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Increasing Enrollment for the Medicare Savings Programs

ABOUT THIS BRIEF

Financial assistance for people with Medicare with low or moderate incomes is available through the Medicare Savings Programs. Yet many people who could use these benefits are unaware that they exist or are reluctant to apply for them. This brief describes efforts that you can undertake to increase awareness about the Medicare Savings Programs and to help your clients apply for these programs.

What Are the Medicare Savings Programs?

Beginning in 1988, Congress enacted a series of Medicaid-financed provisions to provide financial assistance to low and moderate income Medicare beneficiaries who do not qualify for the full Medicaid benefits package. These Medicare Savings Programs (also known as Medicare Assistance Programs or Medicaid Buy-in Programs)—the Qualified Medicare Beneficiary (QMB), the Specified Low-Income Medicare Beneficiary (SLMB) and the Qualifying Individual (QI-1 and QI-2) programs—provide various premium and cost-sharing protections to people with Medicare. People in these programs are sometimes called “dual eligibles” because they qualify for both the Medicare and Medicaid programs.

MEDICARE SAVINGS PROGRAMS

The term Medicare Savings Programs refers to four programs, each with different benefits. Federal law establishes certain eligibility limits for income and assets for each program, but states have the flexibility to set higher limits. For example, federal rules establish asset limits of \$4,000 for individuals and \$6,000 for couples for all four programs, but a number of states have eliminated the asset test or used more liberal asset criteria for one or more of the programs.

- **The Qualified Medicare Beneficiary (QMB) Program** pays premiums, deductibles and coinsurance. The Medicare Part B premium is \$50 per month in 2001. To be eligible for the program, monthly income must be less than or equal to 100 percent of the federal poverty level, \$736 for an individual and \$988 for a couple in 2001.
- **The Specified Low-Income Medicare Beneficiary (SLMB) Program** pays Part B premiums. In order to meet the eligibility requirement, monthly income must be between 100 percent and 120 percent of the federal poverty level, with upper limits of \$879 for an individual and \$1,181 for a couple in 2001.
- **The Qualifying Individual 1 (QI-1) Program** pays the Medicare Part B premiums for Medicare beneficiaries with monthly incomes between 120 percent and 135 percent of the federal poverty level. The cap is \$987 for an individual and \$1,327 for a couple in 2001.
- **The Qualifying Individual 2 (QI-2) Program** pays for a portion of the Part B monthly premiums (\$3.09 per month in 2001) for Medicare beneficiaries with monthly incomes between 135 percent and 175 percent of the federal poverty level, with upper limits of \$1,273 for an individual and \$1,714 for a couple in 2001.

NOTE: Funding for the two QI programs is limited, so assistance is provided on a first-come, first-served basis. Funds for the QI programs are available only through 2002.

Why Are These Programs Important?

Out-of-pocket medical expenses place a substantial financial burden on many Medicare beneficiaries with low incomes. While actual 2000 data are not yet available, estimates of out-of-pocket spending suggest that Medicare beneficiaries age 65 and older would spend, on average, close to 20 percent of their income for primary and acute health care in 2000.¹ Medicare beneficiaries with incomes under the poverty level were estimated to spend more than one-third (34 percent) of their income on these expenses. The Medicaid program offers substantial financial assistance to consumers, but not all of them qualify or are fully aware of their eligibility for assistance. Only about half of poor people with Medicare have Medicaid coverage.² On average, older Medicare beneficiaries who have no supplemental coverage (including the Medicare Savings Programs) were estimated to spend more than one-fifth (22 percent) of their income for out-of-pocket medical expenses. In contrast, among Medicare beneficiaries enrolled in the QMB program all year, out-of-pocket expenditures represent a smaller portion of

income—about 13 percent. Medicare beneficiaries with full Medicaid coverage have out-of-pocket expenses of about 5 percent of their income or \$295.³

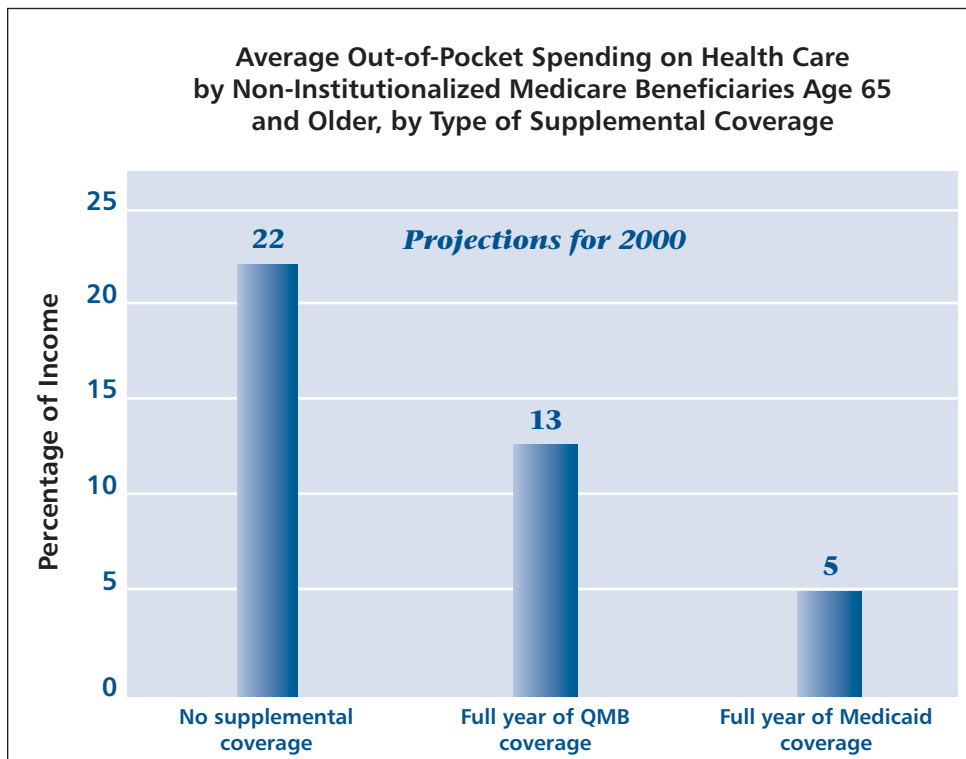
Why Is Outreach Needed?

The Medicare Savings Programs are intended to improve access to health-care services for millions of low-income elderly Americans and to make them more secure financially. Program participation, however, remains relatively low. In 1998, about half of people eligible for the QMB and SLMB programs were participating.⁴

Enrollment for the QMB, SLMB and QI programs also varies considerably from state to state. In 1996, participation rates in the QMB and SLMB programs for older people and younger people with disabilities ranged from a low of 20 percent in North Dakota to a high of 88 percent in California.⁵ Although, there are limitations related to these data, the numbers illustrate that there is considerable variation in participation across states.

Some of the barriers to outreach for Medicare Savings Programs include limited awareness of the programs and confusion about eligibility

criteria among potential applicants and eligibility workers. The complexity of the application process also is cited often as a barrier to participation. Communications barriers related to language, culture, age, vision and hearing have also been identified. A reluctance to apply for benefits has been linked to a wariness of government programs on the part of some. Others say that they do not feel it is worth their time to apply for benefits. Finally, some administrative problems pose barriers; these include difficulties with data systems, poor coordination among programs and a lack of resources to support outreach activities.⁶



SOURCE: AARP Public Policy Institute analysis using the Medicare Benefits Model, version 4.10.

While some states have conducted activities to reach and enroll people in the Medicare Savings Programs, there is a need for more outreach activity in states. For example, in 1999, only about 18 states reported that they used a short application form for the Medicare Savings Programs, and less than half of the states placed eligibility workers in settings other than welfare offices.⁷

What Has Been Done to Foster Outreach Activities?

The need to reach and enroll more eligible people in the Medicare Savings Programs is well recognized, and recently there have been many efforts to promote program outreach. Since 1998, the Centers for Medicare and Medicaid Services, or CMS (formerly the Health Care Financing Administration, or HCFA), has been engaged in a variety of activities designed to increase enrollment in the Medicare Savings Programs.

CMS has developed excellent outreach guidance materials for states and community-based organizations. In conjunction with the Social Security Administration, it is conducting a demonstration project to test different methods that can be used to involve the Social Security Administration in the enrollment process for the Medicare Savings Programs. This initiative, *Building Partnerships for Innovative Outreach and Enrollment of Dual Eligibles*, awarded grants in October 2000 to six states—Connecticut, Maryland, Minnesota, Montana, Texas and Washington—to encourage partnerships at the state, local and community levels.

Organizations for seniors have also taken steps to promote outreach for public benefit programs including the Medicare Savings Programs. AARP has kits available that organizations and volunteers can use to plan outreach activities and has sponsored community-based demonstration projects to help older people with low incomes enroll in health and income support programs. The National Council on the Aging has also developed a new online screening tool that helps older people determine whether they may be eligible for an array of public benefits (see *Additional Resources on page 7*).

However, while a number of very useful guidance materials and tools have been developed to promote

outreach and increase enrollment in the Medicare Savings Programs, there still remains a great need for community-based organizations to use the tools and provide assistance to seniors.

What Can Your Organization Do to Increase Enrollment in the Medicare Savings Programs?

Ideally, outreach involves a broad range of activities including efforts to inform people about available benefits, get them to enrollment sites, streamline the application process, provide assistance to applicants who need it, process applications quickly, and ensure that enrollees are re-certified for benefits at the appropriate times.

In the rest of this brief, we will examine three types of activities—those that:

- Simplify the application process.
- Increase the number of eligibility workers in the community.
- Train eligibility workers and volunteers.

WHAT CAN BE DONE TO SIMPLIFY THE APPLICATION PROCESS?

Efforts to simplify the application process are important because a complex process may discourage people from applying for benefits for which they may be eligible. Many states already have taken steps to simplify the application process for Medicare Savings Programs, but most could do more to reduce the paperwork burden for applicants and for eligibility workers. With fewer forms to interpret, complete or produce, applicants may be less daunted, and the number of people who are overwhelmed by requirements and are convinced that it is not worth their time to apply could be reduced. Several hard-to-reach groups would likely respond positively to a reduction in requirements to produce documents. People whose first language is not English, for example, would benefit from having to deal with fewer written documents. Members of immigrant communities who are wary of providing documents may also be more likely to apply for programs. Finally, older adults who have difficulties because of

inadequate literacy skills would be less intimidated if they were confronted with fewer requirements for written documents.

States that have liberalized the asset test for Medicare Savings Programs can reduce the length of application forms and eliminate the requirements for applicants to provide documents related to assets. States can also make it easier for people to complete the application process by minimizing verification requirements for applicants. A few states already have implemented a “self-declaration” policy. This means that they accept applicants’ statements about their income and resources and do not require documentation. Documentation requirements for applicants also have been reduced in states that use computers to verify information on applications by matching it with administrative records from other programs.

Another point in the enrollment process where verification requirements can be eased is during re-enrollment. One of the most effective ways to ensure that Medicare Savings Programs cover as many eligible people as possible is to keep people in the programs once they are enrolled. Thus, easing the re-determination process is as important as easing the application process. One technique is to use a “passive” or “automatic” re-determination process. Program participants receive notices that ask them to verify that their income or resources have not changed. When they sign and return the notices, they are re-enrolled in the program. Or program participants simply receive a notice that their enrollment will continue unless they inform the Medicaid office that they no longer are eligible for benefits.

Assisting Clients With the Application Process

Regardless of the design of the application process, some applicants will need help as they try to understand what benefits may be available to them, how to apply for these benefits and how to ensure that their application is complete.

Applicants for the Medicare Savings Programs can benefit from knowing what to expect when they apply for programs. One strategy to address this issue might be to create a one-page handout that describes the application process as it occurs in your county. Details such as where and how to get appli-

cations, whether face-to-face interviews are required, how to submit applications and how long it should take to process applications should be included. In addition, you should also provide a list of documents that applicants will need (such as a Social Security card, documents to show proof of age or citizenship, and documents that provide information about income or resources). A similar one-page handout can be prepared to describe the re-enrollment process.

Written materials can be very useful, but it is important to consider that some people may have difficulty reading or understanding these handouts. Therefore, ideally, you should also have staff available to explain the information on the handouts to individuals or to groups of potential program applicants.

Providing one-on-one assistance to clients as they fill out their application forms is extremely helpful. In states where face-to-face interviews are not required for the application process, community-based organizations can make arrangements to submit forms for clients. And, with your clients’ consent, you can act as advocates for your clients, during the application process.

Trained volunteer counselors from Serving Health Information Needs of Elders (SHINE), the Massachusetts State Health Insurance Assistance Program, screen individuals for benefits and call the appropriate local agency to obtain an application for those who appear to be eligible. Counselors also assist in filling out the application, verifying assets and mailing the application. Applicants for the Medicare Savings Programs have the option of completing an authorization form that instructs the local welfare office to mail copies of each correspondence to both applicants and SHINE. Volunteers call people as further action is required on their applications and provide assistance with investigating rejections for benefits. Program volunteers are required to participate in an eight-day training program and pass a state certification exam before they work with clients.

The Red Tape Cutters are county or tribal-based benefit specialists who receive training and ongoing support from Area Agencies on Aging in Wisconsin. These benefit specialists help older people determine whether

they may be eligible for benefits. They help with the paperwork associated with program applications, and they provide assistance for people who have been denied benefits that they think they are entitled to receive.

Area Boards on Aging in three rural regions of Minnesota have received grant funds from CMS to help them provide extensive help to seniors who wish to apply for the Medicare Savings Programs. Counselors make home visits to assist seniors with their applications.

Collecting Data About the Application Process

While state officials are the ones who make decisions about the application process, you can help with this decision-making process by providing information on needed changes. Real-life stories can be persuasive when lawmakers or administrators are considering simplification. Documentation regarding the complexity of forms, the length of time required to complete forms or the type of assistance that is required can also be useful.

Several states already have liberalized or eliminated asset tests. Others are considering it, but some policy-makers are reluctant to change rules related to asset tests because they fear that people who have low incomes but substantial assets will apply for benefits. Organizations that provide assistance with applications can systematically collect information, on an anonymous basis, about the level of assets that applicants at different income levels have. If the data show that applicants typically do not have large assets, lawmakers may be persuaded to consider changes in asset rules.

Connecticut recently eliminated the asset test for the QI programs. One factor that figured in the decision was reports from local Area Agencies on Aging and senior centers. They noted that a number of people who would qualify for the QI program based on income had limited assets, but because their assets exceeded program limits, they could not receive needed benefits.

As you know, it can take considerable time and effort to collect, verify and review information and documents related to income and assets. Your organiza-

tion can systematically track the time it takes to provide assistance with the parts of the application related to income and assets. At a time when many state and county governments have limited resources, policy-makers may be interested in knowing that simplifying applications or eliminating requirements for asset tests or for verification of information may decrease the time needed to process applications. This, in turn, can yield administrative savings.

Statistics regarding the re-determination process may also be useful. Data about the extent to which financial circumstances have or have not changed between the initial application and the annual re-determination would help policy-makers think about whether it would be a good idea to streamline the re-enrollment process.

WHAT CAN BE DONE TO INCREASE THE AVAILABILITY OF ELIGIBILITY WORKERS IN THE COMMUNITY?

Some states have instituted changes that allow applicants to mail, fax or phone in applications or to submit them electronically. But there is still a need for eligibility workers who can assist people who may have difficulty completing applications. Also, ideally, eligibility workers in the community can help locate low-income residents and inform them of the full range of programs and services for which they are eligible.

Hosting Outstationed Medicaid Eligibility Workers

Outstationing is one technique that makes it possible for people to apply for benefits at locations other than the Medicaid or social services office. When Medicaid eligibility workers are outstationed at community-based organizations, individuals who may have difficulty reaching Medicaid offices because of lack of transportation—for example, people who live in rural areas—may have a more accessible alternative. In addition, others who are wary of “government” or “welfare” benefits also may be more willing to apply for benefits in locations other than social services offices.

In Wichita, Kansas, Medicaid eligibility workers are stationed full-time at health departments, clinics, community health centers and other sites that are part

of *Project Access*, a network of health-care providers. In other parts of the state, health departments and many health clinics have special hours when Medicaid eligibility workers are onsite to help people who need health insurance.

Taking Applications and Making Eligibility Determinations

Another technique used in some states to increase access is to allow staff from other organizations to accept Medicaid applications, interview applicants and forward the applications to the Medicaid offices. In some cases, Medicaid may contract with staff from hospitals or community-based organizations to interview applicants or make eligibility determinations.

Medicaid eligibility workers and staff or volunteers from community-based organizations also can help ease the application process by making home visits or traveling on mobile health clinics to reach people in remote areas.

The Mountain Enterprise Community Mobile Medical Clinic in West Virginia sends a physician and a counselor from SHINE, the State Health Insurance Assistance Program, to the most rural areas of the state every week. While seniors receive medical services, the SHINE counselor is also available to answer questions about health insurance and to help eligible beneficiaries enroll in health-related and other public benefits programs. The clinic was funded by a small cities' block grant through the County Commissioner's Office.

WHAT CAN BE DONE TO PROMOTE TRAINING RELATED TO PROGRAM ELIGIBILITY RULES?

One of the identified barriers to outreach for the Medicare Savings Programs is that often eligibility criteria are not well understood by potential applicants or by those who counsel them.⁸ Therefore, there is a need to provide training for eligibility workers and others in the community. Training activities can provide an opportunity not only to convey information, but also to bring together a diverse group of people in the community who inter-

act routinely with the low-income elderly population but may not have occasion to interact with each other. In other words, training sessions can be designed to increase knowledge and foster collaboration.

Sponsoring Training Sessions

State Medicaid programs have a responsibility and a strong interest in assuring that eligibility workers are up-to-date on program eligibility rules and procedures, but state agencies also have limited budgets. Therefore, they may welcome some assistance from community-based organizations that wish to help sponsor training sessions. One approach is to invite staff from your state or county Medicaid offices (those who make eligibility determinations) to conduct training sessions for others in the community. Another approach is to invite outside experts to work with a variety of people in the community such as eligibility workers, outreach volunteers, health and social service professionals, and advocates.

In Connecticut, five local Area Agencies on Aging that house the State Health Insurance Assistance Program known as CHOICES, worked with the state Medicaid agency, the Primary Care Association and the Center for Medicare Advocacy (a private, non-profit organization that provides education, advocacy and legal assistance to help elders and people with disabilities obtain necessary health care). The groups held day-long training programs for outreach workers, social workers, municipal agents, home health agency staff, resident services coordinators, Medicaid eligibility workers outstationed at community health centers and other professionals. The sessions provided not only information about eligibility rules, but also training for outstationed eligibility workers regarding activities they can undertake to reach people in the community who potentially are eligible for Medicare Savings Programs.

Three organizations in Maine, the Associated Hospital Service of Maine, Legal Services for the Elderly and the Maine Ambulatory Care Coalition, sponsored a Hidden Benefit Road Show. A team of professionals conducted training sessions at 10 sites across the state. The team included a legal services attorney, an outreach project manager, an outstationed eligibility worker from a local health center and a special

projects manager from the hospital association. Staff from Area Agencies on Aging, National Health Service Corps sites, home health nursing agencies, housing agencies, disproportional share hospitals and the Department of Human Services attended training sessions. The project was funded in part by a grant from the Health Resources and Services Administration.

Participating in Distance Training Programs

Distance training provides an opportunity for people across a given state to receive training that they might otherwise not have access to if they were unable to travel to a particular training site. New

information can be conveyed to large numbers of people in different locations at the same time. Some states are experimenting with Web-based training materials. Others use satellite technology to broadcast training programs.

In Iowa, the Department of Human Services, the State Health Insurance Assistance Program and the Office of Elder Affairs took advantage of a fiber-optic network to sponsor a remote training program about Medicare Savings Programs. Information about program rules and about how to complete program applications was conveyed to between 300 and 400 people.

Additional Resources

AARP

<http://www.aarp.org/pbo/>

The Public Benefits Outreach Project, sponsored by AARP, provides tools to help organizations establish outreach programs. Fact sheets and training manuals for particular programs also are available from: AARP, PBO/B5-630, 601 E Street NW, Washington, DC 20049.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Savings for Medicare Beneficiaries is an outreach kit developed by CMS. It contains outreach and enrollment materials that can be customized for use by state and community groups. It also includes *Resources for Reaching Out*, a guide for community groups to use in designing outreach and enrollment campaigns. For more information, contact Debby Higgins at dhiggins@cms.hhs.gov.

The Training Manual for Dual Eligible Programs was developed and distributed by CMS to State Health Insurance Assistance Programs. The manual is available at www.hcfa.gov/medicaid/dualelig/.

NATIONAL COUNCIL ON THE AGING

<http://www.benefitscheckup.org>

This Web-based screening tool, developed by the National Council on the Aging, helps older people determine whether they may be eligible for public programs, including the Medicare Savings Programs.

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¹ *Average Out-Of-Pocket Spending on Health Care by Non-Institutionalized Medicare Beneficiaries Age 65 and Older, Projections for 2000*. AARP Public Policy Institute analysis using the Medicare Benefits Model, version 4.10.

² *Medicare and Medicaid for the Elderly and Disabled Poor*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, Key Facts, 1999.

³ *Average Out-Of-Pocket Spending on Health Care by Non-Institutionalized Medicare Beneficiaries Age 65 and Older, Projections for 2000*. AARP Public Policy Institute analysis using the Medicare Benefits Model, version 4.10.

⁴ Families USA Foundation. *Shortchanged: Billions Withheld from Medicare Beneficiaries*. Washington, DC: Families USA Foundation, 1998.

⁵ *ibid.*

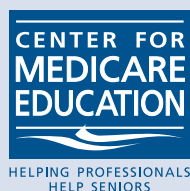
⁶ Rosenbach, M.L., & Lamphere, JoAnn. *Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs*. Washington, DC: AARP Public Policy Institute, 1999.

⁷ Nemore, Patricia B. *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 1999

⁸ Health Care Financing Administration. *Reach Out: A Cooperative Effort by Stakeholders to Enroll Dual Eligibles*. Washington, DC: Health Care Financing Administration, 1999.

About the Author

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