Statement

of

Howard Bedlin
Vice President, Public Policy & Advocacy

National Council on Aging

on

Recommendations for Improving The Medicare Prescription Drug Low-Income Subsidy Program

before the

U.S. Senate Special Committee on Aging

January 31, 2007

I am Howard Bedlin, Vice-President for Public Policy & Advocacy at the National Council on Aging (NCOA) – the nation's first organization formed to represent America's seniors and those who serve them. Founded in 1950, NCOA's mission is to improve the lives of older Americans. Our programs help the nation's seniors improve their health, find jobs and job training, discover meaningful opportunities to contribute to society, enhance their capacity to live at home, and access public and private benefit programs. Our members include senior centers, area agencies on aging, faith-based service agencies, senior housing facilities, employment services, and consumer organizations. NCOA also includes a network of more than 15,000 organizations and leaders from service organizations, academia, business and labor who support our mission and work. On behalf of NCOA and those we represent, I appreciate the opportunity to testify before this Committee today on the Medicare Part D Low-Income Subsidy program (LIS).

NCOA chairs the Access to Benefits Coalition (ABC),[1] comprised of national and community-based organizations dedicated to ensuring that Medicare beneficiaries with limited means know about and make the best use of resources available to access their needed prescription drugs and reduce their prescription drug costs. There are 104 national ABC members, including aging and healthcare organizations such as AARP, the National Alliance for Hispanic Health, and the Catholic Health Association of the U.S.; national charities such as Easter Seals; and groups representing patients and caregivers such as the Alzheimer's Association and the National Alliance for the Mentally Ill. In addition, faith-based and multicultural groups such as the National Council of Churches USA and the National Asian Pacific Center on Aging are committed to finding and enrolling low-income beneficiaries in the LIS. Established in 2004, the Access to Benefits Coalition has involved hundreds of community-based nonprofits through 55 local coalitions in 34 states and the District of Columbia, in educating and enrolling tens of thousands of beneficiaries in the Part D LIS and other prescription savings programs.

[1] www.accesstobenefits.org

ABC and its network of local organizations use powerful web-based tools such as NCOA's BenefitsCheckUp decision support tool[2] and the Medicare Plan Finder[3] to help beneficiaries—as well as family caregivers and organizations who wish to assist them—to understand, apply for, and enroll in public and private prescription savings programs. BenefitsCheckUp also helps determine if individuals qualify for the Medicare Part D Low-Income Subsidy or other prescription savings programs with application forms available on the site, or enabling users to apply on-line for some of the benefits.

As the Committee is aware, NCOA supported the Medicare Modernization Act in 2003. The primary reason for our support was the generous extra help provided to low-income beneficiaries in greatest need, including coverage through the "doughnut hole". We believe several major aspects of Part D program implementation to date have been quite successful – with approximately 90% of Medicare recipients now having coverage, providing choice to consumers, and containing plan costs. However, there is still much work to be done on behalf of LIS eligibles. HHS has estimated that at least 75 percent of the Medicare beneficiaries **still** without any prescription drug coverage are eligible for the Low-Income Subsidy.[4]

Much of NCOA's focus in promoting successful program implementation has been on the need to improve access to the benefit for low-income beneficiaries. NCOA estimates that **between 3.4 and 4.4 million Medicare beneficiaries eligible for the LIS are still not receiving it.** We also estimate that between 35 and 42 percent of Medicare beneficiaries who needed to voluntarily file an application with SSA in 2005 and 2006 to receive LIS have successfully done so (2.2 million out of 5.2 or 6.2 million). By historical standards, this take-up rate is in line with other means-tested federal benefit programs [See Table below]. On the other hand, it also means that **58 to 65 percent of all Medicare beneficiaries who were eligible for LIS and who had to apply to get LIS are not now receiving the benefit.**

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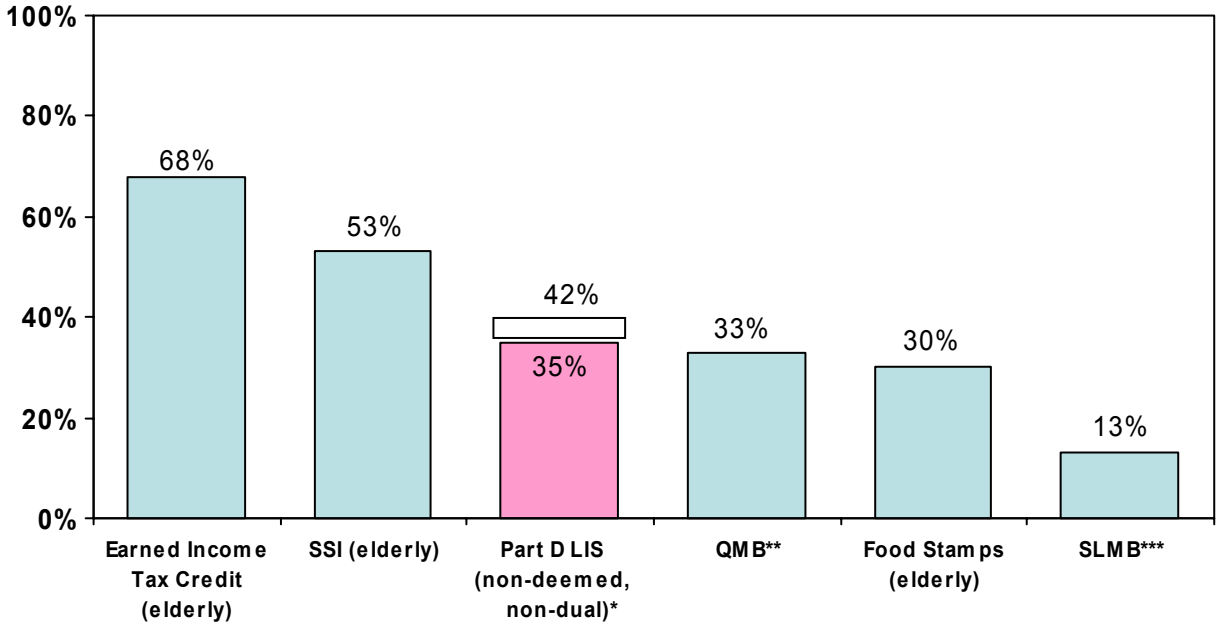
[2] www.benefitscheckup.org
[3] www.Medicare.gov
[4] Statement of Michael Leavitt, Secretary of U.S. Department of Health & Human Services, May 2006.

It is important that Congress not rely on the historically low enrollment rates for other needs-based benefits programs when judging the success of the Medicare Part D program. Congress should raise expectations for both the Part D Low-Income Subsidy and all other needs-based benefits programs to ensure that low-income seniors and people with disabilities receive all the benefits for which they are eligible. Participation in available benefits programs will improve the overall health and quality of life for those in greatest need, allowing them to remain healthy and independent for as long as possible.

Participation Rates in LIS and Other Needs-Based Benefits Programs



*A range of 35 to 42% is included for the Part D LIS because there are different estimates provided by CMS (13.2 million) and CBO (14.2 million) on the total number of Medicare beneficiaries eligible for LIS and, therefore, there are different estimates of the number of non-deemed, non-duals eligible for LIS.
** The Qualified Medicare Beneficiary program is a Medicare Savings Program (MSP) that provides premium and cost sharing assistance for beneficiaries with incomes below 100 percent of the FPL.
*** The Specified Low-Income Medicare program is a MSP that provides premium assistance for beneficiaries with incomes between 100–120% of the FPL.

Another issue of concern involves individuals who have lost their automatic eligibility for LIS. In September 2006, CMS announced that there were approximately 632,000 people who had been automatically receiving the LIS in 2006, but who were at risk of losing their deemed LIS status in 2007. These are people who lost their Medicaid,

MSP, or SSI coverage at some point during the year. In order to continue to be eligible for LIS in 2007, these people would need to voluntarily file an LIS application or regain their eligibility for the Medicaid, MSP or SSI programs. According to the most recent figures available, we understand that roughly one-third of the 632,000 either regained their deemed status or successfully applied for LIS. Therefore, we estimate that approximately 400,000 beneficiaries lost their LIS benefit and still need to apply for LIS this year.

Many of these 400,000 beneficiaries will be spending far more out-of-pocket for their prescription drugs than they did last year. For example, many may be paying a deductible for their drugs for the first time. Anecdotal reports indicate that many plans have granted a 60-day transition period, so a large number of these beneficiaries will not likely find out that they have lost their LIS benefit until March. We urge plans, CMS, and advocates to devote specific, additional resources to working together to contact this vulnerable and help them apply for LIS. Because this problem will reoccur every year, it is especially important to minimize potential harm to this vulnerable population.

NCOA has developed programmatic and legislative recommendations for reaching and enrolling vulnerable, low-income beneficiaries and we would appreciate the Committee's support and recognition that it will require a robust and sustained effort to find the remaining beneficiaries and help them sign up for the LIS. The promise and potential of the Medicare Modernization Act will not be fully realized until we invest in cost effective strategies to find and enroll all of the people who are eligible for and not receiving the Extra Help available to them.

Cost Effective Strategies for Enrolling Beneficiaries in Needs-Based Benefits

Over the past three years, the NCOA, the Access to Benefits Coalition and the Benefits Data Trust (BDT)[5] have been testing a variety of strategies for increasing enrollment in the LIS and other key public benefits. Various pilot projects have been funded primarily by The Commonwealth Fund, The Atlantic Philanthropies, the Center

[5] Benefits Data Trust (BDT) is a charitable organization established in 2005 by NCOA and the Foundation to Benefit Our Seniors specifically to use sophisticated list strategies and specialty call center response to increase enrollments in public benefits.

for Medicare & Medicaid Services (CMS), and Kaiser Permanente. Key findings and supporting documentation are attached to this testimony in an Appendix.

Over the past year, four evidence-based strategies have emerged that are particularly cost-effective for finding and enrolling Medicare beneficiaries in the LIS:

1. **Use comprehensive, person-centered approaches to outreach and enrollment (rather than focused solely on a single benefit).**

   People who are eligible for one means-tested public benefit are highly likely to also be eligible for, but not receiving other key public benefits. Many people who are applying for LIS are also eligible for other public benefits and vice versa. For example, 71 percent of those found who screened eligible for the LIS through online technology also screened eligible for and are not now receiving MSP benefits [See Appendix – Figure 1].

   A major benchmarking study by The Bridgespan Group and NCOA examining more than 30 different single-benefit outreach and enrollment projects shows that, consistently, about 55% of the total costs per enrollment are related to identifying qualified individuals and persuading them to apply and 45% of the costs relate to actual assistance with applications [See Appendix - Figure 2]. Because most federal agencies are limited by statute and/or practice from conducting outreach for more than a few benefits (e.g., USDA conducts Food Stamps outreach; SSA conducts LIS and SSI outreach; CMS conducts MSP outreach), the government is incurring the same costs of identification and persuasion over and over again.

2. **Invest in the aging network and trusted, non-profit community-based organizations that can create broad-based networks to efficiently connect people who are like eligible for LIS to enrollment specialists who will help them apply for the benefit.**

   The "aging network" and other community-based non-profit organizations are well-suited to find and enroll low-income Medicare beneficiaries but need the resources be able to find the remaining population who is harder-to-reach and in need of application assistance. The per-enrollment costs of community-based efforts range between $30 and $280 depending on the approaches, how they are implemented and

the populations targeted [See Appendix – Figure 3]. A particularly cost-effective approach seems to be to create referral networks in which key organizations (such as drug stores, health plans, health centers, social service agencies, etc.) efficiently refer people seeking assistance and likely eligible for LIS to specialty enrollment centers. Ideally, there will be "warm transfers" (i.e., the "real-time" transfer of a person who has been identified as needing assistance with paying for medications) to the enrollment centers [See Appendix – Figure 4].

3. **Promote the widespread use of person-centered, online screening and enrollment services (such as the BenefitsCheckUp) that enable consumers and organizations to screen for multiple benefits and directly file LIS applications; and,**

The BenefitsCheckUp, which is supported by foundations and corporations, served 232,000 clients in 2006 and its consumer edition (serving people and/or their caregivers directly accessing the site) is currently producing enrollments in major public benefits at a cost of $15 per benefit. If the online service was sponsored and/or promoted by government, it could reach and serve many more people and would likely achieve enrollments for $7 - $10 per major benefit [See Appendix – Figure 5].

4. **Encourage states to work across departments and use cross-matched state lists of people already enrolled in other public benefits to identify individuals eligible for and not receiving LIS.**

Cross-matching state lists of people enrolled in other public benefits has resulted in particularly higher percentages of people who apply for and, ultimately receive, other benefits. The experiences of the State of Pennsylvania Department on Aging are particularly compelling and should be replicated in other states.

<u>Recommended Changes to the Medicare Part D Low-Income Subsidy Program</u>

The following recommendations are highlights from a report titled *The Next Steps: Strategies to Improve the Medicare Part D Low-Income Subsidy* issued today by the Access to Benefits Coalition and NCOA. Copies of the report have been provided to

Committee members. The report is being distributed this morning at the hearing and can also be found on our website at: www.ncoa.org and www.accesstobenefits.org. We request that the full report be included in the hearing record.

Recommended Legislative Changes

- **Eliminate the asset test because it is the single-most significant barrier to the Part D LIS for low-income seniors and people with disabilities.** Of the LIS applications filed with SSA, 41 percent are denied because the person is over the asset limits.[6] According to the Congressional Budget Office, an estimated 1.8 million Medicare beneficiaries with incomes below 150 percent of the Federal Poverty Level (FPL) will not qualify for the additional assistance because their assets exceed the amount currently allowable.[7]

People who manage to save a modest sum for retirement and still have very limited incomes should be encouraged and rewarded, not denied the extra help that they need. Half of the people who fail the asset test have excess assets of $35,000 or less.[8] These people tend to be older, female, widowed, and living alone. Often when the husband dies, the wife's income is significantly reduced, but she still has the modest assets that were accumulated during the marriage.[9]

In addition, the asset test is inherently discriminatory against people who rent their homes, instead of own them. People who own their home—regardless of its value—but have limited incomes can qualify for the Low-Income Subsidy. However, people who rent their home and have $20,000 in the bank to pay future rent or other expenses are disqualified from the program regardless of their low income.

Eliminating or increasing the asset limit amount for the Low-Income Subsidy would make the benefit available to significantly more low-income people who

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[6]Statement of Cheri Arnott, Associate Commissioner for External Affairs, Social Security Administration at the 2007 Families USA Conference on January 25, 2007.
[7] http://www.cbo.gov/ftpdocs/48xx/doc4814/11-20-MedicareLetter2.pdf (Accessed July 6, 2006)
[8] Rice, Thomas and Desmond, Katherine. "Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test." The Henry J. Kaiser Family Foundation, April 2005.
[9] See Rice article at footnote 39.

desperately need additional assistance with paying for their prescription drugs. This is also a cost effective way to fill the "doughnut hole" for many of those in greatest need.

- **Enact legislation to make the LIS Special Enrollment Period (SEP) and waiver of the Late-Enrollment Penalty (LEP) permanent.** We applaud CMS for creating SEPs to permit beneficiaries to apply for the LIS and enroll in a plan without experiencing a premium penalty after the May 15, 2006, deadline until the end of 2007. However, we urge Congress to enact legislation that would make both the LIS SEP and waiver of the LEP permanent.

Under Medicare Part B,[10] low-income beneficiaries eligible for Medicare Savings Programs[11] can enroll any time and are exempt from premium penalties. This is not the case under Medicare Part D. Treatment of the most vulnerable seniors and people with disabilities should not vary so significantly within Medicare programs. The Part D rules should be made to be consistent with the Part B rules.

Finding and enrolling the LIS population will take time, as evidenced by take up rates in other needs-based benefits. Low-income beneficiaries are least able to afford premium penalties, and if they are subject to financial punishment, they will never apply for the prescription drug assistance they need. To meet this continuing challenge, we need to reduce barriers, not impose them. Without both a permanent enrollment period and elimination of the Late-Enrollment Penalty, efforts by government agencies, national organizations, and local nonprofit groups to find and enroll LIS-eligible individuals will be thwarted. Failure to permanently extend the SEP and waive the LEP would effectively ensure that there will be no more progress made in helping low-income seniors and people with disabilities—a result that is wholly unacceptable.

[10] Medicare Part B is medical insurance that pays for doctor's services and other costs that are not paid under Medicare Part A (hospital insurance).

[11] Medicare Savings Programs (MSPs), include Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualified Individual programs. Each MSP program has specific income eligibility limits and to be eligible, a person's resources cannot be more than twice the SSI resource limit. Individuals eligible for any of these programs are deemed eligible for the full LIS. MSPs are administered by state Medicaid agencies and pay for the Medicare Part B premium; the QMB program covers Medicare cost-sharing, as well.

- **Appropriate funds to support organizations that use a person-centered approach to outreach, which has been shown to be one of the most efficient and effective ways to find and enroll LIS eligibles.** Finding and enrolling seniors and people with disabilities with limited resources in needs-based benefits programs has been a significant challenge for many years. We know that reaching everyone in this special population will take a great deal of time and energy. We strongly recommend that additional financial resources be made available to support national organizations and local community-based organizations, so they may continue the important grassroots, one-on-one work they have been doing during the initial enrollment period.

The Access to Benefits Coalition report *Pathways to Success: Meeting the Challenges of Enrolling Medicare Beneficiaries with Limited Incomes* (2006) states that the most effective projects involved in the study used a one-on-one "person-centered" approach.[12] The study found that the average cost is approximately $100 per enrollment, although it may be somewhat higher as the remaining LIS beneficiaries are the most difficult to find. We strongly encourage SSA and CMS to fund programs that have a person-centered approach to finding and enrolling LIS eligible seniors and people with disabilities.

The Older Americans Act (OAA), which was reauthorized last October, created a new National Center on Senior Benefits Outreach and Enrollment. In §202 of the OAA, the Assistant Secretary of HHS is authorized to establish a National Center that will:

- Maintain and update Web-based decision support and enrollment tools and integrated, person-centered systems designed to inform older individuals about the full range of benefits for which the individuals may be eligible under federal and state programs;
- Utilize cost-effective strategies to find older individuals with greatest economic need and enroll the individuals in the programs;
- Create and support efforts for Aging and Disability Resource Centers and other public and private state and community-based organizations, including faith-

[12] "The most effective projects in this study used a one-to-one 'person centered' approach—one that provides personalized assistance from a trusted source, and takes a 'holistic' approach to the individual being enrolled." The Bridgespan Group, 2005.

based organizations and coalitions, to serve as benefits enrollment centers for the programs;

- Develop and maintain an information clearinghouse on best practices and cost-effective methods for finding and enrolling older individuals with greatest economic need in the programs for which the individuals are eligible;
- Provide, in collaboration with related federal agency partners administering the federal programs, training and technical assistance on effective outreach, screening, enrollment, and follow-up strategies; and
- Play a critical role in finding and enrolling the remaining seniors and people with disabilities who are eligible for, but not yet enrolled in, the Low-Income Subsidy.

Now that the National Center has been authorized, we urge Congress to appropriate $4 million in initial funding so that its work can begin and low-income seniors and people with disabilities across the country can be enrolled in the LIS and other needs-based benefits programs.

- **Do not require information about the cash surrender value of life insurance policies when determining LIS eligibility.** We have received a great deal of support from local ABCs for removal of the cash surrender value question from the LIS application. Beneficiaries often do not have this information and paperwork readily available, and they do not know how to get the information. Seniors and people with disabilities often plan for their families to use their life insurance benefit to pay for their final expenses—and thus they often are not willing to cash in their life insurance now and place an additional burden on their family members upon their death.

- **Do not take the value of in-kind support and maintenance (ISM) into consideration when determining eligibility for the LIS.** ISM can include the market value of food, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection fees given to the recipient by a third party. Our ABCs report that it is difficult for applicants to estimate the amount of in-kind support as it generally changes from month to month. The unrealistic level of detail involved in

calculating the value of in-kind support and maintenance is likely resulting in potentially eligible beneficiaries not filing LIS applications.

- **Do not count funds in retirement savings plans such as 401(k) accounts as assets, but do count distributions from such plans as income.** For the majority of people who are not covered by traditional defined benefit pension plans, the resources in their 401(k) and other retirement savings accounts represent their only retirement savings. Periodic distributions during retirement from 401(k) accounts often constitute the only income people have to supplement their Social Security benefits.

However, Social Security does not consider a person's pension (defined benefit plan) to be an asset when determining LIS eligibility. Pensions are only counted to the extent that a person is actually drawing money from them. Forcing people to cash in their 401(k) plans to become eligible for LIS is a disincentive for people to save for retirement. As with traditional pension plans, distributions from 401(k) plans should be treated as income, but the funds in the account should not be treated as assets. Treating the two retirement vehicles differently is inconsistent and unfair to people whose primary planned retirement source is a 401(k).

- **Index the co-payments and deductibles for people between 100 and 150 percent of the Federal Poverty Level to the Consumer Price Index (CPI—all items, U.S. city average), as it is more reflective of cost increases and, therefore, more closely mirrors beneficiaries' ability to pay.** LIS-eligible people with incomes below 100 percent of the FPL will have their prescription drug cost sharing increased in 2007 according to the CPI (all items, U.S. city average).[13] Social Security implemented a cost-of-living adjustment of 3.3 percent in 2006[14] that corresponded to the CPI increase in that same year.

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[13] See §1860D-14(a)(4)(A)(i) of the Social Security Act. "The dollar amounts applied under paragraph (1)(D)(ii)—(i) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase in the Consumer Price Index (all items; U.S. city average) as of September of such previous year." http://www.ssa.gov/OP_Home/ssact/title18/1860D14.htm (Accessed January 16, 2007)

[14] SSA Cost of Living is generally equivalent to the Consumer Price Index for Urban Wages Earners and Clerical Workers (CPI-W). http://www.ssa.gov/OACT/COLA/colaseries.html (Accessed June 6, 2006)

However, for LIS-eligible beneficiaries with incomes between 100 and 150 percent of poverty, their cost sharing is increased according to the percentage increase in average per capita aggregate expenditures for covered Part D drugs, without regard to the amount of Social Security benefit increases.[15] For example, Part D co-payments for this group increased in 2007 at a rate of more than twice the CPI, from $2.00 to $2.15 for generics and from $5.00 to $5.35 for brand name drugs.[16] Therefore, the value of the benefit for people between 100 and 150 percent of the FPL diminishes significantly over time.

The co-payments and deductibles for people with incomes between 100 and 150 percent of FPL should be indexed to the CPI in the same way it is for people with incomes below 100 percent of FPL, to ensure that people can continue to afford their prescription drugs.

- **Require the Internal Revenue Service (IRS) to assist SSA with tax-filing data, providing SSA with the names of Medicare beneficiaries who are likely eligible for the LIS to better target outreach efforts, while recognizing privacy concerns.** Currently, SSA does not have access to crucial IRS data that would allow it to better target its outreach for the Part D LIS. IRS data are used only for the purpose of verifying income and asset levels after an LIS application has been filed. The Administration should encourage the sharing of information more effectively among federal agencies for the purpose of reaching out to more potential LIS beneficiaries.

The Department of Health and Human Services Office of the Inspector General issued a memo to CMS on November 17, 2006, expressing concern that CMS and SSA need more effective ways to identify potential LIS-eligible people.[17] The memo points out that data sharing among CMS, SSA, and the IRS already occurs under the Medicare

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[15] See §1860D-2(b)(6) of the Social Security Act. "The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." http://www.ssa.gov/OP_Home/ssact/title18/1860D02.htm (Accessed January 16, 2007)

[16] CMS Letter (Center for Medicaid and State Operations, Disabled and Elderly Programs Group) to State Medicaid Directors, December 18, 2006. http://www.cms.hhs.gov/smdl/downloads/SMD121806.pdf (Accessed January 16, 2007)

[17] Department of Health and Human Services, Office of the Inspector General, November 17, 2006. http://www.oig.hhs.gov/oei/reports/oei-03-06-00120.pdf (Accessed November 28, 2006)

Secondary Payer Program pursuant to §1862(b)(5) of the Social Security Act, enacted by the Omnibus Budget Reconciliation Act of 1989.[18] In 2007, SSA will use information on gross income from prior tax filings to implement an income-related system for Part B premiums for individuals earning more than $80,000. Congress should enact legislation that would allow CMS and SSA to access critical income and resource data contained in IRS files, thereby allowing them to more accurately identify potential LIS eligibles. This information would allow these agencies to target their outreach efforts and would result in increased enrollment in the LIS program. It is important that this sharing of data be done in a way that safeguards the privacy of the individual beneficiaries.

- **Mandate that prescription drug LIS assistance should not be counted when determining eligibility for other needs-based programs.** The Part D LIS provides significant financial assistance to low-income Americans in paying for needed prescription drugs. The effect of the Part D LIS is compromised, however, when reductions are made in other needs-based assistance due to receipt of the LIS benefit. Forcing seniors and people with disabilities to choose between the immediate need that they have for their Section 8 housing and food stamp benefits and what they may perceive to be a more long-term need of their prescription drugs undermines the basic tenets of the LIS benefit. Congress should pass legislation to ensure that beneficiaries do not lose other needs-based benefits, such as food stamps, Section 8 housing, and Medicaid Medically Needy coverage on account of receiving LIS benefits.

Recommended Administrative & Regulatory Changes

- **Make all outreach materials, instructions, applications, and subsequent correspondence from SSA available in at least three additional languages: Russian, Chinese, and Vietnamese. If the SSA budget allows, translate the LIS application into other languages frequently requested at SSA.[19]** While we recognize that SSA has

[18] According to the OIG memo, the sharing of information among these agencies is known as the "IRS/SSA/CMS Data Match."

[19] Other commonly requested languages at SSA include, among others: Korean, Arabic, Armenian, Farsi, and Haitian-Creole. http://www.ssa.gov/multilanguage/LEPPlan2.htm (Accessed July 6, 2006)

undertaken tremendous efforts to reach out to non-English speaking populations by making instructions and outreach materials in different languages, we are hopeful that SSA can continue this effort by working to make the application available in at least three additional languages—Chinese, Russian, and Vietnamese. SSA has made the application and instructions available in Spanish, and we are hopeful that it will do this for the other three most-requested languages at SSA for Retirement Claims.

We understand that SSA has gone to great efforts to develop their optical scanning process to ensure an efficient application process. While we acknowledge that during the initial enrollment period, this has expedited the application process and reduced administrative costs, the need to make extra, specialized efforts to find and enroll the remaining, particularly difficult-to-reach population supersedes these concerns. Specifically, the benefit of making the LIS application available in the most frequently requested languages (other than English and Spanish) outweighs the additional time it may take to manually process these LIS applications.

- **Have each SSA field office employ at least one dedicated worker specifically assigned to process LIS applications, benefiting both the applicants and Social Security by streamlining the application process and providing expert assistance.** Because of the complexity of the LIS program, each local SSA office should have a worker who is dedicated solely to the processing of LIS applications and fielding questions pertaining to the program. An individual needs specialized skills and knowledge to efficiently assist people with LIS applications. A single point of contact would be helpful to both SSA and potential LIS beneficiaries.

The SSA office would not have to spend considerable time and resources training all employees on the LIS program if there was one designated LIS worker and one back-up worker available to assist LIS applicants. This would allow for the designated SSA representative to become an expert in LIS and provide clients with prompt and accurate answers to their questions. A dedicated worker also would be useful to local community-based organizations that try to contact SSA to assist their clients.

- **Amend the LIS application to allow applicants to designate a third party to assist them through the LIS application process. A person so designated should be able to obtain information from SSA regarding the LIS application, including status reports, and the designee should have the authority to provide information to SSA on behalf of the applicant.** Since Medicare Part D began in January 2006, many applicants have sought out assistance from family members, friends, or local community-based organizations. Beneficiaries may prefer that this person continue to assist them by speaking with SSA on their behalf and acting as a liaison for them. As such, the LIS application should be amended to include a space for the applicant to designate a third party to assist them through the application process. If an applicant designates a third party, such as a community-based organization, family member, or friend, that party should be able to interact fully with SSA on the applicant's behalf. SSA could amend the LIS application to include a sufficient consent for release of information, which would allow SSA to interact with a third party on behalf of the LIS applicant.

- **Maintain a link from the online LIS application to a Web page that provides seniors and people with disabilities—as well as their family members, friends, or advocates—state-specific information on other public benefits for which they may be eligible.** People applying for LIS assistance are likely eligible for other needs-based benefits programs. A 2006 report by the ABC found that finding and connecting with people likely to be eligible for needs-based benefits were the most costly part of the process, comprising on average 55% of the total project costs. Technology that also links people to the LIS application after completing the application for other needs-based programs, such as food stamps, is also an efficient way to enroll more eligible seniors. The correlation rate between people who are eligible for LIS and other needs-based programs is high.

Conclusion

Now that the first year of the Medicare Part D prescription drug program has recently ended, we are in a unique position to look back and see what worked and what areas can be improved to benefit low-income Medicare beneficiaries. Removal of the

asset test is critical to increasing enrollment in the LIS, as people with very low incomes are being denied desperately needed assistance with their prescription drugs. Other barriers to enrollment should also be addressed, such as permitting LIS eligibles to apply for LIS and choose a plan without penalty at any time. In addition, appropriating funds for cost- effective strategies and a national network of enrollment centers as authorized under §202 of the Older Americans Act will increase participation in the LIS program.

We are grateful for the hard work of CMS and SSA in implementing this new program and their continued dedication to the low-income subsidy. We remain concerned, however, that an estimated 75 percent of Medicare beneficiaries still without any prescription drug coverage are eligible for the LIS and that 3.4 to 4.4 million eligibles are not participating. To be successful, Congress and the Administration should invest in evidence-based, cost effective outreach and enrollment efforts and make the recommended changes to the program to ensure LIS eligibles have access to the program. Continued partnerships between the government and the private and non-profit sectors will ensure that we enroll everyone eligible for this critical assistance.

APPENDIX:

Cost-Effective Strategies for Finding and Enrolling Low-Income Medicare Beneficiaries in the Limited Income Subsidy (LIS) and Other Key Public Benefits

Over the past three years, NCOA, the Access to Benefits Coalition and the Benefits Data Trust (BDT)[20] have been testing a variety of strategies for increasing enrollment in the LIS and other key public benefits. Various pilot projects have been funded primarily by The Commonwealth Fund, The Atlantic Philanthropies, the Center for Medicare & Medicaid Services (CMS), and Kaiser Permanente.

Over the past year, four evidence-based strategies have emerged that are particularly cost-effective for finding and enrolling Medicare beneficiaries in the LIS:

- Use comprehensive, person-centered approaches to outreach and enrollment (rather than focused solely on a single benefit);
- Invest in the aging network and trusted, non-profit community-based organizations that can create broad-based networks to efficiently connect people who are like eligible for LIS to enrollment specialists who will help them apply for the benefit.
- Promote the widespread use of person-centered, online screening and enrollment services (such as the BenefitsCheckUp®) that enable consumers and organizations to screen for multiple benefits and directly file LIS applications; and,
- Encourage states to work across departments and use cross-matched state lists of people already enrolled in other public benefits to identify individuals eligible for and not receiving LIS.

The rationale and some of the supporting data for each of these approaches are presented below. We conclude that these strategies are cost-effective and scalable. However, greater investment in these four strategies is needed by both the government and the private sector to achieve the higher LIS enrollment goals that we desire.

[20] Benefits Data Trust (BDT) is a charitable organization established in 2005 by NCOA and the Foundation to Benefit Our Seniors specifically to use sophisticated list strategies and specialty call center response to increase enrollments in public benefits.

Strategy #1: Use comprehensive, person-centered approaches to outreach and enrollment (rather than focused solely on a single benefit)

Rationale:

- People who are eligible for one means-tested public benefit are highly likely to also be eligible for, but not receiving other key public benefits. Many people who are applying for LIS are also eligible for other public benefits and vice versa. [Figure 1]

- A major benchmarking study by The Bridgespan Group and NCOA examining more than 30 different single-benefit outreach and enrollment projects shows that, consistently, about 55% of the total costs per enrollment are related to identifying qualified individuals and persuading them to apply and 45% of the costs relate to actual assistance with applications. [Figure 2]

- Most federal agencies are limited by statute and/or practice from conducting outreach for more than a few benefits (e.g., USDA conducts Food Stamps outreach; SSA conducts LIS and SSI outreach; CMS conducts Medicare Part D outreach). As a result, the government is incurring the same costs of identification and persuasion over and over again.

- Much more could/should be done to increase the cost-effectiveness of government-sponsored outreach and enrollment efforts by encouraging/requiring screening for multiple benefits.

Figure 1.
A "person-centered" approach enhances results: *Benefits are highly correlated with one another*

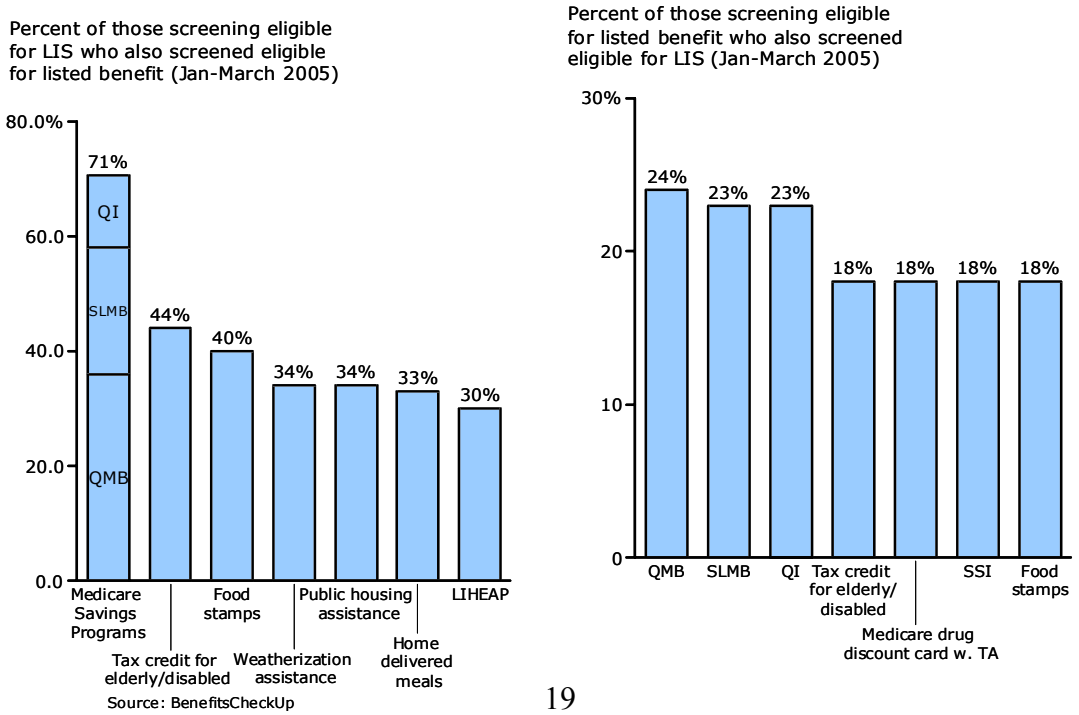
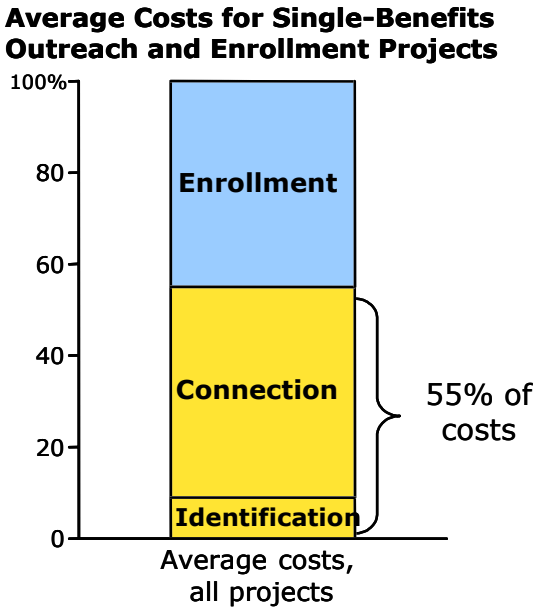


Figure 2.
A "person-centered" approach enhances results because of the high costs of identifying eligible people and persuading them to apply for benefits.



Source: Bridgespan & NCOA outreach & enrollment benchmark study

Strategy #2: Invest in the aging network and trusted, non-profit community-based organizations that can create broad-based networks that efficiently connect people who are likely eligible for LIS to enrollment specialists who will help them apply for the benefit.

Rationale:

- The "aging network" and other community-based non-profit organizations are well-suited to find and enroll low-income Medicare beneficiaries because they:
  a) are client-focused and person-centered;
  b) have trusting relationships with many beneficiaries;
  c) can create community-wide referral systems; and,
  d) are able to leverage funding from multiple sources.

- The per-enrollment costs of community-based efforts range between $30 and $280 depending on the approaches, how they are implemented and the populations targeted. [Figure 3]

- Based on the experiences of local Access to Benefits Coalitions, it appears that the average cost per LIS enrollment was approximately $100 in 2006. However, we expect that the average per-enrollment cost may be somewhat higher in 2007

because the remaining populations are harder-to-reach and may need more assistance to apply.

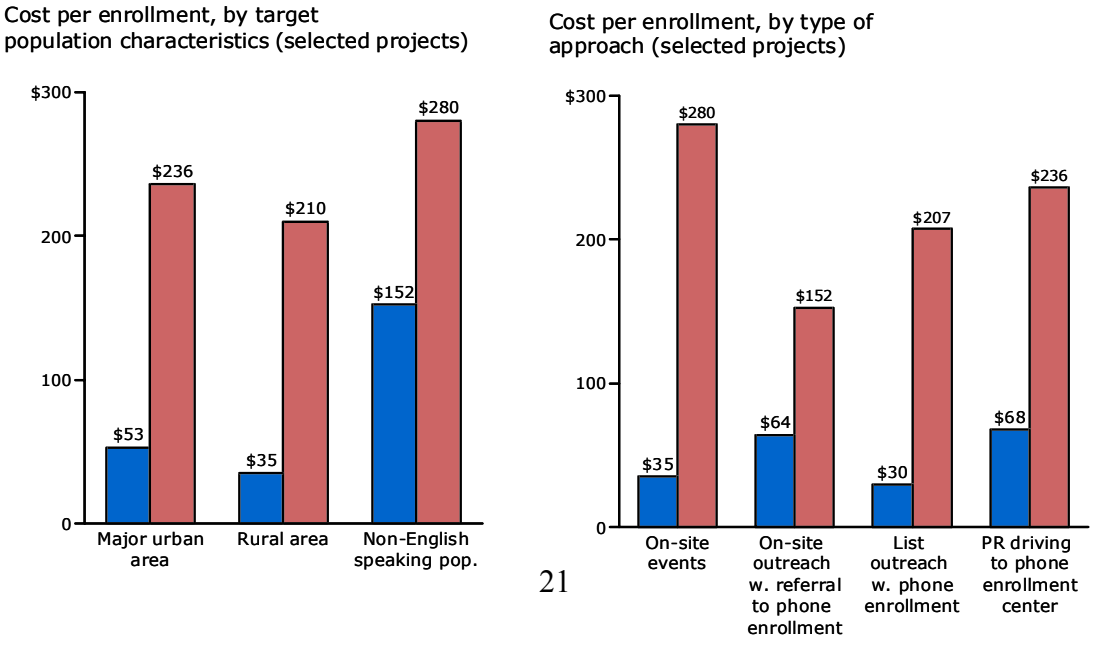
- The most cost-effective, community-based approach seems to be to create referral networks in which key organizations (such as drug stores, health plans, health centers, social service agencies, etc.) efficiently refer people seeking assistance and likely eligible for LIS to specialty enrollment centers. Ideally, these referrals should be "warm transfers" (i.e., the "real-time" transfer of a caller who has been identified in some way as having a specific need) to a helpline dedicated to assisting them with application for LIS.

    - Referrals through lists or warm transfers to specialty enrollment centers (national or local) are three to six times more likely to result in application submissions than outbound calls.
    - Warm transfers to LIS enrollment centers result in the highest numbers of actual applications and are, on average, almost five times more cost-effective than direct mail and three times more cost-effective than outbound calls. [Figure 4]
    - Efficient warm transfers to enrollment specialists (local or national) can produce LIS enrollments at a cost as low as $25 to $30 each..

- In every community, there is a need for some targeted funding, particularly to focus on enrollment assistance (helping people to fill out the application forms once they been identified).

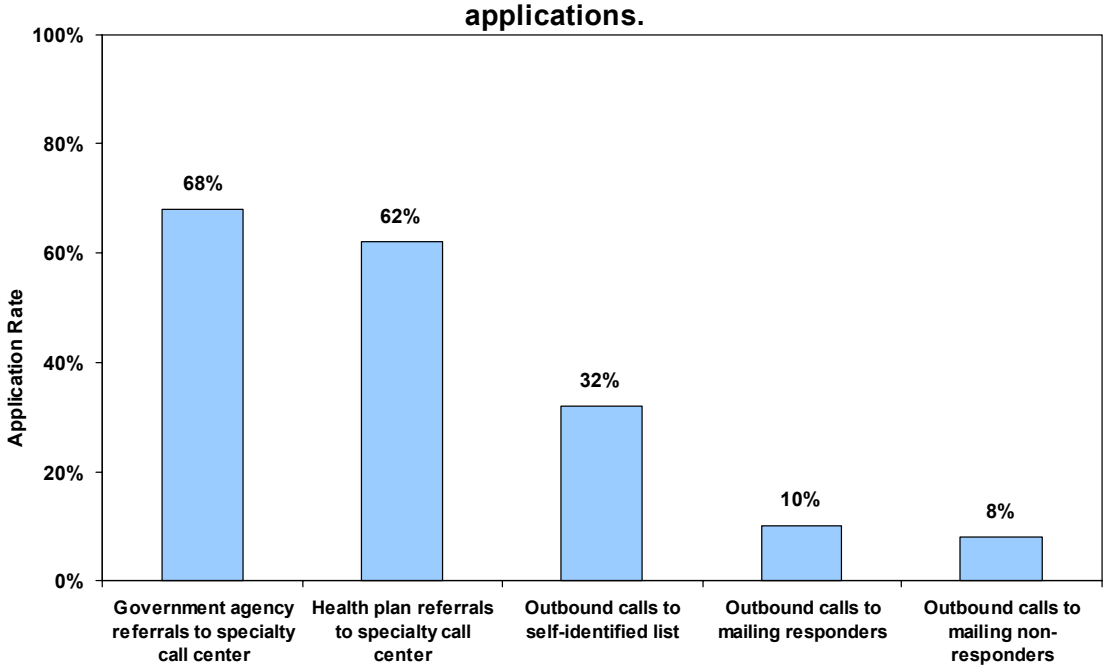
- Federal investment in the aging network, especially to support the enrollment assistance function, can be very cost-effective, and in many cases, will enable organizations to leverage other resources for outreach and referral.

Figure 3.
Outreach and enrollment costs vary widely.



Source: Bridgespan & NCOA outreach & enrollment benchmark study

Figure 4.
Referrals of likely-eligible people to specially enrollment centers produces the highest conversion rates of contacts to applications.



Source: BDT data analyses.

Strategy #3: Promote the widespread use of person-centered, online screening and enrollment services (such as the BenefitsCheckUp) that enable consumers and organizations to screen for multiple benefits and directly file LIS applications.

Rationale

- On-line screening and enrollment services have the potential to help two different groups of low-income Medicare beneficiaries:
  - Consumers who can successfully use the Internet to get benefits for themselves or family members; and,
  - Consumers who need the assistance of intermediary organizations to learn about and enroll in benefits**.**

- There are many advantages to online screening and enrollment tools, including:
  - They can be easily accessed by both consumers and intermediary organizations.
  - They can simultaneously screen for and facilitate enrollment in multiple benefits.
  - Online filing for LIS significantly reduces processing costs for SSA.

- Surprising numbers of low-income seniors and their families are able to successfully use online tools to get benefits for themselves or their family

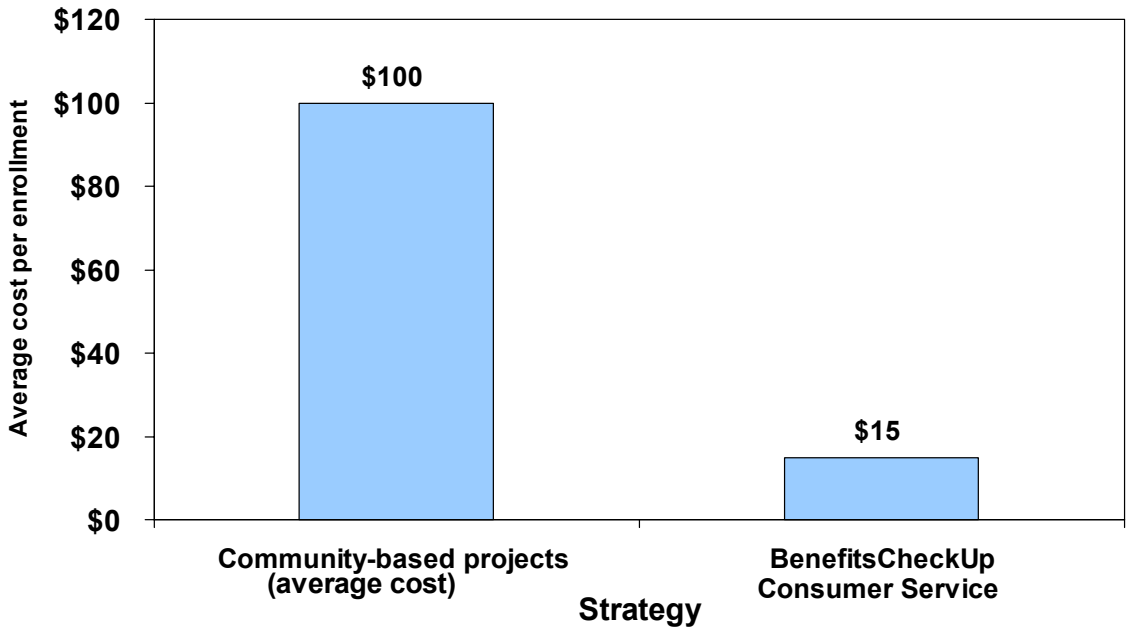
members. More than half (59%) of low-income users of online tools follow through with the application process. This audience has taken the step to screen for benefits and is motivated to apply for them. Additionally, almost one-quarter (23%) of people directly accessing online tools receive application assistance from a friend or family member.

- The BenefitsCheckUp, which is supported by foundations and corporations, served 232,000 clients in 2006 and its consumer edition (serving people and/or their caregivers directly accessing the site) is currently producing enrollments in major public benefits at a cost $15 per benefit. [Figure 5]

- If the online service was sponsored and/or promoted by government, it could reach and serve many more people and would likely achieve enrollments for $7 - $10 per major benefit.

- Online tools also increase the efficiency and effectiveness of community-based organizations.
    - Enrollment centers that assist consumers by filing online for LIS (either directly to SSA or through the BenefitsCheckUp) are more cost-effective than organizations filling out application forms and mailing them in.
    - Online tools make person-centered screening (for multiple benefits) and application filing much easier to do.

Figure 5.
Consumer use of person-centered, on-line screening and enrollment services is very cost-effective.



Source: Bridgespan & NCOA outreach & enrollment benchmark study

Strategy #4: Encourage states to work across departments and use cross-matched state lists of people already enrolled in other public benefits to identify individuals eligible for and not receiving LIS.

Rationale

- State benefit lists are a valuable resource that should be utilized to maximize enrollment in LIS and other benefits. The potential of this approach is being demonstrated in Pennsylvania. For the past three years, the State Department on Aging has been contracting with Benefits Data Trust to locate and apply individuals for the PACE/PACENET program as well as the State of Pennsylvania Property Tax and Rent Rebate Program (PTRR) and the Medicare Savings Program (MSP). This partnership exemplifies how this strategy can work to successfully locate, contact and enroll individuals into benefits they are eligible to receive.

- By cross-matching a list of 300,000 PACE (Pharmaceutical Assistance Contract for the Elderly) enrollees with a list of 250,000 Property Tax and Rent Rebate program enrollees (list came through Department on Aging from Department of Revenue), *the State identified 100,000 Property Tax and Rent Rebate program enrollees that were likely eligible for and not receiving PACE.*

- By cross-matching the 250,000 Property Tax and Rent Rebate program enrollees against the list of 300,000 individuals receiving PACE/PACENET, *the State identified 90,000 PACE/PACENET enrollees who were likely eligible for and not receiving Property Tax and Rent Rebate.*

- By cross-matching the 300,000 PACE file with the Department of Public Welfare (state Medicaid office) file, *the State identified 100,000 PACE enrollees who were likely eligible for and not receiving Medicare Savings Program benefits (MSP).*

- Using state lists of people enrolled in other public benefits has resulted in higher percentages of people who apply for and, ultimately receive, other benefits, as compared to lists that have less accurate income and contact information (i.e., people "believed to be" eligible). Response rates and application conversion rates are higher when outreach efforts are able to use pre-existing benefit lists.

- Accuracy of both the financial and contact information provided by the Property Tax/Rent Rebate program has resulted in response rates for benefits application that are 250% greater than those resulting from efforts using purchased commercial lists. From an economic perspective, this means the cost of getting people into the benefits is also two and a half times less when using a well-targeted list. In other words, for the same fixed cost, more people are being helped at a much lower cost when efforts are much more targeted. Furthermore, the residual effect is that people who were in just one public benefit program in the beginning potentially end up being enrolled into three programs.

References:

Access to Benefits Coalition. (2005). *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes. A Report to the Nation from the Access to Benefits Coalition.* National Council on Aging: Washington, DC.

Firman, J.P., Greenberg, J., Kiefer, K.M., Holmes, C.A., and Kopper, M.T. (forthcoming). *Bridging the Access Divide: How Technology Can Help Low-Income Seniors Obtain Needed Public Benefits.* The Commonwealth Fund: Washington, DC.