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Medicare Savings Programs: Analyzing Options for Expanding Eligibility

The Medicare Savings Programs (MSPs) are designed to provide financial assistance to Medicare beneficiaries who do not qualify for full Medicaid coverage. This paper considers changes in eligibility that would better align MSP program rules with those related to receiving low-income subsidies for the Medicare Part D drug benefit. These changes would make more people eligible for the MSPs and could encourage greater participation; similar changes were incorporated in recently passed legislation. Our analysis, based on 2006 data from the Health and Retirement Study, shows there is a trade-off between making larger numbers of beneficiaries eligible by eliminating resource requirements and better targeting of individuals with greater health care needs by expanding income standards.

Medicare Savings Programs (MSPs) are designed to provide financial assistance to Medicare beneficiaries whose income and assets may be too high to allow them to qualify for full Medicaid coverage. Depending on the beneficiary's income and assets, these joint federal-state programs may pay for Part A (hospital insurance) and Part B (medical insurance) premiums as well as cover cost-sharing. In terms of assistance, they range from the Qualified Medicare Beneficiary (QMB) program, which pays premiums and cost-sharing expenses, to the Specified Low-Income Medicare Beneficiary (SLMB) program, which pays only Part B premiums, to the Qualified Individual (QI) program, which also pays premiums, but is funded as a block grant and can limit the number of participants.

Despite the meaningful financial assistance offered by these programs, many eligible beneficiaries do not enroll. Some estimates suggest that the aggregate MSP enrollment may be as high as 64% of those eligible (Haber et al. 2003), but other estimates indicate that less than one-third of eligible people sign up for the QMB program and only 13% enroll in the SLMB program (GAO 2005). By comparison, about two-thirds of people eligible for Medicaid enroll in that program.

When Medicare introduced a prescription drug benefit (Part D), it was done as an add-on as opposed to being incorporated into either Medicare Parts A or B. In addition to establishing another set of premiums, deductibles, and copayment rules, the decision to keep the drug benefit separate in Part D also resulted in creation of a new set of low-income subsidies. Rather than build on the existing Medicare Savings Programs, policymakers chose to establish new subsidies with different income and resource standards.

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Beneficiaries with incomes just above the MSP levels but below 150% of the federal poverty level (FPL) can pay reduced premiums for Medicare Part D along a sliding scale and face lower deductibles and cost-sharing.[1] Although implementation of the new Part D subsidies deemed that people enrolled in the MSPs were eligible for the full Part D low-income subsidy (LIS), the opportunity to align the eligibility rules for these two sets of programs (and coordinate enrollment) was missed.

As a result, Medicare beneficiaries face different income-eligibility criteria because of discrepancies in how the MSPs and Part D LIS compute income and federal poverty levels, and beneficiaries must satisfy different resource standards in the two programs. Resource requirements for the Part D subsidies are more generous than those used in the MSPs.[2] For example, because the QMB program's resource requirements are generally more stringent than those in the full Part D LIS benefit, it has been possible for beneficiaries with incomes below the FPL (the cutoff for QMB eligibility) to be ineligible for QMB because of their resources but eligible for the full LIS benefit.[3] Policymakers recognized these anomalies and chose to coordinate the Medicare Savings Programs with the LIS offered through Medicare Part D in the "Medicare Improvements for Patients and Providers Act of 2008" (HR 6331). The legislation uses the LIS asset standards for both programs as a way to expand eligibility for the MSPs and to potentially increase participation in the MSPs by reducing their administrative burden and costs.

In this paper, we analyze policies similar to these legislative changes and other ways of making the MSPs work better by simplifying the eligibility requirements and aligning them with the low-income drug subsidy. We also examine policy options that extend eligibility for the MSPs and the low-income drug subsidy by relaxing the resource standards or by expanding eligibility to incomes as high as 200% of the FPL. This higher income level would make many more beneficiaries eligible for the MSPs and Part D subsidies and would be more consistent with eligibility cutoffs for programs such as the State Children's Health Insurance Program (SCHIP) and state health coverage expansions for the nonelderly population. The broad goal of these types of policy changes would be to make more people who need assistance eligible for the MSPs and to potentially improve program participation.[4] We construct a comprehensive eligibility model to simulate baseline eligibility and examine the effect of eliminating the asset tests and increasing the income threshold.

To simulate eligibility for the MSPs, we use 2006 data on Medicare beneficiaries that are available from the Health and Retirement Study (HRS). A 2005 report for the National Academy for Social Insurance (NASI) used data from the 2001 panel of the Survey of Income and Program Participation (SIPP) in a similar exercise (Merlis 2005). Compared to the 9,700 Medicare beneficiaries in the SIPP, the most recent wave of HRS includes more than 11,500 beneficiaries. Like the SIPP, the HRS has high-quality data on income and assets and makes state identifiers available to researchers under a restricted data agreement. The NASI study, for example, considered what might occur if Part D low-income subsidy standards were aligned with a restructured MSP. Results showed that such a policy change would increase the share of beneficiaries in the MSPs, but did not identify the characteristics of the newly eligible individuals. We build on the NASI study by developing a broader range of eligibility changes and show how the new eligibles would compare to the current groups along demographic, health, and economic lines, including race/ethnicity, disability status, urban residence, and marital status.

Current Policies

There are currently three mechanisms through which Medicare beneficiaries can qualify for assistance with the premiums and cost-sharing associated with the traditional Medicare program. These include qualifying for full Medicaid coverage as a dual-eligible, for partial Medicaid coverage through one of the MSPs, or for the full or partial Part D LIS. Eligibility rules for these programs are shown in Table 1. Federal law and regulations require states to cover certain

Table 1. Current program eligibility rules and associated benefits

Program/Pathway	Income standards	Resource standards	Notes
Full Medicaid			
SSI	74% of FPL for singles 82% of FPL for couples	$2,000 for singles $3,000 for couples	209(b) states may have more restrictive standards; participants receive full Medicaid benefits and are deemed eligible for full Part D LIS.
SSP	State established	$2,000 for singles $3,000 for couples	
Medically needy	State established	State established	
Poverty-related coverage	State established	State established	
Long-term care related coverage	State established	State established	
Medicare Savings Programs			
QMB	100% of FPL	$4,000 for singles $6,000 for couples	Medicaid pays Part B premium (Part A premium if applicable) and cost-sharing; participants are deemed eligible for full Part D LIS.
SLMB	120% of FPL	$4,000 for singles $6,000 for couples	Medicaid pays Part B premium; participants are deemed eligible for full LIS.
QI	135% of FPL	$4,000 for singles $6,000 for couples	Medicaid pays Part B premium subject to a state spending cap; participants are deemed eligible for full Part D LIS.
QDWI	200% of FPL	$4,000 for singles $6,000 for couples	Medicaid pays Part A premium for returned workers; participants are deemed eligible for full Part D LIS.
Part D low-income subsidies (LIS)			
Full LIS	135% of FPL	$6,000 for singles $9,000 for couples	Participants pay zero premium and deductible with reduced copayment and coinsurance.
Partial LIS	150% of FPL	$10,000 for singles $20,000 for couples	Participants pay reduced premium and cost-sharing.

Source: Merlis (2005) and Bruen, Wiener, and Thomas (2003).
Notes: SSI = Supplemental Security Income; SSP = State Supplemental Program; QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-Income Medicare Beneficiary; QI = Qualified Individual; QDWI = Qualified Disabled Working Individual.

low-income aged, blind, and disabled individuals, but under various options states also can provide assistance to individuals for whom coverage is not mandated.

Eligibility for Full Medicaid Benefits

People eligible for Medicaid receive the most generous supplemental Medicare coverage. This can occur because a person receives Supplemental Security Income (SSI) or State Supplemental Program (SSP) cash assistance, is eligible for SSI or SSP but does not receive cash assistance, has high health care expenses and qualifies as "medically needy," or gains access through a state's poverty-related program.

Eligibility for Medicare Savings Programs

There are three eligibility categories in Medicaid for the Medicare Savings Programs.[5] For QMB, Medicaid pays the Medi-

care Part B premium and all deductibles and coinsurance for Medicare services. In addition, Medicaid pays the Part A premium for people who are not automatically enrolled in Medicare Part A, but who are entitled to buy in. For the remaining two programs—SLMB and QI—Medicaid pays only the Part A or Part B premiums and beneficiaries are responsible for other cost-sharing.

Under the Medicare statute, all states must use the eligibility rules of the SSI program and any other Medicaid options with higher income eligibility levels as the starting point for determining MSP eligibility. The income limits for the QMB, SLMB, and QI programs are 100%, 120%, and 135% of the FPL, respectively, and the resource limits for all of the programs are $4,000 for singles and $6,000 for couples.[6] Despite these national rules, the way countable income and countable resources are determined varies substantially across states. In fact, several states have completely eliminated the resource limit for the MSPs.

Eligibility for the Part D Low-Income Subsidy

There are two types of low-income subsidies in Medicare Part D. A full subsidy eliminates Part D premiums and requires minimal cost-sharing. All people already receiving full Medicaid benefits or enrolled in any of the MSPs were deemed automatically eligible for the full drug subsidy by Medicare. The full subsidy income standard for people not receiving any Medicaid or MSP benefits is 135% of the FPL—the same as the income standard for the QI program—but the resource limit for the full subsidy under Part D is higher ($6,000 for singles and $9,000 for couples). The partial LIS offers premiums along a sliding scale, a dramatically lower deductible, and a lower rate of coinsurance than standard Part D. In addition, there is no doughnut hole under the partial subsidy. The income limit for the partial LIS is 150% of the FPL and the resource limits are $10,000 for singles and $20,000 for couples, respectively.

Options for Establishing Alternative Eligibility Criteria

In considering approaches for aligning the eligibility rules for the MSPs and the Part D LIS categories, there are several issues that should be addressed. First, despite the overlap between the full LIS and MSP income eligibility criteria, the MSPs impose a lower resource requirement. Using a single resource requirement—presumably, the partial LIS level—for the MSPs and the full LIS would eliminate this difference and increase compatibility across programs. Second, although the income eligibility criteria for both the MSPs and Part D LIS are related to the federal poverty level, the MSPs use the FPL for one- or two-person families, while Part D uses actual family size to determine the applicable FPL. Third, Part D combines the income and resources of married couples (even if only one member is applying for the subsidy), while most states closely follow the more complicated SSI process of deeming income and resources for the applicant when determining Medicaid and MSP eligibility. Finally, Part D excludes nonliquid resources such as income-producing real estate and vehicles, which are included in the MSP calculations.

Uniform Rules for Measuring Income and Resources

The first option we consider would impose a uniform approach to measuring income and resources for the MSPs and Part D LIS. Medicaid eligibility rules are assumed to be unchanged under this option. Given that the LIS standards were adopted more recently than those for MSPs, we opt to use them where discrepancies exist. This means that we would: 1) base the FPL on the actual family size of applicants; 2) exclude from resources income-producing properties, the cash value of life insurance, and the value of all vehicles; and 3) not allow states to adopt less restrictive rules. We would use the current income standards for QMB eligibility, but use resource limits that reflect the full Part D LIS: $6,000 for singles and $9,000 for couples. The Medicare Improvements for Patients and Providers Act of 2008 applies this same resource standard to the MSPs and also excludes the cash value of life insurance as a resource. We would also combine SLMB and QI with the full LIS eligibility groups into one single category and use the same income and

resource standards as those applied to the full Part D LIS. The argument for this is that the benefits of SLMB and QI eligibility are the same: Part B premiums. This approach mirrors and combines the first two options considered in Merlis (2005), but we do not change Medicaid eligibility rules.

Replacing Resource Limits with an Annuitized Income Stream

Some Medicare beneficiaries may have income that would allow them to qualify for MSP or LIS benefits, but resources that are too high. In some cases, their income could be considerably below the eligibility thresholds. However, it may be that adding to their current income the potential income that could be generated from purchasing an annuity would not put them above the income eligibility cutoff. It is possible to estimate this potential income stream as part of the application process, add this to current income, and determine eligibility based solely on this combined income level. This approach was suggested by Moon, Friedland, and Shirey (2002) and was simulated in Merlis (2005). Our approach does not apply to individuals who would qualify under current income and resource rules, but is used only to expand eligibility to those disqualified on the basis of their resources. We again differ from Merlis (2005) by focusing solely on MSP and LIS eligibility as opposed to altering basic Medicaid rules.

Eliminating Resource Limits Completely

Although annuitizing assets would be one way of making more people eligible for the MSPs and LIS, that approach still requires that people report their available resources. A further simplification that would both expand eligibility and make the application process simpler would be to eliminate consideration of resources completely.[7] Therefore, we simulate eligibility using only the income criteria for the MSPs and LIS, leaving all current Medicaid rules unchanged. Although our focus is on MSP eligibility, studies have shown that resource requirements pose a barrier to enrollment for some eligible beneficiaries and that eliminating them could encourage more beneficiaries to enroll (Hoover, Khatutsky, and Haber 2002; Glaun 2002).

Expanding Eligibility to 200% of the FPL

As mentioned previously, federal programs for the nonelderly often view 200% of the FPL as the upper limit of the low-income group. However, even the most generous Medicare low-income subsidies end at 150% of the FPL. Therefore, we also simulate the impact of expanding eligibility for some type of Medicare subsidy up to 200% of the FPL. To keep the basic structure of the current programs intact, this policy option simply assumes that new eligibles with incomes between 150% and 200% of the FPL would be made eligible for a partial drug LIS. This would be the lowest cost and least disruptive way of giving those Medicare beneficiaries at the higher end of the low-income group some additional financial protection. We consider expansions to 200% of the FPL under each of the three previously described eligibility changes—uniform rules, annuitizing resources, and eliminating the resource test.

Data

Our main data source is the 2006 wave of the Health and Retirement Study. The HRS is a biennial panel that began in 1992. The 2006 HRS includes five cohorts of individuals: the original HRS cohort (individuals born between 1931 and 1941), the Study of Assets and Health Dynamics of the Oldest Old (AHEAD) cohort (individuals born before 1924), the Children of the Depression Age (CODA) cohort (individuals born between 1924 and 1930), the War Baby (WB) cohort (individuals born between 1942 and 1947), and the Early Baby Boom (EBB) cohort (individuals born between 1948 and 1953). The 2006 HRS has a sample size of 18,469 respondents and is a nationally representative sample of the noninstitutionalized population age 53 or older.

The HRS introduced innovative methods to improve household economic data, most notably with the use of unfolding brackets to reduce item nonresponse and measurement error on wealth (Juster and Smith 1997), the integration of the question sequences on income and wealth, and the changes in the

period over which income flows are measured to improve income measurement (Hurd, Juster, and Smith 2003). High-quality income and asset data are essential to the success of the eligibility simulation model for Medicaid, the MSPs, and the Medicare Part D LIS. The HRS collects detailed information on various components of income and assets.

The HRS also provides detailed information on demographics, health status, health insurance coverage, health care utilization, and out-of-pocket spending. This information allows us to compare newly eligible beneficiaries to those currently eligible under baseline policies. Demographics include age, gender, education, race and ethnicity, marital status, and whether a person lives in a metropolitan area. Health measures include self-reported health (excellent, very good, good, fair, and poor), functional status and disease conditions (hypertension, heart disease, diabetes, cancer, lung disease, and stroke). Functional status is measured by limitations in activities of daily living (ADLs) and instrumental activities of daily living (IADLs).[8] The HRS makes state identifiers available to researchers under a restricted data agreement, enabling us to model eligibility rules by state.[9]

The 2006 HRS includes 11,576 Medicare beneficiaries. When we apply the survey weights, this sample represents approximately 35 million elderly beneficiaries and 3.3 million beneficiaries with disabilities over age 53.

Eligibility Simulation Model

Program eligibility is determined by comparing countable income and countable resources to the appropriate standards set for each of the programs, with the applied FPL depending on family size. The rules to determine countable income and resources vary by programs, but they all build on the SSI rules. We present findings for elderly Medicare beneficiaries represented in the HRS separately from nonelderly, disabled beneficiaries. We recognize that the HRS only allows us to examine disabled Medicare beneficiaries over age 53.

Family Size

A family includes the applicant, the spouse if living with the applicant, and any people related by blood, marriage, or adoption who are living with the applicant and spouse and are dependent on the applicant or spouse for at least half their financial support. Beyond a potential applicant and spouse, we include only children under age 18 and children between 18 and 22 who are temporarily away at school and do not have another permanent address, since it is difficult to establish dependency for other adults living in the household. This follows the LIS approach; SSI and the MSPs use only a one- or two-person standard in determining the applied FPL.

MSP Countable Income and Resource Determination

Some states have the same eligibility rules for MSPs as for SSI. These include: Arkansas, Louisiana, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, Texas, West Virginia, Wisconsin, and the District of Columbia. Other states have less restrictive rules on the determination of countable income and/or countable resources. Most of the state rules are subtle and only major state variations from the SSI rules are modeled here (Table 2).[10]

LIS Countable Income and Resource Determination

Part D LIS rules differ from SSI program rules in several ways. First, LIS eligibility takes into account additional family members; second, LIS eligibility combines the income and resources of married couples, even if only one member is applying, while SSI uses a more complicated process of deeming; and third, LIS rules exclude most nonliquid assets such as real estate and vehicles. LIS has almost identical rules in determining countable income as SSI.

Results

Elderly Beneficiaries

Table 3 presents results from the simulations of baseline eligibility rules and the three options that use current income standards. Column 1 shows that 79.3% of elderly Medicare beneficiaries are currently not eligible for Medicaid, the MSPs, or either of the Part D LIS programs. The model we developed

Table 2. Less restrictive income and resource standards for MSP by states

State	Description of state rules
Alabama	All resources are excluded.
Arizona	All resources are excluded.
Connecticut	Assets, business or non-business, essential for self-support are excluded if business produces annual income greater than annual expense.
	All resources are excluded for QI.
Delaware	All resources are excluded.
Maine	Excludes assets up to $8,000 ($12,000 for a household of two).
Maryland	For calculation of rental property income and self-employment income, 50% is deducted from gross earnings as cost to produce the income.
	Most vehicles owned by family members, regardless of value, are excluded.
	Income-producing property is excluded if it produces annual income consistent with fair market value.
Minnesota	Excludes $8,000 in non-excluded assets for an individual and $15,000 for a couple.
Mississippi	$20 general exclusion is raised to a $50 general exclusion.
	All resources are excluded.
Tennessee	All equity value in business/non-business resources used to produce income is excluded for QMB and SLMB.
Washington	An amount equal to that expended on medical expenses is excluded when determining the available income for an individual.

Source: Centers for Medicare and Medicaid Services (http://www.cms.hhs.gov/States/Downloads/MSPEligibilityCriteriaChart.pdf).

indicates that current Medicaid rules make 6.9% of elderly Medicare beneficiaries eligible for Medicaid; by construction, this does not change in any of our alternative eligibility simulations. We find that 2.6% of elderly beneficiaries are currently eligible for QMB benefits, 7.7% for SLMB, QI, or full Part D LIS benefits (hereafter called SLMB benefits), and 3.5% for partial Part D LIS benefits. This simulated baseline eligibility distribution is virtually identical to the distribution reported in the Merlis (2005) study that used data from the SIPP.[11] Aligning MSP and LIS rules related to income and FPL determination, as well as using uniform LIS resource standards in all states, has very little impact on the overall number of elderly beneficiaries eligible for these programs. However, largely as a result of the more generous LIS resource standards and the inclusion of actual family size in determining the appropriate FPL, about 1% more of beneficiaries are eligible for the QMB benefit and slightly fewer are eligible for SLMB benefits.[12] Again, this shift toward QMB eligibility was also evident in Merlis (2005).

The effects of changing the treatment of beneficiary resources can be seen in the last two columns of Table 3. Annuitizing resources has the expected effect of making more people eligible for some type of benefits, with the share ineligible dropping from 79.5% (under uniform rules) to 77.1%.[13] This increase is distributed across those eligible for all three classes of additional Medicare benefits. The effect of eliminating the resource standard completely is considerably larger than simply annuitizing resources. This policy change would provide some eligibility to 31% of elderly beneficiaries (10.5% more than using uniform program rules). The increase occurs among those eligible for QMB benefits (3.6% to 7.1%), SLMB benefits (6.5% to 12%), and partial Part D LIS benefits (3.4% to 5%). Although some have argued that relaxing resource requirements would eliminate a potential barrier to enrollment (Haber et al. 2003; Hoover, Khatutsky, and Haber 2002; Glaun 2002), our analysis shows that these policy changes would also make more people eligible.

Simulation results for an expansion of eligibility up to 200% of the FPL are shown in Table 4. An expansion of the income cutoff from 150% to 200% of the FPL would increase the share of elderly beneficiaries eligible for some type of financial assistance beyond the basic Medicare benefit to 27%, somewhat smaller than the effect of eliminating resource requirements but keeping the current income standards. By design, we

Table 3. Percentage of elderly Medicare beneficiaries eligible under the baseline and under alternative policy options to relax asset standards

		Policy options (current income standards)		
	Baseline (%)	Uniform rules (%)	Annuitize assets (%)	Eliminate asset test (%)
Medicaid	6.9	6.9	6.9	6.9
QMB	2.6	3.6	4.4	7.1
SLMB	2.8			
QI	2.6	6.5[a]	8.0	12.0
Full drug subsidy	2.3			
Partial drug subsidy	3.5	3.4	3.6	5.0
Ineligible	79.3	79.5	77.1	69.0

Source: Urban Institute model of eligibility for Medicare low-income assistance based on the 2006 Health and Retirement Study.

[a] The three baseline eligibility groups covering Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and those eligible for a full Part D low-income drug subsidy (full drug) are simulated to have the same eligibility rules in each of the policy options considered and this entry represents the share in this combined group (referred to in the text as SLMB).

place all of the newly eligible beneficiaries in the partial Part D LIS benefit group. An expansion of the income cutoff from 150% to 200% of the FPL would increase the share of elderly beneficiaries eligible for the partial Part D LIS benefit from 3.4% (under uniform rules) to 9.9%. Further expansion of the benefit resulting from annuitizing resources would increase the share of elderly beneficiaries eligible to 12.9% and complete elimination of the resource standard would move the share eligible to 21.3%. Under this final policy scenario, nearly 50% of all elderly Medicare beneficiaries would be deemed as low-income and eligible for some type of financial assistance beyond the basic Medicare benefit.

Table 5 presents data on characteristics of elderly beneficiaries currently eligible for the QMB, SLMB, and Part D LIS benefits and those who would be made newly eligible under the various policy options considered previously. The results show that current rules target these benefits at beneficiaries who are more likely to be in fair or poor health, to have functional limitations, and to have several of the chronic conditions identified on the HRS than newly eligible beneficiaries under any of the options considered. In addition, currently eligible beneficiaries are more likely to be female, nonwhite, or be living without a spouse. Taken together, these data confirm that the current eligibility rules focus benefits on elderly beneficiaries

Table 4. Percentage of elderly Medicare beneficiaries eligible under the baseline and under alternative policy options to increase income cutoffs and relax asset standards

		Policy options (expand to 200% FPL)		
	Baseline (%)	Uniform rules (%)	Annuitize assets (%)	Eliminate asset test (%)
Medicaid	6.9	6.9	6.9	6.9
QMB	2.6	3.6	4.4	7.1
SLMB	2.8			
QI	2.6	6.5[a]	8.0	12.0
Full drug subsidy	2.3			
Partial drug subsidy	3.5	9.9	12.9	21.3
Ineligible	79.3	73.0	67.8	52.8

Source: Urban Institute model of eligibility for Medicare low-income assistance based on the 2006 Health and Retirement Study.

[a] The three baseline eligibility groups covering Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and those eligible for a full Part D low-income drug subsidy (full drug) are simulated to have the same eligibility rules in each of the policy options considered and this entry represents the share in this combined group (referred to in the text as SLMB).

Table 5. Health status and demographic characteristics under baseline eligibility and alternative policy options

					Expand to 200% FPL	
	Baseline	**Annuitize assets**	**Eliminate asset test**	**Expand to 200% FPL**	Annuitize assets	Eliminate asset test
Self-reported health						
Excellent	4.3%	7.5%**	7.9%***	7.2%**	7.5%***	8.6%***
Very good/good	45.2%	64.9%	62.6%***	56.7%***	58.4%***	61.1%***
Fair/poor	50.5%	27.6%***	29.5%***	36.1%***	34.2%***	30.3%***
Functional status						
1 or more ADLs	16.5%	9.8%***	10.8%***	12.9%**	12.2%***	10.5%***
1 or more IADLs	21.3%	13.1%***	12.7%***	14.1%***	13.3%***	13.0%***
Nondisabled	62.2%	77.1%	76.5%***	73.0%***	74.5%***	76.5%***
Chronic conditions						
Hypertension	71.3%	64.8%*	62.4%***	65.4%***	65.1%***	61.4%***
Diabetes	26.7%	17.0%***	16.8%***	23.7%	21.4%***	18.8%***
Cancer	17.5%	15.6%	18.7%	17.4%	16.1%	19.0%
Lung disease	16.4%	12.1%*	11.4%***	18.1%	15.8%	13.1%***
Heart disease	38.2%	31.7%*	33.2%**	32.0%***	32.4%***	32.9%***
Stroke	13.8%	9.7%*	9.8%***	11.6%	10.6%**	9.9%***
Age	77	77	78***	75***	76***	77
Gender						
Male	32.0%	25.5%**	32.3%	41.7%***	35.5%*	37.9%***
Female	68.0%	74.5%**	67.7%	58.3%***	64.5%*	62.1%***
Race						
White, non-Hispanic	71.0%	89.8%***	93.5%***	78.1%***	83.6%***	90.1%***
Black, non-Hispanic	16.6%	4.8%***	2.9%***	11.7%***	8.3%***	4.7%***
Other, non-Hispanic	2.7%	1.7%	1.1%***	2.3%	1.7%*	1.5%**
Hispanic	9.7%	3.6%***	2.6%***	7.9%	6.4%***	3.7%***
Education						
Less than high school	45.7%	27.2%***	19.7%***	41.9%	33.3%***	24.2%***
High school	47.8%	59.9%***	62.5%***	51.8%*	57.3%***	60.6%***
College	5.3%	9.1%*	13.0%***	4.8%	7.0%*	11.3%***
Above college	1.1%	3.8%**	4.9%***	1.4%	2.3%**	3.9%***
Marital status						
Married	32.1%	24.0%**	33.1%	52.2%***	41.9%***	46.7%***
Separated/divorced	15.3%	19.1%	13.0%	12.6%*	13.6%	10.6%***
Widowed	50.2%	55.4%	51.1%	33.5%***	42.8%***	40.6%***
Never married	2.4%	1.5%	2.8%	1.7%	1.7%	2.0%
Urban	59.3%	62.0%	67.6%***	63.9%*	64.3%**	65.5%***
Sample size	1,537	258	1,007	775	1,262	2,717

Source: Urban Institute model of eligibility for Medicare low-income assistance based on the 2006 Health and Retirement Study.
Note: We tested the differences in health status and demographics between the baseline and each of the eligibility options.
* Indicates significance at 10%; ** indicates significance at 5%; and *** indicates significance at 1%.

with greater needs than any of the eligibility expansions considered here.

However, not all of the various eligibility expansions bring in elderly beneficiaries with similar characteristics. The comparison between expanding eligibility to 200% of the FPL without any change in the treatment of resources and the complete elimination of resource standards (at current income thresholds) is particularly illuminating. An expansion resulting from higher-income thresholds would bring in elderly beneficiaries who are more likely to be in fair or poor health ($p<.01$), to have diabetes or lung disease ($p<.01$), or to be in a racial or ethnic minority ($p<.01$) than an expansion achieved by

Table 6. Percentage of disabled Medicare beneficiaries eligible under the baseline and under alternative policy options to relax asset standards

		Policy options (current income standards)		
	Baseline (%)	Uniform rules (%)	Annuitize assets (%)	Eliminate asset test (%)
Medicaid	18.6	18.6	18.6	18.6
QMB	8.0	13.4	15.1	16.9
SLMB	7.0			
QI	1.9	11.6[a]	13.3	15.4
Full drug subsidy	6.4			
Partial drug subsidy	5.4	5.0	4.6	5.1
Ineligible	52.6	51.4	48.4	43.9

Source: Urban Institute model of eligibility for Medicare low-income assistance based on the 2006 Health and Retirement Study.

[a] The three baseline eligibility groups covering Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and those eligible for a full Part D low-income drug subsidy (full drug) are simulated to have the same eligibility rules in each of the policy options considered and this entry represents the share in this combined group (referred to in the text as SLMB).

removing resource requirements.[14] In fact, these data show that, for a given set of income thresholds, relaxing the resource standards makes people eligible who are less likely to be in fair or poor health ($p<.01$), less likely to have diabetes or lung disease ($p<.01$), and less likely to be in a racial or ethnic minority ($p<.01$) than those who would have qualified only at lower resource standards. As such, there appears to be a trade-off between making more people eligible by eliminating resource requirements and better targeting individuals with greater health care needs by expanding income standards.

Disabled Beneficiaries

We also conducted the same set of simulations for disabled Medicare beneficiaries represented in the HRS. It is important to remember that the HRS is not representative of all disabled Medicare beneficiaries—it includes only those over age 53. In addition, the sample size for this subgroup of the HRS is much smaller than for the elderly. Table 6 shows that a far higher share of disabled beneficiaries is eligible for Medicaid, an MSP, or a Part D LIS than is observed among the elderly. At the current baseline, only 52.6% of disabled beneficiaries are not eligible for one of the programs, in contrast to 79.3% for the elderly.[15] As a result, in virtually every program group we examine, the disabled are more likely to be eligible than the elderly. The simulations of the new eligibility policies have similar qualitative effects among the disabled as among the elderly, however some of the simulated impacts are different. For example, in Table 7 we see that expanding the upper income cutoff from 150% to 200% of the FPL makes about 14% more disabled beneficiaries eligible for the partial Part D benefit; this number was only 6.3% for the elderly. Given the baseline differences and the policy effects, we estimate that almost three out of four disabled beneficiaries would be eligible for some of these benefits if the resource standards were eliminated and the upper income cutoff were raised to 200% of the FPL.

Beneficiary Participation

Although not the primary focus of this paper, the combined elderly and disabled baseline eligibility simulations could be used to draw some inferences about participation rates. Our estimates show that roughly 8% of elderly beneficiaries and 17% of beneficiaries with disabilities, or 3.4 million people, are eligible for one of the current set of MSPs (QMB, SLMB, or QI). Enrollment data suggest that 1.2 million Medicare beneficiaries are enrolled in one of these programs (MedPAC 2008). Therefore, about 35% of those currently eligible for the MSPs appear to be enrolled in the programs.

Conclusions

The simulations we present show that applying the same rules in determining eligibility for the MSPs and the Part D LIS would have

Table 7. Percentage of disabled Medicare beneficiaries eligible under the baseline and under alternative policy options to increase income cutoffs and relax asset standards

		Policy options (expand to 200% FPL)		
	Baseline (%)	Uniform rules (%)	Annuitize assets (%)	Eliminate asset test (%)
Medicaid	18.6	18.6	18.6	18.6
QMB	8.0	13.4	15.1	16.9
SLMB	7.0			
QI	1.9	11.6[a]	13.3	15.4
Full drug subsidy	6.4			
Partial drug subsidy	5.4	17.7	19.0	22.4
Ineligible	52.6	38.6	34.0	26.6

Source:Urban Institute model of eligibility for Medicare low-income assistance based on the 2006 Health and Retirement Study.

[a] The three baseline eligibility groups covering Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and those eligible for a full Part D low-income drug subsidy (full drug) are simulated to have the same eligibility rules in each of the policy options considered and this entry represents the share in this combined group (referred to in the text as SLMB).

very little impact on overall eligibility for these programs, but would increase the share of Medicare beneficiaries eligible for QMB benefits. As modeled, this results from the fact that the LIS benefit allows for a higher level of resources than is allowed to qualify for the MSPs. Simply having resources greater than $4,000 but less than $6,000 (in 2006) would have left a Medicare beneficiary living below poverty ineligible for the Part B premium and cost-sharing benefits associated with QMB status while still getting help with Part D costs. Eliminating these inconsistencies between Part D rules and those covering the MSPs could make it easier for beneficiaries to enroll because a decision about their eligibility could be made once for both programs.

Beyond aligning the MSP and Part D LIS eligibility rules, this paper considered two basic strategies for expanding MSP eligibility—reducing resource requirements and increasing income cutoffs. While both strategies would expand eligibility, the complete elimination of resource requirements for a given set of income thresholds has a greater impact on the number of newly eligible beneficiaries than raising income standards to 200% of the FPL and continuing to impose resource requirements.[16] However, it is possible that an expansion based on the elimination of resource requirements could grant eligibility to individuals with very modest income levels but with substantial levels of resources, and this may dilute the effectiveness of the programs in reaching the beneficiaries who are in most need. Moving eligibility standards up the income distribution is more likely to grant access to people with greater health care needs than would relaxing resource requirements. People with incomes between 150% and 200% of the FPL are healthier than those eligible for the MSPs under current rules. However, people in this income group are in worse health and have more chronic conditions than lower-income people who have too many resources to qualify for MSP benefits.

One issue not yet considered in this paper relates to the potential costs associated with the eligibility expansions that we considered. Expanding the MSPs and the Part D LIS would impose costs on state and federal governments related to subsidies for beneficiary premiums and cost-sharing. Options that add more people to the QMB group and cover premiums and cost-sharing would be more expensive than options that add people to groups where the main subsidies only relate to premiums. For example, completely eliminating resource requirements but holding income standards constant would make about 70% more beneficiaries eligible. However, assuming participation rates and the costs of new participants would be roughly comparable to current ones, we estimate that program costs would more than double.[17] In contrast, increasing income eligibility to 200% of the FPL but retaining the resource requirements would expand the numbers of eligibles by about 50% but increase costs by less than 40%.

The primary reason some have proposed for loosening or eliminating resource requirements is that they are seen as a barrier to participation by some enrollees who would benefit most from the subsidy (Haber et al. 2003; Hoover, Khatutsky, and Haber 2002; Glaun 2002). Most of the evidence on this is drawn from case studies or surveys that explore why eligible beneficiaries do not enroll (Hoover, Khatutsky, and Haber 2002; Glaun 2002). A 2005 report by the Government Accountability Office (GAO) that explored the effects of MSP outreach letters sent to low-income beneficiaries in 2002 may also shed some light on this issue (GAO 2005); that report found that the letters resulted in a nationwide increase in MSP enrollment of 74,000 (.5%) more than would have occurred otherwise. In addition, when the results were disaggregated by state, Alabama, Delaware, and Mississippi were estimated to have the greatest percentage increase in MSP enrollment. Interestingly, all three of these states have eliminated resource requirements for MSP enrollment (see Table 2 in this paper). In fact, five of the eight states with the greatest percentage increases in enrollment (the three mentioned plus Maine and Arizona) had eliminated consideration of resources. This suggests that making beneficiaries aware of the MSPs may have a greater impact on enrollment when states do not take resources into account.

Given that the MSPs have suffered from poor participation since their inception, it may seem odd to focus on expanding eligibility when so many are already eligible but not enrolled. However, adding newly eligible beneficiaries may encourage some of those already eligible to enroll. This is precisely what the Congressional Budget Office (CBO) assumed when it was estimating the costs of the Part D benefit (CBO 2004). As a result of having broader eligibility for the Part D LIS than for the MSPs, CBO assumed that 1.3 million beneficiaries would be added to Medicaid as full beneficiaries or through one of the MSPs by 2013. This assumption is consistent with research related to the SCHIP coverage expansions that found an increase in previously eligible children enrolling in Medicaid (Dubay et al. 2007). However, early evidence suggests that the uptick in Medicaid enrollment among low-income Medicare beneficiaries is not as great as had been anticipated (Reinhard 2007).

Our analysis of potential MSP eligibility expansions indicates that there is a trade-off between making larger numbers of beneficiaries eligible by eliminating resource requirements and better targeting individuals with greater health care needs by expanding income standards. If additional resources are going to be allocated to expanding eligibility for the MSPs, this study indicates that policymakers will have to steer a course between these two goals.

Notes

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1 In addition, beneficiaries getting partial subsidies never face the increase in cost-sharing that occurs when spending reaches the "doughnut hole," a coverage gap during which the beneficiary is responsible for 100% of covered drug costs under the standard Part D benefit.

2 In addition, the cutoffs for the Part D LIS resource requirements are indexed to the Consumer Price Index and, as such, will automatically change over time.

3 The newly passed legislation should eliminate this perverse effect of having different resource requirements.

4 However, the analyses presented in this paper do not consider the impact on MSP participation directly.

5 There are also Qualified Disabled and Working Individuals (QDWI) who can have their Medicare Part A and Part B premiums paid by Medicaid if their incomes are below 200% of the FPL. QDWI eligibility is not modeled in this paper due to data limitations.

6 The resource limits for the MSPs are generally twice those allowed for SSI and other state Medicaid options. In this section, we describe the MSP resource standards that existed prior

to the recent legislation that applies the Part D LIS standards to the MSPs.

7 A simpler application process could also increase participation, but that is not the focus of this paper.

8 ADLs are defined as any difficulty dressing, walking, bathing, eating, getting in/out of bed, and using the toilet. IADLs are defined as any difficulty using the phone, taking medicines, making meals, shopping, or managing money.

9 Since the 2006 state identifier is not yet available, we use the 2004 state identifier instead given that only a small fraction of households move between HRS waves. Since HRS asks respondents whether they live in the same residence and whether they live in the same city if not the same residence since last wave, we are able to identify respondents who might have moved since 2004.

10 There were 330 respondents who did not report information on their state of residence and this data element should fit into our baseline eligibility simulation because of the 10 states that have less restrictive eligibility standards for the MSPs. These 10 states account for approximately 15% of Medicare beneficiaries. However, rather than drop these observations from the analysis, we assumed that they were not from one of the 10 less-restrictive states and applied the national rules in simulating their eligibility. To test for the sensitivity of this assumption, we also excluded these observations from the simulations and found that the baseline eligibility distribution was virtually unchanged.

11 Another way to verify the plausibility of the simulation results is to compare simulated eligibility to enrollment in full Medicaid. We explore full Medicaid enrollment because the HRS does not identify enrollment in the MSPs. Among beneficiaries eligible for full Medicaid, we find that 59.2% reported being enrolled in Medicaid. This is consistent with estimates in Ettner (1998) and Pezzin and Kasper (2002). Only 1.5% of the beneficiaries we report as ineligible for full Medicaid or any of the other MSPs report being enrolled in Medicaid in the HRS. This low percentage could be due to errors in income reporting or our inability to consider spending down to eligibility and provides confidence that we are accurately identifying ineligible beneficiaries.

12 We also simulated, in isolation, the effects of the two relevant provisions of the Medicare Improvements for Patients and Providers Act of 2008 (i.e., using the partial LIS subsidy resource requirements and excluding the cash value of life insurance) and again found very little change in overall eligibility and virtually no shift between MSP benefit categories.

13 This change was similar in direction but smaller in magnitude than the shift simulated in Merlis (2005).

14 *P*-values are shown in the text for findings that are featured to avoid confusion that would result from showing multiple sets of pair-wise comparisons in Table 5.

15 Using the SIPP, which covers a broader age spectrum than the HRS, Merlis (2005) found similar results to our baseline (i.e., that only 52% of beneficiaries with disabilities were not eligible for any low-income benefits).

16 Annuitizing resources has a small effect on expanding eligibility than either raising income standards (as considered here) or the complete elimination of a resource requirement.

17 We computed total costs under the baseline and for each eligibility option by deriving costs per eligible person and multiplying by the number of eligible beneficiaries. Annual Part B premium costs per eligible beneficiary for all eligibility categories were $1,062, and Part D premiums were $386 for the QMB and SLMB groups. Part D premiums for those receiving a partial LIS benefit were $193. Using the Medicare Current Beneficiary Survey (MCBS), we computed that Medicaid spending for Part A and Part B cost-sharing for QMBs was $2,840 per eligible for the elderly, and $3,853 for beneficiaries with disabilities. Part D LIS cost-sharing was $709 (elderly) and $1,077 (beneficiaries with disabilities) for those receiving full subsidies. Partial Part D LIS cost-sharing was $557 (elderly) and $858 (beneficiaries with disabilities).

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