Medicare

Four Strategies for Improving Programs that Help Low-Income Medicare Beneficiaries with Health Care Costs

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Low-income people with Medicare often struggle with high out-of-pocket health care costs.

The Medicare Savings Programs and the Part D low-income subsidy offer some relief from these costs for those who enroll. But many vulnerable seniors and people with disabilities are ineligible for these programs, and many others who could qualify have not enrolled.

This brief identifies four strategies that can work at both the federal and state levels to improve the programs that help low-income Medicare beneficiaries. These strategies would raise eligibility levels to cover more people and streamline and simplify the eligibility rules to make getting help easier.

**Background**

Medicare provides vital health insurance to more than 50 million seniors and people with disabilities, including many low-income beneficiaries. (Some of these low-income beneficiaries are eligible for both Medicare and Medicaid—they are called “dual eligibles.”). However, Medicare has substantial monthly premiums and requires beneficiaries to pay some of their health care costs out of their own pockets (this is known as cost-sharing).

The average Medicare household spends 14 percent of its income on health care costs, compared with only 5 percent for non-Medicare households.¹ For low-income beneficiaries, these costs can be overwhelming, at times forcing them to forgo needed care or to reduce spending on other necessities, such as food and utilities.²

Although existing programs that help with Medicare costs provide some relief, they are inadequate both in terms of what they cover and in the number of people they reach.

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Medicare beneficiaries with low incomes can have difficulty paying their out-of-pocket health care costs.

The Medicare Savings Programs and Part D low-income subsidy can help these beneficiaries, but the programs should be improved to cover and enroll more beneficiaries.
Current Programs

Several different programs serve low-income Medicare beneficiaries. There are three Medicare Savings Programs, which are run by state Medicaid agencies:

1. **Qualified Medicare Beneficiary (QMB)** program, which covers beneficiaries with incomes up to 100 percent of poverty

2. **Specified Low-Income Medicare Beneficiary (SLMB)** program, which covers beneficiaries with incomes between 100 and 120 percent of poverty

3. **Qualified Individual (QI)** program, which covers beneficiaries with incomes between 120 and 135 percent of poverty

All of these programs cover Medicare’s Part B premium. (Part B covers most outpatient services, like doctors’ visits.) The Part B premium is $104.90 per month in 2014. Social Security normally deducts the amount of the Part B premium from Medicare enrollees’ Social Security benefits each month.

The QMB program also covers the premium for Medicare Part A (which covers inpatient and hospital care) for those who have to pay it, as well as all deductibles, copayments, and co-insurance for Parts A and B.

The **Part D low-income subsidy** is another program that helps low-income people with Medicare. This program is administered by the federal government (the Social Security Administration) and covers Medicare Part D premiums and most prescription drug copayments. The program is also known as “Extra Help.”

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Strategies for Improvement

Since their inception, the programs that serve low-income Medicare beneficiaries have struggled to fulfill their potential. Even with the expansions and improvements that were included in federal Medicare legislation that was enacted in 2003 and 2008, the programs don’t cover all of the vulnerable people they could, and a large number of those who are eligible remain unenrolled.

There are multiple strategies for improving protections for low-income Medicare beneficiaries. The four strategies we explore can be implemented in different ways at either the federal or state level. These strategies are not mutually exclusive—they could be implemented in different combinations or separately from each other.
STRATEGY 1  
Increase income eligibility standards

The greatest burden of health care costs falls on Medicare households with incomes between 100 and 200 percent of the federal poverty level (between $11,670 and $23,340 a year for an individual in 2014). These low-income Medicare enrollees spend an average of almost 16 percent of their incomes on health care costs, compared to just over 5 percent for the average non-Medicare household.

This is not surprising, because relatively little assistance with Medicare costs is available to people in this income bracket.

» Federal rules limit income eligibility for the Medicare Savings Programs to 135 percent of poverty ($15,755 a year for an individual).

» For beneficiaries with incomes up to 150 percent of poverty ($17,505 a year for an individual), some limited help with prescription drugs is available through the Part D low-income subsidy.

» For beneficiaries with incomes above 150 percent of poverty, no assistance is available.

Federal strategy: Enacting legislation to increase the minimum federal income limits for the Medicare Savings Programs and the Part D low-income subsidy is a straightforward way to help financially vulnerable beneficiaries with their health care costs.

There is no specific, optimal level to which Congress should raise eligibility. However, in other health care programs, such as the Children’s Health Insurance Program (CHIP), people with incomes up to 200 percent of poverty are considered to have limited incomes. Raising income eligibility limits to that level would provide much-needed relief to people who are currently struggling with substantial health care costs: More than one-third of those who are estimated to benefit from such an improvement report being in fair or poor health and are likely already incurring substantial health care expenses.

While such an expansion would increase federal expenditures somewhat, a portion of those costs would be offset by savings elsewhere—for example, from beneficiaries better adhering to prescription drug regimens because their drugs were more affordable.

State strategy: Under current law, states have the option to make the income limits for their Medicare Savings Programs more generous than the federal minimum. They can do this by establishing amounts of income that they will “disregard” (not count) when determining an applicant’s eligibility. A few states, including Connecticut and Maine, as well as the District of Columbia, have increased income eligibility limits for their Medicare Savings Programs.

We encourage states to adopt more generous income eligibility rules for their Medicare Savings Programs, because once beneficiaries qualify for any one of these programs, they are automatically enrolled in the Part D low-income subsidy.
D low-income subsidy. This means that, in addition to what beneficiaries save on Medicare Part B premiums and out-of-pocket costs, they have lower prescription drug costs, too.

Since most of the costs of the Medicare Savings Programs are borne by the federal government through Medicaid matching formulas, what it would cost states to make these improvements would be modest. Some states may even see savings elsewhere. For example, expanding eligibility for the Part D low-income subsidy could produce savings in state pharmaceutical assistance programs (SPAPs) that use state-only funds to provide prescription drugs.

**STRATEGY 2**

**Modernize asset limits**

Asset limits disqualify many low-income Medicare beneficiaries with modest savings from receiving assistance with their health care costs. Federal asset limits are quite low. In 2014:

- Asset limits for the Medicare Savings programs are $7,160 for an individual and $10,750 for a couple.
- The most a beneficiary can have in assets and still qualify for even a partial Part D low-income subsidy is $13,440 for an individual and $26,860 for a couple.

Asset test rules are different in different states. In general, the value of a beneficiary’s home and at least one vehicle do not count toward most states’ asset limits. However, most savings in bank accounts and retirement funds do count toward states’ asset limits.

Asset limits have several harmful effects. They:

- **Penalize people for saving responsibly during their working years**, which may become an increasingly significant problem in years to come as fewer employers offer pensions and workers are expected to save their own retirement funds.
- **Increase agencies’ administrative costs**—verification of assets is considerably more difficult than verifying income, because tax records do not directly report assets.
- **Make it more difficult to identify potentially eligible people**—tax records and applications for other public benefits, such as the Low Income Home Energy Assistance Program (LIHEAP), can help spot those who could meet income rules, but they do not indicate whether someone meets an asset limit.
- **Require applicants to answer intrusive questions and provide documentation**, which can discourage people from applying.

Since most of the costs of the Medicare Savings Programs are borne by the federal government through Medicaid matching formulas, what it would cost states to make these improvements would be modest. Some states may even see savings elsewhere. For example, expanding eligibility for the Part D low-income subsidy could produce savings in state pharmaceutical assistance programs (SPAPs) that use state-only funds to provide prescription drugs.
Easing asset limits for the Medicare Savings Programs also helps beneficiaries with their prescription drug costs, because all Medicare Savings Program enrollees automatically qualify for the Part D low-income subsidy.

**STRATEGY 3**

**Align eligibility criteria across programs**

Differences between the Medicare Savings Programs and the Part D low-income subsidy make it difficult for the programs to operate seamlessly and contribute to low rates of enrollment.

These differences persist even though the changes to the Medicare Savings Programs that took effect in 2010 have brought the programs into closer alignment with the Part D low-income subsidy. Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy. Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13 Asset limits for the Medicare Savings Programs are now similar to, but not exactly the same as, those for the Part D low-income subsidy.13

Key differences remain in how the federal Part D low-income subsidy and the state-run Medicare Savings Programs define income, assets, and household size, as well as in what documentation applicants must provide. In particular, burial funds and life insurance are often treated differently.

Ideally, one application should assess eligibility for both the Part D low-income subsidy and the Medicare Savings Programs. To this end, since 2010, the Social Security Administration (SSA) has sent information...
about all applicants for the Part D low-income subsidy to state Medicaid agencies.

Medicaid agencies are required to treat the application for the Part D low-income subsidy as an application to the state’s Medicare Savings Programs (unless the applicant opts out). However, because states have different rules for income, assets, and household size than the SSA does, many state Medicaid agencies cannot process these applications without getting additional information from applicants.

Some states also require applicants to verify information that has already been provided to and accepted by the SSA. Requiring this additional information creates a hassle for applicants, many of whom never follow up on the initial application and therefore miss out on benefits for which they are eligible. As of 2012, only 15 states reported accepting all Social Security data as verified.

Federal strategy: Federal law could be changed to require states to adopt the same definitions of income and assets for the Medicare Savings Programs as those the SSA uses to make determinations for the Part D low-income subsidy. The law could also require states to accept any information SSA provides to them as verified information. This would greatly diminish the amount of additional documentation beneficiaries would have to provide to complete an application for the Medicare Savings Programs.

State strategy: Under current law, states can change their Medicare Savings Program rules to use the Part D low-income subsidy definitions that are set by the SSA. Changing state rules for how they treat life insurance, burial funds, and household definitions to accord with Social Security rules could be particularly effective at increasing enrollment.

States also have the option to accept Social Security data without requiring any further documentation from applicants. Doing so speeds the enrollment process and reduces administrative burdens on state agencies and applicants.

**STRATEGY 4**

**Improve cost-sharing protections within existing programs**

Paying out-of-pocket health care costs is particularly challenging for Medicare beneficiaries with incomes between 100 and 200 percent of poverty.

For Medicare beneficiaries with incomes up to 100 percent of poverty ($11,670 for an individual in 2014) who meet their states’ asset tests, the Qualified Medicare Beneficiary (QMB) program pays all out-of-pocket costs for Medicare Parts A and B. When combined with the Part D low-income subsidy, the QMB program gives these beneficiaries good protection from out-of-pocket health care costs.
For beneficiaries whose incomes are low but above the poverty level, this protection is considerably less comprehensive.

» The Specified Low-Income Beneficiary (SLMB) and Qualified Individual (QI) programs cover only Medicare Part B premiums.

» The SLMB and QI programs do not cover other Medicare out-of-pocket costs, such as the $1,216 Medicare Part A hospital deductible or the 20 percent co-insurance for doctors’ visits.

» The Part D low-income subsidy covers most out-of-pocket prescription drug costs, but only for those with incomes up to 135 percent of poverty ($15,755 for an individual in 2014).

⚠️ Federal strategy: The out-of-pocket protections of the QMB program could be extended in full or in part to those with slightly higher incomes and assets.

These changes could also help health care providers. Today, when beneficiaries are unable to pay their share of Medicare costs, their providers often end up writing off those costs as bad debt. An expanded QMB program would offer these providers another source of reimbursement.

⭐ State strategy: Under current law, states can use income disregard rules to expand eligibility for the QMB benefit. Income disregard rules give states the flexibility to not count specific amounts of income when making Medicaid eligibility determinations, including determinations for the QMB program.

Several states have already done this. For example, in Connecticut, Maine, and the District of Columbia, low-income Medicare beneficiaries who would normally be eligible only for help with their Medicare Part B premiums under the SLMB or QI programs instead receive full protection from out-of-pocket costs through the QMB program.

This is a simple way for states to provide low-income Medicare beneficiaries with relief from out-of-pocket health care costs without having to create new programs. Making this change may require just a state Medicaid plan amendment, which, depending on state law, may not even require a legislature’s action.
Conclusion: Multiple paths for improvement

At both the federal and state level, advocates and policymakers have a range of incremental and more comprehensive policy options for improving the programs that help low-income Medicare beneficiaries. These changes can relieve vulnerable seniors and people with disabilities from financial hardships that can force them to choose between paying for health care and other necessities. And while these improvements would likely have some costs, a number of them would produce administrative savings or reduce expenditures elsewhere.

At the federal level, making large-scale changes is currently unlikely. But even small changes like aligning eligibility criteria across programs can make a significant difference in simplifying programs. In the states, current federal rules give Medicaid programs considerable flexibility to expand eligibility for their programs. And as the number of Medicare beneficiaries continues to rise over the coming years, the need for these sorts of changes will also grow.

Advocates and policymakers have a range of policy options for improving the programs that help low-income Medicare beneficiaries. While making large-scale changes at the federal level is unlikely, even small changes made at the federal or state level can simplify the programs and protect vulnerable seniors and people with disabilities from high health care costs.
Endnotes


4 These laws are the Medicare Modernization Act (MMA) of 2003 and the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

5 A “Medicare household” is one or more people living together, all of whom are Medicare beneficiaries.

6 Juliette Cubanski et al., op. cit., p. 3.


8 For example, see Congressional Budget Office, Offsetting Effects of Prescription Drug Use on Medicare’s Spending for Medical Services (Washington: Congressional Budget Office, November 2012), available online at http://www.cbo.gov/publication/43741.


11 Ibid.


13 The changes were included in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.


A selected list of relevant publications to date:

*Low-Income Medicare Beneficiaries Need Better Protection from Health Care Costs* (November 2013)

*Improving Low-Income Assistance Programs to Fill Gaps in Medicare* (November 2013)


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