-income beneficiaries, improved access to health care services is likely to lead to better health outcomes.

How Can Enrollment be Increased?

Creation of the low-income prescription drug subsidy offers new opportunities for increasing enrollment in the Medicare Savings Programs. The study panel has identified ten options that span the range of possibilities and deserve serious consideration (see Summary Table). Some options would retain the current divisions of administrative and fiscal responsibility between federal and state governments; others would shift more of these burdens to the federal government.

Some would improve administrative procedures but retain the current eligibility criteria; others would expand eligibility to varying degrees. Some are relatively inexpensive; others entail substantial costs.

Summary Table
Options for Improving the Medicare Savings Programs

Making the Current Programs Work Better

1. Use information from the Medicare low-income drug subsidy to target Social Security Administration mailings
2. Provide targeted information to the states
3. Provide personal assistance to probable eligibles
4. Reinstitute performance goals

Simplifying and Aligning the Medicare Savings Programs and Low-Income Drug Subsidy

5. Adopt uniform methods for counting certain income and resources
6. Reduce number of categories and align MSP and drug subsidy categories
7. Align categories and increase resource limits

Improving the Treatment of Assets

8. Annuitize assets
9. Eliminate estate recovery

Moving Towards a Greater Federal Role

10. Allow for federal administration at state option with additional federal financing

When it enrolls people for the low-income drug subsidy, the Social Security Administration obtains information that could be used to help the same people enroll in the Medicare Savings Programs. One approach (reflected in options 1 through 4) would use the new information and implement processes to make the current Medicare Savings Programs work better, without changing current eligibility rules or administrative responsibilities. Most of these changes could be implemented administratively and would entail few additional costs. Previous efforts of this sort have resulted in measurable but modest increases in enrollment.

A more expansive, and expensive, course of action (options 5 through 7) would simplify and liberalize the eligibility rules to provide greater uniformity between the Medicare Savings Programs and the low-income drug subsidy. State-to-state

differences in the administration of the Medicare Savings Programs and differences between the Medicare Savings Programs and the low-income drug subsidy make the programs hard to understand, impede nationwide outreach efforts, and preclude a unified enrollment process. Revising the current eligibility rules to provide greater uniformity in income and resource limits could simplify the application process, make more people eligible for subsidies, and increase enrollment in the programs. By significantly increasing eligibility, however, these options would all entail significant costs—ranging from $9 billion to $20 billion a year. The panel also considered two other options for improving the treatment of assets—counting as income an asset's annuity value and eliminating estate recovery (options 8 and 9).

A final option (option 10) would gradually shift the administrative and financial responsibility for the Medicare Savings Programs by allowing for federal administration at state option. Now that the Social Security Administration is collecting and maintaining data on the income and resources of Medicare beneficiaries applying for the Part D subsidy, SSA could make decisions on eligibility for the Medicare Savings Programs as well. In determining eligibility for the Medicare Savings Programs, SSA would use the same rules for counting and verifying income and resources that it uses for the low-income drug subsidy but would use the applicable income and resource limits. To make this option acceptable and attractive to the states, the federal government would finance the incremental cost of benefits for new enrollees. Having SSA administer the Medicare Savings Programs would facilitate a national outreach effort, reduce the welfare stigma, and greatly simplify the application process, and may well be the prerequisite for achieving substantial increases in enrollment.

The study panel recognizes the efforts being made by CMS and SSA to enroll as many people as possible in the Medicare drug benefit and low-income drug subsidy. The experiences gained during the implementation process will inevitably generate ideas for administrative and programmatic improvements. Whenever the Administration and Congress consider such proposals, they should also take that opportunity to increase enrollment of eligible individuals in the Medicare Savings Programs by adopting some of the options suggested in this report.

Understanding the Landscape

Medicare, Medicaid, the Medicare Savings Programs, and the low-income drug subsidy are complex programs that have myriad eligibility standards and application processes. The complexity of the enrollment process and its connection to the welfare system are two important barriers to increasing enrollment in the Medicare Savings Programs.

What Benefits Are Available?

This section provides brief descriptions of the Medicare Savings Programs and related programs. Further details may be found in two working papers that were prepared for the study panel (Cusick and Nibali 2005; Merlis 2005). These papers are available on the National Academy of Social Insurance's website.

Medicare

Medicare was created in 1965 to provide insurance for hospital and physician services to elderly individuals. In 1972 coverage was broadened to include people under age 65 who have been receiving Social Security disability benefits for at least two years. Today, it provides 43 million Americans with health care coverage. Medicare consists of four parts, which are outlined in Table 1 on page 8.

Because Medicare does not cover certain services, can require significant cost sharing, and has no limit on out-of-pocket spending, 88 percent of Medicare beneficiaries have some sort of supplemental insurance. Employer-sponsored coverage is the largest source of supplemental coverage (held by 35 percent of non-institutionalized Medicare beneficiaries). This share may decline in the future, however, as many employers cut back on retiree health benefits, particularly for current employees who have not yet retired. Twenty-one percent of beneficiaries purchase individual Medigap policies, and 15 percent are enrolled in Medicare Advantage (MA) plans—primarily health maintenance organizations that provide comprehensive coverage. For about 17 percent of Medicare beneficiaries—those with very low incomes—Medicaid provides supplementary coverage (Cubanski *et al.* 2005). (Note that these data, like most in this report, predate the start of Medicare's prescription drug benefit in 2006.)

Table 1
Medicare, 2006

Part	Services Covered	Eligibility	Premiums and Deductibles	Cost-Sharing
Part A, Hospital Insurance (HI)	▪ Inpatient hospital ▪ Skilled nursing facilities ▪ Hospice ▪ Home health	▪ Age 65 and over ▪ Disabled Social Security beneficiaries after 2 years of cash benefits ▪ People with end-stage renal disease	▪ No premium for beneficiaries who are eligible for Social Security ▪ Deductible of $952 per benefit period for inpatient hospital	▪ Co-insurance of $238 a day in hospital for days 61-90 and $476 a day beyond 90 days ▪ Limit on days covered per benefit period
Part B, Supplementary Medical Insurance (SMI)	▪ Physicians ▪ Outpatient hospital ▪ Lab tests ▪ Medical supplies ▪ Home health	▪ Voluntary enrollment for people age 65 or older and disabled persons eligible for Part A	▪ Monthly premium of $88.50 ▪ Deductible of $124 a year	▪ 20% co-insurance for most services
Part C, Medicare Advantage (MA)	▪ Private plans that provide Parts A, B, and, sometimes, D	▪ Voluntary enrollment if enrolled in Parts A and B	▪ Premium and deductibles vary by plan	▪ Co-payments and coinsurance vary by plan
Part D, Prescription Drug Benefit	▪ Outpatient prescription drugs	▪ Voluntary enrollment if entitled to Part A or enrolled in Part B	▪ Premium varies by plan; averages $25 a month ▪ Deductible of $250 a year for standard plan	▪ Co-insurance of 25% for standard plan up to initial coverage limit ▪ Initial coverage limit of $2,250 for standard plan ▪ Catastrophic threshold of $5,100

Source: Cubanski *et al.* 2005.

Medicaid

Medicaid provides health coverage to specified categories of people with limited resources, including children, their families, pregnant women, the aged, and persons with disabilities. Over 7 million of Medicaid's roughly 55 million enrollees are "dual eligibles," low-income aged or disabled individuals who are also enrolled in Medicare. While representing only 14 percent of Medicaid's enrollees, the dual eligibles account for 40 percent of Medicaid's spending (Cubanski *et al.* 2005).

Most dual eligible beneficiaries are covered for the full range of Medicaid services, which are much more extensive than those provided by Medicare. For this group, termed "full-benefit dual eligibles," Medicaid also pays Medicare's premiums and cost sharing. However, as described in the next section, some dual eligibles receive assistance only for premiums and cost sharing through the Medicare Savings Programs (Merlis 2005).

Medicaid is a state-run program and is jointly financed by federal and state governments. The federal government pays at least half of the cost and pays a larger share for states with low income per capita. In 2006, the federal share ranges from the minimum of 50 percent in 12 states to a high of 76 percent in Mississippi (CMS 2005g). Overall, the federal government pays about 57 percent of the cost of Medicaid nationwide, and the states pay 43 percent. In order to receive federal funding, state Medicaid programs must meet federal requirements relating to eligibility, covered services, and other program features.

Medicaid's eligibility rules are extremely complex and vary from state to state. In brief, Medicare beneficiaries can become eligible for full Medicaid benefits by four major pathways (Merlis 2005):

- *Recipients of SSI cash assistance.* With one important exception, states are required to provide Medicaid coverage to recipients of cash benefits from the federal Supplemental Security Income (SSI) program. However, 11 states that had more restrictive eligibility standards for Medicaid when SSI was established in 1972 are allowed to continue using those standards.

- *Medically needy*. Thirty-three states and the District of Columbia opt to cover medically needy aged or disabled people (SSA 2005b). Individuals qualify as medically need if their income, less medical expenses, falls below a state-established limit and if their assets do not exceed SSI limits ($2,000 for an individual, $3,000 for a couple). Arizona has a state-financed program for the medically needy with different standards.
- *Poverty- related*. States may offer full Medicaid benefits to people with family income below a state-established limit that may not exceed the federal poverty level. Nineteen states (as of 2001) cover this optional group.
- *Long-term care standard*. States may apply a special, more generous income rule for nursing home residents or participants in home- and community-based waiver programs. These special standards, used by 39 states in 2001, may be as high as 300 percent of the SSI benefit rate.

In addition to having flexibility in setting income and resource limits, states may also employ different ways of counting available income and resources. For example, the SSI program disregards the first $20 of countable income, $65 a month of earned income, and half of any additional earned income. Section 1902(r)(2) of the Social Security Act allows states to use methodologies for counting income and resources that are "less restrictive" than the SSI rules. Through a methodological change, states may thereby effectively set higher income or resource limits by ignoring certain categories or amounts of income and resources (Merlis 2005).

Medicare Savings Programs

The Medicare Savings Programs help low-income people pay for Medicare's premiums and cost-sharing for Parts A and B, but they do not pay for services or benefits not covered by Medicare. Four programs provide varying degrees of assistance depending on a person's income and assets (Merlis 2005).

Qualified Medicare Beneficiary (QMB). The Medicare Catastrophic Coverage Act of 1988 required state Medicaid programs to pay premiums and cost sharing for Qualified Medicare Beneficiaries with incomes up to 100 percent of poverty and countable assets no more than twice the SSI limit ($4,000 for an individual or $6,000 for a couple). Although most of that law was repealed the next year, the

QMB provision remained (Kaiser Family Foundation 2005b). Some beneficiaries (termed QMB-only) receive only Medicare premium and cost-sharing assistance. Others (known as QMB-Plus) are eligible for both full Medicaid benefits and Medicare cost-sharing assistance.

Most states, it should be noted, take advantage of the flexibility offered by the Balanced Budget Act of 1997 not to pay full Medicare cost-sharing amounts. The law permits states to limit their payments for QMBs and full dual eligibles so that health care providers receive no more than Medicaid's payment rates. Because Medicaid payment rates are typically lower than total Medicare rates (program payments plus coinsurance), and often below the program payment alone, providers caring for dual eligibles therefore frequently do not receive the full coinsurance (MedPac 2004). The provider generally cannot charge the beneficiary for the difference but must either accept the lower payment amount or decline to accept the beneficiary as a patient.

Specified Low-Income Medicare Beneficiary (SLMB). The Omnibus Budget Reconciliation Act of 1990 required states to pay Medicare Part B premiums—but not cost sharing—for beneficiaries with incomes between 100 percent and 120 percent of poverty. The asset standards for these Specified Low-Income Medicare Beneficiaries are the same as for QMBs. Like QMBs, SLMBs may qualify for full Medicaid benefits through other eligibility pathways.

Qualifying Individual (QI). In the Balanced Budget Act of 1997, Congress provided states with a block grant that would pay the Medicare premiums of Qualifying Individuals with incomes between 120 percent and 135 percent of poverty. The QI program, unlike the QMB and SLMB programs, is not an entitlement. The benefits are funded by federal block grants serving eligible people on a first-come, first-served basis up to the amount available. These block grants were originally set to expire in 2002 but have been reauthorized through September 30, 2007, by Public Law 109-91.

Qualified Disabled and Working Individual (QDWI). States are also required to pay Medicare Part A premiums for certain low-income people who were entitled to

Table 2
Medicare Savings Programs

Category	Year Enacted	Income Limit	Resource Limit	Medicaid Pays	Entitlement
Qualified Medicare Beneficiaries (QMBs)	1988	100% of poverty	200% of SSI limit ($4,000/ individual, $6,000/couple)	Part B premium; Part A premium, if any; all deductibles and coinsurance	Yes
Specified Low-Income Medicare Beneficiaries (SLMBs)	1990	120% of poverty	200% of SSI limit ($4,000/ individual, $6,000/couple)	Part B premium only	Yes
Qualifying Individuals (QIs)	1997	135% of poverty	200% of SSI limit ($4,000/ individual, $6,000/couple)	Part B premium only	No

Note: In 2006, 100 percent of the federal poverty guideline for an individual is $9,800; 120 percent of poverty is $11,760; 135 percent of poverty is $13,230. The limits are higher in Alaska and Hawaii. States may use less restrictive income or resource methodologies.

Source: Merlis 2005.

Medicare on the basis of a disability but who lost their entitlement because they returned to work. Few people have taken advantage of the QDWI program, and it does not figure further in this report.

Table 2 summarizes the features of the three major Medicare Savings Programs. Under the authority of section 1902(r)(2), 37 states use less restrictive income or resource methodologies than those of SSI when determining MSP eligibility. Five states disregard all (or nearly all) assets (CMS 2005i).

Low-Income Drug Subsidy

Medicare's new prescription drug benefit began in January 2006, and low-income beneficiaries are eligible for assistance with the required premiums and cost sharing. Several levels of assistance are provided, depending on a person's situation (see Table 3). Everyone who receives assistance with Part B premiums through a

Table 3
Low-Income Drug Subsidy, 2006

Category	Premium	Deductible	Co-payments
Eligible for Full Subsidy:			
Institutionalized full-benefit dual eligibles	$0	$0	None
Full-benefit dual eligibles with income not above 100% of poverty	$0	$0	$1/generic, $3/brand-name; no co-pays after total costs reach $5,100
Other Medicaid, MSP, and SSI beneficiaries; also individuals with income less than 135% of poverty and assets less than $6,000 ($9,000 for a couple)	$0	$0	$2/generic, $5/brand-name; no co-pays after total costs reach $5,100
Eligible for Partial Subsidy:			
Individuals with income less than 150% of poverty and assets less than $10,000 ($20,000 for a couple)	Sliding scale	$50	15% of total costs up to $5,100; $2/generic, $5/brand-name thereafter

Sources: CMS 2005h; Kaiser Family Foundation 2005a; Merlis 2005.

Medicare Savings Program receives a full federal subsidy for Part D premiums and assistance with cost sharing. The low-income drug subsidy is also available to some people who are not eligible for help paying for Part B.

"Full-subsidy eligible individuals" pay no premium and no deductible. Their co-payments are no more than $2 for generic and $5 for brand-name drugs. Medicare beneficiaries receiving full Medicaid benefits (full-benefit dual eligibles), participants in the Medicare Savings Programs, and SSI beneficiaries are deemed to fall in this category, whatever their income or assets. This category also includes people with incomes below 135 percent of the federal poverty line (FPL) and assets below 300 percent of the SSI limits ($6,000 for an individual, $9,000 for a couple).

People with income up to 150 percent of the federal poverty line and assets up to $10,000 ($20,000 for a couple) are eligible for a partial subsidy of their premium. Their annual deductible is limited to $50, and their co-payments are also reduced.

How Do People Enroll?

Medicare, Medicaid, the Medicare Savings Programs, and the low-income drug subsidy have different enrollment procedures as well as different eligibility criteria. To receive the full complement of benefits, a person may have to deal with as many as four separate organizations: the Social Security Administration, the Centers for Medicare & Medicaid Services, the state Medicaid agency, and a Medicare Advantage plan or prescription drug plan. Some steps have been taken to encourage and simplify enrollment, but much room for improvement remains.

Medicare

Although Medicare is administered by the Centers for Medicare & Medicaid Services, which is part of the Department of Health and Human Services, the Social Security Administration conducts the enrollment process on behalf of CMS. Coordination between Social Security and CMS aims to ensure that enrollment is both simple and reliable for the beneficiary.

An application for Social Security retirement or disability benefits also serves as an application for Medicare. (Individuals who delay receipt of retirement benefits beyond age 65 must submit a separate application for Medicare to the Social Security Administration.) Social Security also includes information about Medicare premiums in its records, thereby allowing premiums to be deducted from beneficiaries' Social Security checks.

Medicare benefits do not begin until a person reaches age 65 or has been entitled to disability benefits for 24 months. Because most people apply for Social Security before reaching age 65, they experience a substantial delay between applying for Social Security and receiving Medicare. Thus, CMS must generally contact individuals when they near Medicare eligibility to update the information that the Social Security Administration collected. Through a contractor, CMS also sends prospective beneficiaries a copy of the *Medicare and You* handbook and other informational material about Medicare and the Medicare Savings Programs (Cusick and Nibali 2005).

Once enrolled in Medicare, beneficiaries must enroll separately in a Medicare Advantage plan or a Medicare prescription drug plan, if they opt to do so. There are several ways to enroll in a prescription drug plan: by sending a paper application to the plan, by using the plan's website, by using Medicare's online enrollment center (if the plan offers this option), or by calling 1-800-MEDICARE. CMS is automatically assigning dual eligible beneficiaries who do not choose a drug plan (both those receiving full Medicaid benefits and those receiving only Medicare premium and cost-sharing assistance) to a prescription drug plan, as detailed below.

Medicaid

The process for enrolling in Medicaid is generally more complicated than applying for Medicare. As noted previously, eligibility for Supplemental Security Income makes a person eligible for Medicaid in all but 11 states. The Social Security Administration has agreements with 32 states and the District of Columbia to make Medicaid eligibility decisions for those individuals found eligible for Supplemental Security Income. In another seven states, eligibility for SSI entails eligibility for Medicaid, but individuals must still file a separate application with their state Medicaid agency. SSA estimates that some 10 percent to 20 percent of SSI recipients in these states do not promptly follow through on applying for Medicaid. The remaining 11 states use criteria for Medicaid that are more restrictive than those for SSI. In these states, too, an SSI recipient must file a separate application for Medicaid, and again many fail to do so (Cusick and Nibali 2005).

Medicare beneficiaries who qualify for Medicaid by another pathway—that is, as medically needy, a member of a poverty-related group, or meeting the long-term care standard—cannot apply through Social Security. However, Social Security routinely refers to state Medicaid agencies all applicants who are found ineligible for SSI and those SSI beneficiaries who later become ineligible. Social Security also provides information about the income and assets of these individuals electronically to the states (Cusick and Nibali 2005).

Nearly all states require proof of income and assets for Medicaid enrollment, although the limits and procedures vary by state and eligibility category (CMS

2005i). Some states require full documentation and in-person interviews; others require only self-attestation of resources and mail-in applications in some circumstances. In most states, redetermination of eligibility occurs yearly, often requiring beneficiaries to provide income and asset documentation each time (Cusick and Nibali 2005).

Medicare Savings Programs

In the 32 states where Social Security determines Medicaid eligibility for SSI beneficiaries, Social Security also automatically screens applicants for eligibility as Qualified Medicare Beneficiaries. However, if the potential QMB resides in one of the other 18 states or is not an SSI beneficiary, he or she must apply with the designated state agency. Most Specified Low-Income Medicare Beneficiaries and all Qualifying Individuals must also apply with the state agency. As with Medicaid, most states require applicants for the Medicare Savings Programs to document their income and assets (Nadel *et al.* 2000; Cusick and Nibali 2005).

Low-Income Drug Subsidy and Part D

A person who is deemed eligible for the low-income drug subsidy by virtue of participating in Medicaid, SSI, or a Medicare Savings Program does not need to go through a separate application process (CMS 2005h). Anyone else seeking the subsidy must apply either with the Social Security Administration or the state Medicaid agency. For some beneficiaries, it may be advantageous to apply with one rather than the other.

Most applicants find it simpler and more convenient to apply with the Social Security Administration. Applications may be submitted to SSA in person, by mail, or on line. Extensive documentation is not required. Income and resource amounts provided by beneficiaries will be checked against other governmental databases for accuracy; only if discrepancies arise will the applicant need to provide supporting documentation. Changes in income, resources, household composition, or other factors will be reviewed only once a year (SSA 2005a).

Some people, however, will find it more beneficial to apply with the state Medicaid agency. If a person applies for the subsidy with the state Medicaid agency, the agency must also screen him or her for the Medicare Savings Programs. In the states that use less restrictive income or resource methodologies when determining MSP eligibility, a person may be eligible for a Medicare Savings Program and, hence, for the low-income subsidy, even though he or she would not be eligible for the low-income subsidy under the basic federal criteria. This situation is particularly likely to arise in the five states (Alabama, Arizona, Delaware, Minnesota, and Mississippi) that disregard most or all resources when determining eligibility for Medicare Savings Programs (CMS 2005h, 2005i).

Once a beneficiary has been enrolled in the subsidy, enrollment in a prescription drug plan is still necessary. Dual eligibles, including MSP enrollees, are enrolled in a low-cost prescription drug plan automatically, although they may still select a plan of their own choosing. Full-benefit dual eligibles were automatically enrolled beginning in the fall of 2005, and this process will continue as more beneficiaries gain eligibility for Medicare and Medicaid. Other beneficiaries of the low-income subsidy were enrolled on May 1, 2006, if they had not chosen a drug plan on their own by April 30 (CMS 2006).

The Challenges of the Medicare Savings Programs

Both the Centers for Medicare & Medicaid Services and the Social Security Administration have worked with the states to increase enrollment in the Medicare Savings Programs. Despite these efforts, however, participation rates remain low—about 33 percent for the QMB program and 13 percent for the SLMB program (excluding those who are eligible for full Medicaid benefits).

In 2000 and 2001, CMS included goals for increased enrollment in the agency's annual performance plan, which is required by the Government Performance and Results Act. In 2002, however, the Administration discontinued the targets for increased enrollment and established a new goal of increasing beneficiaries' awareness of the programs. This goal was itself discontinued in 2005 (Cusick and Nibali 2005).

To learn which types of outreach had the greatest impact, CMS surveyed the states about their activities. States reported use of diverse materials and methods, including:

- Pamphlets explaining the programs,
- Direct mail to potential eligibles identified through state or federal data,
- In-person presentations and talks,
- Training for people who would have access to potential beneficiaries, and
- Partnering with other state and local agencies and organizations.

In addition to conducting outreach, states have also made improvements to the application and enrollment process. In 2000, the Benefits Improvement and Protection Act (BIPA) required the Department of Health and Human Services to develop a simplified application that would serve as an option for States to use for the Medicare Savings Programs. By 2004, 33 states were using a shortened form, and an additional 10 were in the process of moving towards a shortened form.

Many states have also waived the requirement for in-person interviews at a Medicaid office, instead allowing mail-in applications or providing satellite locations at which beneficiaries may complete the interviews (Cusick and Nibali 2005).

The Social Security Administration has also played a major role in efforts to improve enrollment in the Medicare Savings Programs. Its publications provide beneficiaries with basic information about the MSPs. Employees in field offices refer potential dual eligibles to Medicaid offices. Staff at teleservice centers direct callers to local Medicaid offices if they inquire about ways to pay health care costs (Cusick and Nibali 2005).

Besides these recurring efforts, Social Security has spurred enrollment in the Medicare Savings Programs through several one-time projects. Between 1999 and 2001, Social Security conducted several pilot programs to investigate different ways of increasing participation. Sixteen states tested eight different approaches. In the test areas, enrollment in the Medicare Savings Programs increased by about 7 percent. The most successful approach, in which the Social Security Administration took applications and forwarded them to the Medicaid office for adjudication, increased enrollment by 10 percent (Cusick and Nibali 2005).

The Benefits Improvement and Protection Act of 2000 established a requirement for the Social Security Administration to conduct annual outreach efforts to increase awareness of the Medicare Savings Programs. This provision was codified as section 1144 of the Social Security Act. In its initial response in 2002, Social Security mailed 16.5 million notices to beneficiaries who were potentially eligible for MSPs (Cusick and Nibali 2005). The General Accounting Office subsequently estimated that 74,000 more beneficiaries enrolled in the programs because of the mailings, resulting in a 5.9 percent increase from May 2002 to May 2003. This increase was nearly double the rate in the previous 3 years (GAO 2004).

The Medicare Modernization Act of 2003 expanded section 1144 to require Social Security to conduct outreach for the low-income prescription drug subsidy as well as the Medicare Savings Programs. In March 2005, SSA mailed nearly 19 million letters to potentially eligible beneficiaries along with person-specific applications for

the subsidy. In May and June 2005, letters were sent to dual eligibles explaining that they would be deemed eligible for the drug subsidy.

Who Is Enrolled in the Medicare Savings Programs?

Enrollment counts for the Medicare Savings Programs are not easy to determine accurately. Program records may identify the enrollees, but they provide little information about them (Sears 2001/2002). In particular, they often do not properly distinguish those who receive full Medicaid benefits from those who receive only premium or cost-sharing assistance or identify the specific Medicare Savings Program in which beneficiaries are participating (Baugh 2005). Excluding the full-benefit dual eligibles, estimates prepared for the study panel by Mathematica Policy Research show roughly 1 million enrollees (Verdier 2006):

- 430,000 Qualified Medicare Beneficiaries,
- 370,000 Specified Low-Income Beneficiaries, and
- 200,000 Qualifying Individuals.

Participation Rates

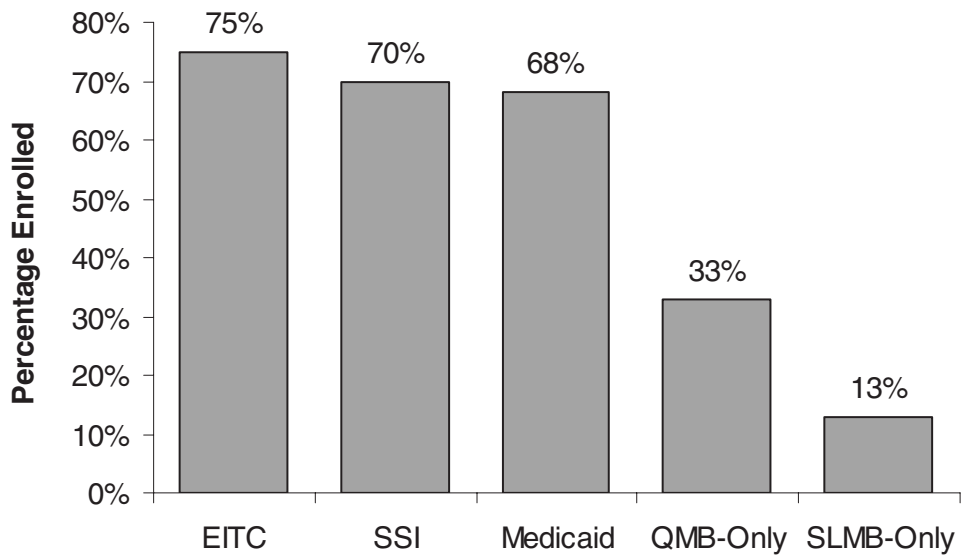
Participation rates in the Medicare Savings Programs are even more difficult to assess with precision. "No single data source is suitable for characterizing the eligible individuals who are not yet enrolled," writes Sears. "Survey data are useful in describing the eligible population, but they generally do not reveal which individuals are already enrolled" (Sears 2001/2002). Surveys may also provide insufficient information about assets, living arrangements, and other factors. Variations from state to state in income and resource methodologies add to the complexity of the task.

Estimates of participation rates vary by study. Rupp and Sears estimated the total enrollment rate for the QMB and SLMB programs to be 63 percent, including the QMB-plus beneficiaries (those who receive full Medicaid benefits) (Rupp and Sears 2000). The Congressional Budget Office estimated QMB and SLMB enrollment rates to be 33 percent and 13 percent, respectively, excluding the QMB-plus beneficiaries (CBO 2004). For these estimates to be consistent, the enrollment

rate for QMB-plus beneficiaries would have to approach 90 percent. Although that rate seems unusually high, it is plausible, since beneficiaries in states that offer full Medicaid benefits up to 100 percent of the federal poverty line are three times more likely to enroll in the Medicare Savings Programs (Haber *et al.* 2003).

The enrollment rates of the QMB and SLMB programs are extremely low in comparison to those of other means-tested programs (see Figure 1). The Government Accountability Office has estimated participation rates of 75 percent for the earned income tax credit, 66 percent to 73 percent for Supplemental Security Income, and 66 percent to 70 percent for Medicaid (GAO 2005). Even with little advance notice, enrollment in the Transitional Assistance program (a $600 credit provided to low-income individuals who signed up for the Medicare drug discount card during 2004 and 2005) reached 25 percent by one estimate (Scala-Foley 2005).

Figure 1
Estimated Enrollment Rates in Various Means-Tested Programs



Notes: EITC = Earned Income Tax Credit
SSI = Supplemental Security Income
QMB = Qualified Medicare Beneficiary
SLMB = Specified Low-Income Medicare Beneficiary

Sources: GAO 2005; CBO 2004.

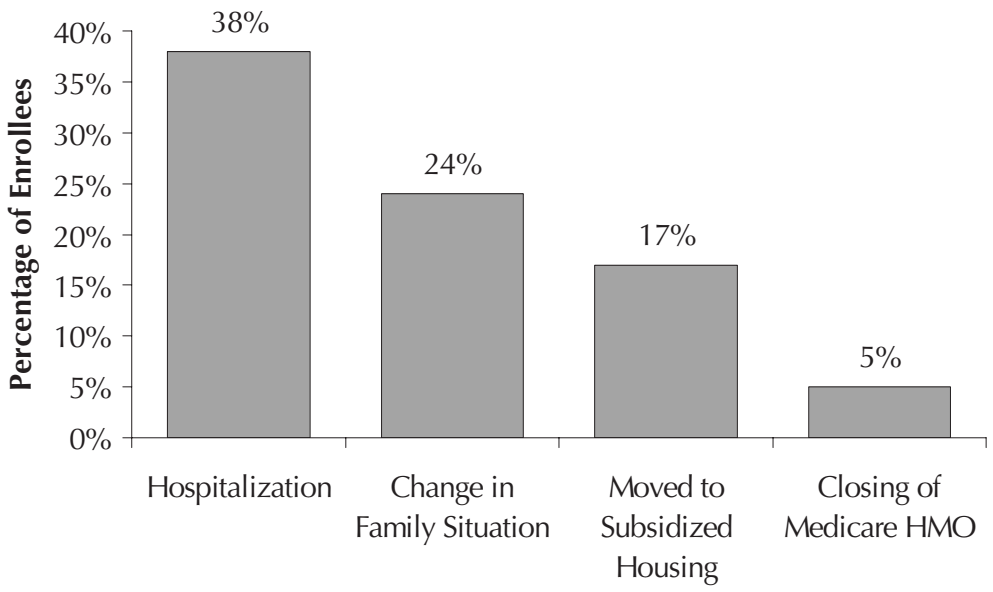
Participation in the low-income prescription drug subsidy may exceed some estimates. Almost all applicants for assistance appear to be filing with Social Security rather than a state agency. As of the end of April 2006, the Social Security Administration had received 4.9 million applications for assistance. Almost 850,000 did not require action because they were duplicate claims or were from people automatically eligible. SSA has made 3.9 million determinations and has found 1.7 million people eligible for assistance (SSA 2006). Another 1.0 million people are deemed eligible for the low-income subsidy because of their participation in the Medicare Savings Programs. In comparison, the Congressional Budget Office estimated that 7.8 million people other than full dual-eligibles would be eligible for a subsidy and that 2.3 million of them would participate in 2006 (CBO 2004). Of the applicants determined to be ineligible, SSA found that 57 percent had too many resources, 32 percent had too much income, and 11 percent had both (Kaiser Family Foundation 2006).

Reasons for Enrollment

What factors lead a person to sign up for the Medicare Savings Programs? Haber and colleagues asked enrollees if a particular event caused them to enroll (see Figure 2). They found that the most commonly cited precipitating events were hospitalization, a change in family situation (such as marriage or widowhood), or a move to subsidized housing. Five percent or fewer enrollees mentioned another reason, such as the closing of a Medicare managed care plan, turning age 65, needing the assistance, entering a nursing home, or the urging of family or friends (Haber *et al*. 2003).

Sears analyzed the determinants of enrollment using data from the Census Bureau's Survey of Income and Program Participation matched to Social Security's administrative records. He found that, compared to non-participants, MSP enrollees were more likely to be SSI beneficiaries, black, disabled, in poor or fair health, or living alone (Sears 2001/2002). The patterns found by Sears are consistent with those reported by the Barents Group in an earlier study using different data (Barents 1999).

Figure 2
Why Beneficiaries Enroll in the Medicare Savings Programs



Source: Haber *et al.* 2003.

Barriers to Enrollment

Why do so many eligible people fail to enroll in the Medicare Savings Programs? In a paper prepared for the panel, Cusick and Nibali identify several barriers to enrollment (Cusick and Nibali 2005).

Lack of Awareness. Among eligible people who are not enrolled in the programs, not knowing that the programs exist is the most significant barrier to enrollment. Seventy-nine percent of non-enrolled eligible people have never heard of the Medicare Savings Programs (Haber *et al.* 2003). Even some workers in state Medicaid offices, community organizations, or advocacy groups are poorly informed about the programs and are unable to help people understand them and apply for benefits.

Hard-to-Reach Population. Many eligible individuals have limitations that make it difficult to reach or communicate with them. They may be very old, unable to read or speak English, have difficulty seeing or hearing, or lack transportation. People who live alone or in assisted living are also less likely to be acquainted with the Medicare Savings Programs (Perry, Kannel, and Dulio 2002).

Connection to Welfare. Many elderly people are reluctant to apply for benefits at a state Medicaid office—a requirement in many states. However, a number of states allow people to apply for MSP benefits at sites other than traditional welfare offices. A survey done for the Kaiser Family Foundation finds that once beneficiaries are informed about the programs, they tend to equate them with Medicare rather than Medicaid, changing their view of them from that of a handout to "deserved help" (Perry, Kannel, and Dulio 2004).

Application Process. The application process for the programs deters many eligible people from enrolling. Two-thirds of enrollees needed help with the application. More than 30 percent of enrollees find the application too long, difficult to understand, or requiring too much documentation (Haber *et al.* 2003). Some states use the Medicaid application form for the MSPs as well, thereby adding unnecessarily to the length and difficulty of the process. Although most states have converted to a short application, the application is still several pages long, and substantial documentation may still be required. In addition to the lengthy application form, many states require at least one face-to-face interview, requiring beneficiaries to appear in a state office at some point during the process.

Asset Reporting. Many potential beneficiaries do not apply for the Medicare Savings Programs because they incorrectly assume they have too many assets to qualify. Some mistakenly believe that an owned home is counted as an asset. Another misperception is that the programs allow no assets, and to qualify beneficiaries would have to give up everything they worked hard for years to attain. (Perry, Kannel, and Dulio 2002).

Misunderstandings also surface in beneficiaries' concerns about estate recovery, even though not all states utilize estate recovery practices for MSPs (Haber *et al*. 2003; Nemore 2004). Regardless of the rules that a state follows, the fear of losing one's estate apparently deters some people from seeking MSP benefits. Finally, the requirement to document one's assets makes the application process burdensome and deters even potential enrollees who might pass the asset test (Merlis 2005).

Why Increase Participation?

The purpose of the Medicare Savings Programs is to assist low-income Medicare beneficiaries in financing their out-of-pocket costs for medical services, thereby assuring their access to needed medical care. Providing this assistance to as many eligible beneficiaries as possible makes sense for several reasons.

Reducing Out-of-Pocket Expenditures

Although the Medicare Savings Programs do not completely eliminate out-of-pocket expenditures for all enrollees, they provide significant savings that free up funds for other necessities. For a SLMB beneficiary just above the poverty level ($9,800 for a single individual in 2006), not having to pay Part B premiums can save 10 percent of income. For QMB beneficiaries, who have incomes below poverty, the saving will be even larger.

As expected, QMB enrollees incur lower out-of-pocket medical expenditures than both SLMB enrollees and eligible non-enrollees. Despite having below average health, nearly 45 percent of QMB enrollees report no cash medical expenditures, compared to 14 percent of SLMB enrollees and 11 percent of eligible non-participants. More than 90 percent of QMB enrollees spend less than $100 per month on medical bills, compared to 71 percent of SLMBs and 66 percent of non-participants (Haber *et al.* 2003).

The low-income drug subsidy also offers substantial cost savings for eligible beneficiaries. By one estimate, beneficiaries receiving the subsidy will spend an average of $174 on prescription drugs in 2006. In the absence of the subsidy, a beneficiary with an income less than 150 percent of poverty would have spent an average of $1,003 (Mays *et al.* 2004).

Reducing Financial Barriers to the Use of Health Care Services

Costs are a significant factor when beneficiaries decide whether to use medical services. Of Medicare-only beneficiaries, 23 percent report that they delay seeking medical care because of costs. The figure is only 8 percent for Medicare/Medicaid

dual eligibles, and it is even less for beneficiaries with other sources of supplemental coverage (MedPAC 2004). Before the Medicare prescription drug benefit, 48 percent of low-income seniors reported not taking their medications as prescribed (Cubanski *et al.* 2005). Thus, for many low-income beneficiaries, the reduction or elimination of cost-sharing responsibilities provides valuable, possibly life-saving access to care.

The Medicare Savings Programs have been shown to improve access to medical care services. Use of all types of medical service is greater for MSP enrollees than for eligible non-enrollees, even when accounting for differences in health status and other characteristics. MSP enrollment has the greatest effect on the use of outpatient hospital services and the frequency of office visits (Haber *et al.* 2003). Another recent study finds that QMB enrollees are half as likely as non-enrollees to avoid visiting a doctor because of concern about cost (Federman, Vladeck, and Siu 2005). The Medicare prescription drug benefit is likely to have a similar effect on the use of prescription drugs.

The ultimate aim of the Medicare Savings Programs is to improve the health of their beneficiaries. Many studies have shown how reducing financial barriers to health care can lead to better health outcomes (Institute of Medicine 2002). Moreover, improving access to health care appears to have the greatest effect on health status and mortality for those with the lowest incomes (Lindert 2004).

Options for Increasing Enrollment

Implementation of the low-income prescription drug subsidy provides many new opportunities for increasing enrollment in the Medicare Savings Programs. One approach would use the new information and processes to make the current Medicare Savings Programs work better, without changing current eligibility rules or administrative responsibilities. A more expansive, and expensive, course of action would simplify and liberalize the eligibility rules to provide greater uniformity between the Medicare Savings Programs and the low-income drug subsidy. Still another alternative is to adopt more limited changes that would facilitate a gradual increase in the federal financial and administrative role. The study panel has identified ten options that span this range of possibilities and deserve serious consideration.

Making the Current Programs Work Better

In the process of enrolling people in the low-income drug subsidy, the Social Security Administration is obtaining information on their income and resources that could be used to facilitate their enrollment in the Medicare Savings Programs. Also, because eligibility for the Medicare Savings Programs now carries with it eligibility for the low-income subsidy, the incentive for people to enroll has increased. This section identifies four options that build on Social Security's efforts to identify and enroll people who are eligible for the low-income subsidy without changing the criteria for MSP benefits or the locus of responsibility for administration.

An analysis prepared by Mathematica Policy Research for the study panel finds that the costs of these four options, while uncertain, are likely to be small. Excluding the full-benefit dual eligibles, whose participation rate has little room to grow, a one-percentage-point increase in the participation rate for the Medicare Savings Programs would cost only about $32 million a year (Verdier 2006).

1. Use Information from the Drug Subsidy to Target SSA Mailings

As Social Security's role in Medicare increases with the implementation of the low-income subsidy, so does its potential for outreach. Between May and August 2005, SSA sent out nearly 19 million letters to beneficiaries who were potentially eligible

for the low-income subsidy but were not enrolled in MSPs or receiving full Medicaid benefits (CMS 2005c). By the end of April 2006, Social Security had received 4.9 million applications for extra help.

At a minimum, Social Security could use the information about the income and resources of applicants for the low-income drug subsidy to target the outreach activities required by the Social Security Act. With the income and asset information generated as part of the subsidy screening and verification processes, SSA would be able to enhance its process for identifying people potentially eligible for the Medicare Savings Programs. With this information, SSA would not only be better able to tailor the audience for its mailings, but it would also be able to provide the states with better lists of potential eligibles. Because its cost is small, this option is worth trying even if it adds only modestly to enrollment.

2. Provide Targeted Information to the States

As a step beyond option 1, the states could be allowed to make direct use of the data that Social Security collects from applicants for the low-income subsidy. If the states had access to these data, they could in many cases determine if applicants for the low-income subsidy were eligible—or were likely to be eligible—for the Medicare Savings Programs. Not only would the states be made aware of individuals to contact, but they would also be provided a ready source of income and asset information that would otherwise have to be obtained from the individuals contacted. This process would save the states time and effort and would be less burdensome to the potential beneficiaries.

In its guidance on the implementation of the low-income subsidy, CMS has informed the states that Social Security will provide them with "leads" data on residents who have applied for the low-income subsidy. The leads data will include the applicant's mailing address, marital status, income as a percentage of poverty, whether the applicant had resources over or under the limit for the subsidy, whether the applicant was approved for the subsidy, and—if denied—the reason for denial (CMS 2005f). If the states were also provided specific dollar amounts for individual items of income and resources, they could in many cases determine

eligibility for the Medicare Savings Programs without having to request additional information from the applicant. In order to satisfy requirements for privacy, it might be necessary to ask applicants for the low-income drug subsidy to provide explicit permission for SSA to share their income and asset information with their state for purposes of determining eligibility for the Medicare Savings Programs.

3. Provide Personal Assistance to Probable Eligibles

Although surveys of beneficiaries and the evaluation of the SSA outreach demonstrations have shown that personal contacts can increase enrollment, personal contact can be costly. Information collected from applicants for the low-income drug subsidy could also be used to target personalized outreach efforts more precisely and to make them more cost-effective.

Here is one possible scenario. Based on information from applications for the low-income drug subsidy, the Social Security Administration would identify a pool of people who are likely to be eligible for the Medicare Savings Programs. A person from a designated organization would phone, write, or possibly visit these people. He or she would provide information to the potential beneficiary and possibly help him or her navigate the enrollment process. Such personalized assistance could be provided either by Social Security staff, state employees, local organizations (such as aging agencies, State Health Insurance Assistance Programs, or faith-based organizations), or commercial entities experienced in dealing with specialized populations. Of course, under any of these alternatives, additional federal funding and staffing would be required.

4. Reinstitute Performance Goals

In addition to the previous options, CMS could reinstitute explicit goals for increasing participation in the Medicare Savings Programs as part of its annual performance plan. When CMS had such goals in 2000 and 2001, the agency achieved some success in raising the growth of enrollment (CMS 2002). Putting new goals in place would refocus the attention of staff and administrators on this important issue.

Working together with CMS and SSA, states have developed a variety of ways to increase enrollment in the Medicare Savings Programs. However, many of these practices have not been universally adopted. CMS could encourage or require states to adopt some or all of these best practices, such as establishing partnerships with other agencies and organizations, providing training for people who come in contact with potential beneficiaries, and distributing informational material. These activities offer low-cost approaches to increasing enrollment; small amounts of additional funding could be targeted to the states with the lowest participation rates. More costly—but more effective—variants would provide financial incentives to the states for undertaking outreach activities, enrolling beneficiaries, or achieving higher take-up rates.

Simplifying and Aligning the Programs

Previous efforts to encourage enrollment in the Medicare Savings Programs have met with only modest success—in large part because the programs are very confusing. State-to-state differences in the administration of the Medicare Savings Programs and differences between the Medicare Savings Programs and the low-income drug subsidy make the programs hard to understand, impede nationwide outreach efforts, and preclude a unified enrollment process. In contrast, revising the current eligibility rules to provide greater uniformity in income and resource limits could simplify the application process, make more people eligible for subsidies, and increase enrollment in the programs. This section describes three options (labeled options 5, 6, and 7) for more closely aligning the Medicare Savings Programs and the low-income prescription drug subsidy. Additional information about these options and others may be found in a working paper commissioned for the panel (Merlis 2005).

5. Adopt Uniform Methods for Counting Certain Income and Resources

Option 5, the first option in this group, would simplify and liberalize eligibility for the Medicare Savings Programs and low-income drug subsidies in three ways:

- The federal poverty level for the applicant's actual family size would be used to determine eligibility for benefits;

- Beneficiaries living with adult children or others would not be treated as receiving income in kind; and
- Three classes of resources—income-producing property, the cash value of life insurance policies, and motor vehicles—would not be counted.

States using less restrictive methods to determine eligibility for benefits would be allowed to continue using them.

The federal poverty level varies with family size. In determining eligibility for the low-income subsidy, the Social Security Administration compares an applicant's income to the poverty level applicable to the number of dependents in his or her family. In determining eligibility for the Medicare Savings Programs, however, several states use the poverty level for one- or two-person families, regardless of the actual family size. This option would remove that inequity and require states to use actual family size.

Medicare beneficiaries with incomes less than $10,000 are much more likely to live with their children or other relatives than those with higher incomes (Westat 2006). In such cases, both the Medicare Savings Programs and the low-income drug subsidy may consider the applicant to be receiving in-kind income. Calculating this in-kind support and maintenance, as it is called, is burdensome to both applicants and administrators. The amount of imputed income may be as much as $201 a month for an individual ($301 a month for a couple) in 2006 and may render the applicant ineligible for assistance. This option would no longer count in-kind support and maintenance for either the Medicare Savings Programs or the low-income drug subsidy.

Because the resource limits in the Supplemental Security Income program, to which the MSP resource limits are tied, have not been increased since 1989, more and more people meet the income test but fail the resource test (Moon, Friedland, and Shirey 2002). Many applicants are excluded because they carry life insurance that has a face value greater than $1,500. Others fail the resource test because they own more than one car or hold real property that is classified as income producing, whether or not it yields any income (Merlis 2005). This option would follow the

lead of some states by excluding all life insurance, vehicles, and income-producing real property from the resource test. This change would simplify the application and verification process by counting only immediately liquid resources—those that are most easily documented and valued.

6. Reduce Number of Categories and Align MSP and Drug Subsidy Categories

Option 6 goes a step further than option 5 by adopting two income and resource categories that would apply to both the Medicare Savings Programs and low-income drug subsidy. Methodologies would be as in option 5, except that states would not be permitted to adopt less restrictive resource methodologies for the MSP programs. Eligibility for full Medicaid benefits would not be affected. Reducing the number of categories would not only encourage enrollment by making the programs more comprehensible for beneficiaries, it would also allow for a unified enrollment process.

Today, with three Medicare Savings Programs and two basic levels of drug subsidy, a low-income Medicare beneficiary who is not eligible for full Medicaid can be eligible for one of five different subsidy levels. Option 6 would reduce the number of MSP groups from three to two, and it would increase the income and resource standards to conform to those for full and partial drug subsidies. Thus, the option would collapse the five current subsidy categories into two, as shown in Table 4.

Table 4
Income and Resource Standards with Uniform Eligibility Categories

Eligibility Category	Income Limit	Option 6: Resource Limits	Option 7: Resource Limits
Medicaid pays Part B premium, deductibles, and coinsurance (QMB); Full drug subsidy	135% of poverty	$6,000 individual; $9,000 couple	$12,000 individual; $18,000 couple
Medicaid pays Part B premium only (QI); Partial drug subsidy	150% of poverty	$10,000 individual; $20,000 couple	$20,000 individual; $40,000 couple

Source: Merlis 2005.

7. Align Categories and Increase Resource Limits

Option 7, a variant of option 6, would set higher resource limits for both the Medicare Savings Programs and low-income drug subsidy. Some have proposed eliminating the resource test entirely because it excludes few applicants and makes the enrollment process more difficult for everyone. As long as even some low-income people have substantial assets, however, eliminating the resource test seems extremely difficult politically. In contrast, raising the resource standard is a more achievable objective. In the absence of any empirical basis for establishing asset limits, this option sets them at twice the current limits for the low-income subsidy (see Table 4). As in option 6, the more generous income and resource limits would not apply to eligibility for full Medicaid benefits.

Effects of Options

Options 5, 6, and 7 make many more Medicare beneficiaries eligible for some form of assistance with their premiums or cost sharing. Under current rules, an estimated 25 percent of non-institutionalized Medicare beneficiaries qualified for some assistance in 2001, as shown in the top panel of Table 5 on page 34. Under option 7, which adds the largest number of eligibles, 31 percent could have received some assistance. In today's terms, this increases represents 2 million to 2 ½ million more beneficiaries eligible for some extra help. These figures, it must be emphasized, are estimates of the number of people who meet the current or alternative standards for financial eligibility. They are not estimates of how many people would actually apply for benefits if they became eligible or of how many more people who are already eligible would apply if the programs and processes were simplified. Two working papers available on NASI's website provide further information about the estimates (Merlis 2005; Verdier 2006).

The options differ in the distribution of beneficiaries by benefit level. By design, none of these options increases the number of people eligible for full Medicaid benefits. All three options increase the number of people eligible for QMB status, but the increase is much greater for options 6 and 7 than for option 5. In addition, the options are likely to increase participation in the programs by simplifying the application and eligibility determination processes.

Table 5
Effect of Options on Eligibility and Costs

Category	Current Rules	Option 5	Option 6	Option 7
Percentage of Medicare Beneficiaries Qualifying for Subsidy				
Full-Benefit Dual Eligibles	8	8	8	8
QMB	3	7	16	17
SLMB	4	6	0	0
Qualifying Individual	2	3	5	5
Full Drug Subsidy (but not MSP)	2	1	0	0
Partial Drug Subsidy	5	5	0	0
No Subsidy	75	70	71	69
Total	100	100	100	100
Additional Annual Cost ($ billions)				
QMB and SLMB	—	5.5	13.0	15.2
Qualifying Individual	—	0.4	1.3	1.3
Medicare Drug Subsidy	—	2.7	2.3	3.4
Total	—	8.7	16.6	19.9

Note: Details may not add to totals due to rounding; see caveats in text.

Sources: Merlis 2005; Verdier 2006.

Because it is difficult to predict the percentage of eligible people who would apply for assistance under any of these options, it is equally hard to predict their effect on federal and state budgets. To provide rough estimates, the panel commissioned Mathematica Policy Research to estimate the additional costs of expanding eligibility, assuming that all of the newly eligible beneficiaries (and no more of the previously eligible ones) applied (Verdier 2006). To the extent that the omitted behavioral responses offset each other, these estimates provide a reasonable indication of costs.

By simplifying the programs and expanding eligibility, options 5, 6, and 7 would enable the Medicare Savings Programs to reach more low-income people with help paying for their medical expenses. However, these options would also entail significant costs. Providing more consistent treatment of income and resources between the Medicare Savings Programs and the low-income drug subsidy (option

5) is estimated to cost nearly $9 billion a year, as shown in the bottom panel of Table 5. Establishing uniform income and resource categories (option 6), as well as using consistent methodologies could cost close to $17 billion a year. Further increasing the resource limits (option 7) could cost almost $20 billion. Since states pay, on average, about 43 percent of the cost of QMB and SLMB as part of their Medicaid budgets, about a third of the cost of these options would fall on the states, if the current financing arrangements are continued.

Improving the Treatment of Assets

The resource standards for the Medicare Savings Programs exclude many potential beneficiaries who would be eligible on the basis of low income alone. Improving the treatment of resources therefore provides further opportunities for reaching more people who could use assistance with their Medicare premiums and cost sharing. Option 8 would exclude financial assets from the resource test and include their annuity value as a component of income. Option 9 would eliminate estate recovery for participants in the Medicare Savings Programs.

8. Annuitize Assets

Under current rules, income from a defined-benefit pension or an annuity is counted in determining eligibility for Medicaid and the Medicaid Savings Programs, but the present value of future benefits is not counted as an asset. In contrast, if income is derived from an Individual Retirement Account or from other funds held directly by an individual, those funds count toward the asset limit. Thus some analysts have suggested excluding financial assets from countable resources and adding to income the estimated income that the funds could be expected to produce if invested in an annuity (Moon, Friedland, and Shirey 2002).

Annuitizing assets would increase from 8 percent to 13 percent the portion of Medicare beneficiaries who are eligible for full Medicaid benefits. The fraction of beneficiaries who are eligible for any form of subsidy would increase from 25 percent to 29 percent (Merlis 2005). The option would cost about $11 billion a year (Verdier 2006).

The major limitation of this option is its complexity. It would still be necessary to identify assets and determine their value; estimating the assets' annuity value would be an additional step in the eligibility determination process. Also, if an asset is already producing income, steps would have to be taken to avoid counting both the cash income and the imputed annuity value. These complications would increase the burden on program administrators and could discourage eligible beneficiaries from applying for assistance.

9. Eliminate Estate Recovery

Nineteen percent of eligible non-enrollees cite worries about estate recovery as a reason that they do not apply for the Medicare Savings Programs. (Haber *et al.* 2003).

Federal law requires states to seek recovery from the estates of Medicaid beneficiaries for payments for mandatory services, including long-term care and associated hospital and drug costs. In such cases, the state must also seek to recover payments for premiums and cost sharing (Cusick and Nibali 2005). States need not seek recovery from estates of beneficiaries who have not received long-term care, and fewer than half the states seek estate recovery for payments made for Medicare Savings Programs. Nonetheless, many beneficiaries still believe that applying for benefits will result in losing their homes (Glaun 2002).

Eliminating estate recovery just for MSP beneficiaries is likely to have only a small cost. Only 22 states include MSP payments in the services for which recovery is attempted, and even they are not likely to recover significant amounts of money. Because premiums and cost-sharing amounts are small, it is not advantageous for states to devote any great effort to collecting them (Verdier 2006). If eliminating estate recovery increases participation in the Medicare Savings Programs, costs would rise, but the size of this effect cannot easily be estimated.

Moving Towards a Greater Federal Role

When the Congress created the QMB and SLMB programs, it assigned both administrative and partial financial responsibility to the states. Because the requirements are conditions of receiving federal financial assistance for Medicaid, they are not—technically speaking—unfunded mandates (according to the definition

enacted in 1995). Nonetheless, many state officials understandably resent the imposition and do not go out of their way to make the programs work effectively. Gradually shifting the administrative and budgetary responsibility for the Medicare Savings Programs from the states to the federal government may well be the prerequisite for enrolling most of those who qualify for benefits.

Requiring low-income Medicare beneficiaries to go through state Medicaid agencies to be relieved of their cost-sharing responsibilities is inherently more burdensome for them than handling the application process within the Medicare system. Originally, this arrangement had a plausible rationale, since Medicaid was equipped to to assess beneficiaries' income and assets and federal agencies were not. With the creation of the low-income prescription drug subsidy, however, the Social Security Administration is now collecting most of the information needed to implement the Medicare Savings Programs. Thus, the case for state administration of the Medicare Savings Programs—whatever its initial merits—has been weakened.

10. Allow for Federal Administration at State Option with Additional Federal Financing

When a Medicare beneficiary is receiving Supplemental Security Income, the Social Security Administration already enrolls full dual eligibles effectively in 32 states (and the District of Columbia). Now that it is collecting and maintaining data on the income and resources of Medicare beneficiaries applying for the Part D subsidy, Social Security could make decisions on eligibility for the Medicare Savings Programs as well, if the Congress appropriates the necessary funds.

States could be offered the option of allowing applications for the low-income drug subsidy to serve as applications for the Medicare Savings Programs and having them evaluated by the Social Security Administration. States unwilling to accept the conditions of federal administration would continue to make their own determinations. Even if states were given no other inducements, many of them would find it appealing to relieve themselves of this administrative burden.

Federal administration of the Medicare Savings Programs would require uniform national standards. In selecting this option, states would need to accept the same methodologies for counting and verifying income and resources that the Social

Security Administration uses for the low-income drug subsidy (see Appendix), as well as nationally uniform income and resource limits. The income and resource limits would not need to be the same for the MSPs and the drug subsidy, although they could be brought into line at a later date, as in Option 6. As with the drug subsidy, estate recovery would not apply.

Federal administration of the Medicare Savings Programs should also be accompanied by federal financing of benefits for new enrollees. The Social Security Administration is using streamlined processes in determining eligibility for the Part D subsidy, relying heavily on an individual's self-attestation of income and resources (with subsequent verification) and increased numbers of disregards. Applying the same standards to the Medicare Savings Programs would increase costs somewhat, as would the increases in participation rates that federal administration would bring about, although the additional costs would be substantially less than for options that increase income and resource limits. Thus, federal administration would be more acceptable and attractive to states if the federal government assumed these incremental costs. States, however, would be expected to continue paying the costs associated with the current level of enrollment.

Finally, provision would have to be made to assure that current MSP beneficiaries were not disadvantaged by the application of the new standards. Without such protection, some beneficiaries in states with less restrictive income and resource methodologies could lose eligibility. Because participation rates are low, few people are likely to fall in this category, but those who do should remain eligible for assistance, barring a major improvement in their circumstances. The Social Security Administration, however, should not be expected to make determinations using the eligibility standards formerly used by individual states.

Giving Social Security a greater role in administering the Medicare Savings Programs would reduce several of the barriers to enrollment and would therefore be likely to increase participation rates. Outreach would be easier, the welfare stigma would be reduced, and the application process would be greatly simplified. Federal administration might make it possible to raise participation rates to the 70-percent levels achieved by SSI and Medicaid.

Conclusion

The Medicare Savings Programs have demonstrated their ability to enhance financial access to health care for low-income beneficiaries, but many people are still not receiving the benefits for which they are eligible. Increasing take-up rates will require important changes.

First, because the convoluted structure of the Medicare Savings Programs is a major barrier to participation, the roles and responsibilities of federal and state governments need to be sorted out. Policymakers should reconsider three basic questions:

- At the policy level, who should set the financial standards, and at what amounts should they be set?
- At the administrative level, who should perform what functions?
- At the financial level, who should pay?

The options in this report illustrate that a sorting out of functions can take place through a succession of small steps or a few big ones. However they occur, their aim should be to enhance the transparency, accountability, and effectiveness of the programs.

Second, because increasing participation in the Medicare Savings Programs will cost money, additional financing must be provided. On the administrative side, the needed amounts are relatively small—but very important. On the program side, however, the amounts required are larger, and potentially substantial. If administrative processes are improved but current income and resource limits and methodologies are left unchanged, the additional spending on benefits for those currently eligible resulting from increased participation is likely to be measured in the hundreds of millions. If the eligibility criteria are standardized and liberalized, however, the cost could run into the billions. The study panel believes that helping low-income Medicare beneficiaries is a national responsibility and that additional funding for the Medicare Savings Programs should therefore come primarily from the federal government.

Appendix
Comparison of SSI and Drug Subsidy Rules

Concept	SSI Rule	Drug Subsidy Rule
Determination Period	Eligibility is determined on a month-to-month basis.	Eligibility is determined for the calendar year (or the remainder of the year for people applying after January).
Income		
Definition	Anything received in a month that can be used to purchase food or shelter	Same
Eligibility	Countable income does not exceed Federal Benefit Rate (FBR) plus state supplement	Countable income does not exceed 150% of Federal Poverty Level (FPL) for the size of the household
Deemed income	Income is deemed from an ineligible spouse to an eligible spouse, from a parent to an eligible child, and from a sponsor to an eligible alien.	SSI deeming rules do not apply. However, all of a spouse's income is considered.
Earned Income		
Definition	Wages, net earnings from self-employment, sheltered workshop payments and certain royalties and honoraria	Same
Exclusions	▪ Any unused portion of the $20 general income exclusion ▪ Student earned income exclusion ▪ $65 per month ▪ Half of remainder ▪ Impairment-related work expenses ▪ Blind work expenses ▪ Plan for Achieving Self-Support	Same except for student earned income exclusion and Plan for Achieving Self-Support
Unearned Income		
Definition	Any income that is not earned	Same
Exclusions	$20 per month general exclusion applied to all income except that which is based on need.	$20 per month exclusion applied to all income including income based on need
In-kind Support and Maintenance (ISM) definition	Receipt of food or shelter or payments to the provider.	Same
Value of ISM	Value assumed to be 1/3 of the FBR for people living in the household of another. Value capped at 1/3 of the FBR + $20 for people who receive ISM in their own household.	Valued at the amount alleged by the individual capped at 1/3 of the SSI FBR.
Definition of Household	Anyone living in the dwelling who shares food and shelter expenses	For purposes of counting ISM, same definition as SSI. For purposes of determined FPL, household includes the individual, his or her living-with spouse and any relatives who live in the dwelling who receive half or more of their financial support from the individual or spouse.

Comparison of SSI and Drug Subsidy Rules—*continued*

Concept	SSI Rule	Drug Subsidy Rule
Resources		
Definition	Anything that can be converted to cash – both liquid and nonliquid (excludes home and one automobile)	Anything that can be converted to cash within 20 days (i.e., liquid) and real property (excludes home and all automobiles)
Eligibility	Countable resources do not exceed $2,000 for an individual or $3,000 for a couple	Countable resources do not exceed $10,000 for an individual or $20,000 for a couple (increased annually for inflation)
Transfer of resources	Transferred resources counted for 36 months	Transferred resources not counted
Deeming	Resources are deemed from an ineligible spouse to an eligible spouse, from a parent to an eligible child, and from a sponsor to an eligible alien.	SSI deeming rules do not apply. However, all of a spouse's resources are considered.
Life Insurance	If the combined face values of all of the individual's or spouse's policies are $1,500 or less, the policies are totally excluded. If the combined face values exceed $1,500, the cash surrender value of the policies is a countable resource.	Same
Burial fund exclusion	SSA excludes up to $1,500 of funds ($3,000 for a couple) that are set aside for funeral or burial expenses. The $1,500 is offset by the face value of life insurance policies excluded under the $1,500 exclusion. The burial fund is also offset by the amount held in an irrevocable trust or burial contract.	SSA excludes $1,500 if the applicant indicates that he or she expects any portion of the resources listed on the application to be used for funeral or burial expenses. The $1,500 is not offset by excluded life insurance, irrevocable trusts, or burial contracts.
Verification and Documentation	Verification is accomplished with documentary evidence of all factors of eligibility	Verification will consist of a comparison of allegations on the application to data obtained from other federal agencies.
Signature	Signature proxy is used	Same
Representation	Benefits may be paid to a representative payee. SSA will discuss claim-related matters with an authorized representative.	Since there is no payment of benefits, there is no need for a representative payee. Per HHS regulations, a personal representative may assist the applicant.

Source: Social Security Administration.

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