THE ROLE OF THE ASSET TEST IN TARGETING BENEFITS FOR MEDICARE SAVINGS PROGRAMS

Laura Summer and Robert Friedland
Center on an Aging Society
Georgetown University

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ABOUT THE AUTHORS

Laura Summer, M.P.H., is a senior researcher at Georgetown University's Institute for Health Care Research and Policy, where she conducts research on the design of health care programs and on access to health and long-term care services, with a focus on the low-income population. Ms. Summer also serves as the deputy director for the Institute's Center on an Aging Society, an organization that studies the impact of demographic changes on public and private institutions and families of all ages. She earned her master of public health degree from the University of Michigan. Ms. Summer can be reached at **lls6@georgetown.edu.**

Robert B. Friedland, Ph.D., is associate research professor at the Institute for Health Care Research and Policy at Georgetown University and the director of the Center on an Aging Society. Dr. Friedland has had a wide range of research and public policy experience, having been chief economist for Maryland's Medicaid program, senior research associate at the Employee Benefit Research Institute, director of the American Association of Retired Person's Public Policy Institute, research director at the National Academy of Social Insurance, and economist on the staff of the U.S. Bipartisan Commission on Comprehensive Health Care, better known as the Pepper Commission. Dr. Friedland earned a Ph.D. in economics from George Washington University.

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EXECUTIVE SUMMARY

The Medicare Savings Programs provide premium protections as well as some cost-sharing protections to Medicare beneficiaries with low incomes and few financial resources. When the programs were created in 1988, income and asset limits were established to target benefits to particularly needy Medicare beneficiaries. A review of incomes and assets of Medicare beneficiaries age 65 and older, however, indicates that some vulnerable individuals do not currently qualify for benefits. Less than half (48%) of people who meet the Medicare Savings Programs' income eligibility limits also meet the asset limits. This means that a substantial number of individuals with low incomes do not benefit from the Medicare Savings Programs. Low-income beneficiaries are more likely than beneficiaries in higher-income groups to be single, older women in fair or poor health and to have a limited education.

Although federal rules regarding asset tests have not changed since the Medicare Savings Programs were created, some 21 states have made changes in the methodology used to count assets, effectively increasing the asset limits. Some states also have made efforts to ease the enrollment process for the Medicare Savings Programs by permitting applicants to make self-declarations about their assets rather than having to submit documents. They can make the self-declarations either when they first apply or at the time when program eligibility is redetermined.

This report examines modifications to the rules regarding asset tests for the Medicare Savings Programs that could extend benefits to more low-income Medicare beneficiaries age 65 and older across the country. Among the findings:

- Some 5.2 million people are estimated to have been eligible for the Medicare Savings Programs in 1998. If asset limits had been raised to reflect the growth in the economy from 1988 to 1998, an additional 230,000 people would have been eligible. These are people whom policymakers envisioned would be eligible when they initially targeted program benefits. The additional cost of providing benefits to people newly eligible under this modification would be $172 million in 2002.

- Current rules regarding asset tests may discourage some people from saving for retirement. Relatively few people who qualify for the Medicare Savings Programs on the basis of income also have substantial retirement funds, though some have saved for retirement. Currently, tax-qualified retirement savings such as 401(k)-type plans and individual retirement accounts (IRAs) are counted as assets, though

retirement savings held in the form of defined benefit pension plans are not counted as such. If the rules were changed so that no retirement savings were counted as assets, program benefits could be extended to 112,000 more people at a cost in 2002 of $67 million.

- Under current rules, about 48 percent of people who meet the income eligibility requirements for the Medicare Savings Programs meet the asset eligibility requirements as well. If asset limits were adjusted for economic growth and tax-protected retirement funds were not counted as assets, the proportion of people who would meet the asset as well as the income requirements would increase to 51 percent.

- A doubling of the asset limits would extend coverage to about 1 million more vulnerable individuals, about 57 percent of whom qualify for the program on the basis of income. The cost of providing benefits for this group would be $673 million in 2002.

- The elimination of the asset test for the Medicare Savings Programs would be the broadest and most costly of modifications, increasing the pool of potentially eligible beneficiaries by almost 6 million at a cost in 2002 of about $3.2 billion.

THE ROLE OF THE ASSET TEST IN TARGETING BENEFITS FOR MEDICARE SAVINGS PROGRAMS

MEDICARE SAVINGS PROGRAMS

The Medicare program is an important source of health care coverage for some 39 million Americans, 34 million of whom are age 65 and older. Even with Medicare coverage, however, substantial numbers of older people have difficulty paying for the health care they need. The Medicare cost-sharing requirements for premiums, deductibles, and coinsurance represent a significant portion of income. On average, Medicare beneficiaries age 65 and older spend out-of-pocket 22 percent of their incomes for health care, and more vulnerable groups spend an even greater proportion. Older low-income women in poor health, for example, spend more than half their incomes on out-of-pocket costs of medical care.[1]

Some low-income Medicare beneficiaries have protection from these costs because they also qualify for Medicaid coverage. Medicaid covers Medicare premiums, deductibles, and copayments. It also pays for prescription drugs and other services not covered by Medicare.[2]

Beginning in 1988, Congress enacted a series of Medicaid-financed provisions to provide partial protection to low-income Medicare beneficiaries not entitled to the full Medicaid benefits package. These Medicare Savings Programs, sometimes called Medicare buy-in programs, include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individuals (QI) programs. They provide various premium and Medicare cost-sharing protections to Medicare beneficiaries with low incomes and few financial resources. Basically, benefits are provided to Medicare beneficiaries with incomes at or below 175 percent of the federal poverty level and with assets up to $4,000 per individual or $6,000 per couple.

The QMB and SLMB programs are entitlement programs. Spending for program benefits is shared by states and the federal government in the same proportions as the

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[1] Stephanie Maxwell, Marilyn Moon, and Misha Segal (2001). *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*. New York: The Commonwealth Fund.

[2] Very poor Medicare beneficiaries who qualify for Supplemental Security Income (SSI) are eligible for Medicaid benefits. Some 35 states provide "medically needy" coverage for those who qualify for Medicaid because of substantial medical expenses. In addition, 19 states provide full Medicaid coverage to elderly individuals who have limited assets and family incomes at or below 100 percent of the federal poverty level. See the American Public Human Services Association (2001). *Aged, Blind, and Disabled Medicaid Eligibility Survey*. Available at: http//www.masterpiecepublishers.com/eligibility.

Medicaid program. The QI programs were authorized by the Balanced Budget Act of 1997 to provide a five-year block grant, beginning January 1, 1998, and ending December 31, 2002. Some $200 million was allocated in 1998 with an increase of $50 million each year through 2002. The QI programs are entirely federally funded and are not entitlements. Enrollment occurs on a first-come, first-served basis. Enrollment in the QI programs, however, has been lower than anticipated.

The protections offered through the Medicare Savings Programs are intended to improve access to care for low-income Medicare beneficiaries, a group that is particularly vulnerable to large unexpected expenses associated with health problems. The Medicare Savings Programs also lessen the financial risks that low-income Medicare beneficiaries pose to states: with this protection, states have more assurance that Medicare beneficiaries have Part B Medicare coverage, for ambulatory care and related services, and that beneficiaries' copayments and deductibles are covered. Beneficiaries are less likely to have to liquidate assets, including income-generating assets, in order to become "medically needy" and hence eligible for full Medicaid coverage.

Eligibility Rules for Medicare Savings Programs

As with a number of other means-tested programs, eligibility determinations for the QMB, SLMB, and QI programs require an assessment of applicants' income and assets. Income eligibility determinations are based on "countable" income, which includes both earned and unearned income. Some exclusions apply. These include the first $20 of any monthly income, the first $65 of monthly earned income, and half the remaining earnings. Countable assets exclude assets such as the applicant's home, household goods, and personal property as well as part of the value of items such as an automobile and life insurance policies. States have the option of excluding other income or assets as well. The specific financial eligibility criteria and benefits for each of the Medicare Savings Programs are presented in Figure 1.

Figure 1. Financial Eligibility Criteria for the QMB, SLMB, and QI Programs

Program	Countable Income Limits	Countable Asset Limits	Benefits
Qualified Medicare Beneficiary (QMB)	At or below 100% of the federal poverty level**	$4,000 for individuals $6,000 for couples	Medicaid pays all Medicare Part B premiums ($54 per month in 2002) and cost-sharing charges***
Specified Low-Income Medicare Beneficiary (SLMB)	Between 100% and 120% of the federal poverty level	$4,000 for individuals $6,000 for couples	Medicaid pays Medicare Part B premiums ($54 per month in 2002)
Qualifying Individuals I (QI-I)*	Between 120% and 135% of the federal poverty level	$4,000 for individuals $6,000 for couples	Medicaid pays Medicare Part B premiums ($54 per month in 2002)
Qualifying Individuals II (QI-II)*	Between 135% and 175% of the federal poverty level	$4,000 for individuals $6,000 for couples	Medicaid pays part of the Medicare Part B premium ($3.91 per month in 2002).

* The QMB and SLMB programs are entitlement programs, but QIs do not have an entitlement to assistance. Federal program funding is capped each year and is due to expire at the end of fiscal year 2002.

** In 2002, the federal poverty level is $8,860 for individuals and $11,940 for couples.

*** States are not required to pay for cost-sharing if the Medicaid payment rates for a given service are substantially lower than the Medicare payment rates.

Source: Andy Schneider, Kristen Fennel, and Patricia Keenan (1999). *Medicaid Eligibility for the Elderly*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured. Revisions by the Center on an Aging Society add values for current benefits.

Program Eligibility Rules Vary Across States

Under general rules for determining Medicaid eligibility, states are required to follow the same rules and processes used by the most closely related cash assistance programs to determine program eligibility. For elderly, blind, or disabled individuals, those would be the rules of the Supplemental Security Income Program (SSI).[3] Under Section 1902(r)(2) of the Medicaid statute, however, states may use less restrictive income and resource methodologies in determining eligibility for most Medicaid eligibility groups than are used by the comparable cash assistance program. Thus, states have some discretion in counting income and assets for the Medicare Savings Programs.

Some 21 states have less restrictive rules regarding assets for the Medicare Savings Programs (Figure 2).[4] A variety of approaches are used to implement these less restrictive methodologies. Four states—Alabama, Arizona, Delaware, and Mississippi—have eliminated the asset test for Medicare Savings Programs. Connecticut does not have an asset test for the QI-I and QI-II programs.

[3] Some states, called 209(b) states, have opted not to provide Medicaid for all SSI recipients. Therefore, eligibility criteria in those states differ somewhat from the SSI eligibility criteria.

[4] The states are Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Maine, Minnesota, Mississippi, Missouri, Montana, Rhode Island, South Carolina, Tennessee, Vermont, and Virginia.

Figure 2. Special Eligibility Rules Related to Asset Tests, 2001

Disregard all assets	AL, AZ, DE, MS
Disregard all assets for QI-I and QI-II	CT
Disregard a portion of countable assets	FL, ME, MN
Disregard the value of one vehicle	FL, KS, MO, SC, VA
Disregard the value of two or more vehicles	GA, ME, VT
Disregard a higher value for burial funds	FL, GA
Disregard a higher value for life insurance	FL, GA
Disregard resources used to pay certain medical, legal, guardianship, or tax assessment fees	ME, RI
Disregard all household goods and personal effects	GA, HI, SC, VT
Disregard income-producing property	AR, FL, IN, KS, SC
Disregard resources necessary for self-support	FL, IL
Disregard property if applicant has made an effort to sell it	IN, KS, ME, MT, VT, VA
Use lowest asset value for the month	KS, ME, MO, SC, TN

Source: American Public Human Services Association (2001). *Aged, Blind, and Disabled Medicaid Eligibility Survey*. Available at: http//www.masterpiecepublishers.com/eligibility (2002).

In all states, certain assets must be excluded when the value is calculated. The value of the home where an applicant lives, for example, is not counted. Some states have specified other categories of assets that are not counted. For example, five states do not count income-producing property. In six states, the value of property is not counted if applicants make an effort to sell it. States that do not count certain assets in making eligibility determinations not only expand eligibility, but also simplify application and administrative procedures because they have less information to verify and process.

Some assets are counted only if they exceed specific values. For example, federal rules specify that the first $4,500 of the value of a vehicle is not counted. In five states, the full market value of one vehicle can be excluded from countable assets even it exceeds $4,500. In three other states, the value of two or more vehicles can be excluded. Federal rules also exclude the first $2,000 of household goods and personal effects in counting assets, but four states have modified the rule to exclude all household goods and personal effects. Federal rules set a standard disregard of $1,500 for burial funds, but two states have higher limits. Similarly, federal rules provide a $1,500 exclusion for life insurance, but two states have more liberal allowances.

Three states disregard some portion of countable assets. Florida excludes the first $1,000, Maine excludes the first $8,000 for an individual and $12,000 for couples, and Minnesota excludes the first $10,000 for individuals and $18,000 for couples.

Another approach to less restrictive guidelines is to use a more liberal definition for the time period that is considered in evaluating assets. In five states—Kansas, Maine, Missouri, South Carolina, and Tennessee—applicants are eligible if their assets fall below the limits at any time during the month.

States also have made efforts to ease the enrollment process for the Medicare Savings Programs. They recognize that requirements to provide documents to verify assets may be daunting for certain applicants and therefore some states allow applicants to make self-declarations about their assets. Similarly, self-declaration is allowed in some states when redeterminations about program eligibility are made.

How Many People Are Eligible for Program Benefits?

Figure 3 shows the number of people age 65 and older who are potentially eligible for Medicare Savings Programs based on countable income and assets.[5] A total of 5.2 million individuals have incomes and assets that meet the eligibility criteria for the Medicare Savings Programs. Of that group, 1.5 million also qualify for full Medicaid benefits.

[5] The numbers represent individuals potentially eligible for benefits in 1998, the latest year for which data are available. Standard rules were used to make eligibility determinations. In states that have more liberal income or asset rules, more people would be eligible. The Center on an Aging Society analyzed data on income and assets of individuals 65 years of age and older from the 1998 Health and Retirement Study sponsored by the National Institute on Aging. The methodology is described in the Appendix.

Figure 3. Number of People Age 65 and Older Potentially Eligible for Medicare Savings Programs, Based on Income and Assets and Number Currently Covered by Medicaid

Program	Countable Income Limits*	People Potentially Eligible for Benefits (in thousands)	People Who Say They Are Currently Covered by Medicaid (in thousands)	People Potentially Eligible For Benefits Who Say They Are Currently Covered by Medicaid (%)
Full Medicaid Coverage	At or below 75% of the federal poverty level	1,536	968	63%
Qualified Medicare Beneficiary (QMB)	At or below 100% of the federal poverty level	1,410	**	**
Specified Low-Income Medicare Beneficiary (SLMB)	Between 100% and 120% of the federal poverty level	922	**	**
Qualifying Individuals I (QI-I)	Between 120% and 135% of the federal poverty level	515	**	**
Qualifying Individuals II (QI-II)	Between 135% and 175% of the federal poverty level	837	**	**
All Medicare Savings Programs	At or below 175% of the federal poverty level	5,221	**	**

* People eligible for full Medicaid benefits who have countable assets below $2,000 for an individual and $3,000 for a couple. The countable asset limits for the QMB, SLMB, and QI programs are $4,000 for an individual and $6,000 for a couple.

** The Health and Retirement Study asks respondents if they have Medicaid coverage, but does not ask about coverage under the QMB, SLMB, or QI programs.

Source: Center on an Aging Society analysis of data from the 1998 Health and Retirement Study.

Program Participation Rates Are Low

Estimates using data from the 1998 Health and Retirement Study sponsored by the National Institute on Aging indicate that the Medicaid program covers only 63 percent of people age 65 and older who are eligible for full Medicaid benefits. Data from the study cannot be used to determine participation rates for the individual Medicare Savings Programs, but a number of estimates made in 1998 indicate that just over half of those eligible for the QMB and SLMB programs were participating.[6] In 1999, the Centers for Medicare and Medicaid Services (CMS) estimated that 54 percent of people eligible for the QMB and SLMB programs were participating and established goals to increase enrollment in subsequent years. Program enrollment has grown since 1999, but CMS has

[6] See, for example, Mary A. Laschober and Christopher J. Topoleski (1999). *A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries*. Washington, D.C.: The Barents Group and Families USA Foundation; and Cynthia Costello (1998). *Shortchanged: Billions Withheld from Medicare Beneficiaries*. Washington, D.C.: Families USA Foundation.

not released new estimates of the extent to which eligible individuals are participating in the programs. Current enrollment figures, however, indicate that enrollment in the QI-I program is particularly low. About 96,000 people are enrolled in the program, a figure far below the 515,000 estimated to be eligible.[7]

INCOMES AND ASSETS OF ELDERLY MEDICARE BENEFICIARIES

Medicare beneficiaries age 65 and older who have incomes less than or equal to 175 percent of the federal poverty level—those who are potentially eligible for full Medicaid coverage or for the QMB, SLMB, or QI programs—are decidedly different from other Medicare beneficiaries (Figure 4). Compared with other Medicare beneficiaries, low-income Medicare beneficiaries are older and more likely to be women. They are more likely to be single and more than twice as likely to be widowed, divorced, or separated. In addition, low-income elderly Medicare beneficiaries are less likely than other beneficiaries to be white and are much less likely to have completed high school. Larger proportions of low-income beneficiaries also report that their health is either fair or poor.

Figure 4. Characteristics of Populations Age 65 and Older That Do and Do Not Meet Income Eligibility Limits for Medicare Savings Programs

	Potentially Eligible for Assistance from Medicaid (income at or below 175% of the federal poverty level)	Others (income greater than 175% of the federal poverty level)
Mean Age	76	74
Female	70%	52%
Marital Status:		
Married	32%	67%
Divorced/Separated	13%	6%
Widowed	51%	24%
Never Married	4%	3%
Race:		
Black	16%	5%
White	79%	94%
Other	5%	2%
Graduated from High School	41%	78%
Self-Reported Health Status:		
Very Good to Excellent	23%	39%
Good	28%	33%
Fair	28%	20%
Poor	21%	8%

Source: Center on an Aging Society analysis of data from the 1998 Health and Retirement Study.

[7] Data from the Third Party Premium Billing File, September 2002 billing cycle, Centers for Medicare and Medicaid Services, Washington, D.C.

Characteristics Differ as Income Increases, Even Among the Low-Income Population

Among groups that do meet income eligibility requirements for the Medicare Savings Programs, consistent patterns appear (Figure 5). The average age and proportion of the population that are women, unmarried, and nonwhite all decline as average income levels increase. As income increases, so does the proportion of individuals that have a high school diploma. Health status also improves with income.

Figure 5. Characteristics of Low-Income Population Age 65 and Older That Meet Income Eligibility Limits for Each Medicare Savings Program

	QMB (income at or below 100% of the federal poverty level)	SLMB (income between 100% and 120% of the federal poverty level)	QI-I (income between 120% and 135% of the federal poverty level)	QI-II (income between 135% and 175% of the federal poverty level)
Mean Age	76	77	77	76
Female	74%	71%	70%	65%
Marital Status:				
Married	24%	33%	35%	41%
Divorced/Separated	17%	12%	11%	8%
Widowed	52%	52%	50%	49%
Never Married	7%	3%	3%	2%
Race:				
Black	23%	14%	12%	10%
White	70%	81%	84%	88%
Other	7%	5%	4%	2%
Graduated from High School	32%	41%	45%	52%
Self-Reported Health Status:				
Very Good to Excellent	19%	24%	21%	30%
Good	26%	26%	32%	31%
Fair	30%	30%	28%	23%
Poor	25%	20%	19%	16%

Source: Center on an Aging Society analysis of data from the 1998 Health and Retirement Study.

Asset Holdings Correspond with Income for Elderly Medicare Beneficiaries

Generally, measures of wealth increase with income for the 65-and-older Medicare population. The median value of assets that would be counted in determining eligibility for the Medicare Savings Programs, for example, is twice as high for the group of people who qualify for the SLMB program based on income as for people who qualify for the

QMB program based on income. Median countable asset values are considerably higher for people in the income range for the QI programs (Figure 6).[8]

Figure 6. Median Value of Countable Assets at Different Income Levels for Population Age 65 and Older

	QMB (income at or below 100% of the federal poverty level)	SLMB (income between 100% and 120% of the federal poverty level)	QI-I (income between 120% and 135% of the federal poverty level)	QI-II (income between 135% and 175% of the federal poverty level)	Others (income greater than 175% of the federal poverty level)
All	$1,200	$4,900	$8,500	$19,000	$132,000
Individuals	$900	$3,500	$9,000	$17,000	$88,500
Couples	$3,500	$7,000	$7,500	$22,000	$156,500

Source: Center on an Aging Society analysis of data from the 1998 Health and Retirement Study.

Countable assets correspond with income, but asset levels vary within low-income groups. Some of the low-income elderly have few assets because their lifetime earnings have been relatively low. Others have earnings and savings that provide a financial cushion to absorb the consequences of a certain level of risk, but risks associated with age, widowhood, and poor health increase over time and may deplete savings. The fact that the least-wealthy members of the low-income group are single, older women in fair or poor health suggests that, over time, certain circumstances have seriously undermined their financial security.

CONSEQUENCES OF CHANGING OR ELIMINATING THE ASSET TEST

The variability in wealth among the low-income population age 65 and older signals the importance of the asset test in targeting benefits. A review of the data regarding the characteristics of those who do and do not qualify for Medicare Savings Programs under current program eligibility rules indicates, however, that modifications of the rules might help target benefits more effectively and offer some individuals much-needed financial protections. This report examines several possible modifications. They are:

- adjust the asset limits for economic growth;
- exclude tax-qualified retirement funds from countable assets;
- adjust the asset limits for economic growth and exclude certain retirement funds from countable assets;

[8] For many Medicare beneficiaries, the home is the most significant asset. Overall, home equity constitutes about 50 percent of average net worth for elderly Medicare beneficiaries with homes. Among low-income elderly Medicare beneficiaries who are homeowners, however, the home comprises 73 percent of net worth.

- double the asset limits; and
- eliminate the asset test.

Figure 7 shows how many more people would potentially be eligible for each of the Medicare Savings Programs under each modification. Figure 8 shows the corresponding proportions of people who would qualify for the Medicare Savings Programs on the basis of income and assets.

These modifications could be applied to all of the Medicare Savings Programs or to particular programs. The modifications could be made legislatively at the federal level. Even without federal legislative changes, however, states still have the option of using alternate methods to make eligibility determinations. If states raised the limit for the amount of assets that could be disregarded before eligibility determinations are made, the asset eligibility limit would be effectively increased. In Minnesota, for example, the first $10,000 of countable assets for individuals and $18,000 for couples is excluded from countable assets. Four other states—Alabama, Arizona, Delaware, and Mississippi—already have eliminated the asset test.

Figure 7. Changing the Asset Test: Number of People Age 65 and Older Who Would Be Eligible for Medicare Savings Program Benefits, Based on Income and Assets (in thousands)

	QMB (income at or below 100% of the federal poverty level)	SLMB (income between 100% and 120% of the federal poverty level)	QI-I (income between 120% and 135% of the federal poverty level)	QI-II (income between 135% and 175% of the federal poverty level)	All Medicare Savings Programs (income at or below 175% of the federal poverty level)
Potentially Eligible Under Current Rules	2,946	922	515	837	5,221
Newly Eligible if Asset Tests Were Modified					
Adjust for Economic Growth	88	39	41	62	230
Exclude Tax-Qualified Retirement Funds from Countable Assets	34	13	16	49	112
Adjust the Asset Limits for Economic Growth and Exclude Tax-Qualified Retirement Funds	118	60	53	112	343
Double the Asset Limits	306	238	144	336	1,025
Eliminate the Asset Test	1,403	944	831	2,536	5,714

Source: Center on an Aging Society analysis of data from the 1998 Health and Retirement Study.

Figure 8. Percentage of People in Each Income Group with Assets That Meet Eligibility Limits Under Current and Adjusted Rules for Asset Limits

	QMB (income at or below 100% of the federal poverty level)	SLMB (income between 100% and 120% of the federal poverty level)	QI-I (income between 120% and 135% of the federal poverty level)	QI-II (income between 135% and 175% of the federal poverty level)	All Medicare Savings Programs (income at or below 175% of the federal poverty level)
Current Rules	68%	49%	38%	25%	48%
Proportion Eligible if Asset Tests Were Modified					
Adjust for Economic Growth	70%	51%	41%	27%	50%
Exclude Tax-Qualified Retirement Funds from Countable Assets	69%	50%	40%	26%	49%
Adjust the Asset Limits for Economic Growth and Exclude Tax Qualified Retirement Funds	71%	53%	42%	28%	51%
Double the Asset Limits	75%	62%	49%	35%	57%
Eliminate the Asset Test	100%	100%	100%	100%	100%

Source: Center on an Aging Society analysis of data from the 1998 Health and Retirement Study.

Adjust the Asset Limits for Economic Growth

The limits for countable assets for the Medicare Savings Programs were adopted in 1988 and implemented in 1989. Since that time, income limits for the Medicare Savings Programs have been increased to account for changes in the cost of living. Although assets have appreciated in both real and nominal terms during the same period, the federal limits have not been adjusted to reflect this appreciation. If the asset test had been raised to reflect the economic growth from 1988 to 1998, the limits would have been increased from $4,000 to $4,953 for individuals and from $6,000 to $7,430 for couples.[9] An additional 230,000 people would have become eligible for the Medicare Savings Programs. They are the people that policymakers had envisioned would have been eligible when they initially targeted program benefits.

Exclude Tax-Qualified Retirement Funds from Countable Assets

Modifying the asset test to exclude tax-qualified retirement savings such as 401(k)-type plans and IRAs from countable assets would respond to the inequity that has emerged in

[9] Using the gross domestic product price deflator, a measure of inflation, the asset limit in 1998 would have been $4,953 for individuals and $7,430 for couples. The estimated limit for 2002 is $5,298 for individuals and $7,948 for couples. If the consumer price index were used instead of the gross domestic product to adjust for inflation, the asset limits would have been somewhat higher in 1998: $5,260 for individuals and $7,890 for couples.

the manner in which defined contribution and defined benefit pension plans are treated. Deferred compensation in the form of a defined benefit pension plan provides pension income for retirees, which is counted as a source of income in Medicaid and the Medicare Savings Programs eligibility tests. Deferred compensation in the form of a defined contribution plan is a financial asset for retirees. Although this asset can be converted into annuities and hence converted from an asset to income, most people do not use their retirement savings to purchase an annuity. Instead, they tend to roll over their defined contribution pension into IRAs or simply hold the pension as is. In this form, retirement savings are considered to be countable assets.

The differentiation that Medicaid and the Medicare Savings Programs eligibility tests make between forms of deferred compensation in the form of a pension plan and deferred compensation in the form of a defined contribution plan favors those whose deferred compensation is in the form of a defined benefit pension. The bias stems from the fact that asset limits are much lower than income limits and that income limits automatically adjust with the cost of living, while asset limits do not. As a result, two workers who have the same amount of deferred compensation but different types of retirement plans will fare differently when they apply for benefits. Consider, for example, a married couple at age 65 with tax-qualified retirement savings of $7,500 and a monthly Social Security benefit of $400. Their retirement savings alone disqualifies them for Medicare Savings Programs because this asset exceeds the countable asset threshold of $6,000, even though their monthly income is well below the poverty level. If they had converted their retirement savings into annuities, their income would increase by about $480 a month. When this amount is combined with the Social Security benefit, their income is increased to about $880 a month, an amount still below the income limit. The couple would no longer have the $7,500 in countable assets and thus would qualify for the Medicare Savings Programs.

Excluding tax-qualified retirement funds from 401(k) plans, 403(b) plans, and IRAs would eliminate the bias in the current system that favors defined benefit plans over defined contribution plans. Moreover, it would help encourage saving for retirement and send a signal that low-income Medicare beneficiaries will not be denied Medicare Savings Program benefits because of their retirement savings.

Relatively few older individuals with incomes below 175 percent of the poverty level have substantial savings in the form of defined contribution plans or IRAs. Some 112,000 people, however, would become eligible for the Medicare Savings Programs if the rules for counting retirement assets were changed. They also would be able to use the retirement savings they have accumulated over the rest of their lives. About half of these people have incomes below 135 percent of the poverty level and therefore would qualify

for the QMB, SLMB, or QI-I programs. If adjustments for economic growth were combined with a modification to exclude certain retirement funds from the asset test, some 343,000 people would be newly eligible for the Medicare Savings Programs.

Double the Asset Limit

Even with adjustments for economic growth and changes in the rules regarding retirement funds, a substantial proportion of people who would qualify for the Medicare Savings Programs on the basis of income would be disqualified because of their countable assets: only 51 percent of those who qualify for the Medicare Savings Programs on the basis of income would also meet the asset limits. Therefore, it may be worth considering a substantial increase in the asset limits. If the limits were doubled to $8,000 per individual and $12,000 per couple, about one million vulnerable individuals would be newly eligible for the Medicare Savings Programs. These individuals may become eligible for the Medicare Savings Programs or even for full Medicaid coverage if their health status changes or if they incur other unanticipated expenses. With earlier access to the benefits provided by the Medicare Savings Programs it is possible that it would be easier for them to maintain their health.

Eliminate the Asset Test

The elimination of the asset test would substantially increase the number of people eligible for the Medicare Savings Programs. It also would simplify considerably program administration, reduce administrative costs, and lessen the burden in states with staffing shortages.[10] Program application forms could be shortened because less information would be required from applicants. The time required to process applications would also decrease. Some individuals who currently meet the income and asset limits for the Medicare Savings Programs might be more likely to apply for benefits if the application process were less cumbersome. The complexity of the application process is one of the barriers often cited in discussions about low participation rates in the Medicare Savings Programs. If the asset test were eliminated, almost 6 million more Medicare beneficiaries age 65 and older would become eligible for assistance.

FINANCIAL CONSIDERATIONS RELATED TO CHANGING OR ELIMINATING THE ASSET TEST

In addition to considering the potential benefits of expanding program coverage, policymakers must consider the costs. Adding people to the Medicare Savings Programs would increase the government's expenditures for benefits. This would include Part B Medicare premiums for each additional person participating in the QMB, SLMB, or QI-I programs. For 2002, the Part B premium is $54.00 per month, or $648.00 annually. Costs

[10] Vernon K. Smith, Eileen Ellis, and Christina Chang (2001). *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*. Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured.

for the QMB program are more significant because Medicare copayments and deductibles are also covered. Average cost-sharing for Medicare services per elderly Medicare beneficiary is estimated to be $690 in 2002.[11] The benefit cost for the QI-II program is significantly less, $3.91 per month or $46.92 annually, since only a fraction of the Part B Medicare premium is covered.

The costs of providing benefits to newly eligible beneficiaries under several potential modifications in the asset test for the Medicare Savings Programs are presented in Figure 9. If the asset test were adjusted for economic growth and all newly eligible individuals enrolled in the program, the public cost for benefits would increase by $172 million. A more modest modification—a change in the rules to exclude certain retirement funds from countable assets—would potentially increase benefit costs by $67 million. If both changes were implemented, the public cost of the new benefits would be $236 million.

Doubling the asset limit to make benefits available to a broader range of low-income individuals than originally was intended in the design of the Medicaid and Medicare Savings Programs would have the substantially higher cost of $673 million. Eliminating the asset test altogether would increase public costs by nearly $3.2 billion.

Figure 9. Cost of Benefits Related to Modifying or Eliminating the Asset Test for Medicare Savings Programs (in millions of 2002 dollars)

	QMB (income at or below 100% of the federal poverty level)	SLMB (income between 100% and 120% of the federal poverty level)	QI-I (income between 120% and 135% of the federal poverty level)	QI-II (income between 135% and 175% of the federal poverty level)	All Medicare Savings Programs (income at or below 175% of the federal poverty level)
Adjust for Economic Growth	117.7	25.3	26.6	2.9	172.5
Exclude Tax-Qualified Retirement Funds from Countable Assets	45.5	8.4	10.4	2.3	66.6
Adjust the Asset Limits for Economic Growth and Exclude Tax-Qualified Retirement Funds	157.9	38.9	34.3	5.2	236.3
Double the Asset Limit	409.4	154.2	93.3	15.8	672.7
Eliminate the Asset Test	1,877.0	611.7	538.5	119.0	3,146.2

Source: Center on an Aging Society.

[11] Center on an Aging Society calculations based on data from Stephanie Maxwell, Marilyn Moon, and Misha Segal (2001). *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*. New York: The Commonwealth Fund.

It is important to note that the actual benefit costs associated with any of the modifications for asset limits would be lower than those presented in Figure 9 because not everyone would apply for the programs. In 1998, about 78 percent of those eligible for the QMB program and 16 percent of those eligible for the SLMB program were participating.[12] In addition, a reduction in public costs could occur if some low-income individuals were able to keep their assets and qualify for Medicare Savings Programs instead of having to expend their assets and then qualify for full Medicaid benefits.[13]

CONCLUSION

Low-income Medicare beneficiaries have few assets and are affected by any change in their budgets. In particular, out-of-pocket health and long-term care expenses can be financially catastrophic for this group. The Medicare Savings Programs provide important protections for some low-income elderly Medicare beneficiaries. A smaller proportion of people with low incomes qualify for assistance today than when the programs were established in 1988, however, because the asset limits have not been adjusted for economic growth. In addition, as a result of the dramatic shift from defined benefit pension plans to defined contribution plans, the protected pool of low-income Medicare beneficiaries has decreased even more.

Many states have recognized the need for change. Some 21 states have modified the asset test for the Medicare Savings Programs in some way to provide assistance to more people. Currently, on a national basis, 48 percent of beneficiaries who meet the income eligibility limits for the Medicare Savings Programs also meet the programs' asset limits. If asset limits were indexed with economic growth and tax-qualified retirement savings treated as defined benefit pension plans are now treated, the proportion of low-income Medicare beneficiaries who meet both income and asset eligibility limits would increase to 51 percent. Doubling current asset limits would increase the proportion to 57 percent. Modifying the asset test could extend benefits to a substantial number of low-income Medicare beneficiaries who are extremely vulnerable to changes in their circumstances.

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[12] Marilyn Moon, Niall Brennan, and Misha Segal (1998). *Improving Coverage for Low-Income Medicare Beneficiaries*. New York: The Commonwealth Fund.

[13] Adding beneficiaries also would increase administrative costs associated with processing new applications. If asset tests were eliminated, however, some savings would result as some of the costs associated with processing applications would be reduced. Time studies from two states, Montana and North Carolina, indicate that it takes approximately four hours, on average, to make an initial eligibility determination for the Medicaid program. The Bureau of Labor Statistics reports that hourly earnings for full-time state and local government workers in 2000 were $18.10. Adjusting for wage inflation and the cost of fringe benefits and overhead, the hourly cost of processing new applications for Medicaid is estimated to be $31.33. Therefore, the estimated cost of processing each new application is $125.33. Assuming that about one of the four hours required to process applications is devoted to making determinations about assets, the administrative savings, per application, related to eliminating the asset test is $31.33.

APPENDIX. CALCULATIONS OF NUMBER OF PEOPLE ELIGIBLE FOR MEDICARE SAVINGS PROGRAMS

A nationally representative survey was used to examine the incomes and asset holdings of elderly Medicare beneficiaries. The Health and Retirement Study (HRS) contains detailed information on incomes and assets for 11,126 people representing the population age 51 and older in 1998. It also includes information about the spouses of respondents age 51 or older, regardless of the spouse's age. Questions were administered from February 1998 through March 1999. HRS data were used to calculate countable income and assets for individuals age 65 and older and their spouses. Program rules about counting spousal assets are complex. For this analysis, the assumption is that all assets are jointly held.

Countable income was calculated using both earned and unearned income. Sources of income included in countable income are: earnings, veterans' benefits, Social Security benefits, pensions, unemployment compensation, workers' compensation, income from assets (such as rental property, a business or farm, stocks, bonds, checking, savings, or money market accounts, certificates of deposit, trusts), annuity income, IRA withdrawals, alimony, lump-sum payments, and other sources. Adjustments were made for sources of income that are excluded when determining eligibility. These include: the first $20 of any monthly income, the first $65 of monthly earned income, and half the remaining earnings.

The value of countable assets includes real estate other than the main home, vehicles, life insurance, IRAs or Keoghs, stocks or mutual funds, bonds, amounts in checking or savings accounts or money market funds, CDs or treasury bills, trusts, and other assets. Exclusions from countable assets include the value of one automobile up to $4,500, household goods and property, burial funds up to $1,500, and the cash surrender value of a life insurance policy up to $1,500.

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#562 *Medicare+Choice After Five Years: Lessons for Medicare's Future—Findings from Seven Major Cities* (September 2002). Brian Biles, Geraldine Dallek, and Andrew Dennington. This field report argues that, five years later, Medicare+Choice has not become what program proponents had envisioned. While it was originally forecast that program enrollment would rise to 34 percent of total Medicare enrollment by 2005, the enrollment has now fallen from its 1997 level of 14 percent to just 13 percent.

#561 *Geographic Inequity in Medicare+Choice Benefits—Findings from Seven Communities* (September 2002). Geraldine Dallek, Andrew Dennington, and Brian Biles. In this field report, the authors show that Medicare+Choice plans in Los Angeles and New York City provide far more generous benefits at lower costs to beneficiaries than plans in five other study sites.

#548 *Medicare+Choice in New York City: So Far, So Good?* (September 2002). Jennifer Stuber, Andrew Dennington, and Brian Biles. In this field report, the authors suggest that New York City's more than 200,000 elderly and disabled enrollees in Medicare+Choice plans—representing about 20 percent of all New York City Medicare beneficiaries—may soon begin to experience large-scale health plan withdrawals, premium increases, benefit reductions, and provider network instability, as have beneficiaries in most other markets.

#544 *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources* (August 2002). Marilyn Moon and Matthew Storeygard, The Urban Institute. In this policy brief, the authors suggest that a modest Medicare prescription drug benefit could be crafted that provides some coverage to all beneficiaries while protecting those with low-incomes and high out-of-pocket expenses.

#530 *State Pharmaceutical Assistance Programs: Approaches to Program Design* (May 2002). Kimberley Fox, Thomas Trail, and Stephen Crystal, Rutgers Center for State Health Policy. State pharmacy assistance programs for Medicare beneficiaries help only a small proportion of the Medicare population—just 3 percent, or 1.2 million beneficiaries out of 39 million nationwide. According to the authors, a federal program is needed to fill this gap in coverage, and it should coordinate with the 28 state programs currently in place.

#538 *A Medicare Prescription Drug Benefit: Focusing on Coverage and Cost* (April 2002). Juliette Cubanski and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, discusses the significant policy challenge of designing an effective and politically viable Medicare prescription drug benefit. Available online only at www.cmwf.org.

#537 *Medicare Managed Care: Medicare+Choice at Five Years* (April 2002). Colleen L. Barry and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, examines trends in enrollment, benefits and premiums, plan payments, and satisfaction and quality in Medicare+Choice. Available online only at www.cmwf.org.

#533 *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002* (March 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. In this report (available on the Fund's website only), the authors note that while increases in monthly premiums will affect all enrollees in 2002, sicker beneficiaries will bear the brunt of changes in the structure of prescription drug benefits and cost-sharing requirements as more plans restrict drug coverage to generics only and raise cost-sharing requirements for services such as inpatient and outpatient hospital care.

#497 *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* (February 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. The authors report that mean premium and cost-sharing levels in Medicare+ Choice plans continued to increase in 2001 while coverage of prescription drugs was reduced. This trend continued despite congressional action that increased the payment rate MCOs received.

#494 *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001* (February 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. Analysis by the authors of Medicare Compare found that out-of-pocket spending for Medicare+ Choice enrollees can be substantial and varies significantly with health status. In 2001, the average enrollee in good health spent $1,195 annually out-of-pocket on health care, while an enrollee in poor health spent $3,578, or about three times as much.

#505 *Drug Coverage for Medicare Beneficiaries: Why Protection May Be in Jeopardy* (January 2002). Becky Briesacher, Bruce Stuart, and Dennis Shea. In this issue brief, the authors evaluate trends in prescription drug coverage for Medicare beneficiaries during the 1990s as a way to project their future coverage, costs, and needs. Based on data from 1993 to 1998, the projections indicate that beneficiary drug coverage likely peaked in 1998 or shortly thereafter, and has been in decline ever since.

#496 *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries* (January 2002). Jennifer Stuber, Geraldine Dallek, Claire Edwards, Kathleen Maloy, and Brian Biles. This executive summary of an unpublished report (available on the Fund's website only) examines recent changes in seven Medicare+Choice markets and the effects of these changes on Medicare beneficiaries.

#495 *Physician Withdrawals: A Major Source of Instability in Medicare+Choice* (January 2002). Geraldine Dallek and Andrew Dennington, George Washington University. The authors find that provider turnover rates within Medicare+Choice plans vary dramatically from state to state. Of the 38 states with reported data for 1999, six states plus the District of Columbia had turnover rates of 20 percent or higher.

#510 *The 2002 Medicare+Choice Plan Lock-In: Should It Be Delayed?* (December 2001). Geraldine Dallek, Brian Biles, and Andrew Dennington, George Washington University. This issue brief

points to large-scale health plan withdrawals and provider turnover in the Medicare+Choice market among reasons to delay or repeal the Medicare+Choice policy to lock beneficiaries into their plans for a specified period.

#491 *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice* (October 2001). Jennifer Stuber, Geraldine Dallek, and Brian Biles, George Washington University. The authors of this field report found a substantial decline in the number of Medicare+Choice plans in five of seven large markets around the country.

#490 *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (October 2001). Geraldine Dallek and Claire Edwards, George Washington University. In this field report, the authors discuss the benefit packages of five Medicare+Choice plans in Cleveland, Ohio, and Tampa, Florida, and find that beneficiaries would have to spend hours calling plans, poring over data, and making complicated calculations in order to make any kind of reasonable comparison of plans.

#474 *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (September 2001). Marilyn Moon and Matthew Storeygard, The Urban Institute. The authors argue that any major change to the Medicare program—such as requiring coinsurance for home health care—must take into account the steep costs seriously ill beneficiaries already pay for health services.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author gives Medicare+Choice (M+C) a "barely passing grade," noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf *or* www.cmwf.org/programs/medfutur/gold_bipa_467.pdf.

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing, the Fund's president cautioned that any effort to reform Medicare's benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

#461 *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures* (May 2001). Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute. This report presents four possible options for modernizing Medicare that would reverse spiraling costs for beneficiaries and reduce or eliminate the need for private supplemental insurance.

#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

Medicare Works (Spring 2001). Bruce Vladeck. *Harvard Health Policy Review,* vol. 2, no. 1. Reprinted from *New Jersey Medicine,* March 2000. Available online at http://hcs.harvard.edu/~epihc/currentissue/spring2001/vladeck.html.

#498 *Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers* (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. The authors analyze the sources and stability of prescription coverage maintained by Medicare beneficiaries in 1995 and 1996. The results show that fewer than half of all beneficiaries had continuous drug coverage over this period, while nearly a third gained, lost, or had spells without coverage.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine,* vol. 344, no. 12. Copies are available from Customer Service, New England Journal of Medicine, P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

#430 *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries* (January 2001). Stephanie Maxwell, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare beneficiaries will have to pay substantially more out of their own pockets for health care in the future, according to this new report. The authors find that those with low incomes and health problems will be at even greater risk than average beneficiaries for costs such as Medicare premiums, medical services, and prescription drugs.

A Moving Target: Financing Medicare for the Future (Winter 2000/2001). Marilyn Moon, Misha Segal, and Randall Weiss, The Urban Institute. *Inquiry,* vol. 37, no. 4. Copies are available from *Inquiry,* P.O. Box 527, Glenview, IL 60025, Tel: 847-724-9280.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#395 *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (August 2000). Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University. This field report, based on research cofunded by The Commonwealth Fund and the California Wellness Foundation, examines the effects of Medicare+Choice—created by the Balanced Budget Act of 1997—on Medicare beneficiaries in four managed care markets.

#394 *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (August 2000). Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc. Using information from HCFA's Medicare Compare consumer-oriented database of Medicare+Choice plans, this report provides a detailed look at changes in benefits offered under Medicare+Choice in 1999–2000, focusing on benefit reductions and small capitation rate increases that are shifting costs to beneficiaries.

#393 *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* (August 2000). Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare+Choice plans are scaling back benefits and shifting costs to enrollees through increases in service copayments and decreases in the

value of prescription drug benefits. This report examines the financial effects of these actions on Medicare managed care enrollees.

#371 *An Assessment of the President's Proposal to Modernize and Strengthen Medicare* (June 2000). Marilyn Moon, The Urban Institute. This paper discusses four elements of President Clinton's proposal for Medicare reforms: improving the benefit package, enhancing the management tools available for the traditional Medicare program, redirecting competition in the private plan options, and adding further resources to ensure the program's security in the coming years.

#382 *Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension* (March/April 2000). Jan Blustein. *Health Affairs,* vol. 19, no 2. This article shows that Medicare beneficiaries age 65 and older with high blood pressure are less likely to purchase hypertension medication if they are without drug coverage.

Who Is Enrolled in For-Profit vs. Nonprofit Medicare HMOs? (January/February 2000). Jan Blustein and Emma C. Hoy. *Health Affairs,* vol. 19, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#365 *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (January 2000). Bruce Stuart, Dennis Shea, and Becky Briesacher. This issue brief reports that prescription drug coverage of Medicare beneficiaries is more fragile than previously reported, that continuity of this coverage makes a significant difference in beneficiaries' use of prescription medicine, and that health status affects drug coverage for beneficiaries primarily through their burden of chronic illness.

#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy,* vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries, reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

#353 *After the Bipartisan Commission: What Next for Medicare?* (October 1999). Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford, and Katherine E. Garrett. This summary of a panel discussion held at New York University's Robert F. Wagner Graduate School of Public Service considers what may happen now that the National Bipartisan Commission on the Future of Medicare has finished its work without issuing recommendations to President Clinton. It also examines possible reform opportunities following the November 2000 elections.

#346 *Should Medicare HMO Benefits Be Standardized?* (July/August 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. *Health Affairs,* vol. 18, no. 4. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this article the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

#232 *Risk Adjustment and Medicare* (June 1999). Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, Harvard University. Medicare's payments to managed care plans bear little relationship to the cost of providing needed care to beneficiaries with different health conditions. In this revised paper, the authors suggest using two alternative health risk adjusters that would contribute to more cost-effective care and reduce favorable risk selection and the incentive to stint on care.

#318 *Growth in Medicare Spending: What Will Beneficiaries Pay?* (May 1999). Marilyn Moon, The Urban Institute. Using projections from the 1998 Medicare and Social Security Trustees' reports to examine how growth in health care spending will affect beneficiaries and taxpayers, the author explains that no easy choices exist that would both limit costs to taxpayers while protecting Medicare beneficiaries from the burdens of health care costs.

#317 *Restructuring Medicare: Impacts on Beneficiaries* (May 1999). Marilyn Moon, The Urban Institute. The author analyzes premium support and defined contribution—two of the more prominent approaches proposed to help Medicare cope with the health care needs of the soon-to-retire baby boomers—and projects these approaches' impacts on future beneficiaries.

#310 *Should Medicare HMO Benefits Be Standardized?* (February 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this paper the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

Budget Bills and Medicare Policy: The Politics of the BBA (January/February 1999). Charles N. Kahn III and Hanns Kuttner. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform (January/February 1999). Marilyn Moon. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

The Political Economy of Medicare (January/February 1999). Bruce C. Vladeck. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#294 *Improving Coverage for Low-Income Medicare Beneficiaries* (December 1998). Marilyn Moon, Niall Brennan, and Misha Segal, The Urban Institute. The authors examine ways in which the Qualified Medicare Beneficiary and related programs could be modified to increase participation and protect more sick and low-income Medicare beneficiaries.