Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled

Under the Medicare Savings Programs (MSPs), state Medicaid programs are required to help pay for Medicare premiums and in some cases, Medicare cost sharing for low-income adults over age 65 and adults with disabilities (MACPAC 2013). In 2013, Medicaid paid for approximately 8.8 million beneficiaries to receive assistance with their Medicare costs through the MSPs (MACPAC 2015).

Historically, not everyone eligible for an MSP actually has enrolled. Low enrollment in the MSPs is of concern because cost-sharing assistance can affect access to care. Although payment policies are only one of several factors affecting access, prior work by MACPAC found as the Medicaid contribution towards Medicare cost sharing increases, beneficiaries are more likely to use selected outpatient services.

In this brief, MACPAC presents new data on MSP participation rates, updating prior studies that are now somewhat dated, with the most recent having been published in 2003.[1]

Using the most recently available data (2009 and 2010), our analysis shows that participation in the MSPs continues to be low:

- 53 percent for the Qualified Medicare Beneficiary (QMB) program;
- 32 percent for the Specified Low-Income Medicare Beneficiary (SLMB) program; and
- 15 percent for the Qualifying Individual (QI) program.

Our analysis also seeks to gain insight into low enrollment, filling in gaps in the existing research by comparing characteristics of MSP enrollees with those eligible but not enrolled, and indicating which segments of the eligible but not enrolled population could benefit from increased outreach efforts. For example, adults eligible but not enrolled in the QMB program, compared to QMB enrollees, were:

- more likely to be 65 and older;
- more likely to be white, non-Hispanic;
- more likely to report excellent or very good health; and
- less likely to have limitations in activities of daily living (ADLs).

Moreover, about 45 percent of adults who enrolled in the QMB program were also enrolled in other public programs: Supplemental Nutrition Assistance Program (SNAP) or the Supplemental Security Income (SSI).

The sections that follow provide background on the MSPs and a detailed explanation of our analysis.[2]

Background

Since Medicare and Medicaid were enacted in 1965, it has been possible for some individuals, referred to as dually eligible beneficiaries, to enroll in both programs. Their Medicare Part A coverage generally pays for institutional services such as hospital services, and their Part B coverage generally pays for outpatient services such as physician services. Both Medicare Part A and Part B services are subject to deductibles, coinsurance, and copayments, and Part B also requires a monthly premium.[3]

MSPs cover some of these costs that could otherwise be a substantial burden for low-income Medicare beneficiaries and could possibly limit their access to necessary services (MACPAC 2013).[4] Under the MSPs, state Medicaid programs pay the full amount of the Medicare premium. States receive federal matching funds at the regular Medicaid match rate for those expenditures (except for expenditures for qualifying individuals (QI) for whom states receive 100 percent federal match) (MedPAC and MACPAC 2017). State Medicaid programs have flexibility in how they pay providers for Medicare Part A and Part B cost sharing. Most states (44 states and the District of Columbia as of December 2016) choose to limit their payment to the lesser of 1) the full amount of Medicare cost sharing (deductibles, coinsurance, or copayments) for a given service, or 2) the amount, if any, by which the Medicaid payment rate exceeds the amount already paid by Medicare (MACPAC 2017).

There are four MSPs: the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, the Qualifying Individual (QI) program, and the Qualified Disabled and Working Individuals (QDWI) program. They differ in terms of what they pay for and what income and assets an eligible MSP enrollee may have (Table 1).

TABLE 1. Medicare Savings Program Enrollment, Income Thresholds, and Asset Limits for 2017

MSP	Enrollment (millions)[1]	Helps pay for	Federal income threshold by FPL	Federal asset limits	
				Individual	Married
QMB	6.9	Part A premiums, Part B premiums, coinsurance, deductibles, and copayments	At or below 100%	$7,390	$11,090
SLMB	1.3	Part B premiums	Between 101% and 120%	$7,390	$11,090
QI	0.6	Part B premiums	Between 121% and 135%	$7,390	$11,090
QDWI	*	Part A premiums	At or below 200%	$4,000	$6,000

TABLE 1. (continued)

Notes: MSP is Medicare Savings Program. FPL is federal poverty level. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. QDWI is Qualified Disabled and Working Individuals. Asset limits are adjusted annually for inflation, with the exception of the asset limits for the QDWI program (GAO 2012). Enrollment is for 2013, the most recent year available (MACPAC 2015).
* Represents less than 200 individuals.

Sources: MACPAC 2015 and CMS 2017a.

QMB program. The QMB program is the first and most expansive of the MSPs in terms of the number of enrollees and help with Medicare out-of-pocket expenses (Rupp and Sears 2000). Originally a state option, Congress subsequently made QMB mandatory in the Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360) (Rosenbach and Lamphere 1999). The QMB program pays for Part A premiums (only paid by people who buy in to Part A) and Part B premiums, coinsurance, deductibles, and copayments for individuals at or below the federal poverty level (FPL). There are two types of QMB enrollees. QMB-only enrollees are eligible for Medicaid payment of their Medicare premiums and cost sharing and are considered partial benefit dually eligible beneficiaries. QMB-plus enrollees are eligible for assistance with their Medicare premiums and cost sharing and are also eligible for full Medicaid benefits through another non-MSP eligibility pathway. The QMB program is an entitlement meaning that if beneficiaries meet the eligibility requirements, they are entitled to coverage (Rupp and Sears 2000).

SLMB program. The SLMB program was enacted as part of the Omnibus Budget Reconciliation Act of 1990; it originally covered beneficiaries with incomes above 100 percent up to 110 percent FPL and later expanded to 120 percent FPL (MACPAC 2016, GAO 2012, Rosenbach and Lamphere 1999). It provides assistance with the Part B premium. Like the QMB program, the SLMB program is an entitlement (Rupp and Sears 2000).

QI program.[5] The QI program was enacted in the Balanced Budget Act of 1997. It provides assistance with the Part B premium for beneficiaries with incomes between 120 and 135 percent FPL. Unlike the QMB and SLMB programs, the QI program is a federal allotment to states that is set at a specific amount each year. States receive 100 percent federal matching up to the amount of the allotment. Originally, the QI program had two parts: QI-1 for individuals with incomes of at least 120 but less than 135 percent FPL and QI-2 for individuals with incomes of at least 135 percent FPL but less than 175 percent FPL (GAO 2004). In December 2002, the QI-2 program was allowed to expire but the QI-1 program was reauthorized (GAO 2004). It was subsequently made permanent with passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10). That legislation funded the QI program through 2016 and established a formula for calculating funding allocations for all future years (CRS 2015).

QDWI program.[6] The QDWI program was enacted as part of the Omnibus Budget Reconciliation Act of 1989. It is the smallest of the MSPs, with fewer than 200 individuals enrolled in 2013 (MACPAC 2015). The QDWI program helps pay the Part A premium for people who have lost premium-free Part A coverage because they returned to work (CMS 2017a and Merlis 2005).

Eligibility and Enrollment in the MSPs

Varying state MSP eligibility policies, lack of program awareness, and burdensome enrollment processes are some of the barriers that have prevented eligible individuals from receiving MSP benefits (GAO 2012, Haber et al. 2003, Merlis 2005, and Perry et al. 2002).

State policies

Like many other aspects of Medicaid policy, eligibility requirements for the MSPs differ across states. The MSPs are mandatory Medicaid eligibility pathways—that is, states must make these programs available to individuals who qualify for them—and eligibility is determined according to specific income and asset limits set by the federal government (KFF 2012). However, states have the option to make the eligibility rules more generous than federal standards by not imposing asset limits or by lowering the income thresholds and many states do so (MedPAC and MACPAC 2017).[7] As a result, a beneficiary may be eligible for an MSP in one state, but not in another.

The process of enrolling in an MSP may be burdensome because the Medicaid application process is complex. In focus groups, many seniors cited the complicated Medicaid application and renewal process, which includes income verification, as a barrier to enrollment in Medicaid (Perry et al. 2002).

Moreover, state incentives for enrolling individuals in an MSP vary depending on what level of Medicaid benefits they are eligible for (GAO 2012). For example, enrolling individuals eligible for full Medicaid benefits into an MSP can reduce spending for the state Medicaid program by making Medicare the primary payer for certain services (GAO 2012). But, for individuals only eligible for Medicaid coverage of Medicare cost sharing, enrolling them in an MSP is likely to increase state Medicaid spending (GAO 2012).

Efforts to increase enrollment

Congress has sought to increase enrollment in the MSPs, most notably through the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275). MIPPA required the Social Security Administration (SSA) to take steps to eliminate barriers to enrollment (GAO 2012). For example, MIPPA directed SSA to transfer information from applications for the Medicare Part D Low-Income Subsidy (LIS) program for prescription drugs to the state Medicaid agency, beginning on January 1, 2010, and required that the state use that information to initiate an MSP application.[8] This created a new eligibility pathway for enrolling in the MSPs (GAO 2012). In its review of the effects of MIPPA on MSP enrollment, the Government Accountability Office (GAO) heard from states that they saw increased MSP enrollment as a result of the application transfers from SSA (GAO 2012). Several states also reported an increased workload because of the added state staff time needed to process the MSP applications (GAO 2012). Part of the increased workload included re-verifying information on the applications transferred from SSA in states that chose not to accept SSA's verification of an eligible individual's information (GAO 2012). GAO found that 35 states reverified at least some of the information on the applications transferred from SSA even though CMS allows states to treat the information as verified (GAO 2012). Verification of assets and the associated documentation requirements are thought to create added burdens and confusion for eligible individuals and that is what states most frequently reverified (Merlis 2005 and GAO

2012). As a result, although the MIPPA requirements were designed to make the enrollment process less cumbersome for the enrollee, how states implement those requirements may affect the beneficiary.

GAO also found that differences between how income and assets are counted in LIS and the MSPs make it difficult for some states to act on the applications transferred from SSA (GAO 2012). For example, state Medicaid programs require income information from each spouse separately in order to determine MSP eligibility whereas the LIS program combines income from spouses. Aligning how income and assets are counted under LIS and the MSPs could make it easier for states to process the applications they get from SSA. Nonetheless, GAO points out that states have the flexibility under federal law to do this but not all states have done so (GAO 2012).

MIPPA also enacted other requirements related to the MSPs. MIPPA increased funding for outreach, beginning in 2010. It also required that SSA make information on MSPs available to potentially eligible individuals and train staff on how to explain it. MIPPA also required SSA to coordinate outreach efforts between LIS and the MSPs. Overall, GAO estimated that MSP enrollment increased by about 5 percent in 2010 and 2011, the first years in which the MIPPA requirements took effect (GAO 2012).

Analysis of Adults Eligible but Not Enrolled in the MSPs

MACPAC contracted with the Urban Institute to estimate participation rates in the MSPs, using the most recently available data (2009 and 2010). It updates previous studies of MSP eligibility with new data and quantifies enrollment levels across MSPs. It adds to the literature by identifying the size and characteristics of the MSP-eligible but not enrolled population and comparing that population to MSP enrollees.

Previous studies have found low MSP participation rates. One study found that only about 63 percent of non-institutionalized eligible individuals had enrolled in the QMB and SLMB programs in 1999 (Rupp and Sears 2000). Another study estimated a combined participation rate of 64 percent in 2001 (Haber et al. 2003).

Studies on MSP eligibility and enrollment are difficult to conduct in part because household surveys, administered by the U.S. Census Bureau and others, do not collect information on MSP participation and there are no administrative data sources that identify the universe of individuals eligible for MSP enrollment. Our study linked survey data with administrative data to estimate program-specific participation rates for different types of MSPs and to identify individual and geographic sources of variation in those rates. Other studies have linked household survey data with administrative data but have not distinguished between the different types of MSPs (Rupp and Sears 2000, Sears 2001).

Methodology

The analysis linked data from two sources: survey data from the Survey of Income and Program Participation (SIPP) and administrative data from the Medicaid Statistical Information System (MSIS).[9] The SIPP was used to identify the population eligible for MSPs. It is a household-based survey of the non-

institutionalized population in the United States conducted by the U.S. Census Bureau to collect data on income, labor force participation, social program participation and eligibility, and other demographic characteristics (Census 2016). MSIS was used to identify MSP enrollees. We reviewed data for 2009 and 2010, the most recently available data from the SIPP 2008 panel. The analysis was completed at the U.S. Census Bureau Research Data Center.[10]

Findings

MSP participation rates continue to be low. We estimated that participation rates were 53 percent for the QMB program, 32 percent for the SLMB program, and 15 percent for the QI program (Table 2). Among eligible adults age 18 to 64, 63 percent were enrolled in the QMB program. Among eligible adults age 65 and older, QMB enrollment was 48 percent. By comparison, 42 percent of eligible adults age 18 to 64 were enrolled in the SLMB program, but for adults age 65 and older, SLMB participation was 28 percent. The QI program experienced the lowest enrollment rates with only 18 percent of eligible adults age 18 to 64 enrolled. QI participation was even lower at 15 percent for enrollees age 65 and older.

TABLE 2. Estimated Medicare Savings Program Participation Rates, 2009 and 2010

Medicare Savings Program	Participation rate
All	
QMB or SLMB	51%
QMB	53
SLMB	32
QI	15
Age 18 to 64	
QMB or SLMB	61
QMB	63
SLMB	42
QI	18
Age 65 and older	
QMB or SLMB	46
QMB	48
SLMB	28
QI	15

TABLE 2. (continued)

Notes: QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. Enrollment is based on average monthly for 2009 and 2010. Inconsistencies in the data that resulted from simulating MSP eligibility meant that some individuals appeared to be ineligible for any MSPs even though they were already enrolled in an MSP. To address these inconsistencies, we expanded the income and asset eligibility categories and made MSP enrollees' eligibility status consistent with the MSP they were enrolled in. As a result, MSP eligibility is not mutually exclusive across MSPs. The Qualified Disabled and Working Individuals (QDWI) program is excluded because enrollment in the program is too small to study with survey data. The reference period for this analysis is best interpreted as mid-to-late 2009 and mid-to-late 2010. The lack of specificity is a result of how Survey of Income and Program Participation (SIPP) interviews are administered. This analysis uses the SIPP 2008 panel.

Sources: Urban Institute analysis of SIPP and MSIS data for 2009 and 2010.

We also analyzed regression-adjusted state-level enrollment rates for QMBs and SLMBs combined for all eligible adults age 18 or older in order to better understand the factors associated with MSP participation (Table 3). We studied the QMB and SLMB populations together in part to increase our sample size and the accuracy of our estimates. The regression-adjusted rates control for differences in observed individual characteristics across states, such as health status, using a standardized population; consequently the regression-adjusted rates are not equivalent to state enrollment rates, which could be higher or lower.

After controlling for those differences, several states show enrollment rates well above the national average of 51 percent, such as Maine (78 percent), New Mexico (71 percent), Idaho (69 percent), and California (67 percent). Several states had enrollment rates below the national average, with the lowest rates found in Georgia (25 percent), Nebraska (27 percent), and West Virginia (29 percent).[11]

TABLE 3. Regression-adjusted State-Level Enrollment Rates for the QMB and SLMB Programs Combined, by State, 2009 and 2010

State	Regression-adjusted enrollment rate	Standard error	State	Regression-adjusted enrollment rate	Standard error
Alabama	52%	3%	Montana	*	*
Alaska	*	*	Nebraska	27%	8%
Arizona	45	5	Nevada	39	12
Arkansas	50	7	New Hampshire	*	*
California	67	2	New Jersey	44	4
Colorado	39	8	New Mexico	71	9
Connecticut	47	4	New York	38	3
Delaware	*	*	North Carolina	56	4
District of Columbia	37	4	North Dakota	*	*
Florida	58	4	Ohio	44	4
Georgia	25	7	Oklahoma	47	4

TABLE 3. (continued)

State	Regression-adjusted enrollment rate	Standard error	State	Regression-adjusted enrollment rate	Standard error
Hawaii	43%	5%	Oregon	54%	13%
Idaho	69	18	Pennsylvania	51	5
Illinois	39	6	Rhode Island	61	7
Indiana	48	5	South Carolina	53	7
Iowa	*	*	South Dakota	*	*
Kansas	53	8	Tennessee	45	5
Kentucky	46	9	Texas	56	4
Louisiana	55	4	Utah	*	*
Maine	78	2	Vermont	*	*
Maryland	38	5	Virginia	48	6
Massachusetts	52	6	Washington	64	7
Michigan	60	6	West Virginia	29	7
Minnesota	57	4	Wisconsin	59	3
Mississippi	45	6	Wyoming	*	*
Missouri	42	2			

Notes: QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. Enrollment is based on average monthly enrollment for 2009 and 2010. The standard error measures the variability of estimates (Urban 2017). For example, Alabama's regression-adjusted enrollment rate is 52 percent with a standard error of 3 percent meaning that the rate will vary by no more than 3 percent. These estimates represent a confidence level of 95 percent. The reference period for this analysis is best interpreted as mid-to-late 2009 and mid-to-late 2010. The lack of specificity is a result of how Survey of Income and Program Participation (SIPP) interviews are administered. This analysis uses the SIPP 2008 panel, which began in 2008 and ended in 2013.
* State sample was too small to display in the table.

Sources: Urban Institute analysis of SIPP and MSIS data for 2009 and 2010.

There are notable differences in characteristics between the eligible but not enrolled and the enrolled populations in QMB programs. Documenting the characteristics of the eligible but not enrolled could provide insights on how to better target outreach efforts to encourage eligible adults to enroll. We found that adults eligible but not enrolled in a QMB program, compared to adults who enrolled:

- were older (71 percent compared to 57 percent 65 and older);
- had slightly higher levels of education (61 percent with a high school degree compared to 58 percent);
- were more likely to be white, non-Hispanic (61 percent compared to 49 percent);
- were more likely to be married (21 percent compared to 16 percent) and;
- were more likely to have private health insurance (35 percent compared to 10 percent).

Adults eligible but not enrolled in a QMB program were less likely to:

- be enrolled in full-benefit Medicaid (16 percent compared to 70 percent)
- have limitations in activities of daily living (ADLs) (55 percent compared to 68 percent); and
- be enrolled in the Supplemental Security Income (SSI) program or the Supplemental Nutrition Assistance Program (SNAP) (12 percent compared to 45 or 46 percent, respectively).

We identified notable differences in characteristics between the eligible but not enrolled and the enrolled populations in QMB programs but in the QI program, the eligible but not enrolled and the enrolled populations were more similar. The exception was private health insurance coverage, which was much higher among eligible but not enrolled adults at 48 percent compared to 25 percent of enrolled adults.

Certain characteristics predict enrollment, in particular, enrollment in SSI or SNAP. Using regression models to predict enrollment, we estimated the percentage point difference in the participation rates associated with selected characteristics for groups of individuals compared to a reference group (Table 4).[12] For example, adults age 18 to 64 were more likely to enroll in the SLMB program than adults age 65 and older. There were several characteristics that were statistically significant predictors of enrollment for eligible adults in our regression model estimates including health status and enrollment in SSI or SNAP.

Enrollment in SSI or SNAP was the strongest predictor of enrollment in the QMB program and enrollment in SNAP was the strongest predictor of enrollment in the SLMB program. SSI enrollees were more likely to enroll in the QMB program than non-SSI enrollees. Further, adults enrolled in SNAP were more likely to enroll in the QMB and SLMB programs than non-SNAP enrollees. Other characteristics predicting enrollment include limitations with ADLs or instrumental activities of daily living (IADLs). Adults reporting limitations with ADLs or IADLs were more likely to enroll in the SLMB program than adults reporting no limitations with ADLs or IADLs. Also, MSP-eligible adults reporting good health or fair or poor health were more likely to enroll in the QMB program than MSP-eligible adults reporting better health.

Several characteristics were related to not enrolling in an MSP. Adults with private health insurance coverage were much less likely to enroll in an MSP, particularly in the QI program, than adults without private coverage, perhaps because they do not perceive a need for additional coverage. In fact, private health insurance coverage was the only characteristic affecting enrollment in the QI program. Other characteristics related to not enrolling in an MSP include race and education levels. Eligible adults who are black, non-Hispanic or Hispanic were less likely to enroll in the SLMB program. In terms of education, college graduates were less likely to enroll in the QMB program and less likely to enroll in the SLMB program than adults with less than a high school education.

TABLE 4. Characteristics Associated with Medicare Savings Program Participation, 2009 and 2010

Characteristic	QMB Participation rate = 53% Percentage point difference in participation rate compared to reference group	SLMB Participation rate = 32% Percentage point difference in participation rate compared to reference group	QI Participation rate = 15% Percentage point difference in participation rate compared to reference group
Age (reference group = age 65 and older)			
18 to 64	*	↑	*
Education (reference group = less than high school)			
High school graduate	*	↓	*
College graduate	↓	↓	*
Gender (reference group = male)			
Female	*	*	*
Health status, self-reported (reference group = excellent or very good)			
Good	↑	↑	*
Fair or poor	↑	*	*
Limitations with ADLs/IADLs (reference group = no ADL/IADL)			
ADL/IADL	↑	↑	*
Marital status (reference group = not married)			
Married	*	*	*
Other sources of coverage			
SSI	↑	↓	*
SNAP	↑	↑	*
Private health insurance	↓	↓	↓
Race and ethnicity (reference group = white, non-Hispanic)			
Black, non-Hispanic	*	↓	*
Hispanic	↑	↓	*
Other, non-Hispanic	*	*	*

TABLE 4. (continued)

Notes: QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. SSI is Supplemental Security Income. SNAP is Supplemental Nutrition Assistance Program. ADL is activity of daily living. IADL is instrumental activity of daily living. Enrollment is based on average monthly enrollment for 2009 and 2010. Inconsistencies in the data that resulted from simulating Medicare Savings Program (MSP) eligibility meant that some individuals appeared to be ineligible for any MSPs even though they were already enrolled in an MSP. To address these inconsistencies, we expanded the income and asset eligibility categories and made MSP enrollees' eligibility status consistent with the MSP they were enrolled in. As a result, MSP eligibility is not mutually exclusive across MSPs. The Qualified Disabled and Working Individuals (QDWI) program is excluded because the program is too small to study with survey data. This table does not include all the characteristics we analyzed. For a complete list, see Caswell and Waidmann 2017. Regression models used to produce these estimates control for all characteristics simultaneously. The reference period for this analysis is best interpreted as mid-to-late 2009 and mid-to-late 2010. The lack of specificity is a result of how Survey of Income and Program Participation (SIPP) interviews are administered. This analysis uses the SIPP 2008 panel, which began in 2008 and ended in 2013.

* Percentage point difference estimate is not statistically different from zero.

↑ and ↓ indicate the characteristic is associated with a higher or lower percentage point difference in participation that is statistically significant at conventional levels.

Sources: Table 4 from Urban Institute analysis of SIPP and MSIS data for 2009 and 2010 (Caswell and Waidmann 2017).

Comparing our findings to prior studies. Our study expanded on past studies by linking survey data with administrative data to estimate participation in different MSPs and to identify variation across states in those participation rates. Our results show that many eligible individuals were not enrolling in MSPs and these findings are consistent with past studies. One study estimated a combined QMB and SLMB participation rate of 63 percent in 1999 and another study estimated a rate of 64 percent in 2001 (Rupp and Sears 2000; Haber at al. 2003). Those estimated participation rates were higher than our finding of 51 percent enrollment for the QMB and SLMB programs combined.

We also identified characteristics associated with MSP participation, such as enrollment in SSI or SNAP, which have not been studied in prior analyses. Understanding these characteristics can help us better understand low enrollment in the MSPs.

Conclusion

Consistent with past studies, this analysis shows that many eligible Medicare beneficiaries are not enrolling in the MSPs. As a result, some low-income Medicare beneficiaries may have difficulty accessing care because they cannot afford the premiums and cost sharing associated with their benefits. MACPAC will continue to focus on research in this area and policies aimed at improving enrollment in the MSPs.

Endnotes

[1] One study estimated a combined participation rate for the Qualified Medicare Beneficiary (QMB) program and the Specified Low-Income Medicare Beneficiary (SLMB) program of 63 percent in 1999 (Rupp and Sears 2000). A later study estimated a combined participation rate for the QMB and SLMB programs of 64 percent (Haber et al. 2003). In 2004, the Congressional Budget Office (CBO) estimated low participation rates in the MSPs with about one-third of eligible individuals enrolled in the QMB program and about 13 percent enrolled in the SLMB program (CBO 2004). However, it is important to note that this study is not directly comparable to other studies referenced in this paper or to MACPAC's analysis because it excluded beneficiaries eligible for full Medicaid benefits, which lowers participation rates.

[2] In our analysis, we also studied the QMB and SLMB populations together in part to increase our sample size and the accuracy of our estimates. The participation rate for the combined programs was 51 percent.

[3] The Part B deductible for 2017 is $183 per year and after the deductible is met, beneficiaries typically pay coinsurance of 20 percent of the Medicare approved amount. The standard Part B monthly premium in 2017 is $134 (CMS 2016a).

[4] Medicare beneficiaries may also purchase Medicare Supplement insurance (or Medigap) for coverage of Medicare copayments, coinsurance, and deductibles. To be eligible, a Medicare beneficiary must have Medicare Part A and Part B coverage. There is a monthly premium associated with Medigap coverage and beneficiaries must pay both the Medigap premium and the Part B premium (CMS 2017b).

[5] Unlike other MSPs, funding for the QI program is capped, potentially affecting enrollment.

[6] See endnote 3.

[7] As of October 2016, eight states (Alabama, Arizona, Connecticut, Delaware, Mississippi, New York, Oregon, Vermont) and the District of Columbia had removed asset limits and three states (Connecticut, Indiana, Maine) and the District of Columbia had expanded income thresholds.

[8] The Low-Income Subsidy (LIS) program provides assistance with Medicare prescription drug plan costs for individuals with limited income and assets and is available under the Medicare Part D prescription drug program. LIS applicants' information is transferred automatically to the state Medicaid program to initiate an application for the MSPs (GAO 2012). Beneficiaries are deemed eligible for LIS (and automatically enrolled) if they (1) receive full Medicaid benefits; (2) receive SSI; or (3) participate in the QMB, SLMB, or QI programs (CMS 2009).

[9] We identified minor data limitations in the analysis. First, there were inconsistencies in the data, which meant that some individuals who were already enrolled in an MSP appeared not to be eligible for an MSP. Second, the potentially lower quality of income and asset data in the SIPP relative to other surveys could have implications for simulating eligibility in the MSPs and estimating participation rates. However, previous research suggests that the implications for MSPs are minimal. For example, one study shows that while the SIPP collects much less earnings than the Current Population Survey Annual Social and Economic Supplement, the SIPP collects more earnings near the bottom of the distribution (Czajka and Denmead 2012). An earlier study shows that the SIPP collects about half of the overall wealth or net worth reported in the Survey of Consumer Finances, which is considered the gold standard as a household survey for wealth measurement (Czajka et al. 2003). However, this discrepancy is primarily found among wealthy households. Together these studies suggest that the known issues surrounding income and asset measurement in the SIPP are much less likely to have important implications for the MSP-eligible population with low levels of income and assets.

[10] Any opinions or conclusions expressed herein are those of the authors and do not necessarily represent the views of the U.S. Census Bureau. All results have been reviewed to ensure that no confidential information is disclosed.

[11] Due to small sample sizes, results for some states have been suppressed.

[12] For more detailed information on the regression model estimates predicting enrollment, please see Table 4 in Caswell and Waidmann, 2017.

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