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M E D I C A R E

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

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EXECUTIVE SUMMARY

The Medicare prescription drug low-income subsidy (LIS) program and the Medicare Savings Programs (MSP) are both designed to provide financial assistance for low-income people with Medicare. The low-income subsidy program, established as part of the new Medicare drug benefit that went into effect this year, pays premiums and cost-sharing requirements for beneficiaries enrolled in Medicare prescription drug plans. The Medicare Savings Program, which began in 1986, assists low-income beneficiaries by helping to pay Medicare premiums and, in some instances, cost-sharing for other Medicare services.[1] Together, these programs are designed to eliminate cost-sharing barriers for low-income Medicare beneficiaries who tend to be sicker than higher-income Medicare beneficiaries, and as a consequence, use more health care services and prescription medications.

To help assess the feasibility of aligning these two programs for low-income Medicare beneficiaries, the Kaiser Family Foundation commissioned the Center for Medicare Advocacy to survey 50 states and the District of Columbia. The study examines:

- Differences in eligibility rules used by both programs and the methodologies used to determine eligibility;
- The extent to which the Social Security Administration's determination of eligibility for the Part D low-income subsidy can provide sufficient information to permit states to determine eligibility for the Medicare Savings Program; and
- Differences in how Part D applicants for low-income subsidies are likely to be treated depending on whether they apply through the Social Security Administration or through the state Medicaid program.

BACKGROUND

The Medicare prescription drug low-income subsidy program and the Medicare Savings Programs appear to function like sister programs, both intended to help Medicare's lower income population with health care cost, and in many ways modeled off of similar rules and practices. For example, in creating the Part D low-income subsidies, Congress used the highest Medicare Savings Program income standard, 135% of the federal poverty level, as the standard for the full subsidy. Moreover, Congress and the administration relied on some of the more streamlined enrollment practices adopted by some states in recent years for their Medicare Savings Programs. Both programs look to the federal Supplemental Security Income (SSI) program for their underlying structure for counting income and resources. Thus, at first glance, the two programs appear well designed to work together to promote greater income security for low-income beneficiaries with respect to health care costs.

Program *differences,* however, are significant enough to thwart efforts to provide easy access to both programs through one centralized channel. The prescription drug low-income subsidy program is fully federal, with a single standard for eligibility applicable nationwide. Medicare Savings Programs, by contrast, are federal-state programs, governed by a federal standard that operates as a floor or baseline but with authority granted to states to liberalize eligibility rules in myriad ways. This state option has resulted in tremendous variability among state Medicare Savings Programs. Another key difference between the programs is that the asset limit for the prescription drug low-income subsidy program is higher than the federal asset limit for the Medicare Savings Programs. Applications for the low-income subsidies are taken at both the Social Security Administration and at the state Medicaid agency; applications for the Medicare Savings Programs are taken only at state Medicaid agencies.

The Secretary of the Department of Health and Human Services has taken one important step to ensure access to both programs: beneficiaries who receive Medicare Savings Program benefits are automatically eligible for the prescription drug full low-income subsidy without having to apply. The opposite, however, is not true: a low-income individual found eligible for the prescription drug full low-income subsidy is *not* automatically eligible for assistance under the Medicare Savings Program.

Congress created an additional link between the two programs by requiring states, when they determine eligibility for the prescription drug low-income subsidy program to screen applicants for the Medicare Savings Program, and to enroll those found eligible who wish to enroll. It did not, however, include a similar requirement for the Social Security Administration when it determines eligibility for low-income assistance under the Medicare drug benefit. As a result, individuals applying for the Medicare drug low-income subsides are not routinely screened for Medicare Saving Program benefits because in practice, most individuals are applying through the Social Security Administration.

Despite the complexities raised by the differences between the two programs, their underlying similarities suggest that low-income individuals could get the benefit of both programs without engaging in two separate and largely duplicative processes, regardless of the agency through which they applied, if greater efforts are made to align the rules and processes for eligibility determination.

FINDINGS

The eligibility rules for the prescription drug low-income subsidy program are more generous than the federal baseline rules used for the Medicare Savings Program, in three key ways:

- Resource standards are higher for the prescription drug low-income subsidy program than the Medicare Savings Program, which has the effect of making more people eligible for this assistance. The resource standards for the low-

income subsidies are $6,000 (individual)/$9,000 (couple) for full subsidy and $10,000/$20,000 for partial subsidy, whereas the minimum resource standards for the Medicare Savings Programs are $4,000 (individual)/$6,000 (couple);

- The prescription drug low-income subsidy program does not count any non-liquid, non real estate resources; by contrast, the Medicare Savings Programs include such resources as second cars, tractors and other equipment, machinery, and livestock in the federal minimum standard for eligibility determinations. This difference makes it easier for individuals to qualify for the prescription drug low-income subsidies.

- The definition of poverty used by the prescription drug low-income subsidy program is based on the actual number of people in the applicant's household, while the Medicare Savings Program relies on the federal standard which counts only an individual or an individual and spouse, where applicable. By taking into account more people in the family, the prescription drug low-income subsidy program allows more people to meet the income standard to qualify for assistance.

As a result of these differences, individuals who qualify for prescription drug low-income subsidies may not qualify for the Medicare Savings Program because eligibility for low-income subsidies is more generous. Furthermore, it is not possible to assume that an individual is eligible for a Medicare Savings Program based on having been determined eligible for low-income subsidies under the prescription drug benefit.
The state Medicaid agency would need additional information about income, resources and family size to make an MSP eligibility determination for an individual found eligible for a low-income subsidy. Thus, states are not easily able to use general information provided by SSA to determine Medicare Savings Program eligibility.

Reasonably close correlation between the two programs' eligibility rules exists in only five states. In five states – Alabama, Arizona, Delaware, Minnesota, and Mississippi – similarities between the two programs are close enough that a finding of low-income subsidy program eligibility is reasonably likely to result in Medicare Savings Program eligibility.

- This is because those states either do not count resources at all for the Medicare Savings Program, or, in one case, Minnesota, the resource standard is the same as that for the partial low-income subsidy. Even in these states, however, full correlation does not exist because of the family size rule or, in one case, the counting of non-liquid resources.

- Despite these differences, in the four states that disregard all resources, more people are likely to become eligible for the low-income subsidy through eligibility for Medicare Savings Program benefits, and thus would be better off applying at their state Medicaid agency, rather than applying for the subsidy alone through the Social Security Administration.

Within any given state, the rules for determining eligibility for the Medicare Savings Program may be both more and less generous than those used to determine eligibility for the prescription drug low-income subsidies. About 39 states have one or more income or resource rules that are more generous than those of the prescription drug low-income subsidies. For example, eighteen states disregard in-kind support and maintenance from income, such as food or shelter provided by family or friends while the low-income subsidy program does not. Ten states have higher disregards for the value of life insurance than that used for the low-income subsidy determination. However, most of the states use a lower overall resource standard and a smaller family size, which offsets the effect of other more liberal income and resource rules.

Florida is an example of a state with rules for its Medicare Savings Programs that are both more and less generous than those used for the low-income subsidies. Florida disregards the value of assistance with food and shelter provided by family or friends, but uses the lower federal baseline standard of $4,000 for resources. In Florida, a person receiving a lot of help from family, but who had less than $4,000 in savings, would fare better applying for the Medicare Savings Program and getting the prescription drug low-income subsidy automatically through MSP eligibility. Alternatively a different person in Florida, who had no assistance from family or friends but higher resources, might not be eligible for a Medicare Savings Program but would still qualify for the prescription drug low- income subsidies.

The fact that states sometimes have more generous rules for Medicare Savings Program eligibility is another strong reason to apply for the Medicare Savings Program as a pathway to the prescription drug low-income subsidy.

Applying for the low-income subsidies at the state agency will almost always be more beneficial to the applicant than applying at the Social Security Administration. This is true for two reasons: first, the state, but not Social Security, is required to screen for Medicare Savings Program eligibility and other benefits, so the individual may come away with greater benefits than expected. Second, depending on the state and on the individual's particular circumstances, an individual who is not otherwise eligible for low-income subsidies under the new drug benefit may be found eligible for the Medicare Savings Program, and will, by that route, become eligible for help under the Medicare drug benefit low-income subsidy program. This finding is contrary to current policy and practice, which is to steer applicants to Social Security to apply for help with the Medicare drug benefit.

Resource tests create a substantial impediment to program alignment. The greatest barriers to closer alignment of the Medicare Savings Programs and the Part D low-income subsidy are the resource tests used by both programs. Not a single state uses the same resource standard and rules as the LIS program. All but five states have a more restrictive resource test for their Medicare Savings Programs than applies to the LIS program.

Conclusion

The Part D low-income subsidy and the Medicare Savings Programs are critically important to making health care affordable for low-income Medicare beneficiaries. These programs are designed to help the same target population; ideally they would be streamlined to work together in a more complementary way in order to achieve that goal.

Yet the fundamental challenge in seeking to align these programs is that the Part D low-income subsidies are administered as a federal program, with standard federal eligibility rules. By contrast, the Medicare Savings Program operates with minimum federal requirements and is administered by each state's Medicaid agency, which has authority to apply different rules and utilize different application procedures. These differences pose major challenges to streamlining or more closely aligning these programs so they can provide maximum assistance to low-income Medicare beneficiaries. Specifically, the differences make it difficult to standardize rules across both programs without having negative unintended consequences of making some beneficiaries no longer eligible for program assistance.

Modifying or eliminating the resource tests altogether would help protect those disadvantaged by low incomes who would otherwise be eligible for additional assistance with medical and drug costs. Resource tests are generally intended to focus benefits on those with low incomes and exclude those with substantial assets, but in fact, such rules may deny many of the nation's lowest-income Medicare beneficiaries from receiving additional assistance with medical costs. A recent analysis by the Social Security Administration found that more than half (57%) of those who were found ineligible for prescription drug low-income subsidies, met the income requirements, but failed the asset test.

A variation on eliminating the resource test entirely for both programs is to raise the minimum standard for the Medicare Savings Programs to conform to the new federal low-income subsidy standard while retaining states' flexibility to adopt more liberal rules. This would create a uniform standard such that a determination of eligibility for the prescription drug low-income subsidies would assure eligibility for the Medicare Savings Program. Although states are currently free to raise their Medicare Savings Program standards and rules to conform to the Medicare drug benefit low-income subsidies, most have not done so – primarily due to budgetary concerns. Short of either of these policy changes, other efforts discussed in the full report, could help to improve the coordination between these two programs to provide needed assistance to low-income beneficiaries on Medicare.

INTRODUCTION

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- Differences in how Part D applicants for low-income subsidies are likely to be treated depending on whether they apply through the Social Security Administration or through the state Medicaid program.

Methodology

We designed a template to receive information about each state's eligibility categories, income and resource rules and enrollment processes for Medicare Savings Programs. Using existing data sources[3], we completed each state's template to the best of our ability. Only then did we send the "completed" template to the State Medicaid Director, asking for confirmation of its accuracy or correction of the information provided. Forty-one states and the District of Columbia responded, providing us additional or corrected information which we clarified, where necessary, through email and telephone contacts. For the remaining 9 states for which our contact efforts were not successful, we are presenting the information gathered from existing data sources, which has not, of course, been verified by the state. Non-responding states are identified on each chart by shading. Data were collected between March and September 2005.

BACKGROUND

1. Medicare Savings Programs

Since 1986, Congress has enacted several programs, now collectively referred to as Medicare Savings Programs (MSPs), to help low-income Medicare beneficiaries pay for Medicare's considerable cost-sharing.[4] At the federal level, all programs have both income and resources tests for eligibility; the resource test is uniform across all the benefits: $4,000 in countable resources for an individual and $6,000 for a couple. The programs are operated through state Medicaid programs (Table 1).

Methods used to count income and resources are derived from the federal Supplemental Security Income program (SSI),[5] but states are permitted to use methods that result in more generous coverage than SSI rules would yield.[6] Thirty-nine states have one or more such generous rules, although many are quite modest. The most dramatic rule modification used by states is elimination of the resources test.

Table 1

Eligibility Pathways & Benefits for Medicaid Assistance

Pathway	Income Eligibility	Asset Limit Individual/ Couple	Covered Costs and Services
SSI **	< 74% of poverty (SSI income eligibility)	$2,000 $3,000	Medicaid benefits, Medicare premiums and cost-sharing
Qualified Medicare Beneficiary (QMB)	< 100% of poverty	$4,000 $6,000	Medicare premiums and cost-sharing
Specified Low-Income Beneficiary (SLMB)	100-120% of poverty	$4,000 $6,000	Medicare premiums
Qualifying Individual (QI1)	120-135% of poverty	$4,000 $6,000	Medicare premiums

Note: ** States that elect the so-called "(209b)" option can set lower levels. QI1 is not an entitlement program. Funding for the program is capped and beneficiaries are eligible to participate on a first-come, first-served basis.

Qualified Medicare Beneficiary Program. The most expansive of the programs, Qualified Medicare Beneficiary Program (QMB), relieves beneficiaries of all Medicare premium and cost-sharing obligations. It is available to beneficiaries with incomes up to 100% of the federal poverty level (FPL) -- $816.67 per month in 2006.

Specified Low-Income Medicare Beneficiary and Qualified Individual Programs. The Specified Low-Income Medicare Beneficiary Program (SLMB) pays for Part B premiums for individuals with incomes between 100% and 120% of FPL -- $980 per month in 2006, and the Qualified Individual (QI) program pays the Part B premium for those with incomes between 120% and 135% of FPL --$1,102.50 in 2006.[7] The SLMB program is, like QMB, an entitlement; QI is a limited entitlement based on a specific grant to each state. The program will end September 30, 2006 unless Congress extends it.

Low enrollment in Medicare Savings Programs has been the subject of numerous reports and policy initiatives over the past two decades.[8] According to the Congressional Budget

Office, about one-third of beneficiaries eligible for QMB-only benefits are currently estimated to enroll in the program. The take-up rate for the SLMB-only program is approximately 13 percent.[9]

Barriers to enrollment. Barriers to enrollment have been identified as including lack of effective outreach to potential beneficiaries; lack of knowledge of the programs on the part of beneficiaries, Medicaid workers, Social Security employees and community-based organizations; resources tests; beneficiaries' fear of losing their resources if they receive benefits because of Medicaid estate recovery policies; difficulties with language and transportation, and obstacle-laden enrollment policies that include lengthy and complex applications, face-to-face interviews and extensive documentation of income and resources.

Policy Initiatives. Documentation of low-enrollment and its causes has led to several federal and state-level policy initiatives.[10] Among these were efforts to get the Social Security Administration more involved in targeting, communicating with and assisting with enrollment of potentially eligible beneficiaries. The results of one such effort supported the view that targeted outreach, in the form of letters addressed to individuals believed to be eligible for benefits, coupled with active assistance in completing applications was more effective in increasing enrollment than models that required the beneficiary to take several steps with less active assistance.[11]

SSA also provided MSP beneficiary-identifying information to states for follow up outreach and assistance. However, according to a report of the (the) General Accounting Office, only two of six states reviewed in depth for a study had used the data.[12]

Concurrent with federal activity, states changed their MSP programs in efforts to improve program participation. For example, between 1999 and 2005, the number of states using some more generous eligibility rules than are required for counting income or resources increased from 13 to 40. In 1999, only 19 states reported not requiring an in-person interview as part of their MSP application process; in 2005, about 39 states report having no in-person interview requirement.[13]

Congress designed the Part D low-income subsidy with apparent attention to the lessons learned over the years about improving MSP participation; it required use of a short application form and encouraged simplicity of administration of the program. Congress also demonstrated its continued interest in expanding MSP enrollment by including a requirement that states, as part of their processing of applications for the Part D low-income subsidy, screen applicants for entitlement to MSP and offer them the opportunity to enroll.[14] Congress did not, however, include a similar obligation for SSA when it processes applications for the low-income subsidy.

2. Part D Low-Income Subsidies

Medicare Part D, the prescription drug benefit, includes extra help for low-income beneficiaries in the form of a full or partial subsidy of Part D cost-sharing, including premiums.[15]

Eligibility and subsidy amount

Those entitled to the full subsidy, with variations only in the amount of copayment, are Medicare beneficiaries receiving full Medicaid benefits (full benefit dual eligibles), beneficiaries receiving Supplemental Security Income and/or one of three Medicare Savings Programs (QMB, SLMB, QI), and beneficiaries with incomes up to 135% of FPL and countable resources of not more than $6,000 for an individual and $9,000 for a couple (Table 2). Beneficiaries receiving the full subsidy pay no premium, no deductible, have no coverage gap[16] and have co-payments of not more than $2 for generic and preferred drugs and $5 for non-preferred drugs. When their out-of-pocket costs, including subsidy payments from Medicare, reach $3600, they have no further co-payments.

Table 2

Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2006

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Individuals with Medicare & Medicaid (Full benefit "dual eligibles")	$0	$0	$1-$2/generic $3-$5/brand-name; no copays after total drug spending reaches $5,100
Individuals with Medicare and Medicaid benefits in nursing homes	$0	$0	No copays
Individuals with income <135% of poverty and resources <$7,500/individual; $12,000/couple (Includes Medicare Savings Program participants other than "dual eligibles")	$0	$0	$2/generic $5/brand-name; no copays after total drug spending reaches $5,100
Individuals with income 135%-150% of poverty and resources <$11,500/individual; $23,000/couple	sliding scale up to $32.20*	$50	15% of total costs up to $5,100; $2/generic $5/brand-name thereafter

Note: The 2006 poverty level is $9,800/individual and $13,200/couple. Resources include $1,500/individual and $3,000/couple for funeral or burial expenses. *$32.20 is the national monthly Part D base beneficiary premium for 2006.

Partial subsidies are available to beneficiaries with incomes up to 150% FPL and countable resources of not more than $10,000 for an individual and $20,000 for a couple. Those eligible for partial subsidies pay premiums on a sliding scale, a $50 annual deductible (rather than $250 for non-subsidy beneficiaries), a 15% co-insurance (rather than the 25% co-insurance for non-subsidy beneficiaries), have no coverage gap and, after $3600 out-of-pocket costs (including Medicare's subsidy payments), pay $2 for generic and preferred drugs and $5 for non-preferred drugs.

Administration of the subsidy

Administration of the low-income subsidy (LIS) program is shared among the Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS), SSA and state Medicaid agencies. Both SSA and state Medicaid agencies must have processes in place for determining eligibility for the subsidy, sharing eligibility information with CMS and processing appeals of denials of subsidy eligibility.

3. Relationship of subsidy to Medicare Savings Programs.
The Secretary of Health and Human Services has determined that eligibility rules and methods for the low-income subsidy will be uniform nationwide. He chose not to exercise authority granted him in the law to permit the states, when they make subsidy eligibility determinations, to use more liberal rules, if any, than they use for their Medicare Savings Programs.

Rules used for counting income and resources for eligibility for the subsidy, like those used for MSPs, generally follow the rules for SSI. The most notable exception for the subsidy is the elimination from consideration of non-liquid resources, such as vehicles, farm equipment and machinery (SSI excludes the value of one vehicle, and a second in special circumstances). Few states have such exclusions in their MSP programs. The resource standard differs, too: the SSI standard for one person is $2,000, the MSP standard is $4,000 and the LIS standard is $6,000 (for full subsidy) and $10,000 for partial subsidy.

The Secretary did exercise authority to grant deemed eligibility status for the full low-income subsidy to all those eligible for QMB, SLMB or QI. The significance of this granting of deemed status is complex; its effect on enrollment in the subsidy varies widely from state to state and, to considerable degree, will depend on the specific circumstances of individual applicants.

On one hand, the LIS resources standard of $6,000 or $10,000 is more liberal than what is required for MSP. In all but the four states that have eliminated their resource test and Minnesota, whose limit parallels the LIS test, certain individuals would be eligible for LIS but ineligible for MSP.

On the other hand, individuals for whom the resource standard is not a barrier but who have certain specific kinds of income or resources that would be counted in determining eligibility for the LIS may fare better in one of the 40 states that have eligibility rules for their MSPs that are more generous in some respect than those of the LIS. In those states, for individuals with specific circumstances, MSP eligibility will result in deemed LIS status whereas a straight determination of LIS eligibility, using the nationwide rules, would result in a denial.

It must be noted that some of the more liberal eligibility rules are fairly limited in their scope and applicability. One state, for example, has as its only more liberal disregard burial plans (presumably of any value) for each member of the family. The burial plan exclusion for LIS is limited to $1,500 per applicant, offset against life insurance.

Other states, however, have multiple disregards for both income and resources. In counting income, some states disregard a larger amount across the board than the LIS $20, or disregard income from state-specific programs benefiting some or all of their residents. Many states do not count as income in-kind help received for food and shelter (referred to as "in-kind support and maintenance"), which is counted for LIS. As noted, some states have no resource test for one or all of their MSPs, while other states have a

resource ceiling above that the $6,000 level applicable for the full LIS subsidy. Some exclude the value of life estates, have a higher exclusion value for life-insurance or burial funds, or a more generous standard for considering property used to produce income. CMS acknowledges the important circumstances that it has created in allowing MSP beneficiaries to be deemed LIS eligible in its guidance to states concerning processing applications for the low-income subsidy:

> If the evidence at the time of application indicates that the applicant would qualify for the subsidy, the subsidy application should be processed immediately. If the beneficiary later qualifies for MSP, s/he will be deemed eligible for the subsidy. On the other hand, if the evidence indicates that the applicant would qualify for MSP but not qualify for LIS, the MSP application should be processed immediately, since the individual would be deemed eligible for the subsidy and need not apply.[17]

Table 3 identifies those states with income and resource rules for their Medicare Savings Program that are more generous than some aspect of the low-income subsidy rules and that are likely to affect a substantial number of applicants. Similar but more detailed information on all states is presented in Appendix 3A. In the four states – Alabama, Arizona, Delaware and Mississippi – that disregard all resources for Medicare Savings Programs, many individuals would be better off going to their Medicaid agency to apply for Medicare Savings Programs where they would become eligible for the low-income subsidy as well.

Table 3 - Income and Resource Rules for Medicare Savings Programs vs. the Medicare Prescription Drug Low-Income Subsidy Program

	Low-Income Subsidy	Medicaid/Medicare Savings Program
INCOME DISREGARDED		
Amount of income disregarded	$20	$20 in most states except: Connecticut ($183); District of Columbia ($418); Illinois ($25); Maine ($55); Mississippi ($30)
In-kind support and maintenance	LIS does not disregard the value of in-kind support and maintenance	In-kind support and maintenance are disregarded in Alabama, Arizona , Florida, Georgia, Illinois, Kansas, Louisiana, Maryland, Michigan, Mississippi, Missouri, New Hampshire, North Dakota South Carolina, South Dakota, Virginia, Wisconsin, Wyoming
Dividend and interest income	LIS disregards dividend and interest income only from resources that are counted	Additional dividend and interest income are disregarded in Alabama, Arizona, Delaware, Kansas, Michigan, Mississippi, Nebraska
RESOURCES DISREGARDED		
Resources disregarded	LIS disregards non-liquid resources	All resources are disregarded in Alabama, Arizona, Delaware, Mississippi; New York – for QI only, Connecticut – for QI only
Resource test	LIS counts liquid resources to $6,000 (full subsidy) or $10,000 (partial subsidy) and non-homestead real property	The minimum resource standards are $4,000 (per individual)/$6,000 (couple). The following states have modified their resource standards: Florida - $5,000, Maine - $8,000, Minnesota - $10,000
Value of non-homestead life estate	LIS counts the value of a life estate in non-homestead real property	The value of a life estate in non-homestead real property is excluded in Florida, Georgia, Missouri, Montana, North Carolina, North Dakota, South Carolina, Vermont, Virginia
Life insurance/burial fund threshold	LIS excludes $1,500 in life insurance, $1,500 in burial fund (offset by value of life insurance)	Florida - $2,500, Georgia - $5,000, Hawaii – full value of bona fide burial plan, Louisiana - $10,000, Maryland – any value if funeral home is recipient of proceeds, Massachusetts – no offset against irrevocable trust, North Carolina - $10,000, South Carolina - $5,000, Vermont - $10,000, Virginia - $3,500.
Exclusion for income producing property	LIS excludes such property up to a value of $6,000, if it produces a rate of return of 6%	More generous exclusions are available in Arkansas, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Missouri, New Hampshire, Tennessee, Vermont

4. Application Process

Both states and SSA must accept applications for the low-income subsidy and both must have processes for determining eligibility.

SSA Application process. SSA will take applications on-site, over the telephone, through the mails or on-line; no interview is required, although the agency may contact the individual with questions. SSA's application is five pages, including a signature page; it can be completed by the applicant or her personal representative.[18] The application includes a self-declaration of the truth of its contents.[19] Verification of amounts of income and resources will be accomplished by SSA mostly through data exchanges with various federal agencies; SSA may ask the applicant to submit bank statements where needed. The hard copy version of the application is scannable, for ease of entering its contents into the computer system; agencies that intend to help people apply for the LIS are asked to use originals of the scannable form, not to photo-copy the form.

SSA regulations provide that a redetermination of eligibility will occur within one year of the initial eligibility determination and, after that, at intervals determined by the Commissioner and based on the likelihood the applicant's situation will change and on whether s/he receives a full or partial subsidy.[20] Redetermination will also occur after the beneficiary reports a change in circumstances. If the change has to do with marriage, divorce or a spouse moving into or out of the household, any change in the subsidy will be effective the month after it is reported. If the change has to do with income or resources or change in family size other than related to a spouse, any change in subsidy is effective in January of the following year. Regulations do not describe a process for redetermination, other than to say that SSA will send the beneficiary a redetermination form, and may verify relevant information through other sources.[21]

State application process. The law contemplates that states will determine LIS eligibility as they do under their state plan for Medicaid, with the frequency and manner of redeterminations and the process for appeals also governed by their state plan.[22] State Medicaid plans may include different enrollment and redetermination processes for different categories of Medicaid eligibility; the category most likely to be followed for an LIS determination is MSP. Like SSA, forty-eight states (including eight non-responders)[23] permit applicants to mail in applications for some or all of their MSPs, although 11 of those states also require a face-to-face interview. While SSA permits applicants to certify to the accuracy of the information they provide (with the possibility of having to provide some documentation at a later date), only 19 states (including six non-responders)[24] permit self-certification of the accuracy of resource information and only 14 (including four non-responders)[25] permit it for income information.

Table 4 compares the SSA LIS enrollment processes with those of each state's MSPs.

Table 5 compares the SSA process for redetermination of LIS eligibility with those of each state's MSP redetermination.

Table 4 - Enrollment Processes for Medicare Savings Programs vs. the Medicare Prescription Drug Low-Income Subsidy Program

	Mail-in application with no face-to-face interview?	Self-attestation of income?	Self-attestation of resources?	Separate application form from full Medicaid	Can apply online?
LOW-INCOME SUBSIDY	✓	✓	✓	✓	✓
MEDICARE SAVINGS PROGRAMS, BY STATE					
Alabama	✓		✓[1]	✓	
Alaska					
Arizona	✓		✓[1]	✓	
Arkansas	✓	✓	✓	✓	
California	-		*	✓	-
Colorado	✓				
Connecticut	✓	✓	✓[2]	✓	
Delaware	✓	✓	✓[1]		✓
District of Columbia				✓	
Florida	✓	✓	✓	✓	
Georgia	✓	✓	✓	✓	
Hawaii	✓	✓	✓		
Idaho	✓	*			
Illinois	✓	✓	✓		
Indiana	✓			✓	
Iowa					
Kansas	✓				✓
Kentucky					
Louisiana	✓		✓	✓	
Maine	✓				
Maryland	✓			✓	
Massachusetts	✓	*	*	*	
Michigan	✓				
Minnesota	✓		✓		
Mississippi	✓		✓[1]		
Missouri	✓			✓	
Montana	✓				
Nebraska	*				
Nevada	✓				
New Hampshire					
New Jersey	*	*		*	
New Mexico	✓			✓	
New York			✓[2]	*	

	Mail-in application with no face-to-face interview?	Self-attestation of income?	Self-attestation of resources?	Separate application form from full Medicaid	Can apply online?
North Carolina					
North Dakota	✓				
Ohio	✓			✓	
Oklahoma	✓				
Oregon	-			✓	
Pennsylvania	✓			*	✓
Rhode Island	✓	✓	✓	✓	
South Carolina	✓			*	
South Dakota	✓			✓	
Tennessee	✓				
Texas	✓	✓	✓	✓	
Utah	✓				
Vermont	✓	✓	✓	✓	
Virginia	✓				
Washington	✓		*	✓	✓
West Virginia	*			✓	✓
Wisconsin	✓	✓			
Wyoming					
TOTALS	**Yes - 38**	**Yes - 11**	**Yes - 16**	**Yes - 21**	**Yes - 5**

LEGEND

✓ Yes

No

* Answers vary across programs. See state chart.

\- Unknown

Note: [1] State does not have an asset test for MSP. [2] State does not have an asset test for QI-1 program. Information in gray has not been confirmed by the state's Medicaid program. MSP data are from 2005.

Table 5 - Information Required for Redetermination for Medicare Savings Programs vs. the Medicare Prescription Drug Low-Income Subsidy Program

	Full Application	Income Documentation	Resource Documentation
LOW-INCOME SUBSIDY	LIS redeterminations done by the Social Security Administration will occur as determined by the commissioner.		
MEDICARE SAVINGS PROGRAMS, BY STATE	MSP beneficiaries have their eligibility redetermined once a year, with the exception of Oregon, which redetermines eligibility every 6 months.		
Alabama		-	-
Alaska	✓	✓	✓
Arizona		✓	
Arkansas	✓		
California	-	-	-
Colorado	-	✓	✓
Connecticut	✓		
Delaware		✓	
District of Columbia		✓	✓
Florida	✓		
Georgia	-		
Hawaii			
Idaho	✓	-	-
Illinois			
Indiana		✓	✓
Iowa	✓	✓	✓
Kansas	✓	✓	✓
Kentucky		✓	✓
Louisiana	*	*	*
Maine		✓	✓
Maryland	✓	✓	✓
Massachusetts	*	*	*
Michigan	✓	✓	✓
Minnesota		✓	
Mississippi		✓	
Missouri		✓	✓
Montana		*	*
Nebraska	*	✓[1]	*
Nevada			
New Hampshire	-	✓	✓
New Jersey	*	✓	✓

	Full Application	Income Documentation	Resource Documentation
New Mexico	✓	✓	✓
New York		✓	*
North Carolina		✓	✓
North Dakota		✓	✓
Ohio	✓	✓	✓
Oklahoma	✓	✓	✓
Oregon	-	-	-
Pennsylvania	*	✓	✓
Rhode Island	✓		
South Carolina	✓	✓	✓
South Dakota	✓	✓	✓
Tennessee	✓	✓	✓
Texas			
Utah	✓	✓	✓
Vermont	✓		
Virginia	-	✓	✓
Washington		✓	
West Virginia	✓	✓	✓
Wisconsin	-	-	-
Wyoming		*	*

LEGEND
✓ Yes
No
* Answers vary across programs.
\- Unknown

Note: [1] Verification occurs every 6 months. Information in gray has not been verified by the state's Medicaid program. MSP data are from 2005. For more information regarding low-income subsidy redeterminations see the Social Security Administration Final Rule 20 C.F.R. 418.3120, 3123, 3125

Considerations of where to apply for the low-income subsidy

While the law and regulations are clear that both states and SSA must take and process applications for the Part D low-income subsidy, various factors are presently operating together to direct beneficiaries to SSA.

Factors promoting applying through SSA. First, CMS's materials, including its guidance to states on the low-income subsidy, promote SSA as the best agency through which to apply:

> States are strongly encouraged to use the Social Security Administration's subsidy application (SSA-1020) for subsidy applicants unless an individual specifically requests that the State make the subsidy determination using a State application form.[26]

It is highly unlikely that a beneficiary seeking assistance at a state Medicaid office would "specifically request" a state determination, unless she or he had been instructed to do so.

Moreover, SSA has mailed individual letters and applications to over 18 million individuals it has determined are likely to be eligible for the subsidy and needing to make an application for it. To the extent that beneficiaries respond to the letter, either by mailing in the completed application or by calling SSA for further assistance, their application will be processed through SSA, using the entire SSA process.

Further, while the law authorizes payment to SSA for its costs in determining eligibility for the LIS, it provides for payment of only 50% of the states' costs for the same activities.[27] And, since the uniform LIS income and resource rules are at least slightly different from every state's MSP eligibility rules, states cannot determine LIS eligibility simply by applying their MSP rules.

Finally, a determination by SSA would be valid for a beneficiary regardless of where she or he lives. If SSA creates a simple redetermination process, a beneficiary could easily retain LIS eligibility even if she moves during the year. A state determination, in contrast, would only be valid in the state in which it was made. While it might be valid for the remainder of the year in which it was made, the beneficiary would have to apply afresh in the new state in the next year.

These factors, together with CMS's and SSA's emphasis on using the SSA process for determining eligibility point beneficiaries away from state offices.

Factors favoring applying at the state. Other factors, however, weigh in favor of applying at the Medicaid office and even of asking for a determination through the state process. (It is important to remember that merely completing an application at the state Medicaid office does not result in that application being processed through the state, as states are encouraged to use the SSA forms and process.) Specific time frames for processing applications and an appeals process that is familiar to advocates for low-income individuals are two such reasons.

Perhaps the most significant reason, however, is that individuals at the Medicaid office must be screened for all Medicaid benefits, including Medicare Savings Programs.[28] Such screening will not occur at the SSA office, or by mailing the SSA application to SSA. As discussed earlier, because in 40 states, it is possible to get both MSP and the LIS through being found eligible for MSP under rules that are more generous in certain aspects than LIS rules, applying at the Medicaid office in those states can be especially advantageous.

And, because the LIS rules are uniform throughout the country, regardless of the agency through which an individual applies, those individuals who will benefit from the LIS disregard of all non-real estate, non-liquid resources, as well as from the LIS rule taking into account the actual size of one's family when determining the poverty level against which to measure eligibility, will still get the benefit of those rules at their state Medicaid

office. (Unlike LIS, most state MSP program rules measure an applicant's income against a poverty level for one or two persons, depending on whether the applicant is married, not fully taking into account the presence of other dependents in the household. The LIS rules require measuring income against the poverty level that reflects dependents in the household.) See Table 6 for a comparison of the family size used by LIS and by state MSPs.

Table 6 - Family Size for Medicare Savings Programs vs. the Medicare Prescription Drug Low-Income Subsidy Program

	Maximum Family Size Applied to MSP Applicants
LOW-INCOME SUBSIDY	Actual family size[1]
MEDICARE SAVINGS PROGRAMS, BY STATE	
Alabama	2
Alaska	2
Arizona	2
Arkansas	2
California	Actual family size
Colorado	-
Connecticut	2
Delaware	2
District of Columbia	2
Florida	2
Georgia	2
Hawaii	Actual family size
Idaho	Actual family size[2]
Illinois	Actual family size
Indiana	Actual family size
Iowa	2
Kansas	2
Kentucky	2
Louisiana	2
Maine	2
Maryland	2
Massachusetts	2
Michigan	Actual family size
Minnesota	Actual family size
Mississippi	2
Missouri	-
Montana	2
Nebraska	Actual family size
Nevada	2
New Hampshire	2 + any child seeking assistance
New Jersey	2

	Maximum Family Size Applied to MSP Applicants
New Mexico	2
New York	2
North Carolina	2
North Dakota	Actual family size
Ohio	2
Oklahoma	2
Oregon	Actual family size
Pennsylvania	Actual family size
Rhode Island	-
South Carolina	2
South Dakota	Actual family size and adjusted income of the adults in the household
Tennessee	Actual family size
Texas	2
Utah	2
Vermont	2
Virginia	2
Washington	Actual family size
West Virginia	2
Wisconsin	2
Wyoming	2

Note: - Unknown. [1] Actual family size includes actual dependents. A person is considered a dependent if they rely on the beneficiary for half their basic sustenance. [2] Idaho applies a family size of 2 to SLMB and QI. Information in gray has not been confirmed by the state's Medicaid program. MSP data are from 2005.

While MSP enrollment is a possible route to LIS eligibility for many individuals and while the MSP benefit is valuable (worth at least $1062 in 2006) independent of its link to LIS, some individuals may be reluctant to take the benefit because it will subject them to Medicaid's estate recovery requirement.[29] That is to say, in some states, MSP benefits can be recovered by the state from the estate of a deceased Medicaid beneficiary. Twenty-one recover MSP benefits, including 17 of the states with more liberal eligibility rules. Table 7 compares LIS with States' MSP rules with respect to estate recovery (LIS has no estate recovery requirement).

Table 7 - Estate Recovery for Medicare Savings Programs vs. the Medicare Prescription Drug Low-Income Subsidy Program

	Is Estate Recovery Applied to MSP Benefits?
LOW-INCOME SUBSIDY	No estate recovery
MEDICARE SAVINGS PROGRAMS, BY STATE	
Alabama	
Alaska	
Arizona	✓
Arkansas	
California	
Colorado	✓[1]
Connecticut	✓
Delaware	
District of Columbia	✓
Florida	-
Georgia	
Hawaii	✓
Idaho	✓
Illinois	✓*
Indiana	✓*
Iowa	✓
Kansas	
Kentucky	
Louisiana	
Maine	
Maryland	✓
Massachusetts	✓
Michigan	
Minnesota	✓
Mississippi	
Missouri	-
Montana	✓
Nebraska	✓*
Nevada	✓
New Hampshire	
New Jersey	
New Mexico	
New York	

	Is Estate Recovery Applied to MSP Benefits?
North Carolina	
North Dakota	✓
Ohio	
Oklahoma	
Oregon	✓
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	✓*
Tennessee	
Texas	
Utah	✓
Vermont	
Virginia	✓
Washington	✓
West Virginia	
Wisconsin	
Wyoming	

Note: - Unknown. * YES (✓) for QMB, NO for SLMB and QI.
[1] Colorado applies estate recovery only if recipient is eligible for both QMB and full Medicaid. Estate recovery is not applied to recipients in QMB only. Information in gray has not been confirmed by the state's Medicaid program. MSP data are from 2005.

SSA Leads Data

For coordination purposes (to ensure an applicant at the state has not already been determined LIS eligible by SSA) and to promote the state's role in screening for MSP eligibility, SSA will send states data about applicants for the LIS. Data elements states will receive are:

Subsidy approval (Yes/No)
Subsidy approval/disapproval date
LIS effective date
Resources over or under LIS limit
Income used for determination (individual/couple)
Income as Percent of federal poverty level
Denial reason (no Medicare, not in USA, failure to cooperate, resources too high, income too high)
Mailing address

The data will not include verified income and resources amounts, as determined by SSA. States will not have sufficient information to determine eligibility for MSP from these leads, even if they wish to do so. They will have to contact the beneficiary and ask for more information: extra work for both the state and the beneficiary. Beneficiaries will

receive, with their notice from SSA of the subsidy determination, a one-page summary of their income and resource eligibility determination that they could take with them to the state Medicaid office if they sought other benefits. It is unclear how or if states will use these summary sheets.

SSA has stated it cannot provide verified income and resources information to states because of privacy agreements with the agencies, including the Internal Revenue Service, through which it will verify the applicant's information. Presumably, the privacy being protected is that of the applicant, who could, if asked, provide consent to the information being released.

Past experience with states use of leads data is mixed, at best. Twenty some states received data about potential QMBs, under an earlier effort to provide leads data, but little is known about how states actually used these data. All but six states received the data required by Congress in 2000, but again, little is known about its use. The GAO found that of the six states in which it studied the effects of related SSA mailings to potential MSPs only two states actually used the leads data. Moreover, it is unclear how the leads to be provided under the Part D LIS differ from those required by the 2000 law, whether states will get both and whether states will have the technological capacity to receive the LIS leads data.

Leads data have the potential to improve enrollment but it is largely unrealized. To be effective, the data themselves and the form in which they are provided must serve to simplify and streamline the process of enrolling potential beneficiaries.

POLICY IMPLICATIONS

Despite the complexities raised by the differences between the Medicare prescription drug low-income subsidy program and the Medicare Savings Programs, their underlying similarities suggest that low-income individuals could get the benefit of both programs without engaging in two separate and largely duplicative processes, regardless of the agency through which they applied, if greater efforts are made to align the rules and processes for eligibility determination.

The following policy options could result in closer alignment of these two programs that provide needed assistance to low-income Medicare beneficiaries.

Elimination of resources tests for both LIS and MSP. Eliminating the resource tests associated with each program would increase participation in both programs by those who need them the most. The literature demonstrates that resource tests are barriers to benefits for very low income people, many of whom are widows or widowers, and that their elimination does not result in huge increases in the number of people eligible but does make the process simpler for both beneficiaries and eligibility workers by eliminating the need to identify or document the resources.[30] A recent analysis by the Social Security Administration found that more than half (57%) of those who were found

ineligible for prescription drug low-income subsidies, met the income requirements, but failed the asset test.

States can eliminate the resources test for MSP administratively, by filing a State Plan Amendment describing how the state intends to use a more liberal methodology than that of SSI. Four states have done so for all MSPs, and two more have eliminated the test for QI applicants only. Eliminating the LIS resources test, however, requires federal legislation. Congress could also amend the MSP law to eliminate the resources test for that program; such action would have the effects of more closely aligning the two programs and of relieving the states of the need to take steps in that direction.

Screening and enrollment for MSP and LIS regardless of where beneficiaries apply. To promote higher participation in both the MSP and LIS programs, beneficiaries could be screened for both LIS and MSP by the states and by SSA, and, at a minimum, told of the possibility of full Medicaid eligibility if that appears likely.

Such activity could be undertaken by SSA under current federal law,[31] but SSA's reluctance to do so over the years suggests that legislative language similar to that used for states in the MMA might be needed, together with appropriations to carry out the tasks.

Elimination of Medicaid estate recovery for MSP. Such a step would make the MSP benefit more attractive to beneficiaries and more closely align the MSP program with LIS. To the extent that states recover such benefits, the benefits themselves are less attractive to beneficiaries and efforts to streamline enrollment through electronic data sharing and other means will be less effective.

Elimination of estate recovery could be accomplished administratively by individual states, relying on permissive language in federal manuals. It could be accomplished for all states uniformly by CMS through a modification of current federal guidance to states. Ultimately, Congress could repeal estate recovery for MSP benefits.

Alignment of more restrictive MSP rules with LIS rules. To the extent states' MSP rules are more restrictive, especially with respect to resource standards, consideration of non-liquid resources, application of estate recovery and use of smaller than actual family size, make joint enrollment in both programs administratively complicated for both the beneficiary and the program administrators.

States could make such changes by filing State Plan Amendments to use more liberal disregards than those of SSI and by eliminating their estate recovery requirement. Since states have, by law, an obligation to screen for MSP eligibility and enroll those who wish to be enrolled, they would ease their administrative burden substantially by being able to automatically enroll LIS beneficiaries into MSPs, with a beneficiary option to decline the benefit. CMS could encourage states to make such changes, through State Medicaid Director letters and other guidance. Congress could amend the MSP law to conform to LIS, while still allowing states to use more liberal rules. Such a move would allow

individuals found eligible for LIS to be deemed eligible for MSP without any further action on their part. This works in reverse under current Part D policy: those eligible for MSP are deemed eligible for LIS.

Elimination of documentation requirements for MSP. Elimination of documentation requirements for MSP would more closely align the program with the LIS process and allow for the easier enrollment of full LIS beneficiaries into MSPs. Research shows that states that allow self-attestation of income and resource information, with verification done largely through the electronic Income and Eligibility Verification System (IEVS) that does not burden the beneficiary do not experience greater error rates than states requiring documentation. Moreover, the states eliminating documentation experienced increased productivity of workers.[32]

States could do this on their own; CMS could encourage them to eliminate these requirements through State Medicaid Director letters and other guidance.

Upgrade of states' electronic systems to receive data from CMS and SSA concerning LIS eligibility. Improved compatibility of systems would allow states to use LIS information easily to enroll those qualified into MSPs or to determine what additional information the state would need to help people qualify.

Acquisition of consent from applicants to share information between agencies. Applicants' consent to share full verified income and resources information between SSA and states would allow states to know the process and outcome of the LIS determination and thus simplify their MSP determination. Consent could be obtained administratively by having SSA employees complete a consent form for all applicants at SSA offices and by obtaining oral consent for those applying by phone. The on-line application could be modified as well to provide consent. When SSA reprints its scannable application form, it could include a sentence seeking beneficiary consent to share information with other agencies.

Stationing of State Health Insurance Counseling Programs (SHIPs) counselors in SSA offices. Until greater alignment between the two programs exists, including more data sharing to promote auto-enrollment, beneficiaries can be spared the need to visit two offices by receiving assistance with MSP applications from a SHIP volunteer housed at the SSA office. Such arrangements exist in several states already.

Elimination of the counting of in-kind support and maintenance and life insurance from LIS income and resource determinations. Eliminating in-kind support and maintenance and life insurance from LIS income and resource determinations would be extremely helpful in simplifying the eligibility process for the low-income subsidy. SSA could accomplish this administratively, by amending its regulations.

CONCLUSION

The Part D low-income subsidy and the Medicare Savings Programs are critically important to making health care affordable for low-income Medicare beneficiaries. These programs are designed to help the same target population and ideally would be aligned to work together in a more complementary way in order to achieve that goal.

Modifying or eliminating the resource tests altogether would help protect those disadvantaged by low incomes who would otherwise be eligible for additional assistance with medical and drug costs. Resource tests are generally intended to focus benefits on those with low incomes and exclude those with substantial assets, but in fact, such rules may deny many of the nation's lowest-income Medicare beneficiaries from receiving additional assistance with medical costs. A recent analysis by the Social Security Administration found that more than half (57%) of those who were found ineligible for prescription drug low-income subsidies, met the income requirements, but failed the asset test.

An alternative to eliminating the resource test entirely for both programs is to raise the minimum standard for the Medicare Savings Programs to conform to the new federal low-income subsidy standard while retaining states' flexibility to adopt more liberal rules. This would create a uniform standard such that a determination of eligibility for the prescription drug low-income subsidies would assure eligibility for the Medicare Savings Program. Although states are currently free to raise their Medicare Savings Program standards and rules to conform to the Medicare drug benefit low-income subsidies, most have not done so – primarily due to budgetary concerns. Short of either of these policy changes, other efforts discussed in the full report, could help to improve the coordination between these two programs to provide needed assistance to low-income beneficiaries on Medicare.

APPENDICES

Appendix 1: Complete Medicare Savings Program Data for Table 3

State	Income	Resources
Alabama	Dividend and interest income. In-kind and support. Averages fluctuating income from past six months and projects over the next 12 months.	All resources.
Alaska	Alaska Permanent Fund Dividend.	Savings from Alaska Permanent Fund Dividend.
Arizona	In-kind support/maintenance. Allowance for dependents. Interest and dividend income from certain excluded resources.	All resources.
Arkansas	Income counted according to AR LTC guidelines.	$6,000 for non-home income producing property that is not part of a business.
California	Apply old AFDC or SSI methodology, whichever is more advantageous.	Apply old AFDC or SSI methodology, whichever is more advantageous.
Colorado	None	None
Connecticut	$183 unearned income.	Resources protected under Connecticut Partnership Act for LTC insurance. Resource eligible first day of the month in which resources fall within limit. Applicant remains eligible even if acquires resources in excess of the limit during the month. All resources for QI.
Delaware	Interest and dividend income.	All resources.
District of Columbia	$418 unearned income	None
Florida	In-kind support & maintenance, irregular or infrequent income. 4-week and 5-week months treated the same when figuring income received more than once per month. Fluctuating, less than monthly income is prorated over period it is anticipated to cover unless this adversely affect client, in which case it is counted in the month received.	$5,000. Resources of comatose applicant if there is no one who can access & expend resource. Life estate. Life insurance up to $2,500. $2,500 (per person) designated to burial funds up to 3 months pre-application. Property essential to self-support if producing income consistent with FMV.
Georgia	In-kind support and maintenance.	$5,000 of resources intended for burial. Any resource designated for burial. Interest earned on dividend accumulations for life insurance designation for burial. Life insurance up to $5,000. Accrued dividends on any life insurance policy. Income producing real property (though not the income it produces). Life interest in real property owned by the applicant or spouse.
Hawaii	None	Bona fide funeral/burial plans or agreements per family member.

State	Income	Resources
Idaho	None	Resources for sale at current market value. Exclusion limited to 3 months for personal property (with one 3-month extension).
Illinois	All in-kind income. Income received under "Illinois Senior Citizens and Disabled Persons Property Tax Relief Act". First $25 of non-SSI income, except contributions.	Resources necessary for self-support and resources derived under provisions of "Illinois Senior Citizens and Disabled Persons Property Tax Relief Act".
Indiana	None	Income-producing property, if income greater than expenses. Resources protected under long-term care partnership policy are exempt for QMB. Real property offered for sale.
Iowa	None	QMB only: resources protected under approved long term care insurance policy.
Kansas	For the aged: Lump sum payments. Standard 25% income producing cost allowance for self-employement. Interest income up to $50 per month. In kind income. Earnings of a child.	For the aged: income producing property. Property for sale exempt for 9 months. A person is resource eligible if under the limit any day of the month.
Kentucky	None	None
Louisiana	In-kind support and maintenance.	Life insurance up to $10,000. $10,000 of burial fund. Certain annuities.
Maine	$55 of any income. Allow child allocation from deemed income of eligible, as well as ineligible, spouse. In-kind income and first $400/month earned income of a student. SSA/Railroad Retirement COLA if they result in loss of eligibility.	Savings up to $8,000 ($12,000 for a couple) and portion drawn by voucher to encumber funds for payment of a legal debt. Property if good faith effort to sell. A person is resource eligible if under the limit any day of the month.
Maryland	In-kind income. Training allowances and expenses. Educational work-study earnings, stipends, and reimbursement for out-of-pocket expenses. Payments under a crime victims compensation program. Interest income accrued to bank accounts. Grants, loans, scholarships, fellowships, and training allowances for education purposes and all educational expenses while in attendance. All charitable contributions received. Infrequent or irregular unearned income up to $200 per 6 months and room and/or board income received. For rental property income and self-employment income, deduct 50% from the gross earnings as the cost to produce.	All burial or funeral plans which specify that a funeral home receives all proceeds; income-producing property if it annually produces income consistent with the fair market value.
Massachusetts	None	Former home of institutionalized person if certain people live in it. $1,500 burial fund not offset against irrevocable burial trust.

State	Income	Resources
Michigan	In-kind support and maintenance. Income, match and interest on Freedom Accounts.	Non-salable property. $75,000 in Freedom Accounts. A person is resource eligible if under the limit any day of the month.
Minnesota	None	$10,000
Mississippi	$30 of any income. In-kind support & maintenance. Interest, dividend and royalty income not exceeding $5 per month. Child allocation applied to ineligible spouse's income.	All resources.
Missouri	In-kind support/maintenance. Amounts withheld for OASDI recoupment. Count actual money received instead of amount due.	Additional vehicles evaluated in accordance with claimant's need. Income-producing property regardless of income yielded. Life estate. Real or personal property may be designated as burial funds.
Montana	TANF (and tribal TANF) cash assistance payments.	Certain contract for deed. Life estates if used to produce income consistent with the value of property. All funds (and interest) in Individual Development Accounts.
Nebraska	The cost of medical insurance premiums if individual is responsible for paying for it. For QMB: Interest income of $10 or less per month. Limited conservator or guardian fees (up to $10/month) and court expenses in certain circumstances.	None
Nevada	None	None
New Hampshire	Unearned in-kind income.	Non-home real property producing income sufficient to meet expenses of ownership and maintenance.
New Jersey	None	None
New Mexico	None	None
New York	Third party health insurance premiums, including Medicare supplemental insurance.	All resources for QI.
North Carolina	None	Life estate, including non-home, and tenancy in common interest. Life insurance up to $10,000. $12,000 of real property contiguous to principal residence if individual has no ownership in principal residence. Current market value for real property is the tax-assessed value (which may be reduced if evidence provided showing current market value is lower).

State	Income	Resources
North Dakota	In-kind income except that in lieu of wages. Legally-appointed guardian or conservator may retain 5% of recipient's monthly benefits as reimbursement for services. $30 work/training expense allowance for non-ABD in unit. Adult or child dependent care expense so spouse or caretaker can attend work or training. Extra checks of earned or unearned income received from a regularly recurring income source (The last check received in the month is considered the extra check.) TANF cash grant. First $25 unearned income from rental property. Income for room rental earned if individual is actively engaged.	Property not able to be sold without hardship. Applicant may choose state or SSI burial provision, and if the latter, also allow $1,500 life/burial insurance exclusion. Life estate and non-producing mineral acres. A person is resource eligible if under the limit any day of the month.
Ohio	None	None
Oklahoma	None	None
Oregon	-	-
Pennsylvania	None	None
Rhode Island	None	Resources used to pay certain medical, legal, guardianship, and tax assessment fees.
South Carolina	In-kind support and maintenance.	Life estate. Undivided interest in real property. Life insurance up to $5,000. A person is resource eligible if under the limit any day of the month.
South Dakota	Excludes unearned in-kind income.	A person is resource eligible if under the limit any day of the month.
Tennessee	Allowance for children related to FPL.	All equity value in business/non-business resources used to produce income. A person is resource eligible if under the limit any day of the month.
Texas	None	None
Utah	40% (flat rate) of the net profit from self-employment, allowable only for business expenses. For business expenses that exceed 40% (that can be verified), the self-employment net profit will be calculated using the same expenses as those allowed by the IRS.	Retirement accounts.
Vermont	Infrequent or irregular cash contributions, gifts. Average lump sum earnings (e.g., sale of crops, livestock) over 6-month accounting period.	Property used to produce goods for home consumption. Life estate in real property when owner does not retain power to sell. $10,000 in burial funds and irrevocable burial trusts, inclusive. Annuities created over 36 months before application.

State	Income	Resources
Virginia	In-kind support and maintenance.	$3,500 for burial funds. Life estates. Real property for which a reasonable effort to sell has been made. A person is resource eligible if under the limit any day of the month.
Washington	Unearned income withheld for tax purposes or otherwise withheld beyond individual's control. For QMB and SLMB: Amount equal to medical expenses.	None
West Virginia	None	None
Wisconsin	In-kind support and maintenance exempt unless it become regular or predictable.	Resources are not considered available if they cannot be converted to cash value within 30 days. A person is resource eligible if under the limit any day of the month.
Wyoming	In-kind support and maintenance are used only when 100% of food and shelter costs are provided.	None

Note: - Unknown. Information in gray has not been verified by the state's Medicaid program. MSP data were collected between March and September 2005.

Appendix 2: Complete Medicare Savings Program Data for Table 5

MEDICARE SAVINGS PROGRAMS, BY STATE	MSP beneficiaries have their eligibility redetermined once a year, with the exception of Oregon, which redetermines eligibility every 6 months.

State	MSP
Alabama	Update old information or take no action unless something has changed.
Alaska	Full application. Income and asset documentation.
Arizona	Redetermination form. Income documentation.
Arkansas	Full application. No documentation.
California	-
Montana	Redetermination form. Income and asset documentation, if they have changed.
Nebraska	Full application each year, but can use a previously completed application. Income verification every 6 months. Resource verification depending on resource level. $3,925-$4,000 reviewed monthly; $3,850 to $3,924.99 reviewed quarterly; $3,500 to $3,849.99 reviewed semi-annually; $0 to $3.499.99 reviewed annually.
Nevada	Redetermination form. No documentation. Office interviews and home visits are optional (at the discretion of the Unit Supervisor or Social Welfare Office Manager).
New Hampshire	Full application. Income and asset documentation. Most MSP-only recipients are eligible for mail-in redetermination. Those enrolled by HICEAS counselor can recertify via that route.
New Jersey	Full application for QMB; for SLMB, QI, redetermination form. Income and asset documentation for all.

State	MSP
Colorado	Redetermination form. Income and asset documentation.
Connecticut	Full application. No documentation.
Delaware	Redetermination form. Income documentation.
District of Columbia	Redetermination form. Income and asset documentation.
Florida	Full application. No documentation.
Georgia	No documentation.
Hawaii	Redetermination form. No documentation.
Idaho	Full application. Income and asset documentation.
Illinois	Redetermination form. No documentation.
Indiana	Redetermination form. Income and asset documentation.
Iowa	Full application. Income and asset documentation.
Kansas	Full application. Income and asset documentation.
Kentucky	Redetermination form. Income and asset documentation.
Louisiana	3 levels of renewals 1) Ex Parte: passive renewal where state agency verifies through 3rd party sources 2) Regular: mail in simplified form 3) Telephone: documentation may be required.
Maine	Full application. Income and asset documentation.
Maryland	Full application. Income and asset documentation.
Massachusetts	Depends upon results of agency's review - recipients must respond to written requests within 30 days.

State	MSP
New Mexico	Full application. Income and asset documentation.
New York	Redetermination form. Income documentation. Asset documentation if seeking coverage for long-term care services.
North Carolina	Redetermination form. Income and asset documentation.
North Dakota	Redetermination form. Income and asset documentation.
Ohio	Full application. Income and asset documentation.
Oklahoma	Full application. Income and asset documentation.
Oregon	-
Pennsylvania	Redetermination form. Income and asset documentation.
Rhode Island	Full application. No documentation.
South Carolina	Full application. Income and asset documentation.
South Dakota	Full application. Income and asset documentation.
Tennessee	Full application. Income and asset documentation.
Texas	Redetermination form. No documentation.
Utah	Full application. Income and asset documentation.
Vermont	Full application. No documentation.
Virginia	Income and asset documentation.
Washington	Redetermination form by mail or online. Income documentation.

State	MSP
Michigan	Full application. Income and asset documentation.
Minnesota	Redetermination form. Income documentation.
Mississippi	Redetermination form. Income documentation.
Missouri	Redetermination form. Income and asset documentation.

State	MSP
West Virginia	Full Application. Income and asset documentation.
Wisconsin	Asset documentation.
Wyoming	Redetermination form. Income and asset documentation if they have changed.

Note: - Unknown. Information in gray has not been verified by the state's Medicaid program. MSP data are for 2005.

REFERENCES

[1] The first Medicare Savings Program, formerly known as the Medicaid Buy-In program, was enacted as a state Medicaid option in 1986, and was converted to a mandate in 1988. States had to pay Medicare premiums and other Medicare cost-sharing for Medicare beneficiaries with incomes at or below the federal poverty level (Qualified Medicare Beneficiary). In 1990, the program was expanded to pay Part B premiums for beneficiaries with incomes up to 120% of federal poverty levels (Specified Low-Income Medicare Beneficiary). (The expansion was phased in, reaching the full 120% in 1995.) In 1997, Congress once again expanded the program, requiring payment of Part B premiums for individuals with incomes up to 135% of federal poverty limits (Qualified Individual). For the QI group, only federal money was used and it was given to states in a block grant; once the money ran out, the state had no further obligation to provide benefits to people between 120% and 135% of federal poverty limits. The QI program has been reauthorized on an annual or less than annual basis for the past several years. These programs are collectively now known as Medicare Savings Programs; CMS began using that name in about 2001.

[2] See *supra* note 1.

[3] The most common sources relied on to complete the templates were on-line: the state Medicaid program's own website, states' fact sheets for beneficiaries, state statutes and regulations, eligibility manuals, CMS' state Medicaid plans and, to provide a general framework for proceeding, a 2001 survey completed by the National Association of State Medicaid Directors. State eligibility offices also provided data.

[4] The Congressional Budget Office estimates the average annual cost-sharing for Medicare will be $3,000 in 2006. Congressional Budget Office, "A Detailed Description of CBO's Cost Estimate for Medicare Prescription Drug Benefit." (July 2004) http://www.cbo.gov/showdoc.cfm?index=5668&sequence=0 (site visited May 16, 2006) ["CBO report"]

[5] 42 U.S.C. §. 1396d(p) (1)(B) refers to 42 U.S.C. §. 1382a (SSI income rules); 1396d(p)(1)(C) refers to 1382b (SSI resource rules).

[6] 42 U.S.C. §. 1396a(r)(2). This section of law is more commonly referred to by its section of the Social Security Act: Section 1902(r)(2). It authorizes states to use more liberal methodologies in determining eligibility for their non-cash-related Medicaid eligibility categories than are used in the related cash assistance program. For older people and people with disabilities, that program is SSI.

[7] A fourth Medicare Savings Program, the Qualified Disabled and Working Individual program, pays Part A premiums for individuals not otherwise eligible for Medicaid who have lost their entitlement to premium free Part A and who have incomes up to 200% fpl. That program is not the subject of this report.

[8] Laura Summer and Emily S. Ihara, "Simplifying Medicaid Enrollment for the Elderly and Individuals with Disabilities," AARP, December 2005; Laura Summer and Lee Thompson, "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits," Commonwealth Fund (May 2004); Kim Glaun, *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings,* prepared for the Kaiser Commission for Medicaid and the Uninsured (2003); Patricia B. Nemore, *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries: A 1999 Update*, prepared for the Henry J. Kaiser Family Foundation (Dec. 1999); General Accounting Office, *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment,* GAO/HEHS-99-61 (Apr. 1999); AARP Pub. Policy Inst. *Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs* (Washington, D.C., AARP Jan. 1999); Families USA, *Shortchanged: Billions Withheld from Medicare Beneficiaries* (Washington, D.C., Families USA 1998); Patricia B. Nemore, *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries* (Washington, D.C., The Henry J. Kaiser Family Found. Nov. 1997); Peter J. Neumann, Mimi D. Bernardin, Ellen J. Bayer, & William N. Evans, *Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program,* Final Report submitted to HCFA (1994); General Accounting Office, *Medicare and Medicaid--Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program,* GAO/HEHS-94-52 (Jan. 1994); Families USA, *The Medicare Buy-In: A Promise Unfulfilled* (Washington, D.C., Families USA Mar. 1993); Families USA, *The Medicare Buy-In: Still a Government Secret* (Washington, D.C., Families USA Mar. 1992); Families USA, *The Secret Benefit--The Failure to Provide the Medicare Buy-In to Poor Seniors* (Washington, D.C., Families USA 1991).

[9] CBO report*, supra* note 4.

[10] For example, in 1998, both the White House and the Health Care Financing Administration (now Centers for Medicare and Medicaid Services) focused attention on the programs with new information distribution activities, the creation of a federal-state-consumer advocate task force and the identification of increased program enrollments as a Government Performance Results Act (GPRA) goal. Activity under the GPRA goal, coupled with state initiatives some of which were supported by foundation grants, resulted in states taking various actions to reduce barriers to enrollment.

[11] See Lisa Maria B. Alecxih, Mary Farrell, Sam Ankrah and BrieAnne Olearczyk, "Results from the SSA Buy-in Demonstration – Final Report" prepared for the Social Security Administration by The Lewin Group, October 4, 2001. http://www.lewin.com/NR/rdonlyres/ewcu7477dpcqthrnysochdaaiuqg36ulmw55snnef55b7c2jepekcaa6vec3y6kohh6ogznlr7y5ghxhrxjp3o7gxna/1488.pdf (site visited June 7, 2005).

[12] United States General Accounting Office, "Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries," GAO-04-363 (March 2004), available at http://searching.gao.gov/query.html?col=+&qt=+04-363&charset=iso-8859-1&ql=&x=7&y=11 (site visited June 7, 2005). In 2000, Congress had directed SSA to continue its outreach to potential MSP beneficiaries by requiring an annual mailing to potential beneficiaries coupled with a sharing of beneficiary-specific identifying information ("leads data") with states to enable them to conduct follow-up outreach to the same beneficiaries.[12] (Six states did not receive the leads data because they failed to provide information necessary for SSA's security protocol. State participation was, however, significantly higher than in an earlier effort to provide such leads to states, when fewer than half the states requested that data.) The GAO evaluation of the 2002 SSA mailing reported that thirty-five states had a statistically significant additional (above expected) increase in enrollment following the mailing. However, of the six states the GAO reviewed in depth, only two had used the leads data to enhance the effect of the mailings.

[13] 1999 data are taken from Patricia B. Nemore, "Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries: A 1999 Update." Kaiser Family Foundation (December 1999).

[14] 42 U.S.C. § 1396u-5(a)(3)

[15] 42 U.S.C. § 1395w-114

[16] Beneficiaries who are not entitled to a low-income subsidy experience a gap in coverage – colloquially referred to as "the doughnut hole" – after personal and Medicare spending on drugs reaches $2250, until the individual has spent $3600 out-of-pocket. At that point, catastrophic coverage is available wherein the beneficiary pays $2 for generic and preferred drugs, $5 for non-preferred drugs or 5% co-insurance, whichever is higher.

[17] CMS' "Guidance to States on the Low-Income Subsidy" May 25, 2005 at http://www.cms.hhs.gov/States/ then click on Low-Income Subsidy, click on "Guidance to States on the Limited-Income Subsidy" (Site visited May 16, 2006.) [Guidance to States], 20 Coordinating LIS and MSP Applications.

[18] "Personal representative" is defined in regulations, at 42 C.F.R. 423.772, as 1) someone authorized to act for the applicant; 2) someone acting responsibly for the applicant if she is incapacitated or incompetent, or) someone the applicant chooses to act for her.

[19] Although applications for public benefits commonly include a certification under penalty of perjury of the truth of the information contained therein, the SSA application includes a more detailed description of the "penalty of perjury" in the following sentence: "I/We understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both." These authors and other advocates have expressed concern that this sentence could be off-putting to would-be applicants.

[20] 20 C.F.R. 418.3125

[21] 20 C.F.R. 418.3120, 3125

[22] 42 U.S.C. §. 1395w-114(a)(3)(B)(i) , 42 C.F.R. 423.774

[23] These states are CT, FL, HI, MS, MO, OR, PA, RI.

[24] These states are CA, CT, FL, HI, MS, RI.

[25] These states are CT, FL, HI, RI.

[26] Guidance to States, *supra* note 17, 10.3.3 The State Application

[27] 42 U.S.C. § 1396u-5(b)

[28] 42 U.S.C. § 1396u-5(a)(3); 42 C.F.R. 423.904(c); Guidance to States, supra note 29, Appendix 1,42 C.F.R. 435.404, State Medicaid Manual sec. 3490.3

[29] Kim Glaun, "Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings," Kaiser Family Foundation (December 2002).

[30] Thomas Rice, PhD and Katherine A. Desmond, M.S. "Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test," prepared for the Henry J. Kaiser Family Foundation, April 2005; Laura Summer and Lee Thompson, "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits," The Commonwealth Fund, May 2004

[31] 42 U.S.C.A. § 1395b-3 (West Supp. 2005)

[32] Laura L. Summer and Emily S. Ihara, "Simplifying Medicaid Enrollment for the Elderly and Individuals with Disabilities," AARP, December 2005.

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