Take-Up Rates in Medicare Savings Programs and the Part D Low-Income Subsidy Among Community-Dwelling Medicare Beneficiaries Age 65 and Older

AUTHORS:

Lauren Popham, PhD,
Howard Bedlin, JD
Leslie Fried, JD, and
Susan L. Silberman, PhD,
National Council on Aging

Jack Hoadley, PhD,
Health Policy Institute,
Georgetown University

Vladislav Slanchev, PhD,
L&M Policy Research, LLC

Many older adults who have trouble affording prescription drugs and health care qualify for Medicare Savings Programs (MSPs), which help pay for Medicare premiums and cost sharing, and the Part D Low-Income Subsidy (LIS) program (also known as Extra Help), which helps pay for prescription drugs. Despite this help being available to qualified Medicare beneficiaries, there is a gap in the literature on the take-up rate in these programs. This paper helps to fill that gap by estimating eligibility, enrollment, and take-up rates in MSPs and LIS among the age 65 and older non-institutionalized population for even years between 2008 and 2014. The estimates reveal that the take-up rate in MSPs was 63.4% in 2014. The LIS enrollment rate is split between automatic enrollees—those who are automatically deemed to qualify based on their enrollment in MSPs, Medicaid, or the Supplemental Security Income (SSI)—and non-automatic enrollees. The LIS take-up rate among automatic enrollees was close to 100% (98.7% to be exact) in 2014, whereas the take-up rate was only 32.8% for non-automatic enrollees in 2014. The results of this analysis reveal that significant numbers of older adults are eligible for, but not enrolled in MSPs and LIS. Understanding trends in enrollment and participation is important for tracking outreach and enrollment efforts. A range of policy solutions are also offered to improve access to these important Medicare low-income assistance programs.

Background and Purpose

Millions of financially vulnerable seniors and adults with disabilities qualify for—but are not yet enrolled in—benefits that could help them pay for prescription drugs, medical care, food, or heat for their homes. Understanding and tracking the size of the eligible population, and what proportion actually enrolls over time, are key to tailoring outreach efforts and charting progress in enrollment.

For some benefits programs, intricate eligibility rules and data source limitations complicate the ability to calculate these estimates. While government agencies are able to publish enrollment numbers, there is scant, or otherwise dated, literature on the sizes of the eligible population and benefit take-up rates. An earlier analysis by the Urban Institute on behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC) found that the take-up rate among Medicare beneficiaries age 65+ and those who have a

disability varied considerably among Medicare Savings Programs (MSPs).[1] In 2009-2010, participation rates for the Qualified Medicare Beneficiary (QMB) program were estimated to be 53.1%, with a 32.2% rate for the Specified Low-Income Medicare Beneficiary (SLMB) program, and a 12.1% rate for the Qualifying Individual (QI) program.[2]

This study addresses the gap in eligibility, enrollment, and take-up estimates for the MSPs[3] and the Part D Low-Income Subsidy/Extra Help (LIS). Specifically, the study calculates the following estimates from 2008 through 2014, focused on a base population of non-institutionalized Medicare beneficiaries, ages 65 or older,[4] residing in the 50 states and the District of Columbia:

- Program Eligibility Rate = the proportion of individuals in the base population eligible for a given program
- Program Enrollment Rate = the proportion of individuals in the base population enrolled in a given program
- Program Take-up Rate = the proportion of the eligible population enrolled in the program (Enrollment Rate divided by the Eligibility Rate)

This analysis differs from the MACPAC estimates in a few ways. This estimate is for the population of adults age 65 and older who are community-dwelling. The MACPAC estimates are for Medicare beneficiaries age 18 and older. This estimate is more recent, representing even years between 2008 and 2014, whereas the MACPAC estimate is for an average of the years 2009 and 2010.

Approach

As no single data source has sufficient quality information to reliably calculate eligibility and enrollment statistics for MSPs and LIS,[5] this study sought to combine the fewest number of data sources to produce credible estimates. Based on a detailed feasibility analysis of available data sources, the research team selected the Health and Retirement Study (HRS), a national longitudinal survey of individuals age 50 and older that collects extensive wealth and income data critical to estimating eligibility. The MACPAC eligibility estimates were from the Survey of Income and Program Participation (SIPP), which we decided against for this analysis because the SIPP data relies only on self-reported income and asset information and has some issues with non-response and misreporting. To determine enrollment, this analysis used the Medicare Current

---

[1] Medicare Savings Programs (MSPs) are Medicaid-administered programs for people on Medicare who have limited income and resources. These programs help those qualified to afford Medicare. There are three different MSPs for older adults, each with different income and resource eligibility limits: (1) under the Qualified Medicare Beneficiary (QMB) program, people may qualify if they have income less than 100% of the Federal Poverty Level (FPL) and resources under $7,860 if single, $11,800 if married. If eligible, QMB will cover the Medicare premiums (Part A, if applicable, and Part B), deductibles, copayments, and/or coinsurance; (2) under the Specified Low-Income Beneficiary (SLMB) program, older adults/adults with disabilities may qualify if they have income between 100-120% FPL and resources under $7,860 if single, $11,800 if married. If eligible, SLMB will cover the Medicare Part B premium ($144.60 in 2020); and (3) under the Qualifying Individual (QI) program, which is a limited program (block-grant to states), and is available on a first-come, first-served basis, people with Medicare may qualify if they have income between 120-135% FPL and resources under $7,860 if single, $11,800 if married. If eligible, QI will cover the Medicare Part B premium. For each of these three programs, Alaska and Hawaii have slightly more generous eligibility limits. The fourth MSP, the Qualified Disabled and Working Individual (QDWI) program, provides assistance for Medicare Part A premiums among disabled individuals who are no longer eligible for Premium-free Part A due to return to work. This research does not include the QDWI program due to the small number of enrollees.

[2] Caswell, K. J., & Waidmann, T. A. (2017). Medicare Savings Program Enrollees and Eligible Non-Enrollees. The Urban Institute, Health Policy Center, Washington, DC.

[3] In this study, the measures related to MSPs combine QMB, QMB plus, SLMB, SLMB plus, and QI.

[4] The restriction to the 65 years of age and older non-institutionalized population for the MSP and LIS estimates is a function of limitations imposed by the lack of nationwide representativeness of institutionalized or younger Medicare beneficiaries in the HRS. The HRS sample is also not representative on the state level, which creates problems for capturing the impact of the higher and more complicated variation in state-specific rules for Medicaid eligibility for determining LIS and MSP eligibility status for younger Medicare beneficiaries.

[5] The Medicare Part D Low Income Subsidy (LIS) enrollment is split between automatic enrollees—those who automatically deemed to qualify based on their enrollment in MSPs, Medicaid, or the Supplemental Security Income (SSI)—and non-automatic enrollees. The subsidy is automatically available based on eligibility status provided by states and the SSA to CMS.

Beneficiary Survey (MCBS), a national survey of Medicare beneficiaries that includes program administrative data on MSP and LIS enrollment. The MACPAC estimate had more detailed MSP enrollment data because they were able to access the Medicaid Statistical Information System (MSIS) data.

For each program and year in which data are available (2008, 2010, 2012, and 2014), we utilize the detailed and verified self-reported income/asset and household composition information from HRS to estimate the number of individuals eligible for each program,[6] and the administrative information in the MCBS to define the number of individuals actually enrolled in each of the programs.

Because the estimated program take-up rate relies on data from two different datasets with different sampling frameworks, their respective respondent samples were reweighted on sex, age, race, marital status, and labor force participation to match the distributions of the nationally representative Current Population Survey (CPS) for even years between 2008 and 2014. Using the distributions of the population in CPS as a benchmark has the additional benefit of reweighting the results so that they are representative of the population for the respective calendar years.

Key Findings

The results summarized in **TABLE 1** show the total numbers of MSP and LIS eligibles and enrollees between 2008 and 2014. **In 2014, the share of the population eligible for these programs was 20.9% in LIS and 16.5% in MSPs. In 2014, the take-up rate in MSPs was 63.4%, up from 55.1% in 2008. The LIS take-up rate is split into auto-enrollees and non-automatic enrollees. Medicare beneficiaries qualify automatically for LIS if they received Supplemental Security Income (SSI), Medicaid, or MSP in the previous year. The take-up rate for auto-enrollees was 98.8% in 2008 and 98.7% in 2014, while the take-up rate for those who are not automatically deemed eligible for LIS was 30.9% in 2008 and increased to 32.8% in 2014.** While take-up rates for LIS increased slightly, the share of the enrolled individuals in the entire population of 65 and older non-institutionalized Medicare beneficiaries remained roughly the same throughout the analyzed period. Furthermore, despite the rise in Medicare Part D participation rates between 2008 and 2014, this increase in enrollment was accompanied by a drop in the share of beneficiaries enrolled in LIS from 2008 to 2014. This suggests that the share of the Medicare Part D population not receiving financial help for their Part D premiums is rising, a change that reflects in part the shift into Part D of non-LIS beneficiaries who had received retiree drug coverage from former employers prior to a change in law in the Affordable Care Act (ACA).

[6] From the restricted-use version of HRS, we also use administrative information for Medicare enrollment, as well as a state buy-in indicator showing whether the state Medicaid agency pays for the Medicare Part B premium of the beneficiary to assess automatic eligibility for LIS.

TABLE 1. LIS and MSP Eligibility and Take-Up Rates Among Non-Institutionalized Medicare Beneficiaries Age 65+, 2008 – 2014

Measure	Population	Year			
		2008	2010	2012	2014
LOW-INCOME SUBSIDY (LIS)					
Total eligible population	Eligible population	8,113,593	8,267,522	8,621,108	8,971,098
	Eligibility Rate	22.7%	21.9%	21.7%	20.9%
	Enrollment Rate	14.1%	13.7%	13.8%	14.0%
	Take-up rate	**61.8%**	**62.3%**	**63.5%**	**66.9%**
Automatically eligible	Eligible population	3,695,794	3,896,337	4,319,704	4,645,384
	Share of total eligible population	45.6%	47.1%	50.1%	51.8%
	Take-up rate	**98.8%**	**99.7%**	**99.7%**	**98.7%**
Non-automatically eligible	Eligible population	4,417,799	4,371,185	4,301,404	4,325,714
	Share of total eligible population	54.4%	52.9%	49.9%	48.2%
	Take-up rate	**30.9%**	**29.0%**	**27.1%**	**32.8%**
MEDICARE SAVINGS PROGRAMS (MSP)					
Total eligible population	Eligible population	6,501,816	6,630,578	6,873,822	7,086,675
	Eligibility Rate	18.2%	17.6%	17.3%	16.5%
	Enrollment Rate	10.1%	9.9%	10.5%	10.5%
	Take-up rate	**55.1%**	**56.3%**	**60.8%**	**63.4%**

This study does include data limitations with respect to the reweighting approach outlined above and the absence of representative data at the state-level to capture differences in MSP eligibility rules across states in the most robust way.[7] However, these limitations primarily impact the magnitudes of the estimates rather than affecting the overall directional trends in the total take-up and eligibility estimates. These directional trends were observed in all analyzed alternative specifications of the sample and the variables used for determining eligibility.

Study Limitations

A degree of caution in interpreting the results is warranted, given underlying conceptual issues and considerations. Notably, the methodology does not allow for calculating credible standard errors around estimates, and thus, we are unable to determine whether observed differences across years are statistically significant. On a more conceptual level, Medicare beneficiaries in this study are determined to be eligible for LIS regardless of whether they have taken up Medicare Part D, as this gives a broader picture of LIS eligibility. Eligible beneficiaries may thus include individuals who have prescription drug coverage through other types of insurance (e.g., employer-based, Veteran's benefits).

Another consideration is that institutionalized Medicare beneficiaries as well as those under age 65 with a disability were excluded from this analysis due to the limitations of the Health and Retirement Study (HRS)

[7] Our method of adjusting for state-specific rules included reweighting the HRS sample to resemble the states with rules that differ from those at the federal-level. We approximated the impact of those rules on the magnitude of the eligible population in each of those states.

data, which includes adults age 50 and older who reside in the community. According to MEDPAC, 4% of Medicare beneficiaries were institutionalized and 17% of Medicare beneficiaries were under age 65 in 2013.[8] Thus, our analysis excludes about a fifth of the Medicare population.

This report highlights the help available for Medicare beneficiaries through federal assistance programs managed inside the Medicare program or in conjunction with Medicaid. More importantly, the report highlights the gaps in the MSPs and LIS programs and reforms that could fill in some of those gaps.

Implications and Policy Solutions

A key finding is that participation gaps in low-income assistance programs for non-institutionalized Medicare beneficiaries age 65 and older remain. Significant numbers of eligible beneficiaries are not enrolled in programs that could provide important financial assistance. About two-thirds of beneficiaries eligible for MSPs are enrolled in that program (Table 1). This means that about 2.5 million Medicare beneficiaries are missing out on the benefits of this program. While some of these individuals may be making an informed decision to not apply, many are unaware that they are eligible or have found the enrollment process too intimidating to attempt or too difficult to complete (for example, unwilling or unable to complete required information on assets).[9]

Enrollment rates for the Part D LIS are similar: 67% compared to 63% for MSP enrollment. LIS enrollment, however, can be broken down in a way that shows a rather different story. Among those eligible for LIS based on already being enrolled as a full-benefit dual eligible,[10] a participant in Medicaid, Supplemental Security Income (SSI), or an enrollee in the MSP program, 99% are enrolled as LIS Part D beneficiaries. As noted above, these beneficiaries are not required to apply for the LIS program; the subsidy is automatically available based on eligibility status provided by states and the SSA to CMS.

By contrast, other beneficiaries eligible for the LIS based on income and assets must apply. The information in this study shows that only one-third (32.8%) of these individuals are enrolled. Thus, nearly 3 million beneficiaries are forgoing the benefits afforded by the LIS. Many of these individuals may be the same ones who are not enrolled for the MSP benefits for which they are entitled. Many of the others may fall in the income range from 135-150% of the FPL and are not eligible for the MSP. These individuals are likely only eligible for the partial LIS,[11] and this status may reduce their interest in enrolling. About 4% of all LIS beneficiaries receive partial LIS benefits.[12]

Policy solutions to increase take-up rates can fall along the lines of several key principles. One is to loosen eligibility standards, which can have the dual effect of making more people eligible and making enrollment easier. A second approach is to align eligibility standards more closely across programs, particularly between the Part D LIS assistance and the MSP. Another approach is to simplify the enrollment process, to make signing up as automatic as possible. Finally, more resources aimed at outreach and enrollment can make a difference.

Loosening Eligibility Standards

The National Council on Aging (NCOA) and other advocacy groups have offered proposals to raise Medicare low-income assistance eligibility standards, thus allowing more beneficiaries to qualify and thereby afford

---

[8] http://www.medpac.gov/docs/default-source/data-book/jun17_databooksec2_sec.pdf

[9] https://www.ncoa.org/centerforbenefits/outreach-toolkit/what-the-research-says/ and https://www.commonwealthfund.org/publications/fund-reports/2009/may/increasing-participation-benefit-programs-low-income-seniors?redirect_source=/publications/fund-reports/2009/may/increasing-participation-in-benefit-programs-for-low-income-seniors

[10] Full-benefit dual eligible refers to individuals who are enrolled in Medicare and receive full Medicaid benefits.

[11] Partial LIS is available to those individuals whose income level is between 136-150% of FPL.

[12] https://www.kff.org/medicare/report/to-switch-or-be-switched-examining-changes-in-drug-plan-enrollment-among-medicare-part-d-low-income-subsidy-enrollees/

the care needed. Such proposals attempt to respond to the concern that by 2030, 42% of Original Medicare beneficiaries will spend at least 20% of their income on health-related expenses.[13]

Families USA (June 2014) suggested that an income threshold of 200% of the FPL would match eligibility levels used in the Children's Health Insurance Program (CHIP). Families USA also notes that states can move income eligibility levels in this direction by adopting more generous income disregards,[14] that is, establishing income reductions that are subtracted from a beneficiary's income to account for the cost of basic living expenses.

A variation would be to raise the income standard for the QMB benefit, which is the only benefit other than full Medicaid eligibility that assists with Medicare cost sharing. The current income standard of 100% of FPL could be raised to 138% of FPL, a level that was used in the Affordable Care Act for Medicaid expansion eligibility. Under current law, low-income Americans in Medicaid expansion states who have incomes between 100% and 138% of FPL lose their cost sharing assistance when they become eligible for Medicare. Aligning these thresholds would address this inequity, which some argue is a form of age discrimination. Those with incomes between 138% and 200% of FPL could receive the more limited Part B premium assistance now available under the SLMB and QI programs.

An even higher priority for many advocates has been to eliminate or increase asset eligibility thresholds. NCOA has argued that the asset test penalizes low-income beneficiaries who did the right thing during their working years by setting aside a modest nest egg of savings to use in case of emergencies. Older adults find themselves in a "Catch-22." If they save, they will be unable to receive assistance. If they do not save, they will receive the extra help but may have little to fall back on other than their Social Security checks.

A UCLA School of Public Health study for the Kaiser Family Foundation found that the LIS asset test falls most heavily on those who are widowed. While 29% of Medicare beneficiaries were widowed, 46% of those failing the asset test were widowed and nearly all of them were women.[15] Similar to the low-income eligibility disparities noted above, poor adults in Medicaid expansion states can receive significant help with their costs regardless of assets—assistance they may lose when they become eligible for Medicare.

Eliminating the asset test can also reduce administrative costs. In a survey of officials in nine states where asset tests for families had been eliminated, respondents reported that eliminating the asset test reduced costs both by simplifying the eligibility determination process and improving the productivity of their eligibility workers. For example, Oklahoma officials reported estimated annual savings of $1.2 million after eliminating the asset test for families.[16] Eliminating the asset test simplifies the application process by easing documentation requirements and reducing the need for program staff to verify information.

Another strategy to ease asset limits as currently implemented would be to use absence of investment income (beyond some threshold) as an alternative to the asset test.[17] Since most assets are associated with related income, this could serve as a simpler version of eliminating those with considerable wealth. Under the Affordable Care Act, premium subsidy eligibility relies on tax return information held by the Internal Revenue Service, and this approach could be applied to eligibility for Medicare subsidy programs. While not a perfect approach given that many low-income older adults do not file taxes, it could simplify the process considerably.

A variation on this approach would be to apply the asset test solely for those who report investment income. Estimates show that at least 75% of those eligible for the MSP have no investment income, so this could offer a considerable simplification. Another variation would be to exempt some or all retirement funds from asset

---

[13] http://files.kff.org/attachment/Report-Medicare-Beneficiaries-Out-of-Pocket-Health-Care-Spending-as-a-Share-of-Income-Now-and-Projections-for-the-Future

[14] https://familiesusa.org/resources/medicare-should-increase-income-and-asset-thresholds-for-low-income-programs/

[15] https://www.kff.org/wp-content/uploads/2013/01/low-income-subsidies-for-the-medicare-prescription-drug-benefit-the-impact-of-the-asset-test-report.pdf

[16] https://assets.aarp.org/rgcenter/health/2005_10_medicaid_msp.pdf

[17] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2011.0443

limits.[18] For example, the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) does not count certain resources such as most retirement and pension plans.[19]

Another option suggested in a policy brief by the Commonwealth Fund[20] uses the policies in Part D as a rough guide for expanding subsidies under the MSP for beneficiaries not eligible for full Medicaid assistance. Under this plan, MSP beneficiaries with incomes up to 135% of FPL would have a uniform benefit that includes (a) a Part A deductible reduced to $100 per admission, (b) complete coverage of the Part B premium, (c) Part B cost sharing reduced from 20% to 10%, and (d) a new limit on out-of-pocket costs of $2,000 per year. The program would have no asset test and would be run by Medicare, rather than by the states. Those with incomes from 135% to 150% of FPL would have the same benefit with the exception that they would pay a partial Part B premium, with percentages stepped down to providing a subsidy of 75%, 50%, or 25% at income levels similar to those for the partial Part D LIS subsidy. Collectively, these changes, according to the Commonwealth Fund analysis, would help an estimated 8.1 million beneficiaries who do not have full Medicaid assistance, including 1.6 million with no supplemental coverage today and another 1.6 million SLMB or QI beneficiaries with no assistance to cover cost sharing. The analysis estimates that the share of low-income Medicare beneficiaries who spend at least 20% of their income on Medicare out-of-pocket costs would drop from 40% to 30%.

Aligning Eligibility Standards

Low-income older adults are often faced not only with a multitude of programs that can provide needed help, but also with different, complex sets of eligibility rules and enrollment procedures that often vary not only from program to program but from state to state. Enrollment decisions are based both on financial eligibility criteria and the methods used to make these determinations. For example, how income and assets are counted can vary considerably.

Some of the confusion and enrollment barriers associated with applying for complex means-tested benefits could be eliminated by aligning eligibility policies and procedures. A more streamlined approach could also promote efficiency and reduce administrative costs. This was recognized when the law establishing the Medicare Part D program specified that individuals already receiving Medicaid, MSP, or SSI benefits would be deemed eligible for LIS, even though the eligibility rules for those programs differed from those of LIS. Alignment of various program standards would promote greater simplicity and cross-deeming opportunities.

As noted above, beneficiaries are eligible for the full Part D Low-Income Subsidy if their incomes are below 135% of the poverty level (and a partial subsidy up to 150%) and if they also meet an asset standard. Eligibility as a QMB, the most generous status available under the MSP, is based on having an income at or below 100% of poverty and a different asset standard. Beneficiaries qualify for SLMB or QI status, which provide less generous benefits with incomes up to 135% of the poverty level. These different standards can be confusing both to beneficiaries and those helping them establish their eligibility. The result can be that beneficiaries fail to take advantage of everything for which they are eligible.

In its March 2008 report to Congress, MedPAC recommended that “The Congress should raise MSP income and asset criteria to conform to low-income drug subsidy criteria.” Other areas in MSPs that could be aligned with LIS include the treatment of in-kind supports, family size, estate recovery, and consideration of non-liquid resources.[21] The Commission specified that the QI eligibility level could be raised to 150% of the poverty level to accomplish this end. Of course, policymakers could implement this concept in ways that would further increase eligibility, although adding to the cost associated with the change. In one variation, eligibility for the

---

[18] *Four Strategies for Improving Programs that Help Low-Income Medicare Beneficiaries with Health Care Costs.* In **https://www.familiesusa.org/resources/medicare-should-increase-income-and-asset-thresholds-for-low-income-programs/**

[19] **https://www.fns.usda.gov/snap/facts**

[20] **https://www.commonwealthfund.org/publications/issue-briefs/2018/sep/medicare-low-income-beneficiaries**

[21] **https://www.kff.org/wp-content/uploads/2013/01/7519.pdf**

QMB program could be raised to match full LIS eligibility at 135% of poverty, raise SLMB eligibility to match the partial LIS from 135% to 150%, and eliminate the separate QI category.

Similarly, asset limit amounts could be made identical in both programs. In addition to the dollar limits, exclusions could be aligned. The LIS eligibility rules explicitly exclude the value of life insurance policies, burial accounts, and the value of certain in-kind support and maintenance funding.

Notably, some of the other proposals to expand program eligibility such as the Commonwealth proposal described above, also use alignment across programs as a guiding principle.

Administrative Simplification

Program simplification would occur with many of the proposals outlined above. Proposals that create a single federal standard for eligibility make it easier to offer some form of "no wrong door" eligibility where applications completed for one program can be used to establish eligibility for other programs. It would, for example, make sense to combine the QMB, SLMB, and QI programs into a single program, and consider integrating LIS, as well.

The application forms are also an important part of the enrollment process. The form can be welcoming and informative or daunting. Shortening the form has often been recommended as a strategy for simplifying the enrollment process.[22] In focus groups of low-income older adults, participants expressed that they felt intimidated by the length of the Medicaid application. Some felt that certain application questions were repetitive and contributed unnecessarily to its length.[23] Applications are more effective if they are concise and only include questions for low-income support.

Consideration should also be given to eliminating or minimizing verification and documentation requirements. Older adults in focus groups[24] felt that having to submit many documents for income and asset verification presented difficulties, particularly when it was difficult to locate the proper documents or make copies. MSP case studies[25] found that states that waived documentation requirements and rely on automated verification systems for detecting inaccuracies did not experience an increase in fraud or errors. Reducing or eliminating verification documents would also likely reduce administrative costs.

Along with its 2008 recommendation on aligning eligibility standards, MedPAC recommended that "The Congress should change program requirements so that the Social Security Administration screens low-income drug subsidy applicants for federal MSP eligibility and enrolls them if they qualify."[26] The goal of this recommendation was to simplify the application process, allowing a single application for both programs—an opportunity further assisted if the programs have aligned eligibility standards. Not only would this lead to more applications and more eligible beneficiaries, but it might be able to accomplish this goal without additional administrative resources.

A related measure is to improve how states process LIS applications. Currently, SSA forwards LIS applications to state Medicaid agencies as "leads" to begin an MSP application. Individuals may be reached through different means. For example, someone who needs assistance with affording drugs may be assisted in applying for the LIS. If those applications are also reviewed automatically for MSP eligibility, then additional assistance will become available even if eligibility criteria are not aligned.[27]

---

[22] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0355

[23] https://www.medicarerights.org/pdf/Investigative_Report_MSPinNYC.pdf and https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0443

[24] Ibid

[25] Ibid

[26] http://www.medpac.gov/docs/default-source/reports/mar08_entirereport.pdf?sfvrsn=0

[27] Ibid

Another opportunity for simplifying enrollment is to screen individuals automatically for MSP in various circumstances; for example, individuals who participate in Medicaid under the expanded coverage for adults added by the Affordable Care Act. In states that have opted to include this adult eligibility, participating individuals lose Medicaid eligibility when they become eligible for Medicare. Automatic screening when individuals with this type of Medicaid enrollment turn 65 or otherwise qualify for Medicare should reduce gaps in assistance for these individuals and would probably increase the number of people who enroll.[28] A similar approach could apply to those who enroll for SSI benefits.

There are also various options for providing those who will soon turn 65 information on the benefits for which they will be eligible. One is to provide automatic assessment and redetermination for eligibility by using existing data in an individual's records. This assessment can precede communication with the individual and enables the state to send an application accurately targeted to the person's situation. Others include a workable no-wrong-door approach so that one application covers multiple programs. There are complications for this approach. One is distinguishing those who are eligible for full Medicaid after turning 65 and those who are only eligible for MSP (as well as differentiating those eligible for the different levels of MSP). Automatic eligibility determination may be more difficult for individuals who become eligible for SSDI and become Medicare eligible than for those who age into Medicare.

The Affordable Care Act included provisions to streamline eligibility determination for premium subsidies by referencing information on file with the Internal Revenue Service on prior-year income tax returns. A similar approach could be used to establish qualifications for the MSP and LIS programs.[29] Although such determinations would be easier if asset tests were eliminated, the idea is to require less collection of information from beneficiaries provided that the beneficiaries permit retrieving information from the IRS. As with the ACA subsidies, eligibility could be verified when later returns are filed. But since income for Medicare beneficiaries is typically more stable than for working-age individuals who may gain and lose employment income, it may be reasonable to skip the stage of making retrospective adjustments.

Improved Outreach and Enrollment Assistance

Studies of the MSPs have found that unfamiliarity with available programs is the top reason eligible beneficiaries fail to enroll. A 2002 RTI survey for CMS of 483 QMB and SLMB eligible non-enrollees found that 79% had never heard of the program. This is followed by 68% of eligible non-enrollees who did not know how to apply for the programs.[30] Similarly, a survey of Medicare beneficiary counselors found that the primary reasons beneficiaries did not enroll for the LIS are that they do not have needed information, were not aware that assistance was available, did not know how to apply, or thought they were ineligible.[31]

An AARP report on QMB and SLMB enrollment concluded that grassroots outreach appeared to be the most effective approach to educating and informing people about the programs. Health insurance counselors, through links with local agencies, played a critical role in disseminating information, screening for eligibility, and filling out applications.[32]

---

[28] https://www.ncoa.org/centerforbenefits/promising-practices/expansion-medicaid-medicare-transitions/ and https://www.medicarerights.org/media-center/medicare-rights-center-identifies-enrollment-gaps-for-people-transitioning-to-medicare-from-expansion-medicaid

[29] https://www.ncoa.org/centerforbenefits/outreach-toolkit/what-the-research-says/ and https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0443

[30] https://innovation.cms.gov/files/migrated-medicare-demonstration-x/qmb_slmb_summary.pdf and https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/haberVol2.pdf

[31] https://www.kff.org/wp-content/uploads/2013/01/8094.pdf

[32] http://www.hpm.umn.edu/ambul_db/db/pdflibrary/DBfile_91001.pdf

A May 2009 Commonwealth Fund report by Laura Summer[33] provides additional support for increased investment in outreach and enrollment efforts:

> *When assistance is available, the application and enrollment processes may not be so daunting for seniors. In focus groups, most seniors currently enrolled in Medicaid indicated that they had needed help with the enrollment process. In a series of interviews regarding early experience with the Medicare Discount Drug Card and the accompanying transitional assistance program, state officials, pharmacists, and beneficiary counselors stressed the importance of one-on-one counseling for Medicare beneficiaries to promote enrollment. To be most effective, however, sufficient staff must be available to provide one-on-one counseling. The General Accountability Office found, for example, that the one-on-one counseling provided to Medicare beneficiaries when the drug card became available was effective, but that only limited numbers of people could be counseled because the demand for help exceeded the capacity of local organizations to provide assistance. State Health Insurance Assistance Program (SHIP) counselors who help Medicare beneficiaries choose Part D prescription drug plans say that it is not unusual to have more than one session with a beneficiary before the individual is successfully enrolled.*
>
> *A national evaluation of the QMB and SLMB programs found that two-thirds of MSP enrollees needed help applying for assistance and concluded that personal assistance is key to successfully educating and enrolling beneficiaries in MSPs. Researchers suggested that it may be most effective to conduct enrollment efforts through those in the community who can identify potentially eligible beneficiaries and assist them with the enrollment process.*

Originally authorized in 2008, the Medicare Improvements for Patients and Providers Act (MIPPA), which has been extended by Congress eight times since then, provided $37.5 million in annual funding to support community-based low-income outreach and enrollment activities. MIPPA funding is shared among State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the National Center for Benefits Outreach and Enrollment (the Center), which provides grants to a network of 84 local Benefits Enrollment Centers (BECs) in 43 states. The Center provides technical assistance to MIPPA grantees and offers competitive grants to develop state and local BECs to provide innovative, holistic, person-centered outreach and enrollment assistance for low-income beneficiaries.

These efforts have contributed to increasing the number of low-income Medicare beneficiaries enrolled in the MSPs from 6.4 million in 2008 to 9 million as of June 2018. Seventy-two diverse national organizations this past December recommended that MIPPA funding be increased and made permanent.[34] Permanent and increased funding would provide the stability and resources that community-based organizations need to staff their organization with trained benefits enrollment counselors and serve the growing number of older adults and people with disabilities who cannot afford their basic needs.

The role of SHIPs is particularly important. Today SHIPs receive over $45 million in federal funding through grants from the Administration for Community Living.[35] Nationally, a network of more than 2,000 local SHIPs and nearly 16,000 counselors (many of whom are volunteers) provide one-on-one counseling for about 3 million beneficiaries, family members, or caregivers.[36] Additionally, counseling services are also provided by telephone. These personal, face-to-face services are especially important for the significant number of Medicare beneficiaries with cognitive illness or other chronic conditions that make it more difficult to process complicated information. SHIP counselors also make many group presentations and host enrollment events. Increased funding would allow SHIPs to expand their services and reach more beneficiaries.

---

[33] https://www.commonwealthfund.org/publications/fund-reports/2009/may/increasing-participation-benefit-programs-low-income-seniors

[34] https://d2mkcg26uvg1cz.cloudfront.net/wp-content/uploads/Medicare-Medicaid-Extenders-Group-Letter-12-16-19.pdf

[35] https://acl.gov/sites/default/files/programs/2019-06/SHIP%20Funding%20revised.pdf

[36] https://acl.gov/programs/connecting-people-services/state-health-insurance-assistance-program-ship and https://d2mkcg26uvg1cz.cloudfront.net/wp-content/uploads/IB16-SHIP-Funding-June.pdf

Conclusions

This report highlights the participation gap in programs aimed at low-income Medicare beneficiaries among those age 65 and older residing in the community. This analysis indicates there are a significant number of eligible Medicare beneficiaries not participating in the critical MSP and LIS programs. As detailed above, significant, needed improvements could be made including loosening and aligning eligibility standards and processes, simplifying programs, and improving outreach and enrollment assistance. Changes such as these would improve access to low-income assistance programs among Medicare beneficiaries who continue to struggle to afford needed health benefits.

Acknowledgement

NCOA would like to thank Gretchen Jacobson, Associate Director at the Kaiser Family Foundation, for reviewing and providing feedback on this paper.

This research project was supported, in part, by grant #90MINC0001-03-01 from the U.S. Administration on Community Living (ACL), Department of Health and Human Services, Washington DC 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

national council on aging

ABOUT NCOA

The National Council on Aging (NCOA) is a trusted national leader working to ensure that every person can age well. Since 1950, our mission has not changed: Improve the lives of millions of older adults, especially those who are struggling. NCOA empowers people with the best solutions to improve their own health and economic security—and we strengthen government programs that we all depend on as we age. Every year, millions of people use our signature programs BenefitsCheckUp®, My Medicare Matters®, and the Aging Mastery Program® to age well. By offering online tools and collaborating with a nationwide network of partners, NCOA is working to improve the lives of 40 million older adults by 2030. Learn more at www.ncoa.org and @NCOAging.