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POLICY BRIEF

IMPROVING COVERAGE FOR LOW-INCOME MEDICARE BENEFICIARIES

Marilyn Moon, Niall Brennan, and Misha Segal
The Urban Institute

Medicare, the federal program that provides health insurance for approximately 39 million elderly and disabled Americans, is widely regarded as one of the nation's most successful public programs. Yet its failure to provide a comprehensive insurance package has left gaps in coverage that beneficiaries—or others on their behalf—must fill. The poor are particularly hard-hit, since they lack the financial resources to supplement Medicare's coverage.

Medicaid, the federal-state program that covers health and long-term care for certain categories of the poor, does provide additional benefits for low-income elderly and disabled Medicare beneficiaries who are eligible for traditional Medicaid coverage. However, because the states set their own Medicaid eligibility standards, some low-income Medicare beneficiaries—even those with incomes that fall within federal poverty guidelines—do not qualify for this additional coverage. Even for beneficiaries with incomes above the poverty level, Medicare's premium and cost-sharing responsibilities can be unduly burdensome.

The Qualified Medicare Beneficiary (QMB) program and two related efforts under the Medicaid umbrella were designed to help these underinsured individuals pay the out-of-pocket costs associated with Medicare coverage. This brief examines the three supplemental programs and explores how they might be made more effective—as well as what improving them would cost. Given Medicare's substantial cost-sharing requirements and the likelihood that these will be hiked to meet financing challenges in the next century, resolving these issues will be crucial to ensuring adequate coverage for some of the nation's poorest and most vulnerable populations. (For a more thorough analysis of this topic, see Marilyn Moon et al., "Options for Aiding Low-Income Medicare Beneficiaries," *Inquiry* 35(Fall 1998):346–356.)

WHAT DOES MEDICARE COVER?

Medicare consists of three parts. Part A covers inpatient hospital services and some skilled nursing facility, home health, and hospice care. Part B, participation in which is voluntary, covers physician services, outpatient hospital services, medical equipment and supplies, and other health services. Part C—the recently enacted Medicare+Choice program—is designed to provide alternative insurance options through a private plan instead of traditional Medicare Parts A and B.

Beneficiaries not only have fairly high cost-sharing responsibilities under Parts A and B, but they must fill in gaps for some important services that are not covered, including prescription drugs, dental care, eyeglasses, and hearing aids. Under Part A, a deductible ($768 in 1999) is assessed at the beginning of each inpatient hospital benefit period; copayments during long hospital and skilled nursing facility stays are also required. Under Part B, beneficiaries must pay a monthly premium ($45.50 in 1999) and a $100 annual deductible. They are also responsible for a 20 percent coinsurance for most Part B services, which, in practice, is the greatest source of cost-sharing for most beneficiaries.

The Balanced Budget Act of 1997 (BBA) permanently set the Part B monthly premium at 25 percent of Part B costs. Over time, the premium is expected to become a growing share of income, especially for the poor: by 2007, the premium is expected to be $105, or 9.4 percent of income for beneficiaries at 125 percent of the poverty level. If, as is likely, health care spending rises at a rate that exceeds the growth in Social Security benefits and other income sources for the elderly and disabled, the cost-sharing burden will increase as well.

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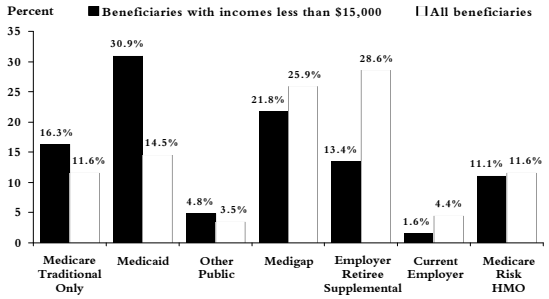
FILLING THE GAPS IN MEDICARE COVERAGE

To fill holes in Medicare coverage, many beneficiaries buy supplemental insurance in the form of Medigap policies. Some have employee-subsidized retiree coverage. Of all beneficiaries, only 11.6 percent rely solely on traditional Medicare; 25.9 percent have Medigap coverage that they must fully fund. Among those with annual incomes less than $15,000, 16.3 percent depend on traditional Medicare only, while 21.8 percent have Medigap.

Additional Health Insurance Coverage for Medicare Beneficiaries



Source: Urban Institute analysis of MCBS data.

Another alternative is Medicare+Choice. Although Medicare beneficiaries who select one of these plans opt out of Parts A and B, they still have to pay their Part B premium and, in some cases, an additional premium required by the private plan to cover any extra benefits. In addition, several of the new options envisioned under Medicare+Choice—such as medical savings accounts and private fee-for-service plans—are likely to raise rather than lower beneficiaries' out-of-pocket costs. These additional costs, if substantial, effectively put this option beyond the reach of low-income beneficiaries.

CURRENT PROGRAMS FOR LOW-INCOME BENEFICIARIES

Historically, certain low-income beneficiaries have been eligible for both Medicare and Medicaid—the so-called dual eligibles. These individuals are eligible either because they qualify for Supplemental Security Income (SSI)—the cash assistance program for aged, blind, or disabled people with low incomes—or because they are considered to be medically needy. The medically needy group comprises the aged and disabled, many of whom are in nursing homes, who are ineligible for SSI but whose health bills are so high that their net incomes put them near or below the poverty level (about $8,000 for a single person in 1998). Although some low-income elderly receive assistance from Medicaid, numerous poor and near-poor Medicare beneficiaries do not qualify.

The QMB and SLMB Programs

The Qualified Medicare Beneficiary (QMB) program was set up under the Medicare Catastrophic Coverage Act of 1988 (the Act was largely repealed in 1989, but the QMB program was retained). Under this program, state Medicaid programs are required to pay Medicare's Part B premium and cost-sharing for Medicare beneficiaries with incomes below the poverty level and assets not exceeding twice the limits set for SSI (see Table 1). Federal matching funds are provided for QMBs.

Since 1995, states have also been required under the Specified Low-Income Medicare Beneficiary (SLMB) program to pay the Part B premium for Medicare beneficiaries with incomes from 100 to 120 percent of poverty and assets not exceeding twice the SSI limits. As in the QMB program, SLMB benefits are treated as part of Medicaid and are partially supported with federal matching funds.

New Protections Under the Balanced Budget Act

The BBA introduced further provisions for poor Medicare beneficiaries, specifically those with incomes from 120 to 175 percent of poverty, to help shield them from short-term increases in Medicare's Part B premium. Under the BBA, $1.5 billion was made available to states to cover these premium costs from 1998 to 2002, at which time this coverage will end unless renewed.

The BBA created two new groups of Medicare beneficiaries who will receive aid: Qualifying Individuals-1 (QI-1), who have incomes from 120 to 135 percent of poverty; and Qualifying Individuals-2 (QI-2), who have incomes from 135 to 175 percent of poverty. Medicaid will pay the full Medicare premium for QI-1s, but for QI-2s will subsidize only that portion of the Part B premium increase directly attributable to the transfer of home health visits to the Part B program.

Both QI-1s and QI-2s will receive assistance only as long as funds are available through the program's federal block grant. Since the program

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Table 1
Estimated Cost of Existing QMB/SLMB/QI Programs, 1998

	Number of Participants (millions)	Federal Costs ($ billions)	Total Costs ($ billions)
Premiums			
Part B	4.5	1.4	2.4
Part A	0.3	4.4	7.7
Cost-Sharing[a]		2.4	4.2
Total QMB	4.5[b]	4.4	7.7
SLMB	.3	.1	.1
QIs[c]	N/A	.3	.3
Total	4.8	4.8	8.2

[a] Assumes full participation in cost-sharing.
[b] This number might be slightly higher to the extent that some Part A QMBs are not bought in to Part B.
[c] Assumes full use of amount appropriated.

Source: Urban Institute estimates using *1997 Current Population Survey* and 1998 unpublished HCFA data.

Table 2
Estimated Number of People Served and New Federal Costs from QMB/SLMB Changes, 1998

Changes to the Program	Persons Served (millions)	New Federal Costs ($ billions)
Moving Program to Medicare		
Moderate increase in participation; no change in use of services	5.3	$4.9
Substantial increase in participation; one-third increase in use of covered services	6.0	$6.7
Moving Program to Medicare and Relaxing Asset Limits		
Moderate increase in participation; no change in use of services	5.8	$5.2
Substantial increase in participation; one-third increase in use of covered services	6.3	$7.0
Moving Program to Medicare and Eliminating Asset Limits		
Moderate increase in participation; no change in use of services	6.0	$5.8
Substantial increase in participation; one-third increase in use of covered services	6.9	$7.9

Source: Authors' estimates using *1997 Current Population Survey* data.

Table 3
Estimated Number of People Served and New Federal Costs from QMB/SLMB Expansions, 1998

Changes to the Program*	Persons Served (millions)	New Federal Costs ($ billions)
Relaxing Asset Limits		
Raise QMB Limit to 120% of Poverty and SLMB Limit to 150% of Poverty		
Moderate increase in participation; no change in use of services	7.4	$6.7
Substantial increase in participation; one-third increase in use of covered services	8.6	$9.0
Raise QMB Limit to 133% of Poverty and SLMB Limit to 175% of Poverty		
Moderate increase in participation; no change in use of services	8.7	$8.4
Substantial increase in participation; one-third increase in use of covered services	10.0	$11.3
Eliminating Asset Limits		
Raise QMB Limit to 120% of Poverty and SLMB Limit to 150% of Poverty		
Moderate increase in participation; no change in use of services	8.3	$7.8
Substantial increase in participation; one-third increase in use of covered services	9.7	$10.5
Raise QMB Limit to 133% of Poverty and SLMB Limit to 175% of Poverty		
Moderate increase in participation; no change in use of services	10.0	$10.0
Substantial increase in participation; one-third increase in use of covered services	11.9	$13.5

*All options assume full costs of program shifted to Medicare.

Source: Authors' estimates using *1997 Current Population Survey* data.

was underfunded in the first place, not everyone who qualifies as a QI-2 will be protected.

PARTICIPATION IN THE QMB PROGRAMS

Many beneficiaries do not participate in the QMB family of programs, even though they are eligible. Of some 5.7 million people who were potentially eligible for the QMB program in early 1998, only about 4.5 million (78%) were participating. For the SLMB program, only 270,000 out of 1.6 million eligibles (16%) were participating.

Beneficiaries are often either unaware of the programs or unwilling to participate. Among the possible reasons are the complexity of the enrollment process, the requirement to apply at a welfare office, and the long lag before QMB eligibility is activated. In addition, low participation is often linked to some states' resistance to conducting outreach efforts among eligible beneficiaries.

OPTIONS FOR REFORM

Possibilities for QMB and SLMB program reform center on three issues. The first concerns low participation rates. Second is the extremely low asset limits, which leave many of the poor and near-poor ineligible and may discourage others from participating. Third, the income cutoff for participation in all the programs is set too low: Medicare beneficiaries facing as much as $1,500 in cost-sharing in addition to their Part B premium still cannot be assured of receiving benefits unless their income is less than $10,000. Above that income level, individuals may have to devote a prohibitive 25 to 30 percent of their incomes to health care.

The following proposals are based on cost estimates that assume high levels of participation; for estimates based on lower levels, refer to Tables 2 and 3.

Option 1: Federalizing Protections

Shifting control of the QMB program from the state Medicaid programs to the federal Medicare program would increase participation from 4.8 million to 6 million beneficiaries and probably also encourage greater standardization across states. Doing so would, however, be relatively expensive: the increase in total federal costs over current levels would be $6.7 billion (see Table 2). Some of these new costs, however, would be offset by reduced burdens on states.

Option 2: Raising or Eliminating Asset Requirements

The second option would also involve moving the QMB program to Medicare, plus either doubling the asset limits for eligibility or eliminating the asset test altogether. The costs of fully eliminating the asset test—and of Medicare's assuming all program expenses—would be about $7.9 billion (see Table 2). Approximately 6.9 million beneficiaries would be served under this proposal.

Option 3: Raising the Income Level

If, in combination with the first two options, the income level were raised, both the cost and the number of beneficiaries served would increase even more. Setting the limits at 133 percent of poverty for QMBs and 175 percent of poverty for SLMBs would cost $13.5 billion but would boost the number of beneficiaries to nearly 12 million (see Table 3). This option would also reduce beneficiaries' premiums and, for some, lower cost-sharing requirements under Medicare.

The Cost of Reform

Shifting responsibility for the QMB and SLMB programs to the federal government would drive up costs at a time when many policy initiatives are attempting to control federal spending. The figures stated above, however, represent upper-bound cost estimates based on optimistic assumptions about participation. Actual participation rates—particularly for the SLMB program—may very well be lower, thus lowering the net new costs of any reform option. Further, with higher contributions likely to be part of anticipated Medicare reforms to deal with the aging baby boom population, ensuring adequate protections for low-income beneficiaries will become that much more important.

THE COMMONWEALTH FUND

One East 75th Street
New York, NY 10021-2692

Tel: 212.606.3800
Fax: 212.606.3500
E-mail: cmwf@cmwf.org
http://www.cmwf.org