CHAPTER 4

Financial assistance for low-income Medicare beneficiaries

CHAPTER 4

Financial assistance for low-income Medicare beneficiaries

Chapter summary

Medicare Savings Programs (MSPs) provide financial assistance with the Medicare Part B premium for beneficiaries with incomes up to 135 percent of the federal poverty level. Medicare's Part D prescription drug benefit, when implemented in 2006, incorporated a new subsidy structure that provided assistance to beneficiaries with incomes up to 150 percent of the federal poverty level. In 2008, the Commission recommended that the Congress align the MSP income eligibility criteria with the Part D low-income drug subsidy (LIS) criteria, effectively extending the Part B premium subsidy to beneficiaries with incomes up to 150 percent of the federal poverty level.

The Commission's 2012 recommendation on the redesign of the fee-for-service (FFS) benefit package balances two main goals: to give beneficiaries better protection against high out-of-pocket (OOP) spending and, at the same time, create financial incentives for them to make better decisions about their use of discretionary care by maintaining cost sharing (deductibles, copayments, or coinsurance) at the "point of sale." Even with the improved FFS benefit, Medicare beneficiaries with limited incomes could still have difficulty paying their OOP costs. The Commission's 2008 recommendation, which would effectively increase the MSP income eligibility criteria to 150 percent of the federal poverty level, would provide additional financial assistance to lower income beneficiaries by fully subsidizing their Part B

In this chapter

premium while still maintaining desirable incentives at the point at which services are provided.

This chapter explains the rationale behind the Commission's 2008 recommendation related to MSPs, provides examples of variation in MSP eligibility across states, describes why premium assistance for low-income beneficiaries through MSPs permits a targeted and efficient approach to help low-income beneficiaries, and explains how the 2008 recommendation addresses more recent concerns about the affordability of low-income beneficiaries' Medicare OOP costs under the redesigned FFS benefit. ■

TABLE 4–1

Previous Commission recommendations on the Medicare Savings Programs and the reformed FFS benefit design

Topic	Recommendation	Report to the Congress
Medicare Savings Programs	• The Secretary should increase State Health Insurance Assistance Program funding for outreach to low-income Medicare beneficiaries. • The Congress should raise Medicare Savings Program income and asset criteria to conform to low-income drug subsidy criteria. • The Congress should change program requirements so that the Social Security Administration screens low-income drug subsidy applicants for federal Medicare Savings Program eligibility and enrolls them if they qualify.	March 2008
FFS benefit design	The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include: • an out-of-pocket maximum; • deductible(s) for Part A and Part B services; • replacing coinsurance with copayments that may vary by type of service and provider; • secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum; • no change in beneficiaries' aggregate cost-sharing liability; and • an additional charge on supplemental insurance.	June 2012

Note: FFS (fee-for-service).

Source: Medicare Payment Advisory Commission 2012. Medicare Payment Advisory Commission 2008.

Introduction

Medicare Savings Programs (MSPs) provide financial assistance with Medicare out-of-pocket (OOP) costs for beneficiaries with incomes up to 135 percent of the federal poverty level. The extent of the financial assistance available through MSPs varies based on income. In 2014, the federal poverty level is set at an annual income of $11,670 for an individual and $15,730 for a couple (Office of the Assistant Secretary for Planning and Evaluation 2014).[1] In 2014, 135 percent of the federal poverty level corresponds to an annual income of $15,755 for an individual and $21,236 for a couple. Beneficiaries with incomes up to 100 percent of the federal poverty level are eligible for financial assistance with their Part A and Part B premiums, deductibles, copayments, and coinsurance through one of the MSPs, the Qualified Medicare Beneficiary (QMB) program. Beneficiaries with incomes above 100 percent and up to 135 percent of the federal poverty level are eligible for assistance with their Part B premium through the other MSPs. In 2008, the Commission recommended that the Congress align the MSP income eligibility criteria with the Part D low-income drug subsidy (LIS) criteria established in 2006, which is 150 percent of the federal poverty level (Table 4-1).[2] If this recommendation were implemented, beneficiaries with incomes up to 150 percent of the federal poverty level would receive financial assistance with their Part B premium. In 2014, the annual Part B premium is almost $1,300.

The Commission's 2008 recommendation to conform the MSP and LIS income eligibility criteria was based on analyses of low-income beneficiaries' OOP spending. The Commission found that, in general, Medicare beneficiaries age 65 and older were more likely to be low income than non-Medicare beneficiaries under age 65; Medicare beneficiaries spent a larger percentage of their income on OOP health costs than non-Medicare beneficiaries under age 65; and beneficiaries eligible for, but not enrolled in, MSPs were more likely than those enrolled in MSPs to report avoiding needed health care because of cost.

In 2012, the Commission recommended a redesigned fee-for-service (FFS) benefit package (Table 4-1). The current FFS benefit design includes a relatively high deductible for

TABLE 4–2 **Medicare premium and cost-sharing assistance by beneficiary income**

	Income			
	Up to 100% FPL	**100–120% FPL**	**120–135% FPL**	**135–150% FPL***
Medicare Part A and Part B				
MSP category	QMB	SLMB	QI	Not covered
Part A premium	X			
Part B premium	X	X	X	
Deductibles (Part A and Part B)	X			
Coinsurance (Part A and Part B)	X			
Medicare Part D LIS				
Part D premium or deductible	X	X	X	X**
Reduced copayment	X	X	X	X

Note: FPL (federal poverty level), MSP (Medicare Savings Program), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), LIS (low-income drug subsidy). There are also asset criteria for MSPs and the LIS program. Since 2008, the listed MSPs and the LIS have used the same asset limits. Most Medicare beneficiaries do not pay the Part A premium because they have worked at least 40 quarters and paid Medicare taxes while working. The table excludes the MSP category of qualified disabled working individuals and other full-benefit dual-eligible beneficiaries who are not part of the MSP program.
* Some Medicare beneficiaries—including those who have incomes within the 135 percent to 150 percent of the federal poverty level range—can meet their state's eligibility for Medicaid benefits. These beneficiaries are not enrolled in the MSPs, however, because they do not meet the MSP income and/or asset eligibility criteria. States may—but are not statutorily obligated to—cover Medicare cost sharing for these beneficiaries.
** These beneficiaries receive a partial Part D premium subsidy based on a sliding scale and a reduced deductible.

Source: Centers for Medicare & Medicaid Services 2013a; Centers for Medicare & Medicaid Services 2013b; Medicare Payment Advisory Commission 2008.

inpatient stays, a relatively low deductible for physician and outpatient care, and a coinsurance requirement of 20 percent of allowable charges for most physician care and outpatient services (see online Appendix 4-A, available at http://www.medpac.gov). Under this benefit, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. Without additional coverage, the FFS benefit design exposes Medicare beneficiaries to substantial financial risk.

The Commission's 2012 recommendation on the redesign of the FFS benefit package balances two main goals: to give beneficiaries better protection against high OOP spending and, at the same time, create incentives for them to make better decisions about their use of discretionary care. There is inherent tension between these two goals. If the benefit design provides too much financial protection, then beneficiaries might not have appropriate incentives to make cost-conscious choices and reduce the use of lower value services. However, if cost sharing is too high, beneficiaries might reduce their use of care indiscriminately, not necessarily based on whether the service is appropriate or essential, and would remain unprotected from the risk of very high and unpredictable medical expenses. The Commission's recommendation protects beneficiaries by adding an OOP spending maximum and creates clearer incentives for beneficiaries to make better decisions about their use of care by replacing coinsurance with copayments (Medicare Payment Advisory Commission 2012).

Even under an improved benefit, however, Medicare beneficiaries with limited incomes could have difficulty paying their OOP costs. The Commission's 2008 recommendation to align the MSP and LIS income eligibility criteria addresses some of this concern. Alleviating the expense of the Part B premium for beneficiaries with incomes between 135 percent and 150 percent of the federal poverty level would enable low-income beneficiaries to use these funds to pay the remainder of their Medicare OOP costs.

Current programs for low-income beneficiaries under Medicare

The Congress created MSPs and the Part D LIS program to help low-income beneficiaries pay for their OOP expenses related to Medicare-covered services. Eligibility for MSPs and the LIS is based on income and asset criteria. There are multiple MSP categories that provide assistance with some

or most of a beneficiary's Part A and Part B premiums and cost sharing, depending on the beneficiary's income. All beneficiaries enrolled in MSPs are considered dual-eligible beneficiaries. As explained in more detail below, some MSP enrollees (referred to as partial-benefit dual-eligible beneficiaries) are eligible only for premium assistance and, in some cases, cost-sharing assistance through MSPs. Other MSP enrollees (referred to as full-benefit dual-eligible beneficiaries) are eligible for full Medicaid benefits in addition to cost-sharing assistance through MSPs. For the LIS, the level of assistance varies by the beneficiary's income and dual-eligible status.

Levels of financial assistance under MSPs and the LIS

Low-income beneficiaries receive varying levels of assistance based on their income. There are four income categories: up to 100 percent of the federal poverty level, 100 percent to 120 percent of the federal poverty level, 120 percent to 135 percent of the federal poverty level, and 135 percent to 150 percent of the federal poverty level. The first three income categories correspond to the following MSP categories: qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and qualifying individuals (QIs).[3] The asset eligibility limit is the same for each of these three MSP categories. To qualify for MSPs in 2014, beneficiaries must have assets that are less than or equal to $7,160 for an individual or $10,750 for a couple. Table 4-2 summarizes the levels of assistance available for various MSP and LIS beneficiary groups.

- ***Up to 100 percent of the federal poverty level:*** Beneficiaries with incomes up to 100 percent of the federal poverty level are eligible for assistance with Part A and Part B premiums and cost sharing through the QMB program. Of all the MSP categories, the QMB program offers the most generous benefits. QMBs are eligible for assistance with Medicare Part A and Part B premiums, deductibles, and coinsurance. Most beneficiaries with incomes up to 100 percent of the federal poverty level also qualify for full Medicaid benefits within their state, such as Medicare wrap-around services and long-term care services and supports. These beneficiaries are full-benefit dual-eligible beneficiaries and are referred to as QMB-plus. QMB-only beneficiaries, who are partial-benefit dual-eligible beneficiaries, do not meet their state's criteria for full Medicaid benefits and are eligible only for assistance with Medicare OOP costs. QMBs are the largest MSP category. In 2011, about 6 million beneficiaries—12 percent of all Medicare beneficiaries—were enrolled in the QMB program (Table 4-3). Under the Part D LIS, beneficiaries with incomes up to 100 percent of the federal poverty level pay a nominal copayment (in 2014, $1.20 for generic drugs, $3.60 for brand-name drugs), but do not pay a Part D premium or deductible.

TABLE 4–3

All Medicare beneficiaries (FFS and Medicare Advantage) enrolled in the MSPs, 2011

MSP category	Number of beneficiaries (in millions)	Percent of all Medicare beneficiaries
QMB	6.0	12%
SLMB	1.1	2
QI	0.5	1

Note: FFS (fee-for-service), MSP (Medicare Savings Program), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual). Table includes beneficiaries enrolled in both FFS and Medicare Advantage.

Source: MedPAC analysis of 2011 Common Medicare Environment data.

- ***Between 100 percent and 120 percent of the federal poverty level:*** Beneficiaries with incomes between 100 and 120 percent of the federal poverty level are eligible for payment of their Part B premium under the SLMB program. Some beneficiaries in this income category also qualify for full Medicaid benefits within their state. They are referred to as SLMB-plus and are full-benefit dual-eligible beneficiaries. SLMB-only beneficiaries are partial-benefit dual-eligible beneficiaries because they are eligible for payment of their Part B premium but are not eligible for full Medicaid benefits. The SLMB program is the second largest MSP category; in 2011, slightly more than one million beneficiaries (2 percent of all Medicare beneficiaries) were SLMBs (Table 4-3). Beneficiaries in this income category are also eligible for the LIS program. They pay a reduced copayment for their Part D drugs (in 2014, $2.55 for generic drugs, $6.35 for brand-name drugs), but do not pay a Part D premium or deductible.

- ***Between 120 percent and 135 percent of the federal poverty level:*** Beneficiaries with incomes between 120 percent and 135 percent of the federal poverty level are eligible for the QI program. Similar to the SLMB program, QIs are eligible only for payment of their Part B premium. Enrollment in the QI program is lower than enrollment in the QMB and

TABLE 4–4

FFS Medicare program spending and beneficiary cost-sharing liabilities by MSP category, 2011

MSP category	Percent of FFS beneficiaries*	Average FFS Medicare program spending	Average FFS Medicare cost-sharing liability
QMB-only	2.5%	$11,140	$1,920
QMB-plus	11.7	13,400	2,220
SLMB-only	1.6	10,540	1,780
SLMB-plus	0.6	19,920	3,400
QI	0.8	11,170	1,890
Non-MSP, non-dual	78.8	8,240	1,470

Note: FFS (fee-for-service), MSP (Medicare Savings Program), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual). MSP categories are based on beneficiaries' status as of July 2011. Program spending and cost-sharing liability numbers are rounded to nearest $10. Beneficiaries enrolled in Medicare Advantage plans are excluded.
* The percentage of beneficiaries does not sum to 100 because the analysis excludes beneficiaries who were not enrolled in Medicare in July 2011 and "other full-benefit dual-eligible beneficiaries." Individuals in the latter group are eligible for full Medicaid benefits but are not enrolled in the MSPs because they do not meet the MSP income and/or asset eligibility criteria. These beneficiaries often reside in long-term care facilities.

Source: MedPAC analysis of 2011 Common Medicare Environment data.

SLMB programs. Currently, the QI program is authorized through March 31, 2015. In 2011, close to 500,000 beneficiaries—1 percent of all Medicare beneficiaries—were enrolled in the QI program (Table 4-3, p. 63). In the LIS program, beneficiaries in this income category pay a reduced copayment for their Part D drugs (in 2014, $2.55 for generic drugs, $6.35 for brand-name drugs), but do not pay a Part D premium or deductible.

- ***Between 135 percent and 150 percent of the federal poverty level:*** Beneficiaries with incomes between 135 percent and 150 percent of the federal poverty level are not eligible for MSPs. They are, however, still eligible for the Part D LIS. These beneficiaries get a partial Part D premium subsidy based on a sliding scale, a reduced deductible ($63.00 in 2014), reduced coinsurance up to the OOP threshold (the lower of the 15 percent coinsurance or the plan copay), and reduced copayments after the OOP threshold (in 2014, $2.55 for generic drugs, $6.35 for brand-name drugs).

Medicare spending on beneficiaries enrolled in MSPs

FFS beneficiaries enrolled in MSPs tend to have higher Medicare program expenditures than non-MSP, non-dually eligible beneficiaries. Table 4-4 summarizes average program spending and beneficiary cost-sharing liability of beneficiaries who were enrolled in only FFS (i.e., enrolled in both Medicare Part A and Part B and not enrolled in Medicare Advantage) in 2011. Their MSP category was based on their status as of July 2011.

In 2011, Medicare per capita FFS spending was higher for MSP beneficiaries than for non-MSP, non-dual-eligible beneficiaries (Table 4-4). Average per capita FFS spending on beneficiaries enrolled in MSPs ranged from a low of $10,540 (for SLMB-only beneficiaries) to a high of $19,920 (for SLMB-plus beneficiaries). SLMB-plus beneficiaries may have such high Medicare FFS spending because, in order to qualify for the SLMB-plus program, individuals must incur OOP expenses that reduce their income to Medicaid eligibility levels. It is likely that these individuals also had high Medicare expenditures while incurring high OOP expenses. In comparison with MSP beneficiaries, Medicare FFS average per capita spending was $8,240 for non-MSP, non-dual-eligible beneficiaries. Within QMB and SLMB categories, full-benefit dual-eligible beneficiaries (the QMB-plus and SLMB-plus) had higher spending than partial-benefit dual-eligible beneficiaries (the QMB-only and SLMB-only). The numbers shown in Table 4-4 are unadjusted and reflect differences in beneficiary characteristics across MSP categories. For example, compared with non-dual-eligible beneficiaries, more dual-eligible beneficiaries report being in poor health and having more limitations in activities of daily living (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2013).

Financing of MSPs and state payment of Medicare cost sharing

The MSP categories are either jointly funded by the federal government and states or fully financed by the federal government. The QI program is fully financed by the

TABLE 4–5 **Examples of state variation in MSP income and asset limits, 2014**

Medicare beneficiary	Annual income	Income as a percent of FPL	Assets	MSP status if the beneficiary lives in: Alabama	Connecticut	Oregon
Individual A	$21,006	180%	$7,000	Does not qualify for any MSPs	Qualifies for the QMB program	Does not qualify for any MSPs
Individual B	$12,837	110	$10,000	Qualifies for the SLMB program	Qualifies for the QMB program	Does not qualify for any MSPs

Note: MSP (Medicare Savings Program), FPL (federal poverty level), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary). Examples are hypothetical. The 2014 federal poverty level is $11,670 for an individual. The 2014 MSP asset limit for QMBs and SLMBs is $7,160 for an individual.

Source: Data for state MSP income and asset thresholds are from Alabama Medicaid Agency 2014, Connecticut Department of Social Services 2013, and Oregon Department of Human Services 2012.

federal government; federal funds are appropriated for the QI program and given through block grants to states to administer the program. In contrast, cost-sharing payments made under the QMB and SLMB programs are jointly financed by states and the federal government. States receive a match through the federal medical assistance percentage for any Medicaid funds they use to pay the QMBs' and SLMBs' Medicare premium and cost-sharing obligations.

States vary as to whether they pay the full cost-sharing obligation for beneficiaries enrolled in MSPs. States must pay the Part B premium on behalf of QI and SLMB enrollees, and they must pay the Part A and Part B premiums on behalf of QMB enrollees. However, states are not obligated to pay QMB enrollees' full Medicare cost-sharing liabilities, and most states do not (Medicaid and CHIP Payment and Access Commission 2013, Medicare Payment Advisory Commission 2008).[4] According to the Balanced Budget Act of 1997, a state does not have to pay any of a QMB enrollee's cost-sharing liability if the amount the Medicare program paid to the provider is greater than the state's Medicaid payment rate for that same service. The combined amount that a provider receives from Medicare and any amount received from Medicaid is considered payment in full on behalf of the QMB, and providers are not permitted to bill beneficiaries for any remaining cost sharing.

Examples of state variation in MSP eligibility

Which beneficiaries qualify for MSPs varies across states. The income and asset eligibility levels for MSPs are statutorily defined. However, states may apply income disregards or eliminate the MSP asset tests; doing so enables beneficiaries with incomes and assets that exceed the MSP statutory eligibility criteria to qualify for MSPs in those states.

With respect to income disregards, by federal law, $20 of monthly income is disregarded when determining MSP income eligibility (Congressional Research Service 2013). States, though, may apply additional income disregards. For example, Connecticut, the District of Columbia, and Maine apply additional income disregards that effectively raise the QMB program income threshold from the federal limit of 100 percent of the federal poverty level to 140 percent of the federal poverty level in Maine, 200 percent of the federal poverty level in Connecticut, and 300 percent of the federal poverty level in the District of Columbia (Connecticut Department of Social Services 2013, Consumers for Affordable Health Care and Maine Equal Justice Partners 2013, Government of the District of Columbia 2013). There are federal asset limits for MSPs. Resources that count toward the asset limit include checking and savings accounts, stocks, bonds, mutual funds, and individual retirement accounts (Congressional Research Service 2013). However, eight states—Alabama, Arizona, Connecticut, Delaware, Maine, Mississippi, New York, and Vermont—do not apply asset limits for eligibility for MSPs (Medicare Rights Center 2014). Therefore, beneficiaries residing in these states could qualify for MSPs even if they had assets that exceed the federal limit.

Table 4-5 presents illustrative (and hypothetical) examples of how state variation in income disregards and asset limits can result in Medicare beneficiaries qualifying for

MSPs in some states but not in others. In the first example, Individual A is a female Medicare beneficiary with an annual income of 180 percent of the federal poverty level and $7,000 in assets. According to federal eligibility limits, she does not qualify for any MSPs because her income exceeds 135 percent of the federal poverty level. If she lived in either Alabama or Oregon, she would not qualify for MSPs because income eligibility for MSPs in those states is consistent with the federal income eligibility limits. However, she would qualify for the QMB program in Connecticut because that state applies income disregards that effectively raise the QMB income eligibility to 200 percent of the federal poverty level.

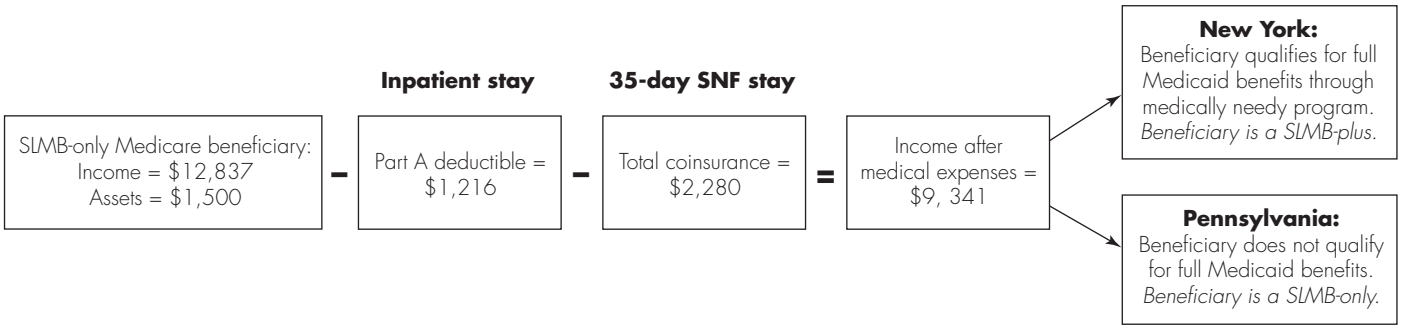
In the second example, Individual B is a male Medicare beneficiary with an income of 110 percent of the federal poverty level and assets of $10,000. Individual B's income meets the federal eligibility limits for the SLMB program, but his assets exceed the federal eligibility limits for any MSPs ($7,160 in 2014). Therefore, according to federal eligibility limits, he does not qualify for MSPs. If he lived in Oregon, he would not qualify for MSPs because the Oregon MSP income and asset eligibility criteria are consistent with federal eligibility limits. If he lived in Alabama, he would qualify for the SLMB program based on his income alone because Alabama does not apply asset limits to MSPs. If he lived in Connecticut, he would be eligible for the QMB program because Connecticut does not apply asset limits to MSPs and applies income disregards to the QMB program that effectively increase QMB income eligibility to 200 percent of the federal poverty level.

Moreover, beneficiaries enrolled in MSPs who qualify for full Medicaid benefits in one state may qualify only for cost-sharing assistance in another state because income eligibility for full Medicaid benefits varies across states.[5] Income eligibility limits, as a percent of the federal poverty level, for full Medicaid benefits range from a high of 133 percent in Massachusetts (for persons with disabilities) to a low of 61 percent in Ohio (for persons age 65 or older as well as those with disabilities). Most states apply a limit of 100 percent for all populations (Medicaid and CHIP Payment and Access Commission 2014). In addition, individuals with higher incomes may be eligible for Medicaid if they have high medical expenses (as described in the next paragraph) of if they require long-term care. As a result, a Medicare beneficiary with an income of 100 percent of the federal poverty level ($11,670 in 2014) who lived in Vermont would qualify for the QMB-plus program and would be eligible to receive full Medicaid benefits in addition to Medicare cost-sharing assistance. However, if this same person lived in Ohio, he or she would qualify for the QMB-only program because this beneficiary's income exceeds Ohio's Medicaid threshold of 61 percent of the federal poverty level. In Ohio, this beneficiary would be eligible for assistance with Medicare premiums and cost sharing, but would not be eligible for full Medicaid benefits.

Medicare beneficiaries—including MSP enrollees and those with incomes higher than federal MSP income thresholds—can become eligible for full Medicaid benefits through the medically needy, or "spend-down," program. Most states have a medically needy program, but income eligibility limits vary across states (Medicaid and CHIP Payment and Access Commission 2014). Individuals can qualify for Medicaid through the medically needy program if they are categorically eligible for Medicaid (e.g., the aged, blind, and disabled) and have medical expenses that—after deducted from their income—reduce their income to meet their state's medically needy income limits. Individuals are eligible for Medicaid through spend-down on a month-by-month basis, though eligibility can also be determined for a longer period of up to six months. However, because medically needy income limits vary across states, the same person could spend down to qualify for full Medicaid benefits in one state but not qualify for the medically needy program in another state.

The following is a hypothetical example of how beneficiaries can spend down their incomes to be eligible for medically needy programs in some states but not others, using the states of New York and Pennsylvania for illustrative purposes (Figure 4-1). Assume that in 2014, an aged male Medicare beneficiary has an annual income of $12,837, or 110 percent of the federal poverty level, and assets of $1,500. Also assume that he does not have any other medical or supplemental insurance. Because this beneficiary's income is between 100 percent and 120 percent of the federal poverty level, he qualifies for payment of his Part B premium through the SLMB program. However, because his income exceeds 100 percent of the federal poverty level, he does not qualify for full Medicaid benefits, even though he is aged (i.e., categorically eligible at age 65 or older). After an acute inpatient hospital stay, this beneficiary pays the Part A deductible of $1,216. He is then admitted to a skilled nursing facility (SNF) for 35 days and—per Medicare policy—pays a coinsurance of $152/day for the 21st day through the 35th day of his SNF stay. After the inpatient and SNF stays, this beneficiary's out-of-pocket medical expenses amount to $3,496. After deducting

FIGURE 4–1 **Example of spend-down and state variation in the medically needy program, 2014**



Note: SLMB (specified low-income Medicare beneficiary), SNF (skilled nursing facility). Example is hypothetical. The 2014 federal poverty level is $11,670 for an individual. The 2014 SLMB asset limit is $7,160 for an individual. The 2014 SNF coinsurance is $152 per day after the first 20 days. Eligibility for the medically needy program is 83 percent of the federal poverty level in New York and 44 percent of the federal poverty level in Pennsylvania.

these medical expenses, his income is $9,341, or about 80 percent of the federal poverty level.[6] If this beneficiary lived in New York, he would qualify for full Medicaid benefits (SLMB-plus) through the medically needy program because New York's income limit for that program is 83 percent of the federal poverty level (an income of about $9,686).[7] But if this same beneficiary lived in Pennsylvania, he would not qualify for full Medicaid benefits (he would be SLMB-only) because Pennsylvania's income limit for their medically needy program is 44 percent of the federal poverty level (an income of about $5,135).

Targeting assistance for low-income beneficiaries through the MSPs

The Commission stated in its 2008 report that the MSPs are a direct and efficient way to target assistance to low-income beneficiaries (Medicare Payment Advisory Commission 2008). Because eligibility for MSPs is based on a beneficiary's income and assets, the assistance provided through MSPs is directly targeted to low-income beneficiaries. Moreover, under the QI and SLMB programs, cost-sharing incentives at the point of service are maintained because beneficiaries in those programs do not receive assistance with their Part A and Part B deductibles, coinsurance, or copayments.

Policy discussions related to providing additional protections for low-income beneficiaries often include higher payments to plans or certain providers who tend to serve them. For example, some believe that payments to Medicare Advantage (MA) plans that exceed the cost of furnishing services to the same population under FFS Medicare are a way of providing extra help for low-income beneficiaries who are more likely to enroll in MA plans. However, higher MA payments and extra benefits financed by those payments do not go only to low-income beneficiaries. Rather, all enrollees in a given MA plan receive the same extra benefits, low income or not. The Commission, therefore, has argued that MA payments are not a direct or efficient way to target assistance to low-income beneficiaries (Medicare Payment Advisory Commission 2008).

Finally, during the Commission's previous discussion of the effects of supplemental coverage, some argued that medigap plans are especially important for protecting low-income beneficiaries from catastrophic financial liability. Although medigap plans fill in some or all of Medicare's cost sharing, their premiums are much higher than their expected benefits because a large share of medigap premiums covers these plans' administrative costs. Moreover, supplemental coverage policies in general can impose additional costs on the Medicare program that are not accurately reflected in the supplemental plans' premiums. Under minimal exposure to cost sharing, beneficiaries have incentives to obtain more care without experiencing commensurate additional costs, and providers have no incentives to manage utilization. For these reasons, medigap plans are neither a targeted nor efficient way to subsidize low-income beneficiaries' health care costs.

Rationale for the Commission's 2008 recommendation

The Commission's 2008 recommendation to align MSP and LIS income eligibility levels was based on analyses of low-income beneficiaries' income and Medicare OOP spending. The Commission's main findings are stated here:

- ***Medicare beneficiaries age 65 and older were more likely to be low income than the non-Medicare population under age 65.*** According to the Current Population Survey (CPS), the median income of an individual age 65 or older in 2006 was $17,045, compared with $28,077 for an individual younger than age 65 (Medicare Payment Advisory Commission 2008).
- ***Medicare beneficiaries spend a larger percentage of their income on OOP health costs.*** In 2003, Medicare beneficiaries age 65 and older had median total annual OOP health care expenditures that were nearly three times as high as the median total annual OOP health care expenditures of the non-Medicare population under age 65. These OOP expenditures accounted for 12.5 percent of income for the 65-and-older population compared with 2.2 percent of income for the under-65 population (Desmond et al. 2007).
- ***Low-income beneficiaries who did not receive financial assistance were more likely to forgo needed care.*** Low-income beneficiaries eligible for, but not enrolled in, MSPs were more likely than those enrolled in MSPs to report avoiding physician visits because of cost (Federman et al. 2005).

Since the recommendation in 2008, the above findings remain generally true. Medicare beneficiaries still have lower incomes than non-Medicare individuals under age 65, and they are still more likely to be low income. According to the CPS, the median income of an individual age 65 or older in 2012 was $20,380 (or about 180 percent of the 2012 federal poverty level of $11,170), compared with $29,788 for an individual younger than age 65 (Census Bureau 2013).

Relationship between the 2008 and 2012 recommendations

The Commission's 2008 recommendation would have the effect of increasing the number of low-income beneficiaries who are eligible for payment of their Part B premium, which is the type of financial assistance provided through MSPs for people with incomes above 100 percent of the federal poverty level. Under this recommendation, the Part B premium's roughly $1,300 annual expense would be alleviated, enabling low-income beneficiaries to use these funds to pay the remainder of their Medicare OOP costs. Moreover, cost-sharing incentives under the redesigned FFS benefit would be preserved because beneficiaries' Part A and Part B deductibles and coinsurance would remain intact.

Although the Commission's 2008 recommendation to align MSP and LIS income eligibility was more general, the illustrative example included in the 2008 report to the Congress assumed that the QI program income eligibility threshold would be raised to 150 percent of the federal poverty level. A benefit to providing extra financial assistance through the QI program is that the program is already fully financed by the federal government. Therefore, increasing the income eligibility for this program would not increase state spending. However, assisting more low-income beneficiaries with their Part B premium would increase Medicare program spending.

Finally, increasing the QI income eligibility to 150 percent of the federal poverty level would directly target assistance to more low-income beneficiaries. And it would be consistent with the Commission's view that extra financial assistance is more directly and efficiently targeted through MSPs than through overpayments to providers or to Medicare Advantage. Part B premium assistance would be directly targeted to low-income beneficiaries because only those with incomes up to 150 percent of the federal poverty level and limited assets would be eligible for the assistance. Further, cost-sharing incentives at the point of service would be maintained because beneficiaries would not receive assistance with their deductibles, coinsurance, or copayments. ■

Endnotes

1 The federal poverty level is higher for Alaska ($14,580 for an individual in 2014) and Hawaii ($13,420 for an individual in 2014).

2 There are also asset limits for MSP and LIS eligibility. To be eligible, beneficiaries must have countable assets below a specified level. In 2014, the asset limit is $7,160 for an individual. Some assets, such as an individual's primary residence and one car, are not counted toward the asset limit.

3 The fourth MSP category includes the qualified disabled working individuals (QDWIs). They are disabled individuals with incomes up to 200 percent of the federal poverty level who lost their Medicare Part A benefits because they returned to work but are eligible to purchase Medicare Part A. The resource limit for the QDWI program is lower than for other MSPs, at $4,000 for an individual in 2014 (compared with $7,160 for the other MSPs). Under QDWI benefits, beneficiaries are eligible for assistance with their Part A premium. In 2009, only 102 individuals were enrolled in the QDWI program.

4 Other full-benefit dual-eligible beneficiaries qualify for Medicaid benefits but are not enrolled in the MSPs because they do not meet the MSP income and/or asset eligibility criteria. States may—but are not statutorily obligated to—cover Medicare cost sharing for these beneficiaries.

5 In the majority of states, asset limits for full Medicaid benefits for the aged, blind, and disabled are $2,000 for an individual and $3,000 for a couple (Kaiser Commission on Medicaid and the Uninsured 2010).

6 Pennsylvania uses a six-month period for spend-down determinations. New York also uses a six-month period for spend-down determinations when a hospital stay is involved. This example assumes that the beneficiary's medical expenses are incurred within the last six months of the year.

7 Income thresholds for medically needy programs in New York and Pennsylvania are for 2014 (Medicaid and CHIP Payment and Access Commission 2014).

References

Alabama Medicaid Agency. 2014. Medicaid income limits for 2014. http://medicaid.alabama.gov/documents/3.0_Apply/3.2_Qualifying_Medicaid/3.2_Medicaid_Income_Limits_Revised_2-7-14.pdf.

Census Bureau. 2013. PINC–01: Selected characteristics of people 15 years old and over by total money income in 2012, work experience in 2012, race, Hispanic origin, and sex. Current Population Survey. 2013 Annual Social and Economic Supplement. http://www.census.gov/.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013a. Announcement of calendar year (CY) 2014 Medicare Advantage capitation rates and Medicare Advantage and Part D payment policies. Note from Jonathan D. Blum, deputy administrator, Center for Medicare, and Paul Spitalnic, director, Parts C & D Actuarial Group, Office of the Actuary, to Medicare Advantage organizations, prescription drug plan sponsors, and other interested parties. April 1.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013b. *Medicaid coverage of Medicare beneficiaries (dual eligibles) at a glance.* Fact sheet. Baltimore, MD: CMS.

Congressional Research Service. 2013. *Medicare: Part B premiums.* Washington, DC: CRS.

Connecticut Department of Social Services. 2013. Frequently asked questions. http://www.ct.gov/dss/cwp/view.asp?a=2345&q=451390.

Consumers for Affordable Health Care and Maine Equal Justice Partners. 2013. *MaineCare eligibility guide.* Augusta, ME: Maine Equal Justice Partners. http://www.mejp.org/sites/default/files/mainecare-guide.pdf.

Desmond, K. A., T. Rice, J. Cubanski, et al. 2007. *The burden of out-of-pocket health spending among older versus younger adults: Analysis from the Consumer Expenditure Survey, 1998–2003.* Medicare issue brief. Washington, DC: Kaiser Family Foundation.

Federman, A. D., B. C. Vladeck, and A. L. Siu. 2005. Avoidance of health care services because of cost: Impact of the Medicare savings program. *Health Affairs* 24, no. 1 (January–February): 263–270.

Government of the District of Columbia, Department of Health Care Finance. 2013. Policies and procedures for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs. Transmittal no. 13–06. http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal%2013-06.pdf.

Kaiser Commission on Medicaid and the Uninsured. 2010. *Medicaid financial eligibility: Primary pathways for the elderly and people with disabilities.* Issue brief. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Medicaid and CHIP Payment and Access Commission. 2014. *Report to the Congress on Medicaid and CHIP.* Washington, DC: MACPAC.

Medicaid and CHIP Payment and Access Commission. 2013. *Report to the Congress on Medicaid and CHIP.* Washington, DC: MACPAC.

Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2008. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. 2013. *Data book: Beneficiaries dually eligible for Medicare and Medicaid.* Washington, DC: MedPAC/MACPAC.

Medicare Rights Center. 2014. Medicare Savings Program financial eligibility guidelines. http://www.medicareinteractive.org/uploadedDocuments/mi_extra/MSPFinancialEligibiltyGuidelines.pdf.

Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. 2014. 2014 poverty guidelines. http://aspe.hhs.gov/poverty/14poverty.cfm.

Oregon Department of Human Services. 2012. Qualified Medicare Beneficiaries. https://apps.state.or.us/Forms/Served/se9017.pdf.