

# Improving health care access for low-income Medicare beneficiaries

Jason Brown and Gopi Shah Goda



## ACKNOWLEDGMENTS

The authors would like to thank Lauren Bauer and Wendy Edelberg for their thought partnership throughout the development of this proposal; Matt Fiedler, Bob Greenstein, and Wendell Pincus for their conscientious and constructive review; participants at the authors' conference for their thought-provoking insights; and Sara Estep for her excellent analytical support.

## MISSION STATEMENT

The Hamilton Project seeks to advance America's promise of opportunity, prosperity, and growth.

We believe that today's increasingly competitive global economy demands public policy ideas commensurate with the challenges of the 21st Century. The Hamilton Project's economic strategy reflects a judgment that long-term prosperity is best achieved by fostering economic growth and broad participation in that growth, by enhancing individual economic security, and by embracing a role for effective government in making needed public investments.

Our strategy calls for combining public investment, a secure social safety net, and fiscal discipline. In that framework, The Hamilton Project puts forward innovative proposals from leading economic thinkers—based on credible evidence and experience, not ideology or doctrine—to introduce new and effective policy options into the national debate.

The Hamilton Project is named after Alexander Hamilton, the nation's first Treasury Secretary, who laid the foundation for the modern American economy. Hamilton stood for sound fiscal policy, believed that broad-based opportunity for advancement would drive American economic growth, and recognized that "prudent aids and encouragements on the part of government" are necessary to enhance and guide market forces. The guiding principles of The Hamilton Project remain consistent with these views.



# Improving health care access for low-income Medicare beneficiaries

**Jason Brown**

*Consumer Financial Protection Bureau*

**Gopi Shah Goda**

*Stanford University*

October 2023

This policy proposal is a proposal from the author(s). This work was conducted independently of Jason Brown's employment and the views expressed do not necessarily reflect those of the Consumer Financial Protection Bureau. As emphasized in The Hamilton Project's original strategy paper, The Hamilton Project was designed in part to provide a forum for leading thinkers across the nation to put forward innovative and potentially important economic policy ideas that share The Hamilton Project's broad goals of promoting economic growth, broadbased participation in growth, and economic security. The author(s) are invited to express their own ideas in this policy proposal, whether or not The Hamilton Project's staff or advisory council agrees with the specific proposals. This policy proposal is offered in that spirit.

BROOKINGS

# Abstract

---

The Social Security Amendments of 1965 established the Medicare and Medicaid programs, which provide health insurance to the elderly, disabled, and people with limited income, respectively. Today, these programs serve over 141 million people in the United States. More than 12 million people receive support from both programs, including dual-enrolled beneficiaries who receive full Medicaid benefits, those who receive support to cover Medicare premiums and cost sharing through Medicare Savings Programs (MSPs), and those who receive full Medicaid benefits and are enrolled in an MSP.

MSPs consist of four separate programs that vary in their eligibility criteria and coverage. These programs are run by state Medicaid agencies with federally-established minimum eligibility criteria pertaining to income and assets, which states may relax or waive altogether.

While these programs serve to reduce the burden of high health care costs for low-income Medicare beneficiaries, certain factors hamper the programs' effectiveness:

- Millions of seniors who qualify for these programs are not enrolled, forgoing considerable support to which they are qualified.
- Sharp eligibility thresholds create discontinuous drops in support for premiums and cost sharing.

We make the following recommendations to improve the MSPs' ability to assist low-means senior citizens:

1. **Increase enrollment among eligible populations.** Effectively reaching low-income elderly populations requires a package of program changes that could together reduce frictions that prevent take-up among those eligible and minimize unnecessary churn in the program.
2. **Replace the current schedule of premium and cost-sharing support with a sliding scale that eliminates sharp changes in benefits as income changes.** Smoothing benefit cliffs would improve the equity of the program by ensuring people of similar means get similar levels of support.

Finally, we also describe additional issues that low-income Medicare beneficiaries face in access to, and coordination of, care that should be addressed in potential reforms to the program.

# Contents

---

- I. Introduction..... 1
- II. The challenge .....3
  - A. Program eligibility .....3
  - B. Enrollment characteristics .....3
  - C. Program take-up and targeting..... 4
  - D. Discontinuous changes in support..... 6
- III. The proposal..... 9
  - A. Increase enrollment among eligible populations ..... 9
  - B. Replace the current schedule of premium and cost-sharing support with a sliding scale of premium and cost-sharing support..... 11
- IV. Questions and concerns ..... 13
- V. Conclusion..... 15
- Endnotes ..... 17
- References ..... 18



# I. Introduction

---

Government provision and funding of health insurance programs support the goals of reducing the burden of high health care costs and promoting access to health care services. For the elderly and disabled population, this support comes through the federal Medicare program. For the low-income population, this comes through the federal/state Medicaid program. Older or disabled, low-means Americans can qualify for support through both programs.

About 12 million beneficiaries received support through both programs in 2020. As shown in figure 1, the largest category of dual enrollees receives full Medicaid benefits in addition to Medicare and cost-sharing and premium support from a Medicare Savings Program (MSP; 55 percent). Twenty-eight percent of dual enrollees are enrolled in an MSP and Medicare but are not receiving full Medicaid benefits. The remaining dual enrollees (17 percent) are enrolled in both Medicare and Medicaid but not in an MSP.

Medicare and Medicaid expenditures for this population are large both in aggregate and relative to total Medicare and Medicaid spending. Total spending on dual enrollees, \$456.2 billion in 2020, was 32.5 percent of total Medicare and Medicaid expenditures despite dual enrollees comprising only 8.5 percent of total Medicare and Medicaid enrollees. Of this spending, roughly 63 percent was funded by Medicare and the remainder funded by Medicaid (Medicare Payment Advisory Commission [MedPAC] and Medicaid and CHIP Payment and Access Commission [MACPAC] 2023).

The high degree of support for premiums and cost sharing, as well as the comprehensive benefits package offered by the Medicare and Medicaid programs, means that those who are enrolled are receiving considerable financial support from federal and state governments. Conversely, some populations with high needs may fall through the cracks either due to the eligibility rules or because of incomplete take-up by eligible populations. In addition, this population especially benefits from well-coordinated care due to their complex health care needs, which can be challenging when the responsibility for care provision is shared by two large programs.

In this proposal, we assess the current system's effectiveness on targeting and access to high-quality care and provide recommendations for improving how benefits are targeted and allocated. The

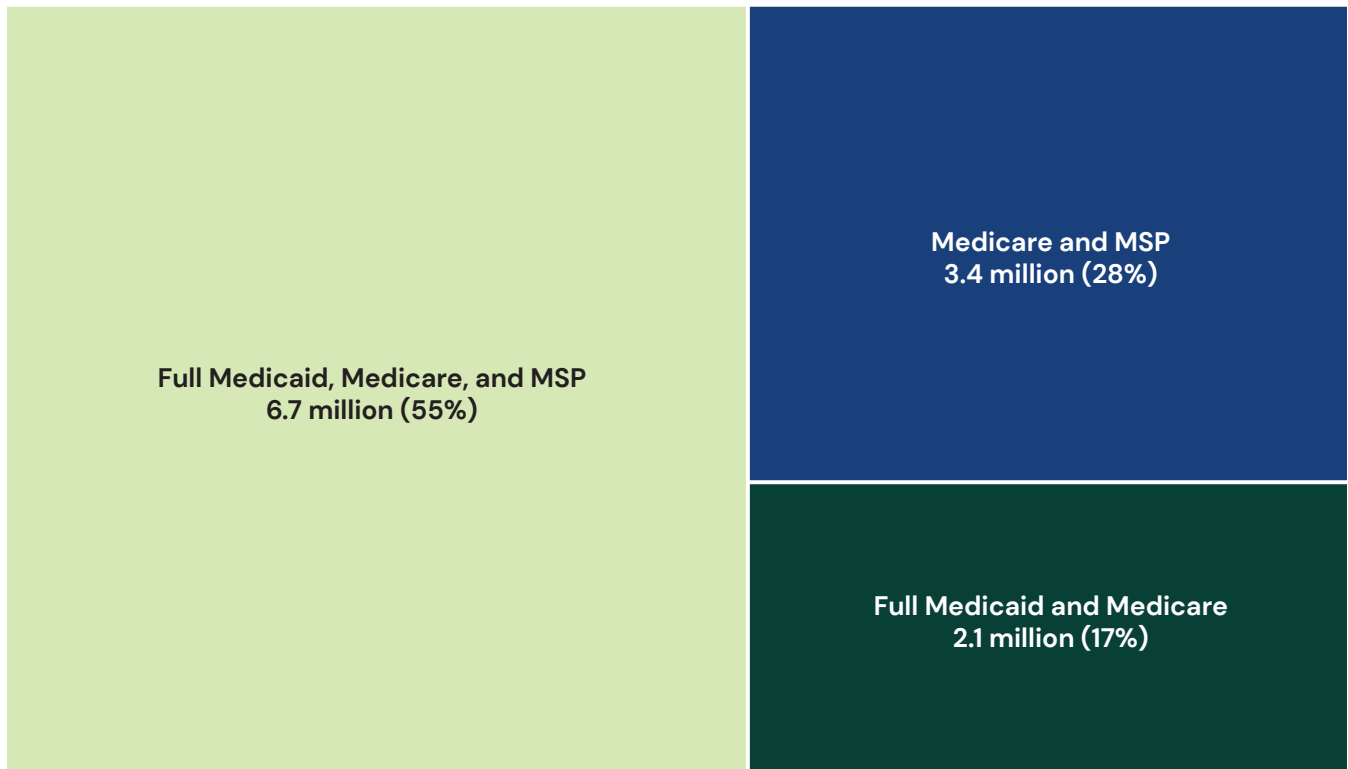
disproportionately high spending on dual enrollees has several implications for the dually eligible population; there is an interest in ensuring that the programs target those with the greatest needs. We show that millions of Americans forgo considerable support to which they are qualified under the current rules. We also present evidence that a considerable share of low-income populations has difficulty accessing care.

We make the following recommendations to improve the programs' ability to assist the target population:

1. **Increase enrollment among eligible populations.** Effectively reaching low-income elderly populations requires a package of program changes that could together reduce frictions that prevent take-up or minimize unnecessary churn in the program.
  - **Streamline eligibility determination for MSPs at the time of Medicare enrollment using lifetime earnings, and automatically enroll eligible beneficiaries.** The time when an individual ages into Medicare eligibility at age 65 represents a prime opportunity to reach low-income elderly populations. If accompanied by a change to eligibility criteria based on lifetime earnings, eligibility for MSPs can be nearly automatic. This is because the Medicare program has tracked recorded earnings subject to Medicare taxes—covering virtually all employment earnings—since 1978, encompassing the entire work histories of nearly everyone nearing Medicare eligibility.
  - **Eliminate annual recertification for those aged 65 and above.** As lifetime earnings would not be expected to substantially change for this population, the redetermination of benefits through MSPs would become largely unnecessary. Removing the need for recertification except for major life events eliminates churn in program enrollment from changing eligibility criteria or frictions in the recertification process. We propose using lifetime earnings up to age 60 to reduce complications in work and claiming decisions closer to eligibility. This means that eligibility would likely change only with a major life event, like marriage, divorce, or the death of a spouse.

FIGURE 1

## Dual-eligible beneficiary enrollment across categories, 2020



Source: MedPAC and MACPAC (2023, exhibit 2, p. 28).



BROOKINGS

2. **Replace the current schedule of premium and cost-sharing support with a sliding scale of premium and cost-sharing support.** Sharp changes in benefits at particular income thresholds can result in an inequitable allocation of benefits between individuals just below and above the threshold. We recommend smoothing the benefit structure such that each additional dollar in lifetime income reduces benefits in a similar way.

We present a framework for a proposal that would achieve these goals. We do not specify the full parameters of a new benefit schedule, which would determine the generosity of assistance at each income level, the breadth of incomes over which people qualify for assistance, and, importantly, the fiscal cost of our proposal. These features of the program are obviously important, but our goal here is to lay out the broad

structure that a more rationally-designed program might take and help readers understand the trade-offs involved in different parameter choices.

To help illustrate the trade-offs, we discuss options under various budget scenarios based on the current program's parameters. Specifically, we discuss the impact if the program's size was limited to current budget expenditures under current take-up levels, as well as if its size were based on current eligibility standards, assuming 100 percent take-up. The latter reform, because current take-up is low, would be considerably more expensive, and cover millions more people, than the current program. We leave it to others to decide what the "right" size of the program is. Finally, we also describe additional issues that low-income Medicare beneficiaries face in access to, and coordination of, care that should be addressed in potential reforms to the program.



## II. The challenge

---

We begin by describing key features of the program and the population’s characteristics, and then relate these features to the challenges we are trying to address.

### A. Program eligibility

Older or disabled Americans who have low incomes and meet asset tests can qualify for both Medicaid and Medicare, but benefits and support differ depending on an individual’s circumstance. MSPs provide premium and cost-sharing support to individuals based on income and asset criteria.

Medicare beneficiaries may also be eligible for full Medicaid benefits based on criteria that vary by their state of residence. The criteria include income and asset thresholds that vary by state but are generally at or below 300 percent of the federal Supplemental Security Income benefit rate (equating to approximately 225 percent of the federal poverty level [FPL]). In addition, there are eligibility pathways for elderly and disabled individuals living in poverty, those with high medical expenses, and those who qualify under specific waivers that states can request.

Eligibility for MSPs is based on federally-determined maximum income and asset limits that vary with the FPL. Each of the MSPs has different income limits, with the lowest-income beneficiaries (those with incomes at or below the FPL) qualifying for Qualified Medicare Beneficiary (QMB). Incomes between 101 and 120 percent FPL qualify for Specified Low-Income Medicare Beneficiary (SLMB), while qualifying for Qualifying Individual (QI) and Qualified Disabled Working Individual (QDWI) requires having an income between 121 and 135 percent FPL and below 200 percent, respectively. Federal asset limits were at least \$7,970 for individuals and \$11,960 for couples in 2021. In 2021, 16 states had expanded their MSPs by either raising their income or asset limits from federally-specified limits, some of which have removed the asset tests entirely.

Partial-benefit dual-eligible beneficiaries (“partial duals”) may be enrolled in one of four different MSPs:

1. QMB program provides coverage of Medicare Part A and Part B premiums, deductibles, copayments, and coinsurance for low-income beneficiaries.

2. SLMB program helps pay Medicare Part B premiums only.
3. QI program helps pay Medicare Part B premiums but has limited capacity. When capacity limits are reached, prior year enrollees are given priority.
4. QDWI program pays Medicare Part A premiums for certain disabled and working beneficiaries under 65 who are not enrolled in Medicaid but meet state income/asset limits.

Full-benefit dual-eligible beneficiaries (“full duals”) generally fall into three categories:

1. Individuals who meet state eligibility requirements for Medicaid (“full Medicaid only”)
2. Individuals who meet state eligibility requirements for Medicaid and QMB (“QMB Plus”)
3. Individuals who meet state eligibility requirements for Medicaid and SLMB (“SLMB Plus”)

Note that in this proposal, changes to MSPs would apply to both partial-benefit dual beneficiaries and full-benefit dual beneficiaries who are enrolled in an MSP. However, the proposal is limited to those benefits under the umbrella of this program and does not address the Low Income Subsidy program, which helps eligible Medicare beneficiaries pay for prescription drugs and lowers the cost of Medicare prescription drug coverage.

### B. Enrollment characteristics

Table 1 presents characteristics of the dual-enrolled population with a comparison to the nondual Medicare population in 2020. From the table, we see that the dual-enrolled population includes a greater fraction of nonelderly than the nondual Medicare population. Women and minorities are also considerably more likely to be dual enrolled. Furthermore, the dual-enrolled population has worse health than the nondual Medicare population, as indicated by a greater incidence of activities of daily living limitations and worse self-reported health status. Dual-enrolled beneficiaries are also much less likely to be married than

TABLE 1

## Characteristics of dual-enrolled population, 2020

	Percent dual enrolled	Percent nondual Medicaid
Total monthly enrollment	11 million	50.6 million
Under 65	37	7
Female	59	53
Race/ethnicity		
White/non-Hispanic	54	82
Black/non-Hispanic	21	9
Hispanic	17	6
Other	8	3
Activities of daily living limitations		
None	54	82
One to two	23	12
Three to six	24	6
Self-reported health		
Excellent or very good	21	52
Good or fair	59	40
Poor	13	4
Unknown	7	4
Living arrangements		
Institution	12	3
Alone	35	27
Spouse	15	54
Children/others	38	16
Per person Medicare spending	\$23,552	\$10,549
Per person Medicaid spending	\$13,854	N/A

Source: MedPAC and MACPAC (2023).

Note: Enrollment reflects average beneficiaries enrolled in any given month.



BROOKINGS

nondual Medicare beneficiaries. They are more likely to live alone, live in an institution, or live with people who are not their spouses.

The table also shows that government spending on each enrollee is over three times higher for this population. This increased spending stems from this population's higher health care utilization, the fact that dual-eligible beneficiaries are entitled to more benefits than the Medicare benefits package alone provides, and the government's coverage of nearly all health care spending for this population.

We also analyze the 2017–2019 Medicare Current Beneficiary Survey, which combines administrative and self-reported information on Medicare beneficiaries. We divide the sample based on the self-reported income of respondents relative to the FPL, using income bins associated with dual eligibility categories (i.e., 100 percent of FPL for the QMB cutoff, 120 percent of FPL for the SLMB cutoff, 135 percent of FPL for the QI cutoff, and 200 percent of FPL for the QDWI cutoff).<sup>1</sup> We then divide the sample into dual enrollment status, which is taken from administrative records. We classify the sample as being enrolled in Medicare only (nondual), having full dual enrollment, or having partial

dual enrollment, with QMB separate from the SLMB/QI/QDWI categories.

Table 2 shows the enrollment patterns largely lining up as we would expect according to income. Half of the Medicare population with incomes below 100 percent of FPL have full Medicaid benefits, and this income category accounts for 69 percent of full dual enrollment. Likewise, 99 percent of the Medicare population with incomes over 200 percent of FPL are not dual enrolled. Nonetheless, we do not observe enrollment in the various programs matching up exactly with the income categories used to determine enrollment in these programs. For instance, 30 percent of the population with income under 100 percent of FPL receives neither partial nor full Medicaid benefits even though we would expect nearly all those individuals to be eligible for full Medicaid benefits or QMB.<sup>2</sup> We explore this and other issues related to access to care in this section.

### C. Program take-up and targeting

As suggested above, a number of people eligible for both programs are not enrolled in both programs. Careful work has found that nearly four million people

TABLE 2

## Medicare population by income relative to the federal poverty level and dual enrollment status, 2017–19

	Full dual	Qualified Medicare Beneficiary partial dual	Specified Low-Income Medicare Beneficiary/Qualifying Individual/Qualified Disabled Working Individual partial dual	Nondual	Total
<b>&lt;100% of FPL</b>					
Observations	4,347	966	497	2,109	7,919
Percent of Income Category	50	12	7	30	100
Percent of Eligibility Category	69	71	33	6	15
<b>100% to 120% of FPL</b>					
Observations	697	152	524	1,262	2,635
Percent of Income Category	23	5	20	52	100
Percent of Eligibility Category	11	11	34	3	6
<b>120% to 135% of FPL</b>					
Observations	296	51	242	1,252	1,841
Percent of Income Category	14	3	12	71	100
Percent of Eligibility Category	5	4	15	3	4
<b>135% to 200% of FPL</b>					
Observations	525	127	183	6,042	6,877
Percent of Income Category	7	2	2	89	100
Percent of Eligibility Category	10	10	12	17	16
<b>Over 200% of FPL</b>					
Observations	250	51	81	21,325	21,707
Percent of Income Category	1	0	0	99	100
Percent of Eligibility Category	5	4	6	71	59
<b>Total</b>					
Observations	6,115	1,347	1,527	31,990	40,979
Percent of Income Category	11	3	3	83	100
Percent of Eligibility Category	100	100	100	100	100

Source: 2017–2019 Medicare Current Beneficiary Survey and authors' calculations.

Note: Shares are weighted using reported survey weights.



BROOKINGS

were eligible for QMB or SLMB and were not enrolled (Caswell and Waidmann 2017). Roughly half of the QMB-eligible population was enrolled, while around a third of the SLMB population was enrolled. Of the unenrolled population, over half have family incomes less than 120 percent of the FPL. In addition, over half have a limitation in either an activity of daily living or an instrumental activity of daily living, indicating some form of physical disability. They also spend nearly \$1,000 out of pocket on health care during a year. This is about half the average amount paid out of pocket among those who are not eligible for any MSP, which could indicate that either those in good health are less likely to seek out additional support from an MSP or those who do not enroll in an MSP to which they are entitled are foregoing care that they would otherwise seek. Research has found that losing QMB coverage does result in

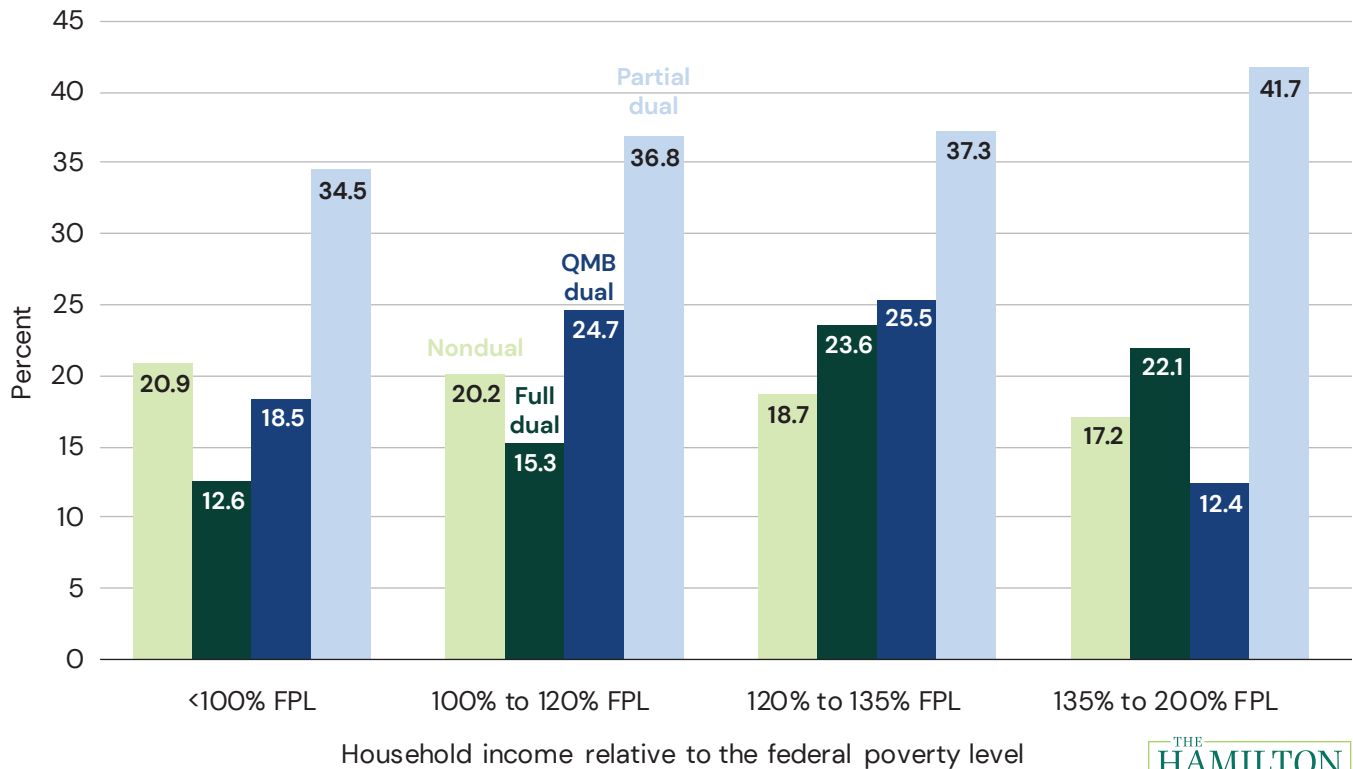
higher out-of-pocket costs yet fewer outpatient visits and filled prescriptions (Roberts et al. 2021).

Taking the population breakdowns we showed in table 2, we next explore the implications of dual enrollment status on access to care. In figure 2, we examine the share of Medicare beneficiaries in different MSP enrollment categories who report having issues paying for care within different income categories. We report the shares separately by income group since we would expect income to be a major driver of access to care, separate from dual enrollment status.

As shown in figure 2, over 20 percent of the population below poverty who are not dual enrolled (30 percent of the below-poverty population) report having trouble paying for care. Moreover, full benefits are associated with a noticeable positive benefit in the ability to pay across the income categories for those

FIGURE 2

## Share of Medicare beneficiaries reporting having issues paying for care, by dual status, and within income categories



Source: Medicare Current Beneficiary Survey and authors' calculations.

THE HAMILTON PROJECT

BROOKINGS

with incomes less than 120 percent of FPL. We also observe that those enrolled in SLMB, QI, and QDWI report even more difficulty paying for care than those who are not enrolled, which may indicate that many of those who especially struggle with paying for care seek out these benefits.

The large population without dual coverage, along with the higher out-of-pocket health care expenses they pay and the struggles they report paying for care, suggests that the dual programs' enrollment rules and procedures leave out many of those it intended to serve. Overall, we conclude that the population that is falling through the cracks—either due to eligibility criteria that disqualify them or those who are not enrolled despite being eligible (“false negatives”)—presents a bigger concern than the population that may be receiving benefits who are actually of higher means (“false positives”).

### D. Discontinuous changes in support

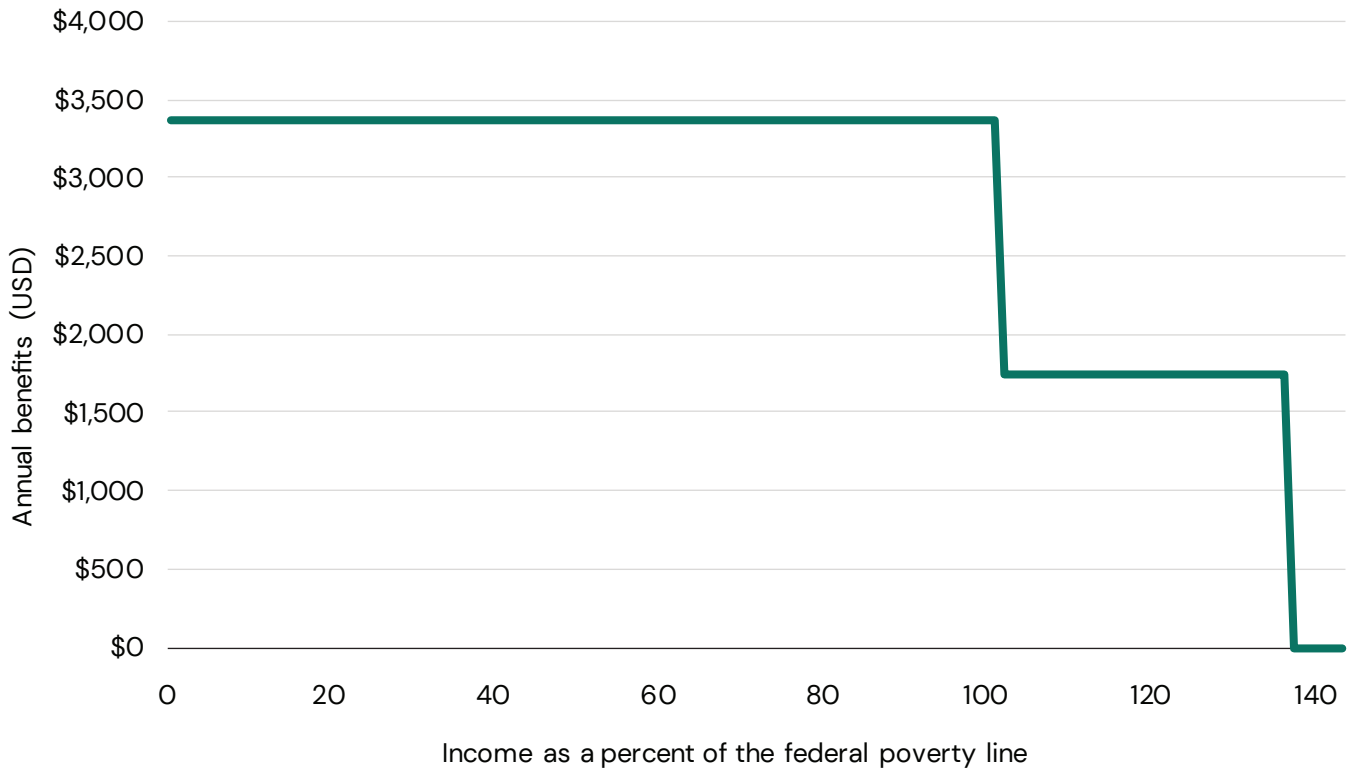
Full dual eligibility can depend on numerous factors, including income, assets, and medical need. For Medicare beneficiaries, the vast majority of people

qualified for Medicaid benefits would also qualify for QMB, thanks to the very low income limits (100 percent of FPL or less) required for most Medicaid eligibility pathways. However, starting at 100 percent of FPL, there are large breaks at income limits whereby support drops off sharply. As a beneficiary's income passes over the 100 percent FPL threshold, the beneficiary loses QMB eligibility and gains SLMB eligibility. With that comes the loss in support for deductibles, copayments, and cost sharing for Parts A and B.<sup>3</sup> This loss in support is considerable: One estimate from 2020 puts the average amount of spending for cost sharing at \$1,639 per beneficiary, or 13 percent of the annual income for a single individual at 100 percent of FPL.<sup>4</sup>

At 120 percent of FPL, an individual loses SLMB coverage and may qualify for their Part B premiums being paid by QI coverage; however, these programs have limited enrollment capacity. And at 135 percent of FPL, a QI beneficiary loses support for Part B premiums. In 2020 that would have amounted to \$1,735 per year. As we saw in table 2, those with SLMB/QI/QDWI coverage were much more likely to report difficulty paying for care than those with QMB and full dual coverage. This may indicate a malapportionment of subsidy across the dually-entitled population.

FIGURE 3

### Estimated average annual benefits from Medicare savings programs by current income as a percent of the federal poverty line, 2020



Source: Authors' calculations.

Note: Annual Part B premium assumed to be \$1,735 and cost-sharing assumed to equal average non-premium Medicaid spending on QMB enrollees (\$1,639). Part A premium assistance, available for QMB enrollees with incomes below 100 percent of FPL, are assumed to be zero as most beneficiaries qualify for Part A without premiums through their own or spouse's earnings history.



The dual-eligible program's subsidy structure contrasts with the subsidy structure on the health insurance marketplaces. Premium tax credits are set such that premiums cannot exceed a maximum amount of the filer's income and maximum share rises with income, leading to a more gradual phaseout of the premium subsidy. Likewise, cost-sharing support for the nonelderly population phases out in multiple increments as income rises (Congressional Research Service 2023a). Further, while Medicare provides considerable subsidies to people regardless of income, the health insurance marketplace subsidy structure is exclusively targeted to low- and moderate-income beneficiaries. These subsidies tend to be more generous at lower- and moderate-income amounts. For instance, a Medicare beneficiary with income at 150 percent of FPL will likely receive no subsidy for Part B premiums beyond the baseline, while someone with that income receiving a premium tax credit on the health insurance marketplace would pay no premium at all. Regarding cost sharing, Medicare pays an estimated 83 percent of costs for Parts A and Part B benefits, while the

cost-sharing subsidy for a nonelderly person at 150 percent of FPL on the marketplace falls from 94 to 87 percent.

Figure 3 illustrates the estimated annual value of the benefits enrollees in MSPs receive as a function of income.<sup>5</sup> We assume that those eligible for QMB, with incomes below 100 percent of FPL, receive cost-sharing support equal to the average out-of-pocket costs for Medicare fee-for-service. We do not include Part A premium assistance since most beneficiaries qualify for Part A at no cost through their own or spouse's earnings history. Note that the figure does not account for asset requirements, assumes eligible individuals have successfully enrolled, and presumes that capacity constraints for the QI program are not binding. To determine the total amount spent on QMB, SLMB, and QI, it would be necessary to replace the annual benefits with average cost-sharing support and Part A and B premiums covered for QMB beneficiaries at each income level, and then multiply the average annual benefits by the number of beneficiaries enrolled at each income level.

As illustrated in the figure, beneficiaries see a large reduction in annual benefits at both 100 percent and 135 percent of FPL. These reductions amount to \$1,639 and \$1,735 per year, respectively. The decrease at 100 percent of FPL comes from the loss of cost-sharing support, the amount of which depends on health care

utilization. Meanwhile, the benefit reduction at 135 percent comes from the drop in premium support, which is the same for all enrollees. The drop in benefits at 100 percent of FPL in the figure is understated if beneficiaries incur higher cost sharing than the average.

# III. The proposal

---

In this policy proposal, we make recommendations to improve the programs' ability to assist low-means seniors in gaining access to health care through increasing enrollment among the eligible population and by rationalizing the schedule of premium and cost-sharing support. We limit our proposal to the partial-dual program, given the especially low take-up in the partial-dual program and promising avenues for reform at the federal level that could be applied nationally.

We do not specify the full parameters of a new benefit schedule, which are what will determine the generosity of assistance at each income level, the breadth of incomes over which people qualify for assistance, and, importantly, the fiscal cost of our proposal. These features of the program are obviously important, but our goal here is to lay out the broad structure that a more rationally-designed program might take and help readers understand the trade-offs involved in different parameter choices. We leave it to others to decide what the "right" size of the program is.

To help illustrate the trade-offs, we discuss options under various budget scenarios based on the current program's parameters. Specifically, we discuss the impact if the program's size was limited to current budget expenditures under current take-up levels, as well as if its size was based on current eligibility standards, assuming 100 percent take-up. The latter reform, because current take-up is low, would be considerably more expensive, and cover millions more people, than the current program.

Furthermore, we note that while these proposals address incomplete take-up among eligible populations and sharp changes in support across income thresholds, they leave another issue unaddressed. Low-income Medicare beneficiaries enrolled in both Medicare and Medicaid also experience lower-quality and inefficient care because they are often subject to conflicting incentives in the two programs.

## A. Increase enrollment among eligible populations

Effectively reaching low-income elderly populations requires a package of program changes that, together,

could increase take-up or minimize unnecessary churn in the program.

### 1. Administrative burdens

We propose to reduce the administrative frictions in the MSP enrollment process by streamlining eligibility determination during Medicare enrollment for aged enrollees and eliminating annual recertification for MSPs.

Making enrollment automatic with an opt-out option at the time of Medicare enrollment will ensure that fewer low-means seniors fail to enroll in programs for which they are eligible. Additionally, eliminating annual recertification once enrolled will also prevent beneficiaries from being overlooked due to the administrative burden that recertification imposes. Since the circumstances affecting the MSP-eligible population are likely to be more stable than those of the working-age population, these administrative burdens likely screen out those with higher levels of need rather than those whose financial circumstances make them no longer eligible for support.

Research has shown that bureaucracy and administrative burdens around enrollment are a major driver of low take-up of public benefits (Herd and Moynihan 2018). An important consideration is who these burdens screen out. One line of argument is that higher hassle costs of enrollment can help programs target assistance toward higher-need populations. However, empirical research has found that in the U.S. context, higher frictions in enrollment have been shown to reduce take-up among higher-need populations for Social Security disability benefits, the Supplemental Nutrition Assistance Program, and the Earned Income Tax Credit (Bhargava and Manoli 2015; Finkelstein and Notowidigdo 2019; Deshpande and Li 2019).

The Biden administration has recently released rules that aim to streamline enrollment into MSPs by automatically enrolling eligible Supplemental Security Income recipients into the QMB program (Centers for Medicare and Medicaid Services 2023). This change leverages data from other programs and reduces duplicative paperwork. The Centers for Medicare and Medicaid Services estimate that this will result in 860,000 eligible individuals newly enrolled in MSPs.

## 2. Lifetime earnings

Our proposal expands on these principles and extends automatic enrollment more generally. We propose simplifying enrollment by changing the eligibility for MSPs to be based on lifetime earnings rather than current-year income and assets.

Calculations of lifetime earnings are based on wage earnings reported as part of the Social Security and Medicare tax system. Historically, not all employment has been covered by Medicare and/or Social Security. However, the Internal Revenue Service has transmitted wage earnings for covered and uncovered earnings to the Social Security Administration since 1978, meaning the Social Security Administration has detailed earnings records for most Americans for the last 45 years (Olsen and Hudson 2009).

We suggest using lifetime earnings as a mechanism for means testing Medicare premiums overall for several reasons. First, current-year income captures only a snapshot of well-being, while lifetime earnings reflect income over the entirety of one's productive years. Lifetime earnings are also subject to less possible manipulation than current-year earnings and could improve incentives to save and work, while also providing a more stable basis for means testing that is not subject to short-term income fluctuations (Samwick 2018).

Our proposal would gradually transition to eligibility based on lifetime earnings as new cohorts of beneficiaries age into Medicare at age 65 or qualify for Medicare benefits by having a qualifying disability. Annual earnings would need to be indexed, either using economy-wide price growth or wage growth, to compute total lifetime earnings. The choice of price indexing or wage indexing would affect people's eligibility differently depending on their earnings trajectory over their working lives, but we do not take a stand here on how those considerations should be assessed.

As lifetime earnings would not be expected to substantially change for this population, the redetermination of benefits through MSPs would largely become unnecessary. Removing the need for recertification eliminates churn in program enrollment from changing eligibility criteria or frictions in the recertification process. We propose using lifetime earnings up to age 60 to reduce complications in work and claiming decisions closer to eligibility, meaning that eligibility would likely change only with a major life event, like marriage, divorce, or the death of a spouse.

One important difference between using lifetime earnings and current income is that lifetime earnings are based on an individual's earning record alone, while current income is at the household level. An individual with low lifetime earnings married to an individual with high lifetime earnings would be considered less needy than someone with similarly low lifetime earnings who is not married to a high-earning individual. Currently,

for high-income Medicare beneficiaries, the income of both spouses is also used to adjust premiums upwards. Analogously, the lifetime earnings of both married individuals should thus be used to calculate eligibility for MSPs. Because lifetime earnings could potentially change from year to year if one spouse under age 60 is employed, joint lifetime earnings could be recomputed annually. Eligibility could then be reassessed automatically, although this would likely have a very small impact on the eligibility for the currently enrolled. For survivors and divorced beneficiaries claiming on a former spouse's work history, an adjustment to the calculation could permit expanded eligibility.

We note that while converting eligibility criteria from current income to lifetime earnings would increase the ability to automatically enroll eligible beneficiaries and eliminate the need for certification, it would also change the program's targeting to lifetime low earners rather than those who experience income shocks later in life. There will undoubtedly be people who would have been eligible under one set of criteria but are not through the other.

Thus, an important consideration is the extent to which lifetime earnings is a good measure of needs. Because lifetime earnings are so closely related to Social Security benefits, we turn to the importance of Social Security for the lowest-income elderly households. Recent work using rich administrative and survey data finds that 14 percent of individuals over the age of 65 rely on Social Security for 90 percent or more of family income, and 21 percent rely on Social Security for 75 percent or more of their income (Dushi and Trenkamp 2021). Another study finds that in the lowest income decile of households with a member 65 and over, on average, 85 percent of income comes from Social Security or Supplemental Security Income, while 87 percent of income comes from the two programs for the second decile. The mean total household income for the two lowest deciles as of 2013 was \$7,518 and \$13,046, putting them well on the lower end of the benefits distribution (Bee and Mitchell 2017). Thus, we conclude that Social Security income, and by extension lifetime earnings, would effectively target the neediest. We also note that full Medicaid benefits will remain available for those who qualify under traditional Medicaid eligibility rules regardless of how MSP eligibility would change.

To begin to understand the trade-offs involved in moving to a lifetime earnings standard from a current income standard for enrollment qualification, we point out that in 2020 there were roughly 54.1 million aged enrollees in Medicare, with 6.4 million seniors (or roughly 12 percent) enrolled in an MSP. Thus, a lifetime earnings standard under budget neutrality would only reach very low lifetime earners, in contrast to the current program where enrollment is split roughly equally between those below the poverty line (QMB) and



those above it (SLMB+QI), and with half of the below-poverty population not enrolled in an MSP.

Given this information, we feel that the benefits of easing the enrollment process through this mechanism outweigh the changes to the program targeting as automating enrollment will allow the program to reach a much larger share of the target population. Nonetheless, we recommend greater study of who would be affected by this change in policy, particularly if it is to be undertaken in a strictly budget-neutral fashion.

## B. Replace the current schedule of premium and cost-sharing support with a sliding scale of premium and cost-sharing support

Currently, partial duals receive various levels of premium, deductible, copayment, and coinsurance support through the QMB, SLMB, QI, or QDWI programs depending on their income, assets, and disability status. We propose to replace these disparate programs for the elderly with one comprehensive program that provides a sliding-scale schedule of support. In other words, we recommend smoothing the benefit structure such that each additional dollar in lifetime income reduces benefits equally across the lifetime income distribution.

For example, the new comprehensive program could provide full cost-sharing and premium support for individuals with low levels of lifetime earnings, and gradually phase out these benefits until reaching a certain level of average lifetime earnings where no support is provided. This schedule of benefits would be more akin to the sliding-scale schedule of premium tax credits available to those obtaining health insurance through the marketplace exchanges.

These changes would serve to reduce the complexity of MSPs, which currently provide an alphabet soup of different structures and eligibility requirements, and streamline the eligibility determination process further. The proposal would also eliminate inequities that result from individuals with very similar incomes receiving very different levels of benefits. Finally, in the absence of adopting our proposal to switch eligibility criteria from current income and assets to lifetime earnings, eliminating the current discontinuous schedule of benefits would also mitigate the incentives for people to distort their income and assets in order to become eligible for benefits at certain discrete points in the income distribution.

In figure 4, we illustrate our proposals and contrast the proposed structure to that illustrated in figure 3. The first proposed change involves modifying the

eligibility criteria from income as a percentage of FPL to lifetime earnings and enrolling beneficiaries automatically. The second proposed change involves removing the discontinuous drops in benefits by income and having benefits phase out as lifetime earnings increase.

The figure shows that the schedule of benefits declines with lifetime earnings. Point A on the vertical axis denotes the maximum benefit available for someone with no lifetime earnings. Point B denotes the highest level of lifetime earnings at which the full benefit is available and point C on the horizontal axis denotes the lifetime earnings level where benefits are completely phased out and equal to zero. At lifetime earnings levels between points B and C, the annual benefits—for both premium support and cost-sharing support—decline.

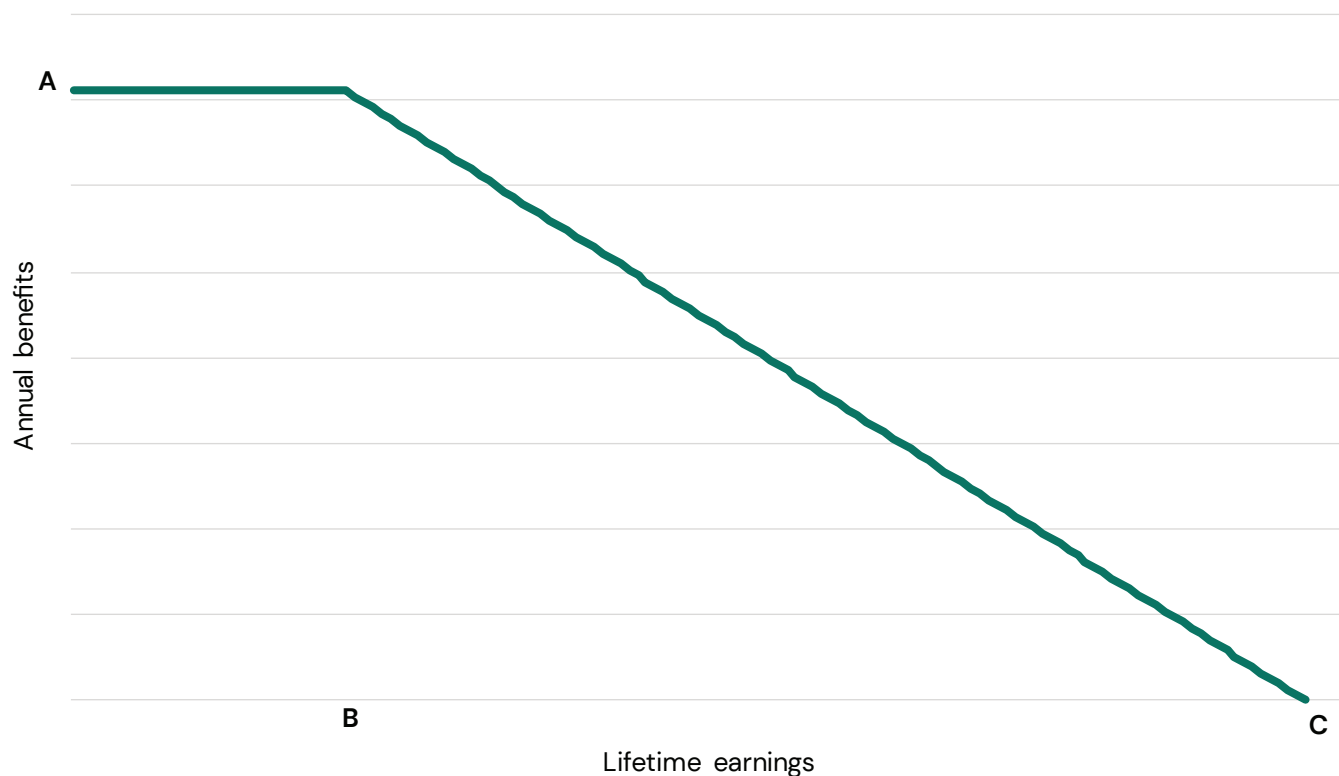
As before, the program's total budget can be determined by multiplying the annual benefits at each level of lifetime earnings by the number of enrollees at each earnings level. However, because we propose automatically enrolling eligible beneficiaries based on lifetime earnings, we expect the number of beneficiaries at each lifetime earnings level less than point B to increase substantially. Therefore, a budget-neutral change would involve setting points A and B to levels that reflect the higher take-up of benefits. Alternatively, keeping points A and B at levels that maintain benefit levels roughly equivalent would likely result in a higher budgetary cost if take-up rates increase.

Looking at current expenditures and take-up can give a general idea of the funds available to redistribute among beneficiaries in a reformed program. As noted above, in 2020, Medicare Part B premiums, which all MSPs covered, were \$144.60 per month, or \$1,735 annually. Using program expenditure data and enrollment data from MACPAC, we estimate that QMB enrollees received, on average, \$1,639 in cost-sharing assistance through the QMB program per year. For the population who is aged 65 and above, we estimate that MSPs covered \$11.1 billion in premiums and \$8.3 billion in cost sharing.<sup>6</sup> If the program had 100 percent take-up, we estimate that premium assistance would total \$28.8 billion and cost-sharing support would total \$17.3 billion. This gives a range of \$19.4 billion and \$46.1 billion in funds to dedicate to the program.

We model the potential reach of this program based on the above dollar figures as constraints. Here we combine the funds dedicated to premium and cost sharing and mockup a benefits schedule that provides varying amounts of support for both premiums and cost sharing for every eligible individual. For our benefits schedule, we apportion half the available funds for 100 percent premium and cost-sharing support for the one-third of potential recipients with the lowest level of lifetime earnings. We apportion the other half for premium and cost-sharing support for the remaining two-thirds, at an average subsidy of 50 percent (phased

FIGURE 4

## Proposed structure of Medicare savings programs



Source: Authors' calculations.

Note: For illustrative purposes. A denotes the maximum annual benefits available for someone with the minimum level of lifetime earnings. B denotes the maximum lifetime earnings level at which maximum annual benefits are available. C denotes the level of lifetime earnings at which benefits are no longer available.



out). Under this schedule, 2.9 million people (the lowest lifetime earners) would be eligible for 100 percent premium and cost-sharing support under current budget expenditures (\$19.4 billion in 2020), and another 5.7 million would be eligible for some level of premium and cost-sharing support. In total, approximately 15.9 percent of the Medicare population would get some level of premium and cost-sharing support. With the higher dollar figure based on 100 percent take-up under current eligibility standards, we find that 6.8 million people would be eligible for 100 percent support, and another 13.7 million would be eligible for an average of 50 percent support. This amounts to 37.8 percent of the Medicare-aged population receiving support.

In a constrained budget environment, apportioning funds for low-income beneficiaries between premium support and cost-sharing support involves difficult trade-offs. Health insurance premiums can deter insurance take-up, and even for those who do take up coverage, they can reduce consumption on other important items. At the same time, even small amounts of cost sharing can suppress the use of high-value care (Artiga, Ubri, and Zur 2017; Gross, Layton, and Prinz 2022). While we do not weigh in on a proposed division

or schedule of benefits here, we note a few considerations. First, take-up of Medicare even for low-income people not enrolled in an MSP is extremely high, so we suspect take-up would not be affected for small premium amounts. Rather, the concern would be the extent to which the premiums curtail consumption elsewhere in a way that has strong, negative well-being implications.

Second, while average cost-sharing support for the partially enrolled QMB population is similar to the premium support, cost-sharing support for the population varies considerably, with some enrollees receiving several thousands of dollars in support, which they would have to pay for in the absence of the QMB program. Indeed, we take the high reported rates of difficulty paying for care among the QMB population as evidence that beneficiaries sought QMB support to help them with their expenses. We also emphasize that around 20 percent of low-income Medicare enrollees without any Medicaid coverage express difficulty paying for care. Third, Medicare Advantage plans—which often charge no premium or in some cases offer a Part B premium rebate while providing additional benefits beyond what Medicare covers—are widely available to offer support beyond the statutory minimum.

# IV. Questions and concerns

---

## Should Medicare premiums be tied to Social Security benefits instead of lifetime earnings?

Because most Medicare beneficiaries have their Medicare premiums deducted from their Social Security benefits, it is intuitive to tie the premium amount to Social Security benefits. Social Security benefits, moreover, are tied to Social Security lifetime earnings and vary with major life events that are correlated with economic security, like marriage and the death of a spouse. However, Social Security benefits also depend on other factors such as when the beneficiary chooses to claim. As a result, tying Medicare premiums to Social Security benefits could influence the timing of claiming in ways that are not intended by the policy. Furthermore, the universe of Social Security and Medicare recipients does not overlap exactly. Many state and local government retirees (and some federal retirees) receive Medicare but not Social Security. Thus, Medicare lifetime earnings would be a better way of determining MSP eligibility.

## Should disabled beneficiaries' Medicare premiums be tied to lifetime earnings?

Nearly eight million Medicare enrollees are under the age of 65 and are eligible because of their enrollment in Social Security's Disability Insurance program (Boards of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds 2023). Many of these enrollees do not have earnings through age 60, and thus their benefits could not be calculated according to the formula we propose. For now, we flag this as a future issue to resolve. Options for determining premiums for disabled beneficiaries include maintaining the status quo of using current income; calculating lifetime earnings using earnings before disability qualification and assuming zero annual earnings after qualification; or calculating lifetime earnings using past earnings and assuming earnings equal disability benefits between one's disability date and age 60.

## Are there alternatives to lifetime earnings that would allow for automatic enrollment determination?

Proponents of determining eligibility based on current-year income might argue that it is a better measure of contemporaneous need than lifetime earnings, and thus the goal should be to find a contemporaneous measure of need that could be assessed automatically to determine eligibility. This would almost certainly require using administrative data. One option would be using contemporaneous Social Security benefits. However, as we have pointed out, the universe of Social Security recipients does not overlap exactly with the universe of Medicare beneficiaries. Plus, Social Security benefits are very highly correlated with lifetime earnings for beneficiaries in both programs, so there is little value added in relying on them.

Another option would be to rely on federal income tax administrative data for income, which would be more comprehensive than the measure we are proposing. Tax data would include not just Social Security benefits but also earnings, retirement income, and interest and dividends. Using tax data would be administratively more complex, and there would necessarily be a lag of at least one year between the data that could be used and benefit determination. Thus, while tax data might capture more income variation than lifetime earnings, they might also be slower to adjust to non-income changes like changes in marital status. And we reiterate that Social Security benefits represent the vast majority of income for the lowest-income beneficiaries, so we question whether the additional income gleaned from tax data would markedly improve targeting. Still, the feasibility and desirability of using tax data as an alternative to lifetime earnings merit further exploration.

## What are the equity considerations for those receiving premiums and cost-sharing support through the health insurance marketplaces before enrolling in Medicare?

Millions of enrollees on the Health Insurance Marketplaces receive income-based premium and cost-sharing subsidies. One question is how enrollees

## BOX 1

### Full duals

Partial duals receive only the Medicare benefits package. Full duals, on the other hand, receive all Medicare benefits plus Medicaid services not covered by Medicare. Medicare is the primary payer for services covered by both programs, with Medicaid paying for the benefits that Medicare does not cover as well as the funding for premium and cost-sharing support under the MSPs (for both partial and full duals).

The additional Medicaid benefits that full duals are entitled to vary from state to state, but they must include inpatient hospital and nursing facility stays when Medicare coverage is exhausted, Medicaid-covered long-term services, supports not covered by Medicare, and transportation to medical appointments. Full duals are also entitled to benefits that states optionally include, including home- and community-based services as well as dental, vision, and hearing services. Not all full duals enrolled in Medicaid also enroll in the MSPs; an estimated 17 percent of people who forgo QMB or SLMB enrollment nonetheless are enrolled in Medicaid (Casswell and Waidmann 2017).

Seventy-two percent of dual-eligible beneficiaries are eligible for full Medicaid benefits, in addi-

tion to Medicare benefits, by virtue of qualifying for both programs. On average, they have greater health care needs than partial-benefit enrollees or nondual Medicare beneficiaries. For example, slightly over half of dual-eligible beneficiaries have at least one limitation on activities in daily living, compared to less than one-third of partial-benefit enrollees. Because of these additional health care needs and the greater value of coverage provided by the two programs' full benefits package, full dual beneficiaries account for 85 percent of Medicare and Medicaid costs of all dual-eligible beneficiaries (MedPAC and MACPAC 2023).

Our main proposals concern partial-benefit enrollees, or those whose care comes exclusively through the Medicare program and who may be expected to pay some portion of premiums or care costs themselves. But we note that the full dual population merits further study and would likely benefit from reforms that would improve the program's efficiency. In our research, we identified two program features in particular that we recommend further investigation, both of which center on the interaction between the Medicaid and Medicare programs.

*(Continued)*

moving from Marketplace coverage to Medicare coverage would fare. Even though both programs use annual income under current law, comparing the subsidies between the two programs is nonetheless difficult. Covered benefits for the two programs differ, and the actuarial value of the insurance plans differ. But there are some superficial comparisons we can make between the two programs. Currently, Medicare provides considerable subsidies to people regardless of income (i.e., all beneficiaries' premiums are subsidized), while the Marketplace subsidy structure is exclusively targeted to low- and moderate-income beneficiaries. However, those subsidies tend to be more generous at low- and moderate-income amounts.

Our proposal would phase out the Medicare premium and cost-sharing subsidies in a way that is more similar to the Marketplace subsidies than the current structure, with sizable cliffs at certain income amounts. Phasing out the premium and cost-sharing subsidies would be designed to create more equity across the income distribution. However, comparisons of the Marketplace and Medicare subsidies would become even more difficult under our proposal due to the switch from current-year income to lifetime income. Consequently, some people might still face relatively large changes in out-of-pocket premiums and cost sharing when moving from Marketplace coverage to Medicare coverage.

### Should the reforms proposed here apply to all beneficiaries, or should they be phased in?

We recommend phasing the reforms for Medicare beneficiaries newly turning age 65 for several reasons. First, the reforms could be disruptive for those who would lose eligibility for premium and cost-sharing subsidies at older ages. Second, more comprehensive earnings records are only available starting in 1978. Comprehensive lifetime earnings could be computed for incoming beneficiaries but would be incomplete for some older beneficiaries.

### Should states have the discretion to expand eligibility?

States are required to provide QMB and SLMB coverage, while they can limit enrollment to QI. States can expand coverage beyond the federal minimum for all three programs by eliminating assets tests or, in a few cases, raising income limits. Under our proposal, asset tests are no longer a consideration, so there would be no expansion along that dimension. However, we see no barrier to a state raising lifetime earnings thresholds to expand eligibility.

## BOX 1 (CONTINUED)

### Full duals

The first feature we highlight in the full dual program arises from the disparate benefits offered by the Medicare and Medicaid programs. Full duals, by virtue of receiving benefits from two different systems, are subject to conflicting incentives, which can harm quality of care, particularly for those who have complex health needs (Grabowski 2007). For example, Medicaid pays for a greater share of long-term care services, while Medicare covers a greater share of acute care services. This gives state Medicaid programs an incentive to transfer care to the acute care setting, potentially reducing the provision of cost-minimizing clinical services that would reduce acute care needs.

The Centers for Medicare and Medicaid Services (CMS) has recently embarked on a series of demonstrations, known as the Financial Alignment Initiative, to test various models for improved coordination between Medicare and Medicaid for dual-enrolled beneficiaries. One of the models tested was a capitated model, where a state, the Centers for Medicare and Medicaid Services, and a health plan enter an arrangement in which the health plan receives a prospective payment and provides comprehensive, coordinated care (MACPAC 2022). This program design could conceivably improve the incentives to coordinate care across services and thus improve outcomes. It will be important to assess the learnings from these demonstrations in order to design an effective option for beneficiaries. Additional programs serve to coordinate care. One such program is the Program of All-Inclusive Care for the Elderly, known as PACE, which is a Medicare and Medicaid program that covers all Medicare- and Medicaid-covered care and services that is designed to help people meet their health care needs in the community instead of in a nursing home or other care facility. Another example is Dual Eligible Special Needs Plans (D-SNPs), which is a type of managed care plans that may provide coordinated Medicaid services in addition to Medicare services.

The second feature we highlight stems from states' "lesser-of" payment policies, meaning that providers are paid less to treat dual-enrolled beneficiaries than to

treat Medicare-only beneficiaries (Keohane and Hwang 2022). Since the Balanced Budget Act of 1997, states have had the explicit authority to limit their payment through lesser-of payment policies to the difference between the Medicaid rate and the amount already paid by Medicare. Since Medicare payment rates often exceed the Medicaid rate, providers covered by these payment policies receive less money to treat dual-enrolled beneficiaries than beneficiaries only covered by Medicare.

MACPAC undertook a study in 2013 of payment policies in each state and the District of Columbia across four provider types: inpatient hospitals, outpatient hospitals, skilled nursing facilities, and physicians. The study shows that lesser-of payment policies are prevalent across states and all services, with about half having a lesser-of policy for all provider types and each provider type falling under lesser-of payment policies in at least 36 jurisdictions. The available evidence suggests that while many states adopted these policies in the few years after the Balanced Budget Act, other states have shifted toward lesser-of payment policies.

These payment policies have been shown to limit access to some types of care. For example, lesser-of payment policies are associated with reduced access to primary care (Zheng et al. 2017). Additionally, gaining dual coverage can result in declines in primary care where Medicaid access is low (Li 2023). When the Affordable Care Act temporarily increased Medicaid payment rates for primary care, primary care utilization among the dual-enrolled population increased (Cabral, Carey, and Miller 2022).

It is worth noting that these payment policies also reduce the incentives for providers to sign up Medicare enrollees for Medicaid benefits if they are eligible, as Medicare beneficiaries gaining dual coverage can result in lower payments to providers. Thus, these payment policies may inadvertently lead to incomplete take-up of Medicaid among dual-eligible beneficiaries. We recommend policymakers at the state and federal levels study this feature and weigh the trade-offs between budgetary savings and access to care.

# V. Conclusion

---

Even with substantial subsidies, premiums and cost-sharing can run into the thousands of dollars for Medicare recipients. For beneficiaries of the lowest means, this results in having to confront difficult trade-offs between health care and other necessities. From the earliest days of the Medicare program, policymakers identified this problem and responded by providing additional support to low-means beneficiaries through programs now referred to as the Medicare Savings Programs (MSPs). These programs, however, have struggled to reach their potential, because only a fraction of the eligible population takes up the support. Even though the potential benefits of enrolling in MSPs are large, the administrative burden of enrolling is prohibitive for many. This problem plagues numerous public benefit programs and has prompted a new effort by the federal government to find ways to increase program participation through reductions in administrative burdens (Office of Management and Budget 2022).

Policy changes over the last several decades have created an opportunity to reduce administrative burdens and better target support to the intended population. The Social Security Administration's collection

of wage data since 1978 would allow construction of lifetime earnings for incoming elderly Medicare beneficiaries. Comprising the totality of earned income over one's working life, lifetime earnings provide a good measure of one's means in retirement. And while other measures—like the current use of annual income—could conceivably narrowly target deprivation or need at a point time, lifetime earnings have the virtue of relying on administrative data, and would not require beneficiaries to take any action upon themselves to qualify for additional support even once, let alone annually. Targeted populations benefit more when they are enrolled in the programs intended for them.

Other policy changes have shown that it is possible to create more variation in premium and cost-sharing to more precisely target support. The Affordable Care Act created a sliding scale of premium subsidies and tiers of cost-sharing support based on income for low-income participants, taking into account that needs do not suddenly start and stop at specific income cutoffs. Incorporating these innovations into the MSPs would smooth support across the population in a way that confronts the realities of budget constraints.

# Endnotes

---

1. Although the income categories in the data match the income cutoffs in the program, differences in information collection between the survey and program administration will lead to different measures of income for the same person.
2. Many Medicaid programs include asset limits, which are another reason why low-income populations may not receive full Medicaid benefits. Other factors that may influence this share include mismeasurement of income or low take-up rates among those who are eligible.
3. Moving from QMB eligibility to SLMB eligibility also results in the loss in support for Part A premiums. However, most people do not pay Part A premiums regardless of income because they or a spouse paid Medicare taxes for at least 10 years while working.
4. We calculate the average cost sharing for QMB beneficiaries by dividing the total Medicaid spending on QMB partial dual beneficiaries (\$2.8 billion) by the number of beneficiaries only enrolled in QMB (12.2 million by 14 percent). These figures are drawn from MedPAC and MACPAC (2023).
5. We do not display QDWI benefits as they are available only to non-elderly beneficiaries and cover Part A premiums, which are generally covered due to the beneficiary's or spouse's work history.
6. These calculations use figures cited elsewhere in this report: A dual eligible population of 12.2 million, of which 63 percent of the population is at least 65 years old and of whom 66 percent are enrolled in QMB.

# References

---

- Artiga, Samantha, Petry Ubri, and Julia Zur. 2017. "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings." June. Kaiser Family Foundation, San Francisco, CA.
- Bee, Adam, and Joshua Mitchell. 2017. "Do Older Americans Have More Income Than We Think?" Working Paper 2017-39, U.S. Census Bureau, Suitland, MD.
- Bhargava, Saurabh, and Dayanand Manoli. 2015. "Psychological Frictions and the Incomplete Take-Up of Social Benefits: Evidence from an IRS Field Experiment." *American Economic Review* 105 (11): 3489–529.
- Boards of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds. 2023. "2023 Annual Report of the Boards of Trustees." Centers for Medicare and Medicaid Services, Washington, DC.
- Cabral, Marika, Colleen Carey, and Sarah Miller. 2022. "The Impact of Provider Payments on Health Care Utilization of Low-Income Individuals: Evidence from Medicare and Medicaid." Working Paper 29471, National Bureau of Economic Research, Cambridge, MA.
- Caswell, Kyle J., and Timothy A. Waidmann. 2017. "Medicare Savings Programs Enrollees and Eligible Non-Enrollees." Urban Institute, Washington, DC.
- Centers for Medicare and Medicaid Services. 2023. "Streamlining Medicaid and CHIP, Final Rule, Fact Sheet." Newsroom (blog), CMS, Baltimore, MD. September 18, 2023. <https://www.cms.gov/newsroom/fact-sheets/streamlining-medicaid-and-chip-final-rule-fact-sheet>.
- Congressional Research Service. 2023. "Health Insurance Premium Tax Credit and Cost-Sharing Reductions." Report R44425. Congressional Research Service, Washington, DC.
- Deshpande, Manasi, and Yue Li. 2019. "Who Is Screened Out? Application Costs and the Targeting of Disability Programs." *American Economic Journal: Economic Policy* 11 (4): 213–48.
- Dushi, Irena, and Brad Trenkamp. 2021. "Improving the Measurement of Retirement Income of the Aged Population." Working Paper 116. Social Security Administration, Washington, DC.
- Finkelstein, Amy, and Matthew J. Notowidigdo. 2019. "Take-Up and Targeting: Experimental Evidence from SNAP." *Quarterly Journal of Economics* 134 (3): 1505–1556.
- Grabowski, David. 2007. "Medicare and Medicaid: Conflicting Incentives for Long-Term Care." *The Milbank Quarterly* 85 (4): 579–610.
- Gross, Tal, Timothy J. Layton, and Daniel Prinz. 2022. "The Liquidity Sensitivity of Healthcare Consumption: Evidence from Social Security Payments." *American Economic Review: Insights*, 4 (2): 175–90.
- Herd, Pamela, and Donald P. Moynihan. 2018. *Administrative Burden: Policymaking by Other Means*. New York, NY: Russell Sage Foundation.
- Keohane, Laura, and Ann Hwang. 2022. "Payment Policy and the Challenges of Medicare and Medicaid Integration for Dual-Eligible Beneficiaries." October. Health Affairs, Washington, DC.
- Li, Gina. 2023. "Becoming Dual: Measuring the Impact of Gaining Medicaid Coverage for Medicare Beneficiaries." Stanford University, Stanford, CT.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. "Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare." May. MACPAC, Washington, DC.
- Medicare Payment Advisory Commission (MedPAC), and Medicaid and CHIP Payment and Access Commission (MACPAC). 2023. *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*. Washington, DC: MedPAC, MACPAC.
- Office of Management and Budget. 2022. *Strategies for Reducing Administrative Burden in Public Benefit and Service Programs*. Memo.
- Olsen, Anya, and Russell Hudson. 2009. "Social Security Administration's Master Earnings File: Background Information." *Social Security Bulletin* 69 (3).
- Roberts, Eric T., Alexandra Glynn, Noelle Cornelio, Julie M. Donohue, Walid F. Gellad, J. Michael McWilliams, and Lindsay M. Sabik. 2021. "Medicaid Coverage Cliff' Increases Expenses and Decreases Care for Near-Poor Medicare Beneficiaries." *Health Affairs* 40 (4).
- Samwick, Andrew A. 2018. "Means Testing Federal Health Entitlement Benefits." *Tax Policy and the Economy* 32 (1): 173–210. University of Chicago Press.
- Zheng, Nan T., Susan Haber, Sonja Hoover, and Zhanlian Feng. 2017. "Access to Care for Medicare-Medicaid Dually Eligible Beneficiaries: The Role of State Medicaid Payment Policies." *Health Services Research* 53 (6): 2219–36.



**GEORGE A. AKERLOF**  
University Professor,  
Georgetown University

**ROGER C. ALTMAN**  
Founder and Senior Chairman,  
Evercore

**KAREN L. ANDERSON**  
Managing Director,  
Social Finance Institute

**ALAN S. BLINDER**  
Gordon S. Rentschler Memorial Professor of  
Economics and Public Affairs,  
Princeton University;  
Nonresident Senior Fellow,  
The Brookings Institution

**RAY DALIO**  
Founder, CIO Mentor, and  
Member of the Bridgewater Board,  
Bridgewater Associates

**BRIAN DEESE**  
Former Director,  
National Economic Council

**STEVEN A. DENNING**  
Chairman Emeritus,  
General Atlantic

**JOHN M. DEUTCH**  
Institute Professor,  
Massachusetts Institute of Technology

**WILLIAM C. DUDLEY**  
Senior Advisor, Griswold Center for Economic  
Policy Studies, Princeton University

**CHRISTOPHER EDLEY, JR.**  
Interim Dean, Berkeley School of Education;  
Dean Emeritus, Berkeley Law School

**BLAIR W. EFFRON**  
Partner,  
Centerview Partners LLC

**DOUGLAS W. ELMENDORF**  
Dean and Don K. Price Professor of  
Public Policy,  
Harvard Kennedy School

**JUDY FEDER**  
Professor and Founding Dean,  
McCourt School of Public Policy,  
Georgetown University

**MICHAEL FROMAN**  
President,  
Council on Foreign Relations

**JASON FURMAN**  
Aetna Professor of the Practice of  
Economic Policy, Harvard University;  
Senior Fellow, Peterson Institute for  
International Economics;  
Senior Counselor, The Hamilton Project

**MARK T. GALLOGLY**  
Cofounder,  
Three Cairns Group

**TED GAYER**  
President,  
Niskanen Center

**TIMOTHY F. GEITHNER**  
Chairman, Warburg Pincus;  
Senior Counselor, The Hamilton Project

**ROBERT GREENSTEIN**  
Visiting Fellow, The Hamilton Project,  
Economic Studies, The Brookings Institution;  
Founder and President Emeritus,  
Center on Budget and Policy Priorities

**MICHAEL GREENSTONE**  
Milton Friedman Professor in  
Economics and the College,  
Director of the Becker Friedman Institute for  
Research in Economics, and  
Director, Energy Policy Institute,  
University of Chicago

**BEN HARRIS**  
Vice President and Director,  
Economic Studies, The Brookings Institution

**GLENN H. HUTCHINS**  
Co-Chair, The Brookings Institution;  
Chairman, North Island and  
North Island Ventures

**LAWRENCE F. KATZ**  
Elisabeth Allison Professor of Economics,  
Harvard University

**MELISSA S. KEARNEY**  
Director, Aspen Economic Strategy Group;  
Neil Moskowitz Professor of Economics,  
University of Maryland;  
Nonresident Senior Fellow,  
The Brookings Institution

**EUGENE A. LUDWIG**  
27th Comptroller of the Currency;  
Founder and CEO, Ludwig Advisors

**LILI LYNTON**  
Founding Partner,  
Boulud Restaurant Group

**HOWARD S. MARKS**  
Co-Chairman,  
Oaktree Capital Management, L.P.

**KRISTON MCINTOSH**  
Chief Communications Officer,  
American Civil Liberties Union

**ERIC MINDICH**  
Founder,  
Everblue Management

**SUZANNE NORA JOHNSON**  
Co-Chair, The Brookings Institution; Former Vice  
Chairman, Goldman Sachs Groups, Inc.

**PETER ORSZAG**  
CEO, Financial Advisory,  
Lazard Freres & Co LLC

**PENNY PRITZKER**  
Chairman and Founder, PSP Partners;  
38th Secretary of Commerce

**MEEGHAN PRUNTY**  
Principal,  
PE Strategic Partners

**ROBERT D. REISCHAUER**  
Distinguished Institute Fellow and  
President Emeritus,  
Urban Institute

**NANCY L. ROSE**  
Charles P. Kindleberger Professor of  
Applied Economics,  
Massachusetts Institute of Technology

**DAVID M. RUBENSTEIN**  
Co-Founder and Co-Chairman,  
The Carlyle Group

**ROBERT E. RUBIN**  
Former U.S. Treasury Secretary;  
Co-Chair Emeritus,  
Council on Foreign Relations

**LESLIE B. SAMUELS**  
Senior Counsel,  
Cleary Gottlieb Steen and Hamilton LLP

**DIANE WHITMORE SCHANZENBACH**  
Margaret Walker Alexander Professor,  
Northwestern University; Associate Provost and  
Senior Advisor to the President for Academic  
Excellence, University of Florida; Nonresident  
Senior Fellow, The Brookings Institution

**RALPH L. SCHLOSSTEIN**  
Chairman Emeritus,  
Evercore

**ERIC SCHMIDT**  
Co-Founder, Schmidt Futures;  
Former CEO and Chairman, Google

**ERIC SCHWARTZ**  
Chairman and CEO,  
76 West Holdings

**THOMAS F. STEYER**  
Co-Executive Chair,  
Galvanize Climate Solutions

**JOSHUA L. STEINER**  
Partner, SSW Partners

**MICHAEL R. STRAIN**  
Director of Economic Policy Studies and  
Arthur F. Burns Scholar in Political Economy,  
American Enterprise Institute

**LAWRENCE H. SUMMERS**  
Charles W. Eliot University Professor,  
Harvard University

**ALLEN THORPE**  
Partner,  
Hellman & Friedman

**LAURA D'ANDREA TYSON**  
Distinguished Professor of the Graduate School,  
University of California, Berkeley

---

**WENDY EDELBERG**  
Director

---

The Social Security Amendments of 1965 established the Medicare and Medicaid programs, which provide health insurance to the elderly, disabled, and people with limited income, respectively. Today, these programs serve over 141 million people in the United States. More than 12 million people receive support from both programs, including dual-enrolled beneficiaries who receive full Medicaid benefits, those who receive support to cover Medicare premiums and cost sharing through Medicare Savings Programs (MSPs), and those who receive full Medicaid benefits and are enrolled in an MSP.

MSPs consist of four separate programs that vary in their eligibility criteria and coverage. These programs are run by state Medicaid agencies with federally-established minimum eligibility criteria pertaining to income and assets, which states may relax or waive altogether.

While these programs serve to reduce the burden of high health care costs for low-income Medicare beneficiaries, certain factors hamper the programs' effectiveness:

- Millions of seniors who qualify for these programs are not enrolled, forgoing considerable support to which they are qualified.
- Sharp eligibility thresholds create discontinuous drops in support for premiums and cost sharing.

We make the following recommendations to improve the MSPs' ability to assist low-means senior citizens:

1. **Increase enrollment among eligible populations.** Effectively reaching low-income elderly populations requires a package of program changes that could together reduce frictions that prevent take-up among those eligible and minimize unnecessary churn in the program.
2. **Replace the current schedule of premium and cost-sharing support with a sliding scale that eliminates sharp changes in benefits as income changes.** Smoothing benefit cliffs would improve the equity of the program by ensuring people of similar means get similar levels of support.

Finally, we also describe additional issues that low-income Medicare beneficiaries face in access to, and coordination of, care that should be addressed in potential reforms to the program.

---