Lessons from New York State: Removing Bureaucratic Barriers and Expanding Eligibility for Medicare Savings Programs

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Executive Summary

The substantial cost-sharing imposed under Medicare means that older adults and people with disabilities can face out-of-pocket costs that prevent them from receiving the medical care and prescription drugs they need. To help people with Medicare and low incomes afford the cost-sharing under original Medicare, the federal government created the Medicare Savings Programs (MSPs) and the Medicare Part D Low-Income Subsidy (LIS) program.

Despite the benefits of MSPs—financial assistance and increased access to care—participation in these programs remains low. Enrollment is low for a variety of reasons, including administrative requirements that prevent people from enrolling, such as the need to travel to often inaccessible and/or unsafe Medicaid offices and burdensome documentation requirements.

New York—and other states that provide drug coverage to Medicare enrollees through a State Pharmaceutical Assistance Program (SPAP)—has a strong financial interest in increasing enrollment in MSPs because MSP enrollment results in automatic enrollment into the federally funded LIS, which pays the majority of drug costs for SPAP enrollees in the LIS. States can maximize enrollment in LIS by expanding enrollment in MSPs, since people in a MSP are deemed eligible for and automatically enrolled in LIS.

Advocates in New York have worked independently and in conjunction with the New York Medicare Savings Coalition to ensure that consumers understand the consequences of bureaucratic disentitlement—when administrative requirements prevent people from enrolling in a benefit to which they are entitled—and to target specific policymakers and legislators with suggestions for reform. Through strategic relationships with a variety of organizations, policymakers and media outlets, advocates have worked to educate the public about the need for

reforms and worked toward state and federal reforms of eligibility requirements and administration of low-income Medicare programs.

As a result of this advocacy, the State of New York has implemented a number of reforms that reduce barriers to enrollment and simplify the application process. In the last two years, New York has eliminated two major barriers to enrollment for all the Medicare Savings Programs: the face-to-face interview requirement and the asset test. Elimination of these two application components in 2008 simplified the MSP application process, making it easier for people with Medicare to apply and for caseworkers to process the applications, which has increased enrollment and is expected to yield administrative cost savings for the state. This report describes how New York State has helped ease the MSP enrollment process and recommends that the state go beyond these reforms to eliminate income documentation requirements and streamline recertification, thereby removing remaining bureaucratic obstacles to enrollment and raising income thresholds to expand eligibility. The work described in this report could serve as a model for other states seeking to increase enrollment of people with Medicare in low-income assistance programs.

Introduction and Background

Medicare Consumer Income and Access to Care

Many people with Medicare age 65 and older rely on Social Security as their primary source of income.[1] As a result, this population is more likely to be poor or near poor; in 2006, half the over-65 population had incomes of $17,045 or less.[2] Incomes for people over 65 also tend to decrease as they age.[3] For example, in 2005, people with Medicare aged 65 to 74 had average incomes of $23,470, while people over age 85 had average incomes of $20,063.[4] And

the situation is even worse for people under 65 with disabilities: these individuals with Medicare are twice as likely as those 65 and older to have incomes below the federal poverty level (FPL).[5] In 2005, the mean income for people under the age of 65 with a disability was $14,361.[6] In New York State, in 2007, 20.5 percent of the total Medicare population had incomes below 100 percent of FPL ($10,210 for an individual, $13,690 for a couple).[7] Additionally, 28.3 percent of enrollees had incomes between 100 and 199 percent of FPL.[8]

In addition to having lower incomes, people with Medicare face higher medical expenses because of poor health and the high cost-sharing under Medicare.[9] In 2005, average out-of-pocket health spending for Medicare enrollees age 65 to 74 was $3,381, while for people over 85 it was $7,002.[10] In 2006, the average out-of-pocket cost for Medicare enrollees was $4,068, almost two times the out-of-pocket spending by non-Medicare enrollees.[11] People with Medicare, particularly people with incomes near the poverty line, may avoid seeking needed care because of the cost.[12]

While Medicare offers valuable protection against the high cost of medical care, it also imposes substantial financial obligations on enrollees. On an actuarial basis, the Medicare benefit covers 76 percent of the cost of prescription drugs and medical services, far less than the typical coverage provided under an employer-sponsored HMO (93 percent) or the standard option Blue Cross Blue Shield Preferred Provider Organization (PPO) plan offered to federal employees (87 percent).[13] (See Figures 1-3 for a detailing of the costs associated with Medicare Parts A, B, and D.)

Figure 1: Medicare Part A Costs for 2009

Inpatient Insurance (Part A)	
· **Premiums:**	Free if you have worked for 40 quarters (10 years) or more. $244/month if you have worked 30–39 quarters (between 7.5 and 10 years) $443/month if you have worked fewer than 30 quarters (7.5 years)
Inpatient Hospital Care	
· **Deductible:**	$1,068 each benefit period
· **Coinsurance:**	$0 for days 0–60 each benefit period $267/day for days 61–90 each benefit period $534/day for days 91–150 (lifetime reserve days—total of 60 lifetime reserve days, which are nonrenewable)
Skilled Nursing Facility	
· **Coinsurance:**	0 for days 0–20 each benefit period $133.50/day for days 21–100 each benefit period

Figure 2: Medicare Part B Costs for 2009

Medical Insurance (Part B)	
· **Premium:**	$96.40 per month
· **Deductible:**	$135 per year
· **Coinsurance:**	20 percent of the Medicare-approved amount for doctor's services 50 percent of the Medicare-approved amount for mental health services

Figure 3: Medicare Part D Costs for 2009

Prescription Drug Coverage (Part D)	
· **Premiums:**	$30.36 average monthly premium
· **Deductible:**	$295 per year
· **Coinsurance:**	25 percent until the total costs (what both enrollee and plan pay) reach $2,700 100 percent until the enrollee spends $4,350 out of pocket $2.40 for generic drugs and $6.00 for brand-name drugs or 5 percent coinsurance, whichever is greater, after the enrollee spends $4,350 out of pocket

Programs to Assist Low Income People with Medicare

The Medicare Savings Programs

Congress created the MSPs to help low- and moderate-income Medicare enrollees pay for the cost-sharing under Medicare.[14] The Medicare Savings Programs encompass three separate programs with different benefits and eligibility standards. The Qualified Medicare Beneficiary (QMB) program pays the Medicare Part B monthly premium, Medicare Part A and Part B deductibles and coinsurance for enrollees.[15] To qualify for QMB a person's income must be at or below 100 percent of FPL.[16] The Specified Low-Income Medicare Beneficiary (SLMB) program pays the Medicare Part B monthly premium. To qualify for SLMB a person's income must be between 100 and 120 percent of FPL.[17] The Qualified Individual (QI) program also pays the monthly Medicare Part B premium. To qualify for QI a person's income must be between 120 and 135 percent of FPL.[18] (See Table 1.)

Table 1: Medicare Savings Programs Details

	QUALIFIED MEDICARE BENEFICIARY	SPECIFIED LOW INCOME MEDICARE BENEFICIARY	QUALIFIED INDIVIDUAL
Income	100 percent of FPL	100–120 percent of FPL	120–135 percent of FPL
Assets	$4,000 individual $6,000 couple	$4,000 individual $6,000 couple	$4,000 individual $6,000 couple
Benefit	Deductibles, Coinsurance, and Part B Monthly Premium	Part B Monthly Premium	Part B Monthly Premium

* In 2009, the federal poverty level is $10,380 for an individual and $14,570 for a couple.

Under current federal law, the asset limit for all three MSPs is $4,000 for an individual and $6,000 for a couple.[19] These limits have not been increased since the programs' implementation in the late 1980's. However, effective January 1, 2010, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) increases the MSP asset limit so that it aligns with the asset limit of the Part D Low-Income Subsidy ($8,100 for an individual and $12,910 for a couple in 2009; limits for 2010 have not yet been announced), and is indexed to ensure that the asset limit increases with inflation over time.[20] To qualify for a Medicare Savings Program, a person must meet the federal income and asset limits, if applicable, or the more generous limits established by state Medicaid programs.

The QMB and SLMB programs are entitlement programs administered by state Medicaid offices and jointly funded with federal and state dollars. The QI program is a fully federally funded block grant also administered by state Medicaid offices.[21] States have considerable flexibility to expand eligibility for MSPs by using income disregards (excluding amounts or specific sources of income) to raise income thresholds or by raising or eliminating asset limits through a state plan amendment approved by the Centers for Medicare and Medicaid Services.[22]

New York and 7 other states—Alabama, Arizona, Connecticut, Delaware, Maine, Mississippi and Vermont—have eliminated the MSP asset test entirely.[23]

MSPs have proven their value in reducing barriers to care for low-income people with Medicare. Research shows that those eligible for but not enrolled in an MSP are more likely to report that they did not receive needed care because of the cost than people enrolled in an MSP.[24]

The Part D Low-Income Subsidy

To help low-income people with Medicare afford the cost-sharing under the prescription drug program, in 2003 Congress established the Low-Income Subsidy (LIS) program—commonly referred to as Extra Help—which is an entitlement funded entirely by the federal government.[25] Approximately 10 million people with Medicare are enrolled in LIS. People with incomes below 135 percent of FPL and assets below $8,100 for individuals and $12,910 for couples qualify for the full low-income subsidy.[26] Those enrolled in full LIS do not pay the monthly Part D premium, do not have an annual deductible, have coverage through the coverage gap and pay limited cost-sharing.[27] The average annual value of Part D coverage with LIS is $3,900 in 2009.[28]

People whose income is between 135 and 150 percent of FPL and with assets below $12,510 for an individual and $25,010 for couples qualify for the partial Low-Income Subsidy. Those enrolled in partial LIS pay Part D premiums on a sliding scale, have a $60 annual deductible, have coverage through the coverage gap, and pay cost-sharing capped at 15 percent of the cost of the drug.[29] (See Table 2.)

Table 2: Part D Low-Income Subsidy

	FULL LOW-INCOME SUBSIDY	PARTIAL LOW-INCOME SUBSIDY
Income	135 percent of FPL	135 to 150 percent of FPL
Assets	$8,100 individual $12,910 couples	$12,510 individual $25,010 couples
Benefit	No monthly premium No annual deductible Coverage through gap Limited cost-sharing • $2.25 for generics • $5.60 for brand-name • $0 during catastrophic coverage	Sliding scale premium $60 annual deductible Coverage through gap Limited cost-sharing • 15 percent of the cost of the drug • $2.40 for generics, $6.00 for brand-name during catastrophic coverage

Relationship between LIS and MSPs

The Social Security Administration (SSA) is responsible for the administration of the LIS program. SSA screens and enrolls applicants for the LIS program and also conducts education and outreach. SSA, however, does not play any role in MSP screening and enrollment. State Medicaid offices, on the other hand, educate, screen and enroll applicants for MSPs. [30,31]

The law provides the Secretary of Health and Human Services (HHS) with the authority to allow people eligible for an MSP to be "deemed" eligible for the LIS—meaning that the enrollee does not have to demonstrate that he or she meets the LIS income and asset eligibility standards.[32] However, deeming works in only one direction. People who are found eligible for LIS are not automatically deemed eligible for a MSP.

State Pharmaceutical Assistance Programs

New York State provides additional drug coverage to people over the age of 65 through its State Pharmaceutical Assistance Program (SPAP), the Elderly Pharmaceutical Insurance Coverage (EPIC) program.[33] The EPIC program was created before the inception of Part D in order to help older New Yorkers with low or moderate incomes pay for their prescription costs. The EPIC program is limited to people with annual incomes of less than $35,000 for individuals or a combined $50,000 for married couples, thresholds that are above 300 percent of FPL.[34] EPIC is not available to people under 65, even if they are enrolled in Medicare, and it is not available to individuals who are enrolled in full Medicaid.[35] EPIC does not have an asset test. Twenty-four states have pharmaceutical assistance programs to help older adults or people with disabilities or specific conditions with the cost of their prescription drugs.[36]

With the inception of the Part D drug benefit in 2006, EPIC coverage became secondary to Part D for individuals enrolled in both programs, meaning that it provides coverage during the coverage gap in Part D. EPIC also pays the difference when its copays are lower than those charged by Part D plans. To maximize the share of drug costs paid by Part D, EPIC requires most of its members to enroll in a Medicare Part D plan as a condition of eligibility.[37] In addition, EPIC applies for LIS on behalf of its members whose income and assets likely qualify them for the benefit. EPIC estimates that, for each EPIC member enrolled in LIS, the state program saved $1,430 in drug costs in 2007.[38] Thus a substantial portion of an EPIC enrollee's prescription drug costs is paid for by Part D. In addition, beginning July 1, 2009, EPIC is assisting all of its members who are potentially eligible for an MSP with the application process.[39] This assistance will ensure that Medicaid offices (formally known in New York as Department of Social Services offices) receive properly completed MSP applications for people who are the most

likely to be eligible for the benefit, since EPIC will be able to prescreen applicants for eligibility. Through this process, New York stands to save money not only as a result of administrative cost savings but also because people enrolled in a MSP will be deemed eligible for LIS, which will bring in additional federal dollars. And EPIC enrollees who are deemed eligible for LIS will pay less out of pocket for generous drug coverage under EPIC and Part D.

Efforts to Increase Enrollment: Reducing Bureaucratic Disentitlement

Despite the benefits of MSPs—financial assistance and increased access to care—participation in the Medicare Savings Programs remains low nationwide. Only 33 percent of people estimated to be eligible for QMB are enrolled and 13 percent of those eligible for SLMB are enrolled.[40] When individuals apply for enrollment, they often encounter multiple obstacles, including burdensome income and asset documentation requirements, copious paperwork, travel to often inaccessible Medicaid offices, and long wait times for service once they get there. Further, many older adults and people with disabilities feel Medicaid offices are in areas that are unsafe. These hurdles prevent many people with Medicare from applying for the assistance they need. These sometimes insurmountable hurdles often lead to bureaucratic disentitlement—when administrative requirements prevent people from enrolling in a benefit to which they are entitled.

Advocates have worked independently and in conjunction with the New York Medicare Savings Coalition (see Text Box 1) to ensure that stakeholders understand the consequences of bureaucratic disentitlement and to present New York policymakers and legislators with recommendations for reform. Through strategic relationships with a variety of organizations, policymakers and media outlets, advocates have worked to educate the public about the need for reforms and worked toward state and federal reforms of eligibility requirements and

administration of low-income Medicare programs. In their efforts to achieve reform, advocates have leveraged the cost savings that would result to New York State if the MSP application process were simplified and eligibility expanded: EPIC expenditures would decrease and the amount of federal dollars coming to the state would increase as a result of more EPIC members being deemed eligible for LIS.[41]

Text Box 1: New York State Medicare Savings Coalition

The New York State Medicare Savings Coalition, led by the Medicare Rights Center, is an alliance of over 150 community-based organizations, advocacy groups, businesses and government agencies in New York State. By bringing government officials and advocates together in dialogue, the monthly meetings offer Coalition members the opportunity to review the latest information on implementing health care programs for people with limited incomes. Coalition members stay connected through regular e-mail updates, conference calls, enrollment initiatives and advocacy projects.

Founded in 2003 with a grant from the Robert Wood Johnson Foundation, and in coordination with Rutgers University's State Solutions Project, the Coalition has successfully advocated for state and federal policy reforms affecting people with Medicare, including the elimination of the face-to-face interview requirement for MSPs in New York State, elimination of New York's MSP asset test, and reauthorization of the QI program. The Coalition also developed the Deputization Project, a first-of-its-kind initiative to educate professionals and consumers on the benefits of the MSP, and to submit applications in bulk to various Medicaid offices across the state.

The Coalition regularly identifies and works to eliminate the systemic barriers that limit access to affordable health care programs and benefits for older adults and people with disabilities. This is accomplished through various means, including legislative advocacy, regular exchange of best practices and continuous information-sharing and communication among government agencies and non-governmental groups and organizations.

As a result of advocacy efforts, New York has implemented a number of reforms that reduce barriers to MSP enrollment and simplify the application process, including reforms specific to the QMB program (see Text Box 2).[42] In the last two years, New York has eliminated

two major barriers to enrollment for all the Medicare Savings Programs: the face-to-face interview requirement and the asset test.

Text Box 2: QMB-Specific Reforms

Following the elimination of the face-to-face interview in 2007, the New York State Department of Health implemented a project to screen 7,000 people with Medicaid and Medicare Part A, but no Medicare Part B, for QMB, without requiring them to visit their local Medicaid office.[43] As a result, as of June 2009, 2,625 people were automatically enrolled into QMB, thus giving them the premium-free Part B for the first time.[44] This mass enrollment not only resulted in improved coverage for New Yorkers with Medicare, but also has the potential to save the state money by making Medicare the primary payer for Part B services, which include doctor visits and outpatient hospital services. Prior to the consumer having Medicare Part B, Medicaid was solely responsible for the cost of these health care services.

In addition, after eliminating the face-to-face interview requirement, the MSP coalition was able to persuade the New York State Department of Health that it could allow QMB applicants to use the simplified, one-page application that SLMB and QI applicants use.[45] Previously, QMB applicants were required to use the cumbersome, 16-page Medicaid application.[46] Filling out an application for QMB is now less complicated and requires less time of the applicant, with fewer intrusive questions to answer.

Removing Enrollment Barriers to Medicare Savings Programs

Elimination of the Face-to-Face Interview Requirement

While there is no federal requirement for the MSP application process to include a face-to-face interview, these interviews are often thought necessary to ensure that applicants are in fact eligible and to reduce fraud. Prior to this reform in New York State, an MSP applicant had to visit a Medicaid office, on his or her own or with a representative, to complete the MSP application *on site* and to be interviewed face-to-face.[47] However, there is no evidence that face-to-face interviews prevent non-eligible people from enrolling or reduce fraud.[48] It has, however, been demonstrated that face-to-face interview requirements do prevent eligible people from applying for benefits.[49]

People with limited mobility are often unable to visit the Medicaid office in person because, for example, some offices have stairs that people are unable to climb. In addition, many applicants are unable to drive, lack access to public transportation or have difficulty using public transportation.[50] Many are also reluctant to go to a Medicaid office only to wait for hours to see a caseworker or arrive after the office has closed because of limited office hours. Additionally, many people do not understand why they must visit a Medicaid office to receive a benefit that helps them with their Medicare expenses.

The face-to-face interview requirement was also problematic because caseworkers at Medicaid offices often did not know about the MSPs and sent the applicant away without completing an application.[51] In addition, Medicaid offices often do not have the staff or time necessary to help all applicants with the application and documentation processes.

As the above factors indicate, the face-to-face interview for MSPs in New York State led to inordinate delays and unnecessary administrative expense. MSP applicants did not have the option of completing a mail-in form or of completing an application at home and then bringing it in at the time of the in-person interview. Additionally, the processing of applications was often delayed because many applicants did not bring sufficient documentation with them to complete the application, and had to come back.

In December of 2007, New York acknowledged the barrier that a face-to-face interview presents to MSP enrollment and eliminated this requirement, effective January 1, 2008.[52] This major change in state law and regulations had an immediate positive impact on MSP applicants and general administration of the benefit.[53]

Since the elimination of the face-to-face interview requirement, rather than having to go to a Medicaid office to complete an application with a caseworker, New Yorkers with Medicare

and low incomes can have an MSP application and a list of required documents mailed to them. They can mail the application back to the county's Medicaid office for processing. As a result, people who could not get to a Medicaid office can now apply for MSPs.

Now that MSP applicants can mail in their completed application, they can seek assistance in completing it from a trusted source, such as a social worker or other professional at a community-based organization, who can ensure that the application is properly completed and includes all required documentation. (See Text Box 3 for a description of how professionals in New York City are helping clients apply for MSPs.) For example, staff in community-based organizations that work with homebound applicants are able to assist their clients with applications in their homes. In addition to assisting the applicant, the professional can retain copies of the application and supporting documents and assist with follow-up if there are complications. The professional can also help the applicant with the benefit recertification process.

As a result of the elimination of the face-to-face interview, MSP applications are processed more quickly. Medicaid caseworkers no longer spend time conducting face-to-face interviews, and the quality of the completed MSP applications have improved, both factors that have improved the application process.[54,55]

The positive impact of the elimination of the face-to-face interview requirement will continue to be realized as provisions of the 2008 Medicare Improvements for Patients and Providers Act are implemented. Specifically, beginning January 1, 2010, MIPPA requires the Social Security Administration to send verified LIS application information to state Medicaid agencies, the Department of Health in the case of New York State. LIS information must then be used to automatically initiate an application for Medicare Savings Programs, potentially

increasing the number of MSP enrollments.[56] If the face-to-face interview was still a requirement for MSP enrollment, individuals would not be automatically enrolled into MSPs, negating the value of the MIPPA reform.

Text Box 3: Medicare Rights Center Deputization Project

The Medicare Rights Center Deputization Project began in 2003 and was created so that community-based professionals—a trusted source to help people apply for the MSPs—could improve application submissions, ease the recertification process, assist with understanding the benefit, and increase enrollment. Through the deputization project the Medicare Rights Center trains community advocates, SHIP volunteers, legal services staff, social workers, case managers and other professionals to become deputized agents—representatives on behalf of their clients. Deputized agents are trained to understand the complex MSP application process, including income calculations and documentation requirements. In addition to helping clients submit properly completed applications, deputized agents are able to receive the decision notice regarding whether the beneficiary was found eligible, and if not, why the person was not found eligible.

The Medicare Rights Center submits MSP applications on behalf of over 600 deputized agents, and receives decision notices about every application. Medicare Rights Center staff notifies each deputized agent about the status of the application(s).

As a result of this project and others like it, MSP applications are processed more quickly and improper denials are avoided or remedied quickly.

Elimination of the Asset Test

An increasing number of people with Medicare meet MSP income requirements but do not qualify for the benefit because of the asset limit ($4,000 for an individual, $6,000 for a couple). The asset test penalizes applicants who have saved to provide some security for themselves and their families, typically through bank savings accounts and life insurance policies.[57] In addition to prohibiting enrollment of low-income people who would otherwise qualify, asset tests greatly complicate the application process. Applicants often are unable to complete the application themselves because they have difficulty quantifying assets and

gathering the required documentation.[58] An asset test also creates administrative burdens and expenses for states because Medicaid staff must process longer, more complicated applications and verify asset data.[59] For example, a typical QMB applicant in New York had to provide a variety of documents to demonstrate the value of her assets, including bank statements for savings and checking accounts, CD statements, life insurance policies showing her current cash surrender value, investment portfolios, and other documents.[60] Obtaining copies of these documents is not always easy, especially copies of life insurance policies that may have been purchased years before. Eliminating the asset test not only makes it easier for people who need the assistance to apply but also results in administrative cost savings to the state because caseworkers no longer have to review and verify all of the required documents.

While federal law sets a minimum eligibility standard for MSPs, states are permitted to change the MSP eligibility criteria, as long as the state does not impose stricter standards.[61] In 2002, New York recognized the advantages of eliminating the asset test and did so for the QI MSP. When implementing this change, New York decided to also enroll people into QI who qualified for SLMB based on income, but whose assets were over the limit.[62] In September 2002, New York extended this process to people who would qualify for QMB based on income, but not assets.[63] While this saved the state money—the state did not have to pay for any part of the benefit, because the federal government pays for the entire benefit under QI—it also prevented people from being enrolled in the appropriate MSP.

However, in 2002, the Centers for Medicare and Medicaid Services—the federal agency that administers Medicare and Medicaid—notified New York State that it could not implement the elimination of the QI asset test in this way. According to CMS, federal law permits only people with incomes between 120 and 135 percent of FPL to enroll in QI. CMS stated that by

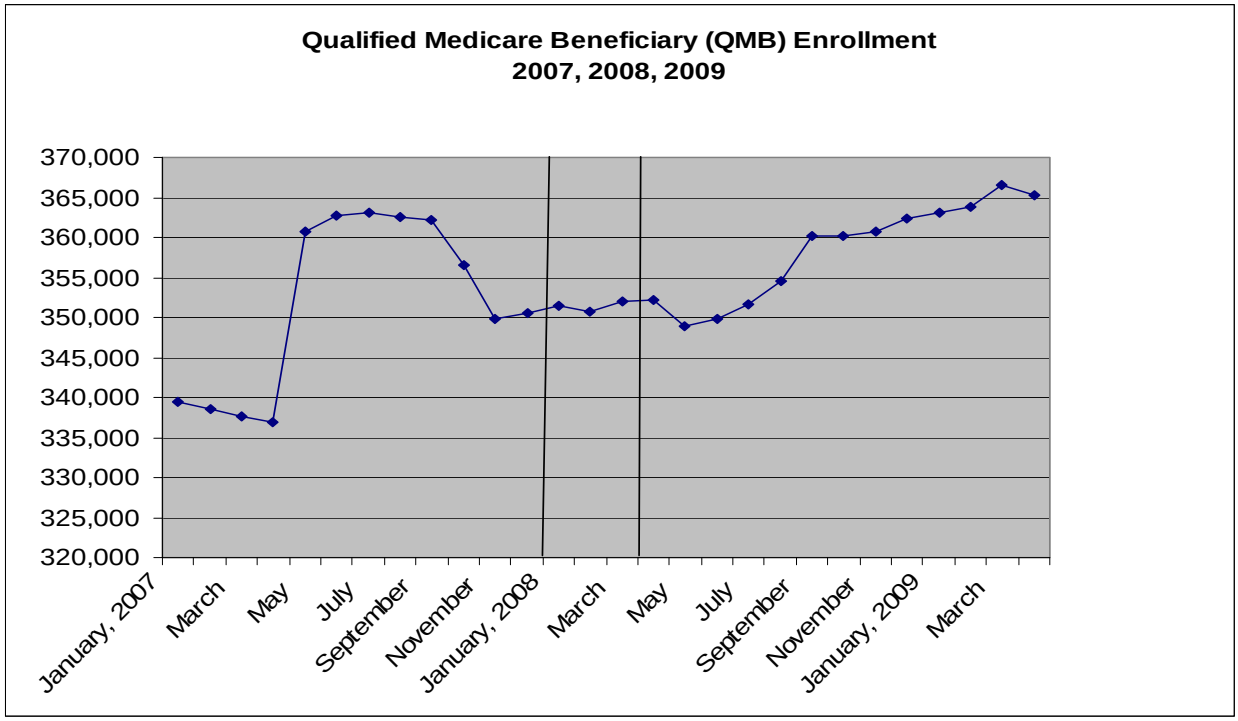
enrolling people into QI when they qualified for QMB or SLMB based on income, but not assets, New York violated that requirement. New York, however, continued to use this process until April 1, 2008, when the state eliminated the asset test for all MSPs.[64]

Elimination of the asset test for all MSPs had a significant impact on enrollees. People who previously were enrolled in QI were automatically reassigned to QMB or SLMB according to their income.[65] Reassignment worked in favor of the people who were reassigned, because as entitlement programs, QMB and SLMB are not in danger of being underfunded or eliminated. More importantly, QMB offers more assistance than QI, covering Medicare coinsurance and deductibles in addition to the Part B monthly premium.

Increased Enrollment in the Medicare Savings Programs and Administrative Cost Savings

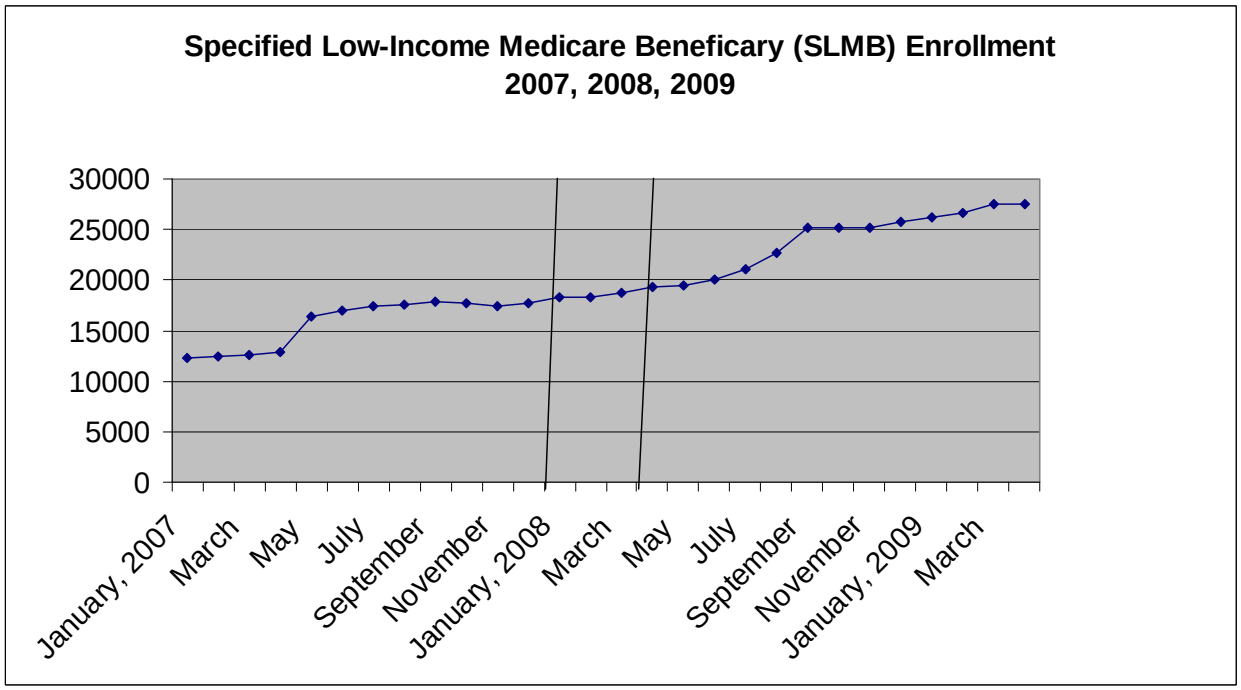
Elimination of the asset test and removal of the face-to-face interview requirement for the MSPs in New York in 2008 have led to gains in enrollment, and administrative cost savings for the state are anticipated. In 2007, the year before the changes were implemented, the average annual enrollment in QMB was 351,717 and 15,783 in SLMB.[66] In 2008, the year during which both reforms took effect, average annual enrollment in QMB increased to 354,560 and to 21,603 for SLMB. That represents an almost one percent increase in QMB and an almost 37 percent increase for SLMB. While the increase in QMB in 2008 was modest, it is worth noting that in the first quarter of 2009, enrollment had already increased 3.7 percent. (See Graphs 1 and 2.)

Graph 1: Qualified Medicare Beneficiary Enrollment Over Three Years



* Vertical lines denote when the administrative reforms became effective. The face-to-face interview requirement was eliminated effective January 2008 and the asset test was eliminated effective April 2008.

Graph 2: Specified Low-Income Medicare Beneficiary Enrollment Over Three Years



* Vertical lines denote when the administrative reforms became effective. The face-to-face interview requirement was eliminated effective January 2008 and the asset test was eliminated effective April 2008.

Enrollment in SLMB also continues to climb steadily. Some of the increased enrollment in these programs is the result of enrollees being disenrolled from QI and enrolled in QMB or SLMB.[67] More time and study are needed, and a follow-up will be published when more data are available.

While New York State did not conduct its own analysis of the enrollment data to identify the impact of the administrative changes and asset test elimination, it is reasonable to assume that these reforms contributed to enrollment gains. The growth in enrollment is contemporaneous with the administrative changes and eligibility expansions made in 2008. Analyses in other states with similar reforms have found enrollment gains due to these types of changes.[68] Moreover, it seems that the effect of the reforms is still gaining momentum. In the first quarter of 2009, both QMB and SLMB have shown steady growth, which is expected to continue.

In addition to increased MSP enrollments, New York should expect administrative cost savings as a result of the elimination of the asset test and face-to-face interview requirement.[69] Unfortunately, administrative cost data for the Medicare Savings Programs in New York is not available.[70] The state should expect savings per application, since the elimination of the asset test and face-to-face interview should have led to a decrease in the time needed to process each MSP application. In addition, as noted previously, because trained, community-based professionals now can help applicants complete MSP applications, the quality of the completed applications has improved, making it easier for caseworkers to process them. While postage expenses may have increased because the MSP application is now mailed to the applicant, printing costs may have decreased, since there are fewer forms that the state must produce, and because the application is now only one page, rather than the full 16-page Medicaid application.

Other states have documented administrative cost savings as a result of similar administrative reforms. In 2001, Arizona conducted an analysis of the impact of its elimination of the asset test for MSPs prior to enacting the reform, and found that administrative costs would decrease.[71] In addition, an analysis of the changes to the enrollment and renewal process for MSPs in Louisiana found that lower administrative costs were partly the result of caseworkers spending less time on MSP applications because there was less required documentation once Louisiana modified the asset test for MSPs.[72]

Next Steps

While New York has taken many important steps to increase enrollment in the MSPs, other improvements are still needed to significantly expand MSP enrollment and maximize federal assumption of EPIC drug costs through increased LIS enrollment. Pending legislation to expand coverage to the under-65 population includes reforms that could be adapted to the MSP program. Specifically, both the House and Senate health reform bills recognize the need for substantial cost-sharing assistance, including through an expansion of Medicaid, for individuals well above the federal poverty level, the income ceiling for QMB—the only MSP that provides assistance with cost-sharing for medical services. The health reform bills also will establish more streamlined processes for determining eligibility for the under-65 population both for Medicaid and premium subsidies. These simplified eligibility processes may serve as models for states seeking to remove bureaucratic hurdles to MSP enrollment.

Increase Income Limits

First, to measurably boost both MSP and LIS enrollment in New York, the state should increase the income limits for MSPs. At present, New York applies the federal minimum income eligibility requirements. (See Table 1.) Other states have increased MSP income limits above the federal limits to help offset state SPAP expenditures with federal dollars. In 2007, Maine increased the income limits for QMB to 150 percent of FPL, for SLMB to 170 percent of FPL, and for QI to 180 percent of FPL.[73] The QI income limit was set to equal the income limit for the state's SPAP, the Drugs for the Elderly and Disabled Program (DEL), which allowed the state to automatically enroll everyone in DEL into an MSP.[74] This reform significantly increased the number of people enrolled in MSPs, and resulted in the federal government paying for a substantial portion of drug costs under DEL, since people in MSPs are deemed eligible for the LIS.[75] If New York aligned MSP criteria with EPIC criteria, the federal government would cover a greater portion of the costs of drugs under EPIC, and the state could use the money saved to help cover a substantial portion of the increased financial obligations resulting from the increased enrollment in QMB and SLMB.[76]

Allow Self-Attestation of Income

The MSP application process could be further streamlined to allow self-attestation of income, eliminating the requirement to provide documentation. Currently, applicants must provide copies of their Social Security award letter, pension letter or three stubs from recent payments, 1099-DIV tax form, bank statements showing annuity deposits, pay stubs for earned income, unemployment payment statement, and any other documents necessary to demonstrate income.[77]

New York has realized the value of self-attestation before: when New York had an asset test for MSPs, it allowed applicants for SLMB to use self-attestation for assets, rather than submit documents.[78] Numerous studies have found that eliminating documentation requirements does not increase the risk of error or fraud.[79] States are already required to use Income and Eligibility Verification Systems to confirm that income information provided by the applicant is accurate, regardless of whether the applicant uses self-attestation or submits documentation.[80] The Social Security Administration allows self-attestation for income and resources for the Low-Income Subsidy application and verifies the information using data exchanges with various federal agencies.[81] An eligibility determination process based on self-attestation of income is also envisioned under pending health reform legislation for determining eligibility for premium subsidies under the health insurance exchange, where eligibility is verified by using the most current tax records.

Self-attestation would also make it possible for people to complete and submit the MSP application online, as LIS applicants are able to do. Not only would this change make it easier for applicants to apply for MSPs—particularly since it would make it easier for professionals to help people complete and submit applications—but it would also reduce administrative costs. Starting in 2010, New York state will accept self-attested income data that has been verified by the Social Security Administration, when the latter transfers information to initiate MSP applications from people with Medicare who have applied for LIS. New York could similarly accept self attestations of income if it implemented verification procedures that are on par with those used by the Social Security Administration.

Streamline Recertification

The recertification process must also be addressed to ensure that as many eligible individuals as possible are enrolled in MSPs. While federal law requires MSP enrollees to annually recertify their eligibility, states can streamline the recertification process to ensure that people who are still eligible for the benefit remain enrolled.

The MSP recertification process in New York varies from county to county. For example, recertification forms are labeled differently in different counties and provide different explanations of what the enrollee must do, depending on which Medicaid office received the initial application. In New York City, the recertification forms for QMB, until recently labeled "DAB Renewal Notification," are the same as for Medicaid, and often did not refer to the Medicare Savings Programs. In addition, people recertifying for QMB only (people who do not also have Medicaid) are asked to document proof of income and resources, despite the fact that the asset test has been eliminated for all MSPs.[82]

In addition to the variation in recertification forms and instructions across counties, enrollees must generally recertify for MSPs approximately three months before their granted benefit period ends. This requirement is often problematic because MSP recipients are not made aware of their MSP end date. It is often difficult to predict an end date for an MSP period, as some counties grant retroactive MSP coverage, depending on the category of MSP. For example, if someone applies for SLMB in July, they may be granted coverage retroactive to April 1st. This means their end date would be March 31st of the following year, which would require the individual to recertify around December 31st of the year of application—only five or six months after filing their initial application. Naturally, this timeline may be confusing to MSP recipients.

To simplify the recertification process, New York could implement a number of changes, including adopting a passive or automatic recertification process. Using a passive recertification process, the state could notify the enrollee of the information on file and ask the enrollee to verify income information. The consumer could be required to sign and return the form verifying the information is correct or provide any updated information. Alternatively, the state could further simplify the process by notifying enrollees of the information on file and asking the enrollee to take action only if the information has changed. The state could also use *ex parte* or administrative recertification, by which the state would use available databases to verify income and eligibility data. This process has been used in Louisiana's Medicaid, State Children's Health Insurance Program, and the Medicare Savings Programs with very high retention, low error rates and administrative cost savings.[83]

Given that the Medicare population's income does not generally change over time, and in fact tend to decrease with age, it makes sense to use programs such as passive verification and recertification, since it is unlikely that the enrollees' information will be different from year to year.[84] Efficiencies such as these would result in higher retention rates and a lower administrative burden.

Conclusion

The State of New York has done a great deal to increase enrollment in the Medicare Savings Programs, which will go a long way to ensuring that people with limited incomes have access to needed health care. Specifically, New York has eliminated the asset test for all MSPs, created a streamlined application that can be downloaded from the internet and mailed in, and eliminated the face-to-face interview requirement. As a result of these reforms, New York has

seen an increase in MSP enrollment and should expect a decrease in administrative costs. To solidify these gains and further promote MSP enrollment, New York needs to continue adopting eligibility expansions and administrative reforms, including the elimination of income documentation requirements and the streamlining of the recertification process.

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[1] MedPAC Report to Congress: Medicare Payment Policy, Ch. 5, pg. 317, March 2008, available at http://www.medpac.gov/chapters/Mar08_Ch05.pdf, accessed on May 20, 2009.

[2] *Id.* at 314

[3] *Id.* at 314, 317

[4] T. Neuman, J. Cubanksi, and A. Damico, Kaiser Family Foundation, Revisiting 'Skin in the Game' Among Medicare Beneficiaries: An Updated Analysis of the Increasing Financial Burden of Health Care Spending from 1997 to 2005, February 2009, at 2, available at http://www.kff.org/medicare/upload/7860.pdf, accessed on June 19, 2009.

[5] MedPAC Report, *supra*, note 1, at 318

[6] Neuman, *supra*, note 4, at 2

[7] Kaiser Family Foundation, New York: Distribution of Medicare Enrollees by Federal Poverty Level, states (2006-2007), U.S. (2007), available at http://www.statehealthfacts.org/profileind.jsp?ind=295&cat=6&rgn=34, accessed on June 19, 2009. *See* 2007 HHS Poverty Guidelines, available at http://aspe.hhs.gov/POVERTY/07poverty.shtml, accessed June 19, 2009.

[8] *Id.*

[9] MedPAC Report, *supra*, note 1, at 318

[10] Neuman, *supra*, note 4, at 2

[11] J. Cubanksi, A. Damico, and T. Neuman, Kaiser Family Foundation, Health Care on a Budget: An Analysis of Spending by Medicare Households, February 2009, available at http://kff.org/medicare/upload/7859.pdf, accessed on June 19, 2009.

[12] MedPAC Report, *supra*, note 1, at 319

[13] C. Peterson, Congressional Research Service, Setting and Valuing Health Insurance Benefits, April 6, 2009, available at http://assets.opencrs.com/rpts/R40491_20090406.pdf, accessed on June 19, 2009.

[14] There are four Medicare Savings Programs; however, this brief addresses only the QMB, SLMB and QI programs. The fourth program is the Qualified Disabled and Working Individual (QDWI) program, as defined in 42 USC 1396a(a)(10)(E)(ii). The QDWI program pays the Medicare Part A premium for those who are not eligible for premium-free Medicare Part A.

[15] 42 USC 1396d(p)(3)

[16] 42 USC 1396d(p)(2). In 2009, the FPL is $10,830 per year for an individual and $14,570 for a couple. See 2009 HHS Poverty Guidelines, available at http://aspe.hhs.gov/poverty/09poverty.shtml, accessed on May 20, 2009.

[17] 42 USC 1396a(a)(10)(E)(iii)

[18] *Id.*

[19] 42 USC 1396a(a)(10)(E) and 42 USC 1396d(p)(1)(C)

[20] Medicare Improvements for Patients and Providers Act of 2008, §112, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6331enr.txt.pdf, accessed on May 28, 2009.

[21] 42 USC 1396u-3(d)

[22] Social Security Act §1902(r)(2)

[23] Medicare Rights Center, Medicare Savings Program Financial Eligibility by State, available at http://www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/mi_extra/msp_chart.html, accessed on December 8, 2009

[24] MedPAC Report, *supra*, note 1, at 311

[25] 42 USC 1395w-114

[26] 42 USC 1395w-114(a)(1) and 42 USC 1395w-114(a)(3)(D)

[27] 42 USC 1395w-114(a)(1)

[28] Center for Medicare and Medicaid Services, Lower Medicare Part D Costs than Expected in 2009, August 14, 2008, available at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3240, accessed on June 3, 2009.

[29] 42 USC 1395w-114(a)(2)

[30] 42 USC 1396u-5(a)(2)

[31] Despite the legal obligation to also screen for LIS eligibility, states often do not, and in some cases, caseworkers are not even aware of the legal obligation to do so.

[32] 42 USC 1395w-114(a)(3(B)(v)(II)

[33] Medicare Rights Center, State Pharmaceutical Assistance Programs, available at http://www.medicareinteractive.org/ext_url.php?url=http://www.medicareinteractive.org/uploadedDocuments/mi_extra/spap_chart.html, accessed on December 8, 2009

[34] New York State's Elderly Pharmaceutical Insurance Coverage (EPIC), available at http://www.health.state.ny.us/health_care/epic/, accessed on June 12, 2009.

[35] *Id.*

[36] Medicare Rights Center, *supra*, note 33

[37] As of December 14, 2009, exceptions are allowed for New Yorkers with drug coverage through a former employer and for people who are enrolled in a Medicare Advantage plan without drug coverage.

[38] Medicare Rights Center, Expanding Eligibility for Medicare Savings Programs: The Case for New York State, December 2007, available at www.medicarerights.org/pdf/Expanding_Eligibility_for_MSP.pdf, accessed June 19, 2009.

[39] State of New York, 2009–2010 Enacted Budget Financial Plan, April 28, 2009, available at http://www.budget.state.ny.us/budgetFP/2009-10EnactedBudget-FINAL.pdf, accessed on May 29, 2009.

[40] MedPAC Report, *supra*, note 1, at 311-312

[41] *See* Medicare Rights Center, *supra*, note 38

[42] *See* State Solutions, Maximizing MSP Enrollment with Part D: Lessons from Three States, May 2006, available at http://www.statesolutions.rutgers.edu/Reports/Lessons%20from%20three%20states.pdf, accessed on May 21, 2009.

[43] State of New York Office of Health Insurance Programs, General Information System 08 MA/032, Enrollment in Medicare Part B, November 14, 2008, available at http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/08ma032.pdf, accessed on May 28, 2009.

[44] As reported by the New York Department of Health at the New York Medicare Savings Coalition meeting, June 4, 2009.

[45] State of New York, Office of Health Insurance Programs, GIS 07 MA/027, December 26, 2007, available at http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma027.pdf, accessed on June 3, 2009.

[46] *See* State of New York Medicaid application, available at http://www.otda.state.ny.us/main/apps/2921.pdf, accessed on June 15, 2009.

[47] N.Y. Soc. Serv. Law §366-a (2007) and 18 N.Y. C.R.R. 360-2.2(d)(2)(f)(1)

[48] S. Lueck, Center for Budget and Policy Priorities, Mississippi's 'Face-to-Face' Rule Blocks Coverage for Eligible People, Not Fraud, available at http://www.cbpp.org/cms/index.cfm?fa=view&id=2740, accessed on June 16, 2009.

[49] *Id.*

[50] *See* J. Weiss, J. Baker, and D. Archer, An Investigative Report on Medicare Savings Programs in New York City: Local Involvement in Federal Programs Impedes Access for People with Low Incomes, Medicare Rights Center, December 2001, available at http://www.medicarerights.org/pdf/Investigative_Report_MSPinNYC.pdf, accessed on June 3, 2009.

[51] *Id.*

[52] State of New York Office of Health Insurance Programs, General Information System 07 MA/027, Elimination of Face-to-Face Interview for Medicare Savings Programs, December 26, 2007.

[53] *Id.*

[54] Personal communication with Deborah Hankewich, Social Welfare Examiner II, Nassau County Department of Social Services, May 2009.

[55] While an in-person interview may have resulted in an applicant being screened for other benefits while at the Medicaid office, there has been no evidence to suggest that applications for other public benefits have decreased. To the contrary, the Medicare Rights Center's Deputization Project often encounters people who already have

Medicaid, Supplemental Nutritional Assistance Program (SNAP, formerly known as Food Stamps), or other benefits but were never informed about or screened for a MSP. Since the elimination of the face-to-face interview requirement, people who should have been screened for a MSP, but were not, are now able to more easily access the benefits of the MSPs, because they can apply without having to return to the Medicaid office.

[56] Medicare Improvements for Patients and Providers Act of 2008, §113, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6331enr.txt.pdf, accessed on May 28, 2009.

[57] MedPAC Report, *supra*, note 1, at 313

[58] *Id*. at 312, 323

[59] *Id.* at 323

[60] State of New York, Medicaid Reference Guide, Resource Section, available at http://www.health.state.ny.us/health_care/medicaid/reference/mrg/resources.pdf, accessed on June 17, 2009.

[61] Social Security Act §1902(r)(2)

[62] State of New York, Office of Medicaid Management, GIS 02 MA/009, Elimination of the Resource Test for Qualified Individuals (QIs) and Changes to the SLIMB Program, April 1, 2002.

[63] State of New York, Office of Medicaid Management, GIS 02 MA/025, Clarification of the Elimination of Resource Test for Qualified Individuals (QIs) and Changes to the SLIMB/QMB Program, September 2, 2002.

[64] State of New York, Office of Health Insurance Programs, GIS 08 MA/016, Elimination of Asset Test for the QMB and SLIMB Programs, June 27, 2008.

[65] *Id*.

[66] New York State Dual Eligible Statistics 2007, provided by the State of New York Department of Health (NYDOH) June 2009. Note: This portion of the brief does not address QI enrollment. According to the NYDOH, the statistics provided for years prior to 2009 are not accurate. As a result of reporting inaccuracies the QI enrollment numbers appear higher than enrollment actually was. NYDOH has resolved the systems problems that resulted in the inaccuracies and data for 2009 QI enrollment is accurate.

[67] *Id*.

[68] A. Tiedemann and K. Fox, Rutgers Center for State Health Policy, Promising Strategies for Medicare Savings Programs Enrollment: Modifying Eligibility Criteria and Documentation Requirements, 2004, available at http://www.statesolutions.rutgers.edu/Reports/Promising_Strategies_Brief_2005.pdf, accessed on June 8, 2009.

[69] MedPAC Report, *supra*, note 1, at 323

[70] In the State of New York, Medicaid expenditure data is presented in the aggregate. *See* New York State Department of Health, Medicaid Statistics—Quarterly and Annual Medicaid Reports by Aid Category, available at http://www.health.state.ny.us/nysdoh/medstat/quarterly/quarterly.htm, accessed on June 8, 2009. In addition, according to the New York State Department of Health Budget Office, administrative cost data is presented by county as the number of eligibility workers and the total cost attributable to eligibility workers.

[71] Tiedeman, *supra*, note 68

[72] L. Summer, Rutgers Center for State Health Policy, Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Louisiana, available at http://www.statesolutions.rutgers.edu/Reports/LA_CaseStudy_v1.pdf, accessed on June 8, 2009.

[73] MedPAC Report, *supra*, note 1, at 315

[74] *Id.*

[75] *Id.*

[76] *See* Medicare Rights Center, Expanding Eligibility for Medicare Savings Programs: The Case for New York State, December 2007, available at www.medicarerights.org/pdf/Expanding_Eligibility_for_MSP.pdf, accessed June 19, 2009.

[77] State of New York, Medicaid Reference Guide, available at http://www.health.state.ny.us/health_care/medicaid/reference/mrg/income.pdf, accessed on June 17, 2009.

[78] GIS 02 MA/009, *supra*, note 62

[79] *See* K. Glaun, Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings, Kaiser Commission on Medicaid and the Uninsured, December 2002, available at http://www.kff.org/medicaid/20030522-index.cfm, accessed on June 11, 2009. *See also* L. Summer, Getting and Keeping Coverage: States' Experience with Citizenship Documentation Rules, The Commonwealth Fund, January 2009, available at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jan/Getting-and-Keeping-Coverage--States-Experience-with-Citizenship-Documentation-Rules.aspx, accessed on June 11, 2009.

[80] L. Summer and L. Thompson, How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits, The Commonwealth Fund, pg. 9, May 2004, available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2004/May/How%20Asset%20Tests%20Block%20Low%20Income%20Medicare%20Beneficiaries%20from%20Needed%20Benefits/summer_assettests_ib_727%20pdf.pdf, accessed on May 21, 2009.

[81] P. Nemore, J. Bender, Wey-Wey Kwok, Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules, Kaiser Family Foundation, pg. 9, May 2006, available at http://www.kff.org/medicare/7519.cfm, accessed on May 21, 2009.

[82] As reported by the New York State Department of Health at the New York Medicare Savings Coalition meeting, August 2008.

[83] *See* Georgetown University Health Policy Institute, Center for Children and Families, The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP, February 2009, available at http://ccf.georgetown.edu/index/cms-filesystem-action?file=postcards/the%20louisiana%20experience.pdf, accessed on May 21 2009. *See also* L. Summer, Rutgers Center for State Health Policy, Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Louisiana, available at http://www.statesolutions.rutgers.edu/Reports/LA_CaseStudy_v1.pdf, accessed on June 8, 2009.

[84] Summer, *supra*, note 80