National Center for Benefits Outreach and Enrollment

Helping Seniors and Adults with Disabilities Access Benefits

Retaining Benefits:

An Important Aspect of Increasing Enrollment

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Efforts to increase participation in public benefit programs often focus on helping people obtain benefits for the first time. However, making sure that eligible individuals *retain* their benefits once they are enrolled in a program is also critical to achieving high program participation rates.

Background

Most public benefit programs—like the Medicare Part D Extra Help/Low-Income Subsidy (LIS), Medicare Savings Programs (MSP), or Medicaid—require that a person's eligibility be redetermined at least annually. A substantial number of eligible beneficiaries lose their benefits at renewal, however. This disruptive cycle of losing and regaining benefits within a short period of time is sometimes called "churning." An emphasis on improving retention rates is particularly relevant in programs for low-income seniors because their financial circumstances are not likely to improve over time. Therefore, they continue not only to need, but also to qualify for benefits.[1]

The most important reason to keep eligible seniors and adults with disabilities enrolled in programs is to be sure that benefits for vulnerable individuals continue uninterrupted. But there are also significant administrative advantages to continuous participation. Keeping eligible people enrolled is more efficient and less costly than having to undertake the activities associated with disenrollment and then with reprocessing a new application for the same person who may well re-apply.

What are the reasons for low renewal rates?

Lack of awareness about the need to renew coverage and confusion about the renewal process are frequently cited as reasons that renewal does not occur. Such problems are particularly likely to occur among individuals with limited English proficiency.[2] Complex renewal processes are also cited as a barrier to retention, as are confusing forms, extensive verification requirements, insufficient translated materials, and limited guidance from the administering agency.

Key factors in helping people to retain benefits

Simplicity

The simpler the recertification process is, the more effective programs are likely to be in retaining eligible participants.[3] Below we discuss four strategies to achieve a simpler retention process: the use of administrative reviews, the establishment of longer, more stable enrollment periods, a mandate to screen and enroll individuals for similar programs if they no longer qualify for benefits they have been receiving, and the elimination of resource tests.

Conduct administrative renewals

Administrative renewals generally are initiated and managed by the agencies that administer various benefit programs rather than by benefi-

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[1] *T. Rice, and K. Desmond. "Who Will Be Denied Medicare Prescription Drug Subsidies Because of the Asset Test?"* The American Journal of Managed Care, *Jan. 2006 12(1): 46–54; L. Summer, and L. Thompson.* How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits *(New York: The Commonwealth Fund, May 2004).*

[2] *M. Youdelman, J. Perkins, J. Brooks, and D. Reid.* Providing Language Services in State and Local Health-Related Benefits Offices: Examples from the Field *(New York: The Commonwealth Fund, January 2007); Medicare Rights Center,* Maximizing MSP Enrollment with Part D: Lessons from Three States *(New Brunswick, NJ: Rutgers Center for State Health Policy, May 2006).*

[3] *D. Remler and S. Glied. "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs,"* American Journal of Public Health, *Jan. 2003 93(1): 67–74.*

ciaries. The agencies use information on hand to minimize requests for information from enrollees. Programs verify that current participants remain eligible using electronic systems to check wage reporting, Social Security Administration or other databases. If information cannot be verified internally, program participants are asked to supply it. Often this can be accomplished with a telephone call. Programs may request specific information or in some instances, programs simply ask participants to verify that their circumstances have not changed. Enrollees may be told that their benefits will continue unless they report a change or they may be asked to confirm that their circumstances have not changed. The terms "automatic," "passive" or "express lane" are also used to describe these sorts of renewal activities. "Off-cycle" renewals use information supplied by applicants for one program as the basis to extend the eligibility period for another program even if information from the first program becomes available before the renewal date for the second program. For example, if a couple provides information about their financial circumstances to the Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp program) to ensure that their benefits continue, that information could be shared (with their permission) and used by Medicaid to extend their MSP benefits even if their MSP renewal date has not yet occurred.

Louisiana has used an administrative renewal process for MSP enrollees since July 2007. The new system was developed using CMS guidance for ex-parte renewals and suggestions for removing barriers for enrolling and retaining children.[4] An examination of MSP data shows a five percent decrease in MSP enrollment in the year prior to the change and an eight percent *increase* in the 12 months following the change. The administrative renewal is completed without any involvement from a caseworker unless an enrollee reports a change in his/her circumstances. MSP enrollees receive a system-generated letter indicating that program records show they qualify for one of the MSPs and advising them that no action is necessary unless their circumstances have changed. Otherwise, they are asked to call a toll free hotline or their local eligibility office. If no changes or corrections are reported, the renewal date is automatically extended for 12 months. Eligibility workers can exclude individual cases from this process if there are reasons to expect that circumstances may change. The administrative renewal process was implemented after a review of historical program data showed that MSP cases were almost never found to be ineligible at renewal because of an increase in income or resources. Thus the state concluded that the risk of providing benefits to enrollees who are no longer eligible was quite low and the potential for administrative savings was substantial given that there would be reductions in spending for printing and postage associated with a paper renewal system and a decrease in the amount of time Medicaid analysts would have to spend on each case. In the new system, more renewals were processed each month by fewer eligibility workers. State officials note that two factors contributing to the success of the effort are early investments to establish electronic eligibility systems and extensive training for eligibility workers.

The Social Security Administration also uses an administrative renewal process for a portion of the people who receive the Part D Low-Income Subsidy (LIS); they do not have to complete a redetermination form and so they retain their eligibility with minimal participation in a redetermination process. Each year the agency also selects a group of beneficiaries who receive redetermination forms in the mail and must complete them, even if

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[4] *Centers for Medicare & Medicaid Services.* Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage *(Washington, DC, 2001).*

no changes have occurred, in order to retain benefits. In an effort to ease the process, the agency provides an Income and Resources Summary with each redetermination, which reflects information previously supplied by applicants, and allows them to check a box if their circumstances have not changed.

Other methods that are less comprehensive but still helpful can be used to simplify the renewal process. Some states have developed renewal forms that are much simpler than the original application. In 2005, some 19 states and the District of Columbia reported that they used shorter MSP renewal forms rather than using the full application at renewal.[5] Some states prepopulate renewal forms with information they have on hand; enrollees can then sign and return forms to verify that their financial circumstances have not changed. In other cases, enrollees can make self-declarations about their financial circumstances.

Establish longer, more stable enrollment periods

Limiting the occasions when renewal is required is another effective way to limit the loss of benefits for program participants. Under federal rules, states must conduct renewals for Medicaid at least once every 12 months. They may require more frequent renewals, but almost all states conduct annual reviews for older Medicaid beneficiaries. Older participants in SNAP can be certified for up to 24 months provided that they fulfill the requirement for contact with the program every 12 months.

Continuous eligibility is another program feature to consider. Under this policy, which is used by 30 states in the Children's Health Insurance Program (CHIP) or the Medicaid program for children, individuals are eligible to receive benefits for the full certification period even if their circumstances change during the course of that year. This approach is used for LIS as well. Those who qualify for the LIS at the start of the calendar year remain eligible for the benefit throughout the year. For SNAP, states now have the option to use "simplified reporting" for households containing older adults. Under this option the household is only required to report changes in circumstances annually. (Households have to report within the 12 months if their income increases above 130 percent of the federal poverty level). Some State Pharmacy Assistance Programs (SPAPs) have established two-year enrollment periods.

Given that the financial circumstances of older adults with low incomes seldom improve from year to year, it is reasonable to consider conducting less frequent renewals for programs and to provide continuous eligibility for longer periods. In Medicare, beneficiaries enroll just once for Part A and B benefits; it might also be reasonable to consider making benefits such as the LIS permanent for some Medicare beneficiaries.

Screen and enroll individuals whose eligibility status changes

Certain people are deemed eligible to participate in one program based on their participation in another. For example, some individuals automatically receive the LIS because they are enrolled in SSI, Medicaid, or MSP. Thus, if they are no longer eligible for one program they may lose their eligibility for the other. If individuals lose their eligibility for the Medicare Savings Programs, there is no requirement for state Medicaid programs to then screen and help them retain their LIS benefits (which currently have somewhat higher income

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[5] *P. Nemore, J. Bender, and W. Kwok.* Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules *(Washington, DC: The Kaiser Family Foundation, May 2006). The states were: AK, AZ, DE, DC, HI, IL, IN, KY, ME, MN, MS, MO, MT, NV, NY, NC, ND, TX, WA, and WY*

and asset limits than the MSP limits) but states do have the capacity to do so. With the routine use of such "screen and enroll" procedures fewer LIS beneficiaries would have interruptions in their benefits.

Eliminate resource tests

Eliminating the asset or resource test used to make eligibility determinations in programs for older adults and younger people with disabilities would make both the application and renewal process simpler and less time consuming for beneficiaries, those who assist them, and those who determine eligibility for programs. States can also have lower administrative costs if just income, rather than income and resources must be verified and evaluated. A 2006 study in Minnesota estimated that on an annual basis, the state saved more than $800,000 after the implementation of a rule that only requires verification of resources if the declared value is within $300 of the resource limit. The state also increased the MSP resource limit to $10,000 for individuals and $18,000 for couples.[6] There are other administrative advantages. Income data are more readily available than resource data from national surveys, tax records, and program records. Therefore, when income is the sole financial criterion for program participation, it is easier to make accurate estimates of the eligible population, to identify potential program participants, to verify information, and to complete the application and renewal processes. These advantages have been evident as most state Medicaid and CHIP programs have made financial eligibility determinations and re-determinations for children based on income alone.

State Medicaid programs have the option to use eligibility criteria, including methods to count income or resources, which are less restrictive than the federal rules. Several states have already used this flexibility to essentially eliminate the resource test for the MSPs. Eight states have eliminated the resource test for some or all of the MSP programs and others do not include certain sources of income or resources when they make MSP eligibility determinations.[7] States that continue to use the resource test in making eligibility determinations might consider eliminating it at renewal in order to boost renewal rates and promote administrative efficiency. Data from national surveys show that older people with limited incomes tend not to have fluctuations in their financial circumstances and that the value of resources is closely tied to income for this group. Older people with low incomes tend to have few resources and those who qualify for programs based on income, but fail resource tests tend to have modest resources.[8]

Provide assistance with renewal

The second important factor in promoting retention is the availability of assistance. Regardless of how user-friendly renewal systems are, some beneficiaries may still need help. In instances when enrollees must respond to renewal notices, there is value to thinking about what those notices look like and how they are received. Traditionally they have been sent by mail, but as the use of email and cell phones increases, there may be advantages to sending reminders using multiple methods. Asking beneficiaries when they enroll whether they would like a reminder about renewal provides an opportunity to alert them to the fact that they will have

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[6] *L. Summer.* Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Minnesota *(New Brunswick, NJ: Rutgers Center for State Health Policy, February 2006).*

[7] *Medicare Payment Advisory Commission.* Report to the Congress: Medicare Payment Policy *(Washington, DC; MedPAC, March 2008).*

[8] *T. Rice, and K. Desmond. 2006; L. Summer, and L. Thompson. 2004.*

to take action to retain their benefits. It also allows them to express a preference about how to receive the reminder. As part of that process, it may be helpful to give them an opportunity to designate another person, such as an adult child, a spouse, or a contact at a community organization, who could receive a reminder as well. Electronic systems that have the capacity to track enrollment status and renewal dates can generate and send reminders directly to enrollees or to a designated person or organization. Some community-based organizations have developed internal systems to flag renewal dates for clients. They generate their own renewal reminders and offer assistance in completing the renewal process.

A natural experiment from Virginia, where the state administers separate Medicaid and CHIP programs that provide health insurance for children demonstrates the difference that program procedures can make. One program sent a standard one-page form four weeks before the renewal date for beneficiaries to complete. By contrast, the other program incorporated many elements to facilitate renewal. The program sent a postcard to announce that the renewal date was approaching in 12 weeks. Ten weeks before the renewal date, program participants received a renewal packet with a letter, a renewal form that had some individual information pre-printed, an instruction sheet, and an envelope with return postage. All of the forms and notices were available in Spanish as well as English. Both the renewal postcard and the renewal packet were marked "Return Service Requested" so that eligibility workers could follow up on address changes before the end of the eligibility period if necessary. In addition, if they did not receive a response to the renewal notice and packet, eligibility workers made up to two reminder calls. A survey of program participants showed that families participating in the program that provided more assistance were much more familiar with renewal requirements and procedures.[9]

Conclusion

Any effort to boost enrollment in benefit programs must consider not only the application but also the renewal process. Simplicity is one of the key factors associated with high benefit retention. Steps that have been taken to simplify renewal include eliminating resource tests, conducting administrative reviews to verify continued eligibility, and providing immediate screening when beneficiaries lose eligibility for one benefit if other similar benefits are available. More widespread use of these approaches could increase program enrollment and decrease administrative program costs. Another key factor is to ensure that assistance with benefit renewal is available for those who need it.

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[9] *L. Summer and C. Mann.* Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences and Remedies *(Washington, DC: The Commonwealth Fund, June 2006).*

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The National Center for Benefits Outreach and Enrollment

The National Center for Benefits Outreach and Enrollment ***(www.CenterforBenefits.org)*** helps organizations enroll seniors and younger adults with disabilities with limited means into the benefits programs for which they are eligible so that they can remain healthy and improve the quality of their lives.

The Center accomplishes its mission by:

- providing **tools, resources and technology** (such as ***www.BenefitsCheckUp.org***) that help local, state and regional organizations to find, counsel and assist seniors and younger adults with disabilities to apply for and enroll in the benefits for which they may be eligible;
- generating and disseminating new knowledge about **best practices and cost effective strategies** for benefits outreach and enrollment; and
- **funding and establishing** Benefits Enrollment Centers in 10 areas of the country. Using web-based tools and person-centered approaches, these Centers help seniors in need and people with disabilities find and enroll in all the benefit programs for which they are eligible.

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