Chapter 3:

Improving Participation in the Medicare Savings Programs

Improving Participation in the Medicare Savings Programs

Recommendation

3.1 Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

Key Points

- Many beneficiaries who are dually eligible for Medicaid and Medicare are eligible to receive assistance paying for their Medicare premiums, cost sharing, or both, through the MSPs. Under these programs, state Medicaid programs pay for such assistance for Medicare enrollees who are low-income adults age 65 and older or people with disabilities.
- Qualifying beneficiaries must enroll in the MSPs and have their eligibility redetermined each year through their state Medicaid programs.
- Low enrollment in the MSPs has been an ongoing concern for policymakers because cost-sharing assistance can affect beneficiaries' ability to access care. Although some federal action has been taken to simplify eligibility and enrollment, participation rates remain relatively low.
- The Commission focused on the interplay between the MSPs and the Medicare Part D LIS program to increase enrollment because both provide financial assistance to low-income Medicare beneficiaries to cover out-of-pocket Medicare costs. Although LIS eligibility data are shared with states, different state rules for counting key MSP eligibility factors, such as income, household size, and assets, may keep states from using LIS data to determine MSP eligibility. As a result, individuals applying for the MSPs may have to submit a new application or additional documentation, which may keep many eligible beneficiaries from enrolling.
- If adopted, the recommendation would increase enrollment and retention in the MSPs while allowing states that currently use less restrictive income and asset limits to continue to do so. We also expect that it would improve access to care for beneficiaries who are unable to afford Medicare cost sharing and reduce state administrative spending. On the other hand, enrollment growth would increase state and federal spending on Medicaid and Medicare benefits. However, many of those who would enroll in the MSPs as a result of this policy change would already be eligible to participate.

CHAPTER 3: Improving Participation in the Medicare Savings Programs

Many beneficiaries who are dually eligible for Medicaid and Medicare are eligible to receive assistance in paying for their Medicare premiums, cost sharing, or both, through the Medicare Savings Programs (MSPs). Under the MSPs, state Medicaid programs pay for such assistance for Medicare enrollees who are low-income adults age 65 and older or people with disabilities. Qualifying beneficiaries must enroll in the MSPs and have their eligibility redetermined each year through their state Medicaid program.

Low enrollment in the MSPs has been an ongoing concern for policymakers because cost-sharing assistance can affect beneficiary use of services. In recent years, some federal action has been taken to simplify eligibility and enrollment in the MSPs, but participation rates remain relatively low.

Over the past year, the Commission has examined issues related to MSP enrollment, identifying barriers faced by beneficiaries and states and exploring policy options aimed at increasing participation of eligible beneficiaries and thus improving their access to care. The Commission found that varying state approaches to program administration, conflicting enrollment and eligibility requirements between the MSPs and related federal programs serving similar low-income individuals, and lack of awareness among eligible beneficiaries all contribute to low enrollment in the MSPs.

In considering how to increase enrollment, the Commission had multiple lengthy discussions of policy options of varying levels of complexity. These options ranged from a simple increase in federal funding for outreach, to streamlining eligibility and enrollment to align more closely with similar federal programs, to consolidating the multiple MSPs into one program covering Medicare premiums and cost sharing for beneficiaries age 65 and older and people with disabilities with incomes up to 135 percent of the federal poverty level (FPL). The Commission focused much of its discussion on the interplay between the MSPs and the Medicare Part D Low-Income Subsidy (LIS) program because both programs provide financial assistance to low-income Medicare beneficiaries to cover out-of-pocket Medicare costs. While the Social Security Administration (SSA) administers the LIS program, which has automatic processes in place to contact and enroll many eligible individuals nationwide, the MSPs are administered by state Medicaid programs that develop their own outreach and enrollment processes. Although SSA shares LIS program eligibility data with states, different state rules for counting key MSP eligibility factors, such as income, household size, and assets, may limit a state's ability to use the LIS program data to automate their MSP enrollment process. As a result, individuals applying for the MSPs may have to initiate an application and submit additional documentation to meet state requirements, burdens that may keep many eligible beneficiaries from enrolling in the program.

In the Commission's view, two changes in federal law would improve information sharing between SSA and the states, ease administrative burden for states and beneficiaries, and contribute to increased enrollment in the MSPs. Specifically, MACPAC makes the following recommendation:

- Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

We expect that this recommendation, if adopted, would increase enrollment and retention in the MSPs while allowing states that currently use less restrictive income and asset limits to continue to do so. We also expect that adoption of the recommendation would improve access to care for beneficiaries who have foregone care due to the financial burden associated with Medicare cost sharing and that it would reduce state administrative spending. On the other hand, the resulting growth in enrollment would increase state and federal spending on Medicaid and Medicare benefits. It is important to note, however, that many of those who would enroll in the MSPs as a result of this policy change would already be eligible to participate.

The chapter begins with a brief overview of Medicaid and Medicare coverage for dually eligible beneficiaries. It then describes the MSPs and discusses participation rates and factors affecting enrollment, including state policies, program administration, and outreach. The chapter concludes with the Commission's recommendation and its rationale for adopting it.

Coverage for Dually Eligible Beneficiaries

Medicaid and Medicare cover some of the same services, but when benefits overlap, Medicare is the primary payer. As a result, Medicare generally pays for physician services, inpatient and outpatient acute care, post-acute skilled care, and prescription drugs for dually eligible beneficiaries.

All Medicare beneficiaries are eligible for the same benefits, and all are required to pay premiums and cost sharing, which can be challenging for low-income beneficiaries. For example, in 2020, premiums for Medicare Part B coverage (which covers physician services and outpatient care) are $144.60 per month and the annual deductible is $198 (CMS 2020a). Once beneficiaries meet this deductible, they typically pay 20 percent of the Medicare-approved amount for physician services, outpatient therapy, and durable medical equipment. Medicare beneficiaries may also pay premiums and deductibles for Medicare Part A and Part D, although most people qualify for premium-free Part A because of their work history and payment of Medicare taxes.[1] Medicare beneficiaries may purchase private supplemental insurance (generally referred to as Medigap) to cover the cost of many of these copayments, coinsurance, and deductibles; the cost of such plans varies widely (CMS 2019a).

Medicaid wraps around Medicare's coverage for dually eligible beneficiaries by paying Medicare premiums and cost sharing and by covering services not covered by Medicare, such as long-term services and supports. Dually eligible beneficiaries receive either full or partial Medicaid benefits, and both groups may receive assistance through the MSPs. Partial-benefit dually eligible beneficiaries, about 29 percent of the dually eligible population (3.5 million people), are Medicare beneficiaries who qualify for the MSPs but do not receive full Medicaid benefits (MMCO 2020). They become dually eligible when they enroll in the MSPs, but outside of Medicaid assistance with their Medicare costs, they do not receive Medicaid benefits.

The majority of the dually eligible population, about 71 percent (8.7 million people), is eligible for full Medicaid benefits, but these beneficiaries may or may not qualify for an MSP (MMCO 2020). Medicaid and MSP eligibility criteria vary by state because federal law gives states flexibility in how they administer their programs. For example, states have the option to make the eligibility rules for MSPs more generous than federal standards by effectively removing asset limits or by raising income limits (MACPAC 2017). To enroll in an MSP, full-benefit dually eligible beneficiaries must meet both their state's Medicaid eligibility criteria and the income and asset limits for one of the MSPs in their state. Individuals who qualify through optional Medicaid pathways such as medically needy or special income level, referred to as other full-benefit dually eligible beneficiaries, do not meet the MSP income and asset criteria, regardless of state-set limits (CMS 1999).

Overview of the Medicare Savings Programs

Four separate MSPs provide varying levels of assistance and have different eligibility criteria (Table 3-1). They include 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. State Medicaid programs receive their regular federal medical assistance percentage (FMAP) under all of the MSPs except the QI program, which is fully federally funded.

Qualified Medicare Beneficiary program

The QMB program began in 1986 and is the most expansive of the MSPs in terms of the number of enrollees it covers and the benefits it provides. Originally a state option, Congress made the QMB program mandatory in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) (Rosenbach and Lamphere 1999). It helps pay for Medicare Part A premiums (paid only by people with fewer than 40 quarters of work history in their lifetimes) and Medicare Part B premiums, as well as Medicare coinsurance, deductibles, and copayments for individuals with incomes at or below 100 percent FPL and limited assets.

In addition to receiving assistance with their Medicare premiums and cost sharing, most QMB enrollees also qualify for full Medicaid benefits through eligibility pathways available to individuals who receive Supplemental Security Income (SSI) benefits, individuals who are low-income and age 65 and older, or people with a disability.[2] The QMB program is an entitlement, meaning that if beneficiaries meet the eligibility requirements, they are entitled to coverage (Rupp and Sears 2000).

Specified Low-Income Medicare Beneficiary program

The SLMB program was enacted as part of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508); it originally covered beneficiaries with limited assets and incomes between 101 percent and 110 percent FPL, a limit that was later increased to 120 percent FPL (MACPAC 2017, GAO 2012, Rosenbach and Lamphere 1999). The SLMB program provides assistance with Medicare Part B premiums only. Like the QMB program, the SLMB program is an entitlement (Rupp and Sears 2000).

Qualifying Individual program

The QI program was enacted in the Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33). Initially authorized to provide assistance with the Medicare Part B premium for beneficiaries with incomes between 120 percent and 175 percent FPL and limited assets, the upper income eligibility limit was lowered to 135 percent FPL in 2002. Unlike the QMB and SLMB programs, QI program funding is provided to states through a federal allotment that is set at a specific amount each year. States receive 100 percent federal match up to the amount of the allotment.[3]

Qualified Disabled and Working Individuals program

The QDWI program was enacted as part of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). It helps pay for the Medicare Part A premium, which in 2020 can be as high as $458 per month for people under age 65 with a disability who have lost premium-free Part A coverage because they have returned to work (CMS 2019b, Merlis 2005). The QDWI program is the smallest of the MSPs in terms of enrollment because it is designed for a specific subset of dually eligible beneficiaries and covers Medicare premiums that most people are not required to pay.

TABLE 3-1. Medicare Savings Programs: Eligibility and Benefits, 2020

Program	Income range (percentage of FPL)	Helps pay for	Asset limit	
			Individual	Couple
Qualified Medicare Beneficiary (QMB)	≤ 100%	Part A premiums, Part B premiums, coinsurance, deductibles	$7,860	$11,800
Specified Low-Income Medicare Beneficiary (SLMB)	101–120	Part B premiums	$7,860	$11,800
Qualifying Individual (QI)	121–135	Part B premiums	$7,860	$11,800
Qualified Disabled and Working Individuals (QDWI)	≤ 200	Part A premiums	$4,000	$6,000

Notes: FPL is federal poverty level. The income and asset limits shown here are the federal standards; states cannot use more stringent standards but can raise the income and asset limits. In 2020, 15 states set their income or asset limits higher than federal levels.

Sources: CMS 2020b, MACPAC and MedPAC 2018.

Enrollment and Participation Rates

Individuals must apply to their state Medicaid program to enroll in the MSPs, and, like anyone applying for Medicaid, they must provide documentation to verify their eligibility. There are several ways to enroll in the MSPs. States may screen people who apply for Medicaid to see if they are also eligible for the MSPs or offer a streamlined application specifically for MSP enrollment (GAO 2012). Another point of entry is through eligibility for SSI, which provides an automatic link to Medicaid; in most states, an SSI application is also a Medicaid application (SSA 2019a). The Centers for Medicare & Medicaid Services (CMS) automatically enroll such individuals in Medicare Part B with the state paying the premium, effectively enrolling them into the MSPs (GAO 2012).[4]

Enrollment

Medicare administrative data tracks enrollment in each MSP for both full- and partial-benefit dually eligible beneficiaries. In 2018, approximately 9.9 million dually eligible beneficiaries received Medicaid assistance with their Medicare costs through the MSPs (Table 3-2). The majority of these 9.9 million enrollees, 79 percent, were enrolled in the QMB program.

TABLE 3-2. Medicare Savings Program Enrollment, 2018

Program	Enrollment	
	Number (millions)	Percentage of total
Total enrollment	**9.9**	**100%**
Qualified Medicare Beneficiary (QMB)	7.8	79
Specified Low-Income Medicare Beneficiary (SLMB)	1.5	15
Qualifying Individual (QI)	0.7	7
Qualified Disabled and Working Individuals (QDWI)	0.0	0

Note: 0.0 indicates a number between 0 and 0.05 that rounds to zero. Components may not sum to 100 percent due to rounding.

Source: Acumen LLC, 2019, analysis of Medicare data from the Common Medicare Environment and Medicare Enrollment Database.

Annual redeterminations. Once beneficiaries are enrolled in an MSP, federal law requires that states redetermine their eligibility at least once every 12 months. Although subject to minimum federal requirements, states have flexibility in setting up the redetermination process. If feasible, states must conduct an ex parte renewal, which means using information available to the state Medicaid agency, including information from electronic data sources, to renew eligibility without requiring additional beneficiary action. Where the state lacks sufficient information to renew eligibility or has information that would result in a loss of eligibility, states may send beneficiaries a prepopulated form containing the information available to the agency with instructions to provide any requested information and report relevant changes (42 CFR 435.916(b)).

Although dually eligible beneficiaries typically do not have big fluctuations in income that are likely to make them ineligible for Medicaid, few states have automatic renewal policies in place for the MSPs. As of 2016, four states used ex parte renewals, five states used prepopulated forms, and four states used automatic renewals for enrollees who did not have major changes in circumstances (NCOA 2016). Nevertheless, individuals have been dropped from the program for failure to produce paperwork that simply verifies that their situations have not changed. A recent study found that almost 30 percent of new full-benefit dually eligible beneficiaries lost Medicaid coverage for at least one month during the 12 months after they became dually eligible (ASPE 2019). Of the people who lost coverage, nearly 30 percent had short breaks in coverage of one to three months, likely for administrative reasons such as lack of familiarity with Medicaid policies and eligibility verification procedures (ASPE 2019).

Participation rates

There have been a limited number of studies examining participation rates in the MSPs. Such studies are difficult to conduct in part because federal 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 the MSPs. Some studies have linked household survey data with administrative data, but have not distinguished among the different types of MSPs (Sears 2002, Rupp and Sears 2000).

In a 2017 report for MACPAC, the Urban Institute studied participation rates in each of the MSPs. Using data from 2009 and 2010, this analysis filled a gap in the research on MSP participation by linking survey data from the Survey of Income and Program

Participation with administrative data from the Medicaid Statistical Information System (MSIS) to estimate program-specific participation rates for the MSPs and to identify variations in participation rates by individual characteristics and geographic location. We estimated participation rates in each MSP measured by enrollees as a share of eligible beneficiaries (Table 3-3).

TABLE 3-3. Medicare Savings Program Participation Rates, 2009 and 2010

Program	Participation rate		
	All	Age 18–64	Age 65 and older
Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB)	**51%**	61%	46%
QMB	**53**	63	48
SLMB	**32**	42	28
Qualifying Individual (QI)	**15**	18	15

Notes: Participation rates are calculated using 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 MSP even though they were already enrolled in one. 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 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.

Source: Caswell and Waidmann, 2017, analysis of SIPP and Medicaid Statistical Information System (MSIS) data for 2009 and 2010.

We found low participation rates across all MSPs and all age groups (MACPAC 2017). The QMB program had the highest participation rate at 53 percent across all age groups. Of SLMB-eligible beneficiaries, 32 percent participated. Of QI-eligible beneficiaries, 15 percent participated. Previous studies also found low MSP participation rates. One study found that 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).

The 2017 Urban Institute study also examined the characteristics of MSP enrollees and MSP-eligible but not enrolled individuals. The analysis found that individuals enrolled in the MSPs were less likely than eligible non-enrollees to have private health insurance coverage, and were more likely to be younger, under age 65, have lower assets, and be eligible for Medicaid on the basis of a disability. Enrolled beneficiaries were also more likely to be receiving benefits from other government programs, such as SSI and the Supplemental Nutrition Assistance Program. Enrollment in these other government programs may serve as a touchpoint for beneficiaries who are eligible for the MSPs.

The 2017 study found that full-benefit dually eligible beneficiaries were the most likely to participate in an MSP. Among individuals eligible but not enrolled in the MSPs, about 16 percent were full-benefit dually eligible beneficiaries (Table 3-4). This finding makes sense considering that most of these individuals were enrolled in an MSP due to their eligibility for SSI, which has an automatic link to Medicaid, or because they were receiving full Medicaid benefits.[5] Fewer partial-benefit dually eligible beneficiaries were enrolled in the MSPs, likely because they would not have had prior contact with the Medicaid program, and therefore would not

have been familiar with the MSPs or how to enroll. Eligible but not enrolled individuals were also more likely to have private health insurance coverage, suggesting that some may not have perceived a need for additional coverage. This cohort was also more likely to be age 65 and older.[6]

TABLE 3-4. Selected Characteristics of Individuals Enrolled in the Qualified Medicare Beneficiary or Specified Low-Income Medicare Beneficiary Programs and Individuals Eligible but Not Enrolled, 2009 and 2010

Characteristic	Share of all enrollees in QMB or SLMB programs	Share of population eligible for QMB or SLMB programs but not enrolled
Age 18–64	42%	29%
Age 65 and older	58	72
Covered by private health insurance	12	36
Enrolled in SNAP	43	12
Enrolled in SSI	39	12
Enrolled in full-benefit Medicaid	70	16
Eligible for Medicaid on the basis of a disability	49	11

Notes: QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. SNAP is Supplemental Nutrition Assistance Program. SSI is Supplemental Security Income. Statistics in this table are based on a sample of person-month observations.

Source: Caswell and Waidmann, 2017, analysis using the Survey of Income and Program Participation (SIPP) 2008 panel and the Medicaid Statistical Information System (MSIS), executed at the U.S. Census Bureau, Research Data Center. https://www.macpac.gov/publication/medicare-savings-program-enrollees-and-eligible-non-enrollees/.

Factors Affecting MSP Enrollment

As noted above, many beneficiaries who are eligible for an MSP are not enrolled in one. A number of reasons have been cited for low enrollment, including conflicting enrollment and eligibility requirements between the MSPs and related federal programs, program rules and administration, and lack of awareness among eligible beneficiaries (CMS 2018, NCOA 2020a). Federal policymakers have taken some steps to simplify and encourage enrollment in the MSPs with limited success—these issues are discussed below.

State policies

State policy choices can affect enrollment in the MSPs and may be inconsistent with standards used by other states and the federal government for other programs serving a similar population. In some cases, those inconsistencies may help increase enrollment; for example, state-specific income and asset limits that are more generous than the federal standards enable more beneficiaries to enroll in the MSPs. But in other cases, they may act as barriers that limit enrollment; for example, if state policies for counting income, assets, and household size for MSP eligibility differ from federal policies for programs that serve similar low-income populations, such as the Medicare Part D LIS program, then automating and streamlining MSP enrollment becomes difficult.

More generous income and asset levels. Income and asset limits for the MSPs are established in statute.[7] States have the option, however, to set guidelines that are more generous than the federal standard, and 14 states and the District of Columbia do so for one or more MSP categories (Table 3-5). Some states with more generous rules, such as Connecticut and Maine, have enrolled a higher share of eligible beneficiaries in the MSPs and reduced state administrative burden. Alabama, Mississippi, and New York have all reported administrative savings in time and money from eliminating asset tests (NCOA 2016). (Detail on income and asset levels for all 50 states and the District of Columbia can be found in Appendix 3A, Table 3A-1.)

TABLE 3-5. States with Beneficiary Income and Asset Eligibility Limits More Generous than the Federal Standard for Medicare Savings Programs, 2020

State	Monthly income limit, as a percentage of FPL			Asset limit
	QMB	SLMB	QI	
Federal standard	**100% plus $20 disregard**	**120% plus $20 disregard**	**135% plus $20 disregard**	**$7,860 (single); $11,800 (married)**
Alabama	Federal standard			No limit
Arizona	Federal standard			No limit
Connecticut[1]	211%	231%	246%	No limit
Delaware	Federal standard			No limit
District of Columbia	300%	–	–	No limit
Illinois	Federal standard plus $25 disregard			Federal standard
Indiana	150%	175%	185%	Federal standard
Louisiana	Federal standard			No limit
Maine[2]	150% plus $75 disregard	175% plus $75 disregard	185% plus $75 disregard	$58,000 (single); $87,000 (married)
Massachusetts	130%	150%	165%	$15,720 (single); $23,600 (married)
Minnesota	Federal standard			$10,000 (single); $18,000 (married)
Mississippi	Federal standard plus $50 disregard			No limit
New York	Federal standard			No limit
Oregon	Federal standard			No limit
Vermont	Federal standard			No limit

Notes: FPL is federal poverty level. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. The Qualified Disabled and Working Individuals program is not included in this table. States with no limit have eliminated the asset test.

– Dash indicates that the category is not applicable.

[1] Connecticut does not include the standard $20 income disregard in their income levels.

[2] Maine's asset limits apply to liquid assets only.

Source: MACPAC analysis of data from National Council on Aging as of February 2020 (NCOA 2020b).

Differences with Part D LIS. The MSPs and the Medicare Part D LIS program all provide financial assistance to low-income Medicare beneficiaries to cover out-of-pocket Medicare costs.[8] The LIS program is administered by SSA and CMS, and has automatic processes in place to contact and enroll many eligible individuals.[9] The MSPs, on the other hand, are administered by state Medicaid programs, which develop their own outreach and enrollment processes.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires SSA to transfer LIS application information to states, and requires states to use that information to initiate an MSP application.[10] SSA sends files daily (except on weekends and holidays) to state Medicaid agencies. Data transferred by SSA contain demographic information, household composition, income, assets, whether SSA approved or denied LIS program enrollment, and the reasons for a denial (Lakhmani 2019, GAO 2012).

But in many states, SSA's data are not comparable to those used by the state for enrolling beneficiaries in MSPs. For example:

- SSA does not count in-kind support from family as income, but states may count it.
- SSA does not count the cash value of a life insurance policy, but states may count it (term life insurance policies are excepted). If a state does count cash value, then beneficiaries must contact the life insurance company to determine the policy's cash value, and that value is counted as an asset.
- SSA assumes beneficiaries will use some of their assets for funeral or burial expenses and applies a disregard of $1,500 for an individual's assets ($3,000 for a couple's assets) to account for that. In some states, beneficiaries cannot get the same disregard for MSP eligibility unless they can prove that they have set aside that money in a burial trust.
- Under SSA rules, household size is defined as the individual, his or her spouse if married, and any additional relatives who live with the individual and are dependent on the individual or the individual's spouse for at least one-half of their income. States may use the narrower SSI-based interpretation that counts only the individual or the individual and spouse.

Different state rules for counting key MSP eligibility factors, such as income, assets, or household size, may limit a state's ability to use SSA data to automate its MSP enrollment process (CMS 2018). As a result, a determination of eligibility for the LIS program by SSA does not necessarily provide enough information for a state to determine an individual's eligibility for an MSP (CMS 2018). In such cases, individuals whose information came from SSA who are applying for the MSPs may have to submit a separate application or provide additional documentation to the state to verify what may be minor differences in countable assets or income (Lakhmani 2019).

Federal action

Federal statutes, guidance, and funding have been used to encourage both eligible beneficiaries to enroll in the MSPs and states to streamline and automate program administration. These efforts, however, have had limited success.

Program administration. As noted above, in 2008, MIPPA required SSA to transfer data from LIS applications and required states to use that information to initiate MSP applications. MIPPA also changed the asset limits used for the MSPs to match the asset limits for full LIS benefits in an effort to expand eligibility and eliminate barriers to MSP enrollment (GAO 2012, CBO 2008). MSP enrollment increased by about 5 percent in 2010 and in 2011, the first two years that the MIPPA requirements were in effect, although it is difficult to determine what share of that growth, if any, can be attributed to the SSA application transfer (GAO 2012).

In 2018, CMS released new guidance for states that included an opportunity to simplify eligibility and enrollment in the MSPs (CMS 2018). Following that, the Integrated Care Resource Center, a CMS initiative that provides technical assistance to states, described steps states could take to improve the MSP eligibility determination process, including the use of LIS program policies for counting income and assets or for determining household size. Although states can use Section 1902(r)(2)(A) of the Social Security Act (the Act) to accomplish this, few states use this authority (CMS 2010).

Outreach. Policymakers have also been concerned that beneficiaries' lack of awareness of their eligibility for an MSP may be limiting enrollment. For example, beneficiaries who do not qualify for full Medicaid benefits might not know they are eligible for an MSP because they are unlikely to have prior contact with a state Medicaid program (Haber et al. 2003).

Federal law requires SSA to identify individuals potentially eligible for the MSPs and LIS program and notify them about the programs. SSA mails outreach letters to individuals who are potentially eligible for the QMB, SLMB, QI, and LIS programs in May and June each year, asking beneficiaries to contact their state or local Medicaid office, social service, or welfare office about the MSPs and to contact SSA about the LIS program.[11] Federal law also requires SSA to share the lists of potentially eligible individuals with state Medicaid agencies. SSA transmits files electronically to each state at about the same time it sends its letters to beneficiaries, and also notifies the state Medicaid agency how many and which beneficiaries will receive an outreach letter (SSA 2019b). States may then conduct outreach to such individuals to inform them of how and where to apply for benefits.

To increase MSP enrollment, MIPPA provided outreach grants totaling $20 million to state health insurance assistance programs, area agencies on aging, and aging and disability resource centers, starting in fiscal year (FY) 2009 (GAO 2012). This funding has been reauthorized a number of times, including in the Bipartisan Budget Act of 2018 (P.L. 115-123), which made $25.5 million available each year for FY 2018 and FY 2019, and through a series of laws that ultimately made $25.5 million available for FY 2020 (P.L. 116-69, P.L. 116-94, P.L. 116-136).

Grantees have used this funding to conduct outreach and to enroll low-income Medicare beneficiaries into the LIS program and the MSPs, and to promote the use of Medicare preventive services. Outreach has been targeted to multiple audiences, including people with disabilities, tribal populations, veterans, caregivers, and people experiencing homelessness (NCOA 2017).

Commission Recommendation

After weighing the potential impact on enrollment and costs to states and the federal government, the Commission makes one recommendation containing two companion statutory changes aimed at increasing enrollment in the MSPs and simplifying the enrollment and eligibility redetermination process for beneficiaries and states.

Recommendation 3.1

Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

Rationale

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-27) amended Section 1905(p)(1)(C) of the Act to make the asset limits used for the MSPs conform to the asset limits for full LIS program benefits. Although this change was intended to expand eligibility and eliminate barriers to MSP enrollment, many states still use asset counting rules that differ from those used by SSA for the LIS program. This can prevent states from using the SSA data to assess eligibility for the MSPs and may require beneficiaries to submit additional documentation. For example, SSA does not count the cash surrender value of life insurance policies as an asset, but some states do, requiring beneficiaries to contact their life insurance companies to determine the policy's cash value so they can report it on their applications (Lakhmani 2019). Similarly, SSA assumes beneficiaries will use some of their assets for funeral or burial expenses and applies a disregard of $1,500 for an individual or $3,000 for a couple to account for that. Some states will not apply the same disregard for MSP eligibility unless beneficiaries can prove they have set aside that money in a burial trust.

Even though states have the authority under Section 1902(r)(2)(A) of the Act to define assets in the same manner as SSA, as of 2012, 29 states required reverification of asset data transferred from SSA because the definitions did not match (GAO 2012). Requiring states to adopt SSA definitions of income, household size, and assets for purposes of the MSPs eliminates the need to reverify the SSA data and enables states to process the applications transferred from SSA without requiring additional information from beneficiaries, an additional step that can create a barrier to the completion of their applications (GAO 2012). This recommendation would not prevent states from using less restrictive definitions of income and assets, as 14 states and the District of Columbia currently do for one or more MSP categories. In addition, requiring SSA to send continuing LIS eligibility data to states on an annual basis will provide states with sufficient data to conduct ex parte eligibility redeterminations, reducing administrative burden for both states and beneficiaries, and enabling more beneficiaries to retain coverage.

Implications

Federal spending. Increased enrollment in the MSPs would increase federal costs for both the Medicaid and Medicare programs, including costs related to matching payments to state Medicaid programs, increased spending on Medicare Parts A and B, and increased enrollment in the LIS program. The Congressional Budget Office (CBO) was unable to provide an estimate of the specific budgetary effects of this recommendation. According to CBO, development of such an estimate would require access to data that are not currently available. For example, complete information on the number of people who are eligible for but not enrolled in each MSP is not available at this time. In a 2017 study conducted for MACPAC by the Urban Institute, the number of individuals who were eligible but not enrolled could be estimated at the national level, but not at the state level due to sample size limitations (Caswell and Waidmann 2017). Even if the number of individuals eligible but not enrolled in each MSP category in each state were known, we do not know how the enrollment rate among eligible individuals differs between states already using SSA counting rules and the other states. In addition, the effect of the change in policy on the relative distribution of enrollment in each MSP is difficult to predict. Requiring states to use the SSA calculation of income, assets, and household size could change the distribution of enrollment among the QMB, SLMB, and QI programs. Because the QI program is fully federally funded, a large increase in the number of enrollees in that program would increase federal costs more than a similar enrollment increase in the QMB or SLMB programs, which are matched at the regular FMAP.

The adoption of this policy would have additional consequences for Medicaid and Medicare. To the extent that some individuals who enroll in the MSPs as a result of this policy will also qualify for full Medicaid benefits, overall Medicaid costs

would increase. If this policy results in any new MSP enrollment outside of the enrollment that results directly from the application transfers from SSA, enrollment in the LIS program would increase because individuals enrolled in the QMB, SLMB, or QI programs are deemed eligible for the LIS program. This policy could also have spillover effects on Medicare Parts A and B because it could improve access to services for beneficiaries who receive Medicaid assistance with Medicare cost sharing; these spillover effects are difficult to quantify.

States. Increased enrollment would increase state Medicaid costs. At the same time, simplifying the eligibility determination and redetermination processes would reduce state administrative burden and related costs. State payments for Medicare cost sharing would increase as enrollment increases, but some costs could be offset if more Medicaid beneficiaries enroll in Medicare Parts A and B, making Medicare the primary payer for services that Medicaid had been covering.

Enrollees. This policy would increase enrollment and retention of eligible beneficiaries in the MSPs, improving access to care for beneficiaries who have foregone care due to the financial burden associated with Medicare cost sharing. This policy would reduce the burden on beneficiaries of having to submit additional paperwork to demonstrate their eligibility for the MSPs. In some states, however, beneficiaries seeking full Medicaid benefits may have to submit additional paperwork to show they meet the state's eligibility criteria for those benefits.

Plans and providers. This recommendation would not have a direct effect on plans or providers.

Endnotes

[1] Although most beneficiaries are not required to pay a premium for Part A coverage (hospital insurance), they are required to pay a deductible ($1,408 in 2020) and copayments for inpatient hospital stays exceeding 60 days. Medicare beneficiaries pay no coinsurance for the first 60 days of an inpatient hospital stay. Coinsurance is $352 per day for days 61–90 and $704 per day for days 91–150 (CMS 2020a).

[2] Some QMB enrollees do not qualify for full Medicaid benefits. Such beneficiaries receive Medicaid assistance only for help with Medicare premiums and cost sharing. Individuals who do qualify for full Medicaid benefits are referred to as QMB Plus enrollees. They qualify for full Medicaid through a non-MSP eligibility pathway that can be either mandatory or optional in their state of residence. A similar structure exists for the SLMB program, in which SLMB enrollees who also qualify for full Medicaid benefits are eligible through a non-MSP pathway and are referred to as SLMB Plus enrollees.

[3] Originally, the QI program had two parts: QI-1 for individuals with incomes of at least 120 percent but less than 135 percent of the FPL and QI-2 for individuals with incomes of at least 135 percent 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 reauthorized a number of times before being made permanent with the 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).

[4] In most states, receipt of SSI confers Medicaid eligibility.

[5] Individuals applying for full Medicaid benefits are screened for MSP eligibility.

[6] We do not have coverage details regarding benefits covered or enrollee expenses.

[7] Federal standards for the MSPs are found in Section 1902(a)(10)(E) of the Social Security Act (the Act) and state flexibility to establish more generous standards is found in Section 1902(r)(2).

[8] The LIS program, also called Extra Help, provides subsidized prescription drug coverage to Medicare beneficiaries with low income and assets. The Social Security Administration (SSA) determines eligibility and enrolls beneficiaries. Eligible beneficiaries may qualify for a full subsidy if their incomes are below 135 percent FPL and their assets in 2020 do not exceed $7,860 for an individual or $11,800 for a married couple; they may qualify for a partial subsidy if their incomes are less than 135 percent FPL and their assets are between $7,860 and $12,890, or if income is between 135 percent and 150 percent FPL and assets do not exceed $13,110 for an individual and $26,160 for a married couple.

[9] Many individuals are deemed eligible for the Medicare Part D LIS program (CMS 2019d). Such individuals receive a notice of their eligibility to enroll in a Part D plan from CMS and can either select a plan on their own or be auto-enrolled in one. Individuals deemed eligible for the LIS program include full-benefit dually eligible beneficiaries, individuals receiving SSI benefits, and individuals already enrolled in the QMB, SLMB, or QI programs. QDWI enrollees are not deemed eligible for LIS (SSA 2019c). Medicare beneficiaries with limited income and resources who are not deemed eligible must apply for LIS through SSA or their state Medicaid programs, either of which can determine their eligibility (CMS 2009).

[10] MIPPA amended Section 1144(c)(3) of the Act to require SSA to transmit data from LIS applications to state Medicaid agencies for the purpose of initiating MSP applications. Section 1935(a)(4) of the Act requires states to accept data transmitted under Section 1144(c)(3) and to act on such data as if they constituted an application for MSP benefits that had been submitted directly by an applicant (Lakhmani 2019).

[11] Letters to individuals potentially eligible for QDWI are mailed at the end of November, shortly before the Medicare general open enrollment period begins so that potential enrollees will contact their Medicaid offices prior to contacting SSA (SSA 2019b).

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Commission Vote on Recommendation

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation on improving participation in the Medicare Savings Programs. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 3.1 on April 2, 2020.

Improving Participation in the Medicare Savings Programs

3.1 Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

Yes:	Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	16	Yes
Not present:	Barker	1	Not present

APPENDIX 3A: Medicare Savings Programs

TABLE 3A-1. Medicare Savings Program Beneficiary Income and Asset Eligibility Limits, by State, 2020

State	Monthly income limit, as a percentage of FPL			Asset limit
	QMB	SLMB	QI	
Federal standard	**100% plus $20 disregard**	**120% plus $20 disregard**	**135% plus $20 disregard**	**$7,860 (single); $11,800 (married)**
Alabama	Federal standard			No limit
Alaska	Federal standard			Federal standard
Arizona	Federal standard			No limit
Arkansas	Federal standard			Federal standard
California	Federal standard			Federal standard
Colorado	Federal standard			Federal standard
Connecticut[1]	211%	231%	246%	No limit
Delaware	Federal standard			No limit
District of Columbia	300%	–	–	No limit
Florida	Federal standard			Federal standard
Georgia	Federal standard			Federal standard
Hawaii	Federal standard			Federal standard
Idaho	Federal standard			Federal standard
Illinois	Federal standard plus $25 disregard			Federal standard
Indiana	150%	175%	185%	Federal standard
Iowa	Federal standard			Federal standard
Kansas	Federal standard			Federal standard
Kentucky	Federal standard			Federal standard
Louisiana	Federal standard			No limit
Maine[2]	150% plus $75 disregard	175% plus $75 disregard	185% plus $75 disregard	$58,000 (single); $87,000 (married)
Maryland	Federal standard			Federal standard
Massachusetts	130%	150%	165%	$15,720 (single); $23,600 (married)
Michigan	Federal standard			Federal standard
Minnesota	Federal standard			$10,000 (single); $18,000 (married)
Mississippi	Federal standard plus $50 disregard			No limit
Missouri	Federal standard			Federal standard

TABLE 3A-1. (continued)

State	Monthly income limit, as a percentage of FPL			Asset limit
	QMB	SLMB	QI	
Montana	Federal standard			Federal standard
Nebraska	Federal standard			Federal standard
Nevada	Federal standard			Federal standard
New Hampshire	Federal standard			Federal standard
New Jersey	Federal standard			Federal standard
New Mexico	Federal standard			Federal standard
New York	Federal standard			No limit
North Carolina	Federal standard			Federal standard
North Dakota	Federal standard			Federal standard
Ohio	Federal standard			Federal standard
Oklahoma	Federal standard			Federal standard
Oregon	Federal standard			No limit
Pennsylvania	Federal standard			Federal standard
Rhode Island	Federal standard			Federal standard
South Carolina	Federal standard			Federal standard
South Dakota	Federal standard			Federal standard
Tennessee	Federal standard			Federal standard
Texas	Federal standard			Federal standard
Utah	Federal standard			Federal standard
Vermont	Federal standard			No limit
Virginia	Federal standard			Federal standard
Washington	Federal standard			Federal standard
West Virginia	Federal standard			Federal standard
Wisconsin	Federal standard			Federal standard
Wyoming	Federal standard			Federal standard

Notes: FPL is federal poverty level. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. The Qualified Disabled and Working Individuals (QDWI) program is not included in this table. States with no asset limit have eliminated the asset test.

– Dash indicates that the category is not applicable.

[1] Connecticut does not include the standard $20 income disregard in its income levels.

[2] Maine's asset limits apply to liquid assets only.

Source: MACPAC analysis of data from the National Council on Aging as of February 2020 (NCOA 2020).