PROTECTING LOW INCOME MEDICARE BENEFICIARIES

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EXECUTIVE SUMMARY

In 1996, Medicare contributed nearly $4,700 per capita towards the cost of health care for elderly persons. But even with this federal contribution, the cost of Medicare premiums, deductibles, and coinsurance—along with other out-of-pocket health expenditures and premiums for supplemental insurance—results in substantial burdens for beneficiaries. Excluding the costs of institutional care, Medicare beneficiaries will spend an average of $2,605 per person on their own health care in 1996, representing 21 percent of their family income. The percentage of family income devoted to health spending is even higher for poorer individuals: 30 percent for beneficiaries with incomes below the federal poverty level and 31 percent for beneficiaries between 100 and 125 percent of poverty. Even those with higher incomes (above 400 percent of the federal poverty level) devote 11 percent of their incomes to health expenses. The Medicaid program helps to alleviate some of these costs for persons with the lowest incomes. In addition to comprehensive coverage offered to a portion of those below the official poverty thresholds, state Medicaid plans have been required since 1988 to pay Medicare's premiums and cost-sharing for all beneficiaries below 100 percent of poverty (called Qualified Medicare Beneficiaries, or QMBs). In 1993, states were also required to pay Medicare's premium for those between 100 and 110 percent of poverty (Specified Low-Income Medicare Beneficiaries, or SLMBs). The SLMB program was expanded to 120 percent of poverty in 1995.

In 1996, only 63 percent of those eligible for QMB benefits and only 10 percent of those eligible for SLMB benefits participate. These rates are low for several reasons, including the fact that many eligible QMB beneficiaries may not be aware the program exists and states may not be aggressive about enrolling eligible people and incurring high state budget costs. In addition, SLMB rates may be low because the program is relatively new and because income eligibility was just expanded to include those up to 120 percent of poverty in 1995. Even though participation in the QMB and SLMB programs may continue to increase as more beneficiaries become aware of the programs, these programs are increasingly vulnerable in an environment where states are looking for ways to scale back their Medicaid programs. To address this vulnerability and increase participation in the programs, several options for reforming QMB and SLMB could be explored. Federalization of QMB and SLMB would likely increase participation in the program and alleviate states of substantial expenditures. Federalization would likely mean that more of those who need protection would receive it, thus treating equals more equally than at present and reducing some of the disparities that currently exist across states.

Federal action to reform the QMB and SLMB programs could extend protections to a larger share of low income Medicare beneficiaries. But shifting these programs to Medicare would add costs at a time when most of the political discussion concerns reducing spending. If the changes were fully implemented in 1996, net new costs to the federal government would likely range from $3.8 billion to as much as $5.4 billion,

depending on what happens to participation rates in the programs. Net costs to the federal government could be reduced if the basic premium were increased from 25 percent to 30 percent of Part B spending. Under such a scenario, the net impact of these two changes would be $2 billion dollars or less in additional federal expenses, depending on the participation rates assumed. If an expansion of SLMB to 150 percent of poverty were added into the picture, net new costs would total $3.0 billion.

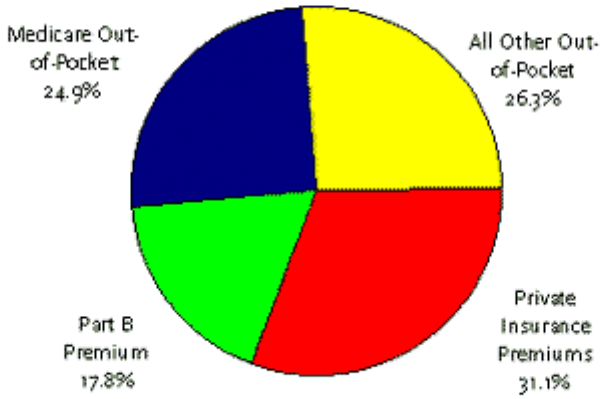
While states would benefit from these options, making a case for new federal spending that merely offsets public spending elsewhere may be difficult politically. Other less comprehensive options could also be pursued, such as federalizing only the premium piece of QMB and SLMB or discounting the amount of the premium that states must pay. When new revenues from an increase in the premium to 30 percent of costs are factored in, these options would result in federal savings of between $.9 billion and $2.3 billion.

Because there are likely to be further requirements on Medicare beneficiaries to pay higher costs in the form of increased premiums or higher copayments, additional protections for the most vulnerable beneficiaries make good sense. Some or all of the costs of these new low- income protections could be absorbed by other changes in Medicare, but some may also appropriately come out of general revenue if this is a high priority.

INTRODUCTION

Medicare provides health insurance coverage to elderly persons and individuals with disabilities. Yet even with this coverage, the costs of Medicare premiums, deductibles, and coinsurance—along with other out-of-pocket health expenditures and premiums for supplemental insurance—often result in substantial burdens for some beneficiaries. Even excluding the costs of residents of nursing homes and other institutions, health care spending by persons aged 65 and above averaged $2,605 per person in 1996.[1] This represents 21 percent of household income for elderly individuals, up from 15 percent in 1987. **Figure 1** illustrates how this spending is distributed. Nearly 43 percent is spent directly for Medicare cost-sharing and Part B premiums. Another 31 percent is spent on private insurance premiums, much of which supplements Medicare. Thus, over half of all health spending attributable to persons aged 65 and above is for expenses related to Medicare-covered services.[2]

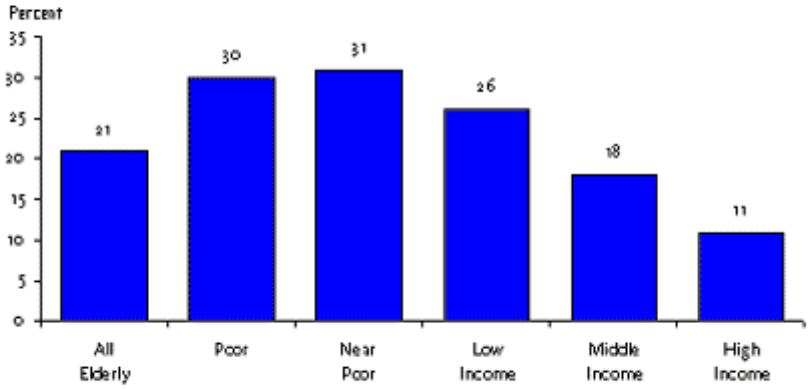
Figure 1
Health Expenses for the Noninstitutionalized Elderly, 1996



Source: Author's simulations using National Medical Expenditure Survey

The potential for high out-of-pocket costs for beneficiaries, even after accounting for Medicare's payments, was recognized from the beginning and was one major reason for also creating Medicaid for those with low incomes.[3] However, Medicaid still left substantial numbers of low- and moderate-income elderly persons and persons with disabilities at risk (Rowland and Lyons, 1987; Davis, 1986). In an effort to alleviate some of these high out-of-pocket costs, a Qualified Medicare Beneficiary (QMB) program was made a mandatory part of Medicaid in 1989 (and subsequently expanded) to build on Medicaid's protections for low-income elderly persons and persons with disabilities.[4] A companion program, for Specified Low-Income Medicare Beneficiaries (SLMBs), was added in 1993. These two programs have the potential to aid most poor elderly persons and Medicare beneficiaries with disabilities, but participation is a problem. In 1996, even with the existence of the Medicaid and QMB and SLMB programs, health spending by the low-income elderly remains very high. Those below poverty spend an estimated 30 percent of their incomes on health care, and the figure rises to 31 percent for those between 100 and 125 percent of poverty (see **Figure 2**). Age groups also show important differences in the share of income devoted to health care, with the proportion rising steadily up to age 85 (**Figure 3**).

Figure 2
Total Health Spending by the Noninstitutionalized Elderly as a Percent of Family Income, 1996

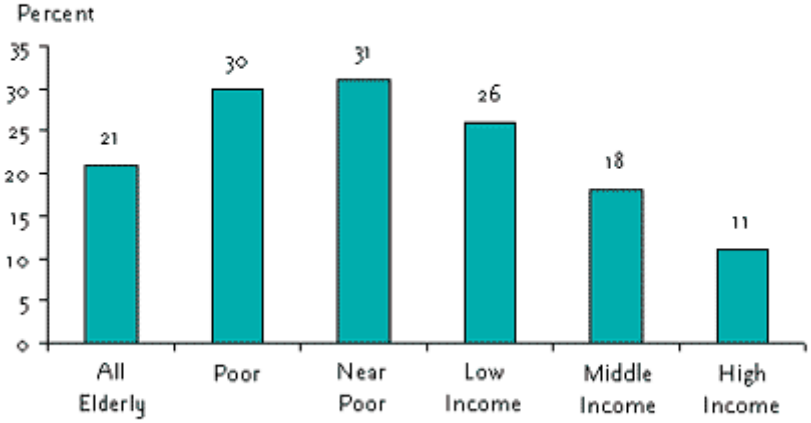


Poverty status definitions: poor=<100% of poverty; near poor=100-125%; low income=125-200%; middle income=200-400%; and high income=400%+

Source: Author's simulations using National Medical Expenditure Survey

Figure 3

Total Health Spending by the Elderly as a Percent of Family Income, 1996



Poverty status definitions: poor=<100% of poverty; near poor=100-125%; low income=125-200%; middle income=200-400%; and high income=400%+
Source: Author's simulations using National Medical Expenditure Survey

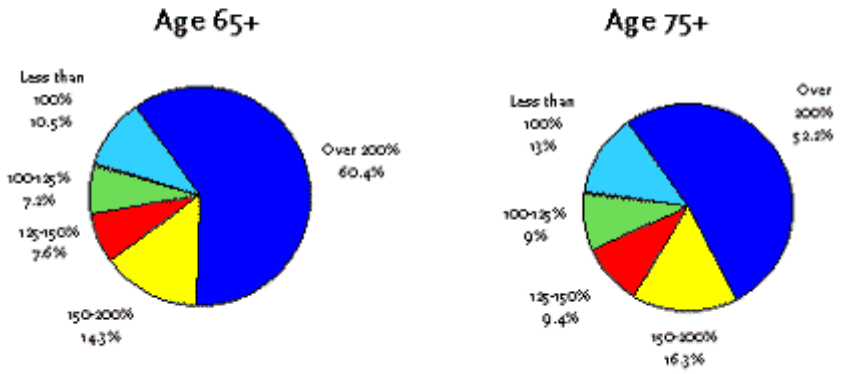
Further, as the debate over how spending on Medicare and Medicaid may be reduced in the future continues, the status of the QMB and SLMB programs has become more tenuous. If these program are considered a high federal priority, it may be time to consider either shifting them fully into Medicare or increasing the federal share of their costs. This paper looks at the evidence on participation in the QMB and SLMB programs and some

possible options for expanding the federal guarantees for low-income Medicare beneficiaries.

BACKGROUND

Despite substantial improvements in the economic status of many Medicare beneficiaries over the last thirty years, many continue to have only modest incomes. In 1995, 10.5 percent of all persons over age 65 were below the official Census poverty level of $7,309 for singles and $9,219 for couples. Another 14.8 percent had incomes between 100 and 150 percent of those thresholds (see **Figure 4**). Altogether, approximately 3.3 million elderly persons have incomes below the Census poverty lines. The proportion of women (especially those living alone) and persons over age 75 in these low-income categories are even higher.[5] Out of those low incomes, beneficiaries must not only meet their basic needs for housing and food but also substantial medical expenses.

Figure 4
Distribution of the Noninstitutionalized Elderly by Ratio of Income to Poverty Level: 1995



Source: Baugher and Lamison-White, 1996

Historically, some low-income persons have been eligible for both Medicare and Medicaid (the so-called "dual eligibles"). Medicaid provides medical care for low-income individuals and families and insures elderly persons and persons with disabilities who are eligible for Supplemental Security Income (SSI).[6] Most states also cover the medically needy—aged and disabled persons who are ineligible for SSI because of their incomes or assets but who, after paying high health bills, have net incomes near or below poverty.[7] Many in the medically needy group are persons in nursing homes. While Medicaid provides assistance to these two groups, these categories exclude many poor and near-poor Medicare beneficiaries. Federal eligibility for SSI stops well short of the poverty guidelines,

and few states supplement that benefit sufficiently to reach the poverty level. Moreover, in some ways, the number of persons eligible for Medicaid has become more restricted over time. While the federal income eligibility standard for SSI has kept pace with inflation, the qualifying income levels for persons who are medically needy declined 23 percent between 1980 and 1992, after adjusting for inflation.[8]

For these dual eligibles, Medicaid provides relief to low-income Medicare beneficiaries because it covers more services and usually requires no beneficiary contribution. Medicaid covers services for its beneficiaries that Medicare does not, including long-term care and prescription drugs. Before 1989, states were allowed to "buy-in" Medicaid recipients eligible for Medicare—that is, to pay their Part B premiums so that Medicare would cover a substantial share of their health care costs.[9] Under this option, states could decide to buy-in some or all of their eligible recipients. It should be noted that the federal government does not provide matching funds for paying the Part B premium for the medically needy.[10] While the buy-in to Medicare had historically been an *option* for states, buy-in requirements for certain groups became mandatory with the passage of the Medicare Catastrophic Coverage Act (MCCA) of 1988. The MCCA was designed to alleviate the high costs of health care through changes in both Medicare and Medicaid.[11] Although the MCCA was repealed the following year, the Medicaid portions of the legislation were retained. One of these pieces included a requirement that beginning in 1989, state Medicaid programs buy-in poor Medicare beneficiaries and persons with disabilities eligible for the program—that is, to pay the Medicare premiums, deductibles, and copayments for these persons, known as Qualified Medicare Beneficiaries (QMBs). Federal matching funds are provided for QMBs.

The QMB program includes both those who qualify for full Medicaid services (that is, the categorically eligible and medically needy, hereafter referred to as "full benefit" Medicaid beneficiaries) and those who are not eligible for the regular part of Medicaid ("QMB-onlys"). While technically full benefit Medicaid recipients are also QMBs, the term QMB is often used to refer to those who are covered by Medicaid only because they meet QMB eligibility criteria. For purposes of this paper, we use the term QMB to refer to all Medicaid buy-ins who are eligible to be QMBs, recognizing that this group can be divided into full benefit and QMB-only Medicaid recipients.[12]

By January 1, 1989, states were required to cover QMBs with incomes at or below 85 percent of the federal poverty guideline and with resources of up to $4,000 for individuals or $6,000 for couples—twice the resource limits used in the federal SSI program.[13] The income standard was increased to 100 percent of poverty in 1991. In addition to the assistance provided to QMBs, states were also required beginning in 1993 to pay the *premiums only* for those between 100 and 110 percent of poverty who meet the resource limits. These individuals are known as Specified Low-Income Beneficiaries (SLMBs). Beginning in 1995, SLMB eligibility expanded to include persons between 100 and 120 percent of poverty.

PARTICIPATION IN THE BUY-IN

Many Medicare beneficiaries do not participate in the QMB program even though they are eligible. Many eligible beneficiaries—particularly those who would be QMB-only participants—remain unaware of the program. They may largely come in contact with the QMB program only if they apply for Medicaid or other assistance.[14]

Low participation has been demonstrated in two recent studies—one that looked at the participation of elderly QMBs and SLMBs; the other, at all QMBs. According to Families USA, as of January, 1993, approximately 58 percent of seniors eligible for QMB were participating.[15] This study also found that in 1993, only 5,000 out of the approximately one million eligible were receiving SLMB benefits. In the second analysis, Neumann et al. found that 41 percent of elderly persons and persons with disabilities eligible for the QMB program were enrolled, or 1.9 out of 4.7 million eligible.[16] Both these analyses excluded the institutionalized.

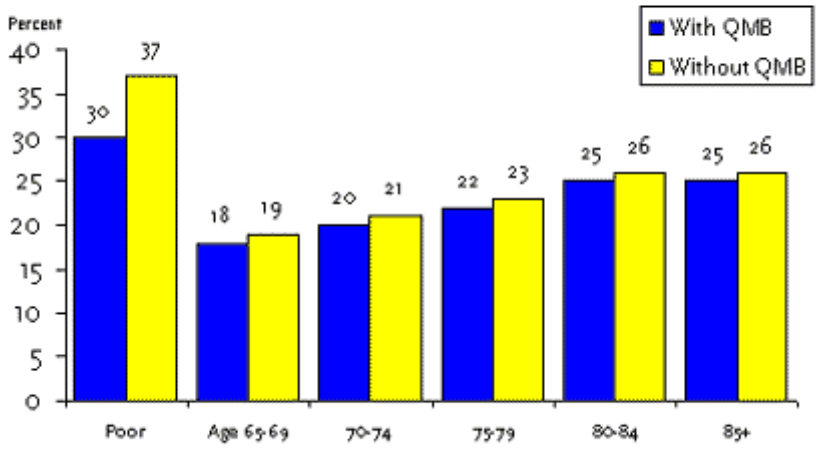
To update these numbers, we used data reported to the Health Care Financing Administration on the number of participants at the beginning of 1996 and compared these numbers to projections of eligibles based on adjusted Current Population Survey (CPS) data.[17] Our participation rate estimates are 63 percent for QMBs and 10 percent for SLMBs in 1995. Translated into actual numbers, we find that about 3.3 million of the 5.3 million eligible QMB beneficiaries participate in the program. This differs somewhat from the rates found in previous studies, both because of differences in who is included and the passage of time. Our higher rates reflect a natural increase in participation over time as the program has become more widely known and fully implemented.[18] For SLMBs, the numbers are 190,000 participants out of 1.9 million eligibles.

It is desirable but difficult in practice to subdivide the participation estimates into two subgroups of QMBs: those who also receive full Medicaid benefits and the QMB-onlys. The legislation establishes requirements for states to participate in the QMB program, so we should expect full service Medicaid beneficiaries to be participants in most instances. Particularly for SSI beneficiaries, this is likely to be the case, and indeed, we assume essentially 100 percent participation. But it is not clear that all the eligible medically needy participate.[19] Differences in participation rates for various subgroups of QMBs are supported by both logic and historical data. Individuals already receiving government assistance through Medicaid are much more likely to be aware of the program and participate.[20] For many years before the MCCA legislation, a majority of states took advantage of the option to buy-in Medicaid recipients, at least the categorically (SSI) eligible, if not all recipients. For example, in 1978, the nationwide ratio of buy-ins to Medicaid recipients was 0.84, although with much state variation.[21]

Even though participation in the QMB program remains low, it still has helped to reduce burdens on those with the lowest incomes. For example, our estimates for the

noninstitutionalized elderly for 1996 indicate that spending on Medicare cost-sharing and Part B premiums by poor elderly persons is $370 lower as a result of QMB coverage. Individuals who are QMB-onlys average savings of about $1,900. Without QMB protections, the poor would have burdens averaging 37 percent of their incomes (**Figure 5**), and while persons in all age groups benefit, the greatest dollar effects are felt by the oldest beneficiaries.

Figure 5
Total Health Spending by the Elderly as a Percentage of Income, 1996



Source: Author's projections using National Medical Expenditure Survey

Lags in participation as a new program comes on line seem to be particularly an issue in the SLMB program. That program only started in 1993, and the numbers of SLMBs have been steadily rising since then. Furthermore, the 1995 expansion to cover those under 120 percent of poverty (up from 110 percent) added a large group of eligibles who presumably are, in early 1996, still just being introduced to the program. Consequently, participation by SLMBs may be artificially low in 1996 because of this expansion and could be expected to rise substantially in future years. Another possible limiting factor for SLMBs, however, is that fewer of those eligible are likely to apply for Medicaid, since their incomes are well above Medicaid eligibility levels. Thus, they must actively seek coverage. For those with higher incomes, the chances are greater that they may already have some protection through employer-subsidized retiree health plans.

OPTIONS FOR REFORMING THE BUY-IN

Although the tenor of the discussion over the Medicare and Medicaid programs is currently to restrict spending, changes in the QMB program that would expand it or at least shift it away from the states make considerable sense. Initially, a major rationale for putting the QMB program in Medicaid was that the MCCA would shift other costs from Medicaid to Medicare and hence this new benefit would result in no net additional burden on states. The financial relief was eliminated with the repeal of the MCCA. Moreover, the QMB program is not a popular program with the states. Since states are now looking for ways to streamline and scale back their Medicaid programs, the QMB benefit could be at risk.

For example, in its most stringent form in the Balanced Budget Act of 1995, proposed Medicaid reform would have ended the individual entitlement to benefits and capped the amount that states receive.[22] While the Balanced Budget Act included some requirements for states to devote a specific *percentage* of past expenditures on low-income elderly persons and persons with disabilities, the requirements were weak. This approach was heavily criticized, however, and some of the possible compromise plans for Medicaid reform, such as the National Governors' Association proposal, would have retained stronger requirements to protect various groups, including QMBs. Even if states are merely given more latitude in the future in determining which populations they will serve, QMBs and SLMBs may not be at the top of the list.

Any shift of the QMB and SLMB programs to the federal level, if there are no offsetting changes affecting states, has the disadvantage of raising federal costs, even if no new beneficiaries are protected. While states would benefit, it is harder to make a case for new federal spending that merely offsets existing spending elsewhere. At present, the federal government effectively pays about 57 percent of the costs of the QMB program.[23] One way to make such options more attractive would be to require a phase-out period in which states would pay all or a substantial share of the contributions they had been making toward the costs of the QMB program. Alternatively, other rules could also be changed, such as lowering the federal matching rates by an amount sufficient to partially offset the costs of this federalization. This could be done just for QMB-related copayments and premiums or on a more general level. Finally, one way to convince states to accept tighter constraints on growth in Medicaid in the future would be to relieve them of the QMB/SLMB burden. Federalization would likely mean that more of those who need protection would receive it and would likely improve the fairness of the program, treating equals more equally than at present.[24] For instance, if participation rates increased to even 70 percent of all the eligible persons in the below-poverty group, nearly another 370,000 persons would be added to the program. Raising participation under SLMB to 20 percent would add nearly 200,000 to the number of participants.

A number of practical problems arise in terms of considering moving the QMB program into Medicare. Medicaid now has a mechanism for determining eligibility in terms of income and asset holdings. Should Medicare continue to use that same mechanism (and risk keeping participation low), or should it establish a new mechanism within Medicare for testing eligibility? The Social Security Administration already provides this function for determining eligibility for SSI in most states, so there could certainly be some coordination that would lower costs, but a substantial increase in the numbers of persons subjected to eligibility testing would occur.

To provide a sense of what a range of policy options might cost the federal government, we simulated QMB and SLMB costs for 1996 under the existing program and costs, assuming several policy and participation rate changes.[25]

The spending estimates provided here represent net federal spending in calendar year 1996 unless otherwise indicated. For the sake of simplicity, we assume full implementation of policy changes in 1996. More formal cost estimates would need to adjust for phase-in periods and other complicating factors. These numbers are presented here to illustrate the orders of magnitude involved in various policy options.

Federalization of QMB/SLMB

We estimate that the potential total costs of federalized QMB/SLMB programs in 1996 would be about $8.9 billion. Since the federal government already pays a substantial share of the costs of QMB through Medicaid, the net new costs would total only $3.8 billion, as shown in **Table 1**.[26] This assumes no change in participation, thus covering only the 4.1 million current participants.[27] This represents a little over 2 percent of estimated total spending on Medicare of about $200 billion in 1996. As noted above, some or all of this cost could be defrayed by policies to reduce federal matching rates for other Medicaid beneficiaries.[28]

Table 1: The Fiscal Impact of the Medicare QMB and SLMB Programs

Specific Policy Change & Participation Assumptions	QMB/SLMB Change Only★	If Combined with Higher Premiums★
Shift QMB & SLMB Programs into Medicare, Retaining Current Premium		
With existing participation	$3.8	$—
Moderate participation increase	$4.7	$—
High participation increase	$5.4	$—
Shift QMB & SLMB Programs into Medicare, Increasing Premium to 30%		
Moderate participation increase	$5.1	$1.2
High participation increase	$5.9	$2.0
Shift QMB & SLMB Programs into Medicare, Raise SLMB Limit to 150% of Poverty, and Increase Premium to 30%		
Moderate participation increase	$5.6	$1.7
High participation increase	$6.9	$3.0

*Net New Federal Costs, 1996 (Billions)
Source: Author's simulations using data from Current Population Survey and Health Care Financing Administration

If participation rates rose from 63 percent and 10 percent, respectively, under the current QMB and SLMB programs to 70 percent and 20 percent, respectively—our assumed "moderate" participation levels—net new federal costs would rise to $4.7 billion in 1996. Participation would increase to 4.6 million beneficiaries. Federal costs would increase by an additional $700 million under the "high" participation assumption of 75 percent and 40 percent, respectively, for QMB and SLMB.29 This would bring the number of participants to 5.3 million elderly persons and persons with disabilities.

Federalization and an Increased Part B Premium

The second set of policy changes in **Table 1** assumes that the Part B premium is increased across the board to 30 percent of Part B costs from its current level of 25 percent. In this case, the first column in **Table 1** indicates the net costs to the federal government for the QMB and SLMB changes. They rise as compared to the costs if the premium were to remain at 25 percent to $5.1 or $5.9 billion, depending upon the participation assumption. The second column indicates the combined net costs after incorporating the new revenues from the 30 percent premium on those not eligible for the QMB or SLMB programs. The combined effect would still be a cost to the federal government but of no more than $2 billion. While there is no inherent reason why these two policy changes would need to be linked, a higher basic Part B premium may be more politically acceptable if the burdens on those with low incomes are softened by improved QMB protections.[30]

Adding an Expanded SLMB Program to Other Changes

The final option in **Table 1** assumes that the SLMB eligibility level is raised to 150 percent of the poverty guidelines. Costs rise substantially under this option, to as much as $6.9 billion. Under the high participation option, the number of participants would rise to 6.8 million. Expanding protections for lower-income beneficiaries would insulate them from premium increases, thus making such changes more palatable to those who object on the grounds of excessive burdens from premium increases. The net costs of this option, even after accounting for a higher premium, would be as much as $2 billion. Moreover, the estimates here assume full SLMB protection up to 150 percent of the poverty level. A more realistic expansion, and one that would cost less, might be to phase out the premium subsidy between 120 and 150 percent of poverty, thus avoiding a "notch" problem with this benefit.[31]

Less Comprehensive Options

An alternative to full federalization of the QMB/SLMB programs would be options to make the federal government responsible for only part of the programs. One possibility

would be to simply waive the Part B premium for anyone who qualifies as a QMB or a SLMB. Yet, as argued above, it is difficult to separate those who have long been bought in by Medicaid. Indeed, if the federal government began to pay the full costs of QMB and SLMB premiums, we would expect more accurate state reporting. Further, participation overall might increase when the states do not have as much to lose in encouraging enrollment, but the continuing stigma from Medicaid might restrain participation to the lower participation rate assumed here. Both of the participation expansion assumptions used in **Table 1** are shown in **Table 2** for purposes of comparison.

Table 2: The Fiscal Impact of Federalization of Other QMB and SLMB Reforms

Specific Policy Change & Participation Assumptions	QMB/SLMB Change Only*	If Combined with Higher Premiums*
Shift Premiums Only to Medicare, Increasing Premium to 30%		
No participation	$1.7	($2.2)
Moderate participation increase	$2.4	($1.5)
High participation increase	$3.0	($0.9)
Provide 50% "Discount" Premium to States, Increase Premium to 30%		
Moderate participation increase	$1.6	($2.3)
High participation increase	$2.1	($1.8)

*Net New Federal Costs, 1996 (Billions)
Source: Author's simulations using data from Current Population Survey and Health Care Financing Administration

The costs of a premium-only federal takeover are substantially below the costs shown in all the options of **Table 1**. Cost-sharing protections constitute over half of our estimated QMB costs, so eliminating them in this way largely eliminates them from our cost estimate. The exception, however, is that if participation rates rise, cost-sharing for new participants will also increase, and the 57 percent federal share of those expenditures needs to be added to the costs as well. Thus, even this limited option, assuming a moderate increase in rates of participation and an across-the-board Part B premium increase to 30 percent, would increase federal costs to $2.4 billion. The additional revenues from the premium increase would result in net savings of $1.5 billion.

An even more modest alternative would be to charge a premium of only half the actual rate for those in the QMB program, effectively discounting costs to the states.[32] This would further lower federal costs, but since the states would still bear at least a portion of the premium costs, they would be less likely to urge any increase in participation. This alternative fails to address one of the major problems facing the current programs. In this case, the new costs would total about $1.6 billion, and net savings, when accounting for the higher premium, would be $2.3 billion.

CONCLUSIONS

The QMB and SLMB programs fill some important gaps in Medicare coverage for low-income persons. Medicaid traditionally has not helped all poor elderly persons and persons with disabilities, and likely future limits in the program suggest that a need for QMB/SLMB protections will continue. The health spending burdens on those with modest incomes, up to about 200 percent of poverty, are substantial—routinely averaging more than one-fourth of the incomes of these families. Further, higher beneficiary contributions may be part of future packages to reduce Medicare spending, also implying that burdens may otherwise increase on low-income populations. Thus, further federal action would be important to extend protections to a larger share of low-income Medicare beneficiaries.

Shifting these programs to Medicare would add costs at a time when most of the political discussion concerns reducing spending. Opponents of this change argue that we cannot afford new spending at the federal level. Further, absorbing costs now being paid by states would constitute a substantial share of such proposals, suggesting that some type of maintenance-of-effort requirements might be needed. On the other hand, reducing burdens on the states would allow them to potentially expand health care coverage to other populations.

Precisely because there are likely to be further requirements on beneficiaries to pay higher costs in the form of increased premiums or higher copayments, additional protections for the most vulnerable beneficiaries make good sense. Some or all of the costs of these new low-income protections could be absorbed by other changes in Medicare, but some may also appropriately come out of general revenue if this is a high priority for this public program. Finally, federalization of the program would reduce or eliminate some of the disparities that currently exist across states. If states are to some degree responsible for low participation, this policy change could increase the rates in areas where they are particularly low.

A less comprehensive option would be to retain the QMB and SLMB programs as part of Medicaid but further subsidize state activities in this area. This might involve waiving or limiting the Part B premium while requiring states to continue paying the cost-sharing portion of the program. This would likely continue the low participation and disparities across states that now characterize the program. This would at best represent only a partial solution.

REFERENCES

Baugher, Eleanor, and Leatha Lamison-White. 1996. *Poverty in the United States: 1995.* U.S. Bureau of the Census, Current Population Reports, Series P60-194. Washington, DC: U.S. Government Printing Office.

Commonwealth Fund. 1987. *Old, Alone, and Poor: A Plan for Reducing Poverty Among Elderly People Living Alone.* New York: Author, April.

Congressional Research Service. 1993. *Medicaid Source Book: Background Data and Analysis, A 1993 Update.* Subcommittee on Health and the Environment, U.S. House of Representatives. 103rd Congress, 1st Session. Washington, D.C.: U.S. Government Printing Office, January.

Coughlin, Teresa, Leighton Ku, and John Holahan. 1994. *Medicaid Since 1980.* Washington, DC: The Urban Institute Press.

Davis, Karen. 1986. "Medicaid: Medigap for the Poor Elderly," testimony before the U.S. House of Representatives Committee on Energy and Commerce, Hearing on Economic Status and Financial Burden for Health Care of the Elderly, March 26, 1986.

Davis, Karen, and Cathy Schoen. 1978. *Health and the War on Poverty: A Ten-Year Appraisal.* Washington, DC: Brookings Institution.

Families USA Foundation. 1995. "Medicare Beneficiaries With Low and Modest Incomes Hurt by Proposed Cuts." Washington, DC: Author. Families USA Foundation. 1993. *The Medicare Buy-In: A Promise Unfulfilled.* Washington, DC: Author, March. Health Care Financing Administration. 1996. "Medicaid Services State by State." Washington, DC: U.S. Department of Health and Human Services.

Health Care Financing Administration. 1995. *Health Care Financing Review Medicare and Medicaid Statistical Supplement.* Baltimore, MD: U.S. Department of Health and Human Services.

McMillan, Alma, Penelope Pine, Marian Gornick, and Ronald Prihoda. 1983. "A Study of the 'Crossover Population': Aged Persons Entitled to Both Medicare and Medicaid." *Health Care Financing Review* 4(4):19-46.

Medicare Beneficiaries Defense Fund (now known as Medicare Rights Center). 1994. "QMB and SLMB: Programs That Help Low-Income Beneficiaries." New York: Author, March.

Moon, Marilyn. 1996. *Medicare Now and in the Future*, second edition. Washington, DC: The Urban Institute Press.

Moon, Marilyn, and Janemarie Mulvey. 1995. *Entitlements and the Elderly: Protecting Promises, Recognizing Realities.* Washington, DC: The Urban Institute Press.

Neumann, Peter, Mimi Bernardin, Ellen Bayer, and William Evans. 1994. *Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program.* Bethesda, MD: Project HOPE Center for Health Affairs, August.

O'Sullivan, Jennifer. 1995. "Qualified Medicare Beneficiary Program." *CRS Report for Congress*. The Library of Congress, Washington, D.C., mimeo, July 31.

Rosenbaum, Sara, and Julie Darnell, *A Comparison of the Medicaid Provisions Under Current Law, The President's Balanced Budget Proposal, The Medigrant Provisions of H.R. 2491, and The National Governors' Association Proposal* (Washington, DC: Henry J. Kaiser Family Foundation, April 1996).

Rowland, Diane, and Barbara Lyons. 1987. *Medicare's Poor: Filling the Gaps in Medical Coverage for Low-Income Elderly Americans,* a report of The Commonwealth Fund Commission on Elderly People Living Alone, November 1987.

ENDNOTES

[1] This includes Medicare cost-sharing and Part B premiums, non-covered services, private health insurance premiums, and balance billing. We focus on the noninstitutionalized elderly for our simulations of the impact of health care spending on income. They constitute approximately 86 percent of all beneficiaries.

[2] Medicare liabilities—that is, cost-sharing and Part B premiums associated with Medicare, regardless of who pays—will average about $1,251 in 1996. Spending by the noninstitutionalized elderly is lower than for all beneficiaries, so this number is higher than an amount comparable to the information provided in **Figure 1**. Moreover, the estimates in **Figure 1** also capture the administrative costs of private supplemental insurance and the implicit subsidies contained in most employer-sponsored retiree coverage. Thus, care is necessary in comparing this estimate with others presented here.

[3] Karen Davis, and Cathy Schoen, *Health and the War on Poverty: A Ten-Year Appraisal* (Washington, DC: The Brookings Institution, 1978). [4] This program was earlier added as an optional benefit and was only made mandatory with the passage of the Medicare Catastrophic Coverage Act of 1988. [5] For example, see the Commonwealth Fund, *Old, Alone, and Poor: A Plan for Reducing Poverty Among Elderly People Living Alone* (New York:Author, April 1987). Income data for persons with disabilities are not discussed in this paper. [6] As of October 1995, twelve states were designated as "209(b) states." These states may not cover all SSI beneficiaries. See Health Care Financing Administration, *Medicaid Services State By State* (Washington, DC:U.S. Department of Health and Human Services, 1996). [7] Not all states have a medically needy program per se but instead have similar programs that provide essentially the same coverage. [8] Enrollment, however, has still increased. Enrollment of elderly medically needy recipients increased by 500,000 between 1988 and 1992. So while the eligibility criteria may be more stringent, increasing numbers of individuals still have incomes after medical expenses low enough to qualify for assistance. See Theresa Coughlin, Leighton Ku, and John Holahan, *Medicaid Since 1984* (Washington, DC: The Urban Institute Press, 1994).

[9] They must also pay the Part A premium for elderly Medicaid beneficiaries who would not otherwise receive Medicare. Persons over age 65 are allowed to buy-in to Parts A and B of the program, and states must do so for older beneficiaries below 100 percent of the federal poverty level who are not entitled to Social Security benefits, such as those with too few years of qualifying employment. [10] Congressional Research Service, *Medicaid Source Book: Background Data and Analysis, A 1993 Update*, Subcommittee on Health and the Environment, U.S. House of Representatives, 103rd Congress, 1st Session (Washington, DC: U.S. Government Printing Office, January 1993). [11] Marilyn Moon, *Medicare Now and in the Future*, second edition (Washington, DC: The Urban Institute Press, 1996).

[12] In practice, it is sometimes difficult to distinguish between buy-ins who are and who are not QMB-eligible. Medically needy persons whose incomes and assets exceed the qualifying limits comprise the largest group of those who are ineligible for QMB participation.

[13] Medicare Beneficiaries Defense Fund (now known as Medicare Rights Center), "QMB and SLMB: Programs That Help Low-Income Beneficiaries" (New York:Author,

March 1994). Assets include bank accounts, stocks and bonds, and property. Homes, automobiles (if necessary for transportation to work or medical treatment), some life insurance policies, and a burial fund of $1,500 (singles) and $3,000 (couple) are excluded.

[14] Another important participation issue is the degree of variation among the states. Some variation is to be expected reflecting higher numbers of elderly persons and persons with disabilities persons or greater generosity in providing SSI benefits. But, some states may simply be more active in encouraging beneficiary enrollment in the QMB and SLMB programs. Finally, data reporting is left completely up to the states, resulting in a degree of inaccuracy that makes it difficult to assess the full extent of disparities. [15] Families USA Foundation, *The Medicare Buy-In: A Promise Unfulfilled* (Washington, DC: Author, March 1993).

[16] Peter Neumann, et. al., *Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program* (Bethesda, MD: Project Hope Center for Health Affairs, August 1994).

[17] Our adjustments to the CPS trended the data forward to 1996, estimated the proportion of those income-eligible for the program who would not meet the asset screens, and adjusted the denominator upward to reflect the number of institutionalized persons likely to be eligible. [18] For example, the number of overall buy-ins increased from 4.2 million in 1993 to 4.8 million in 1995, a 14 percent rise over this period as compared to an increase of approximately 4 percent in the number of Medicare beneficiaries.

[19] Indeed, the data suggest a relatively low participation rate for this group, but it is difficult to disentangle data and reporting issues from actual compliance by states. Some basic facts about Medicaid beneficiaries seem unreliably reported, and others, such as who among the medically needy are eligible as QMBs, are unknown.

[20] Although many of these persons would have been bought in anyway, some states preferred to pay the full costs of physician services rather than pay to enroll beneficiaries in Medicare's Part B. Beneficiaries could gain by enrollment since this gives them access to a broader range of physicians and other providers.

[21] Alma McMillan, et. al., "A Study of the 'Crossover Population,' Aged Persons Entitled to Both Medicare and Medicaid," *Health Care Financing Review* 4(4, 1983):19-46. [22] Sara Rosenbaum and Julie Darnell, *A Comparison of the Medicaid Provisions Under Current Law, The President's Balanced Budget Proposal, The Medigrant Provisions of H.R. 2491, and The National Governors' Association Proposal* (Washington, DC: Henry J. Kaiser Family Foundation, April 1996).

[23] This is the overall federal share of the jointly funded Medicaid program. Because matching rates vary by state, the federal contribution in each state to QMB also varies from 50 percent to nearly 80 percent. [24] In particular, SLMBs might be in a better position to learn about the program if it is based in Medicare rather than Medicaid. As a consequence and because we expect an increase in SLMBs over time as the program is better known, we assume a greater increase in participation in this part of the program than in the QMB program. [25] We estimate Medicare cost-sharing expenses from the 1987 *National Medical Expenditure Survey* (NMES) using cost-sharing for Medicare-covered services by elderly persons and persons with disabilities with incomes under the

poverty thresholds. Levels of spending were aged to 1996. See Marilyn Moon and Janemarie Mulvey, *Entitlements and the Elderly: Protecting Promises, Recognizing Realities* (Washington, DC: The Urban Institute Press, 1995) for a description of the techniques used. The techniques use Congressional Budget Office projections of spending by type of service to update the NMES data and HCFA estimates of cost-sharing liability to further calibrate our estimates. See *Health Care Financing Administration, Health Care Financing Review, Medicare and Medicaid Statistical Supplement* (Baltimore, MD: U.S. Department of Health and Human Services, 1995). [26] This is actually higher than what states may now be contributing if they are paying less than the full cost-sharing amounts that Medicare prescribes—that is, a number of states seem to pay less than the required cost-sharing under Medicare, a requirement that seems to have been somewhat inconsistently applied by the courts. See Jennifer O'Sullivan, "Qualified Medicare Beneficiary Program," *CRS Report for Congress*, mimeo (Washington, DC: The Library of Congress, July 31, 1995). Depending upon how widespread this practice is, the current state costs would be less than $3.8 billion, but if the program were shifted to the federal government, we assume that the cost-sharing payments would be made in full. [27] We also estimate about 700,000 buy-ins are not QMB or SLMB eligible, and about half of those are medically needy persons whose before-health-expense incomes are above 120 percent of the poverty guidelines. Our 4.1 million figure does include some SSI beneficiaries whose incomes could make them ineligible but who would be difficult to exclude from participation.

[28] Assuming a 1996 total Medicaid expenditure of $174 billion, reducing the federal matching rate by about 2 percentage points in each state would generate enough savings to nearly offset the impact of shifting this program out of Medicaid. Since the size of the QMB/SLMB programs varies in each state, a more complicated arrangement might well be necessary to prevent or minimize actual higher burdens by states. Thus, it is unlikely that a full recoupment of costs would be accomplished, and since matching rates vary across the states, their impacts as a share of current payments would also vary. [29] Full participation would obviously raise the costs even further, but since no means-tested programs in the United States achieve 100 percent participation, and since it is usually believed that participation declines for those with higher incomes, we believe the high participation assumption represents a reasonable upper bound for the foreseeable future. [30] Indeed, changes in cost-sharing or premiums could be combined with federalization of the QMB program to generate net savings. However, if we have a national commitment to protecting low-income beneficiaries, it is also reasonable to argue that it should not be financed merely by other beneficiaries but by taxpayers as a whole. [31] The current QMB/SLMB programs have a problem with a notch. That is, one additional dollar of income can move a person from eligibility to a full benefit to no eligibility for any protection.

[32] This is in contrast to proposals in the Reagan and Bush administrations, which would have raised states' shares of the cost of the buy-in.

BRIEFING NOTE

Protecting Medicare's Poor

Karen Davis, President

While Medicare has undoubtedly eased the worries of America's elderly people when it comes to their health, seniors still pay a significant portion of their often high medical bills. In 1996, the average out-of-pocket cost per person over age 65 was $2,605—21 percent of their average household income.

A key issue in the coming debate on the future of Medicare is how much seniors should be required to pay for their health care. Proposals to increase the Medicare premium, deductibles, and copayments are likely to be on the table.

A new Commonwealth Fund report by Marilyn Moon, Crystal Kuntz, and Laurie Pounder of the Urban Institute, entitled *Protecting Low Income Medicare Beneficiaries*, spells out the financial risks of these proposals for poor and near-poor seniors. The report also analyzes options for improving Medicaid protection for the poorest of Medicare's beneficiaries.

The researchers explain Medicaid's role in picking up some of Medicare's costs. Since Medicaid was expanded in 1988, for instance, states have been required to cover the cost of Medicare's premiums and cost-sharing for all beneficiaries below 100 percent of the poverty line (called Qualified Medicare Beneficiaries, or QMBs) and premiums for those up to 120 percent of the poverty line (Specified Low Income Medicare Beneficiaries, or SLMBs). These provisions, however, still do not shield poor beneficiaries from the brunt of their medical costs.

One explanation for the continued high percentage of income spent on health care, according to the Urban Institute analysis, is that too few poor are registered in these programs—only 63 percent of those eligible for QMB benefits and 10 percent of those eligible for SLMB benefits. The reasons for this lack of participation vary, ranging from the newness of the programs and lack of awareness of their existence among the poor, to states' non-aggressive enrollment techniques as a means of controlling their costs.

Any changes in Medicare, the researchers say, should also shore up protections for those at the lower end of the economic scale. Among the options: making supplemental coverage for low income beneficiaries a part of Medicare rather than Medicaid, which would make the federal government responsible for the bills; or increasing the federal portion of costs to lessen the burden on states.

Facts and Figures

- Of the $2,605 spent on average per Medicare beneficiary, 42 percent is for Medicare's cost-sharing and Part B premiums, 31 percent is for supplemental insurance, and 27 percent is for non-covered services such as prescription drugs.
- In 1994, 11 percent of all people over age 65 were below the poverty line; another 14.6 percent had incomes from 100 to 150 percent of that threshold.
- QMB coverage saves an average of $370 per year per elderly poor person.
- The federal government would pay an estimated $3.8 billion to pick up the entire cost of QMB/SLMB for the 4.1 million participants.