INSIGHT on the Issues

Transitioning from Medicaid Expansion Programs to Medicare: Making Sure Low-Income Medicare Beneficiaries Get Financial Help

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The Affordable Care Act allows states to offer Medicaid coverage to low-income adults who would not have qualified under previous law. Thus far, 28 states and the District of Columbia offer such coverage. This population will face higher cost-sharing requirements when they transition to Medicare, although some may be eligible for traditional Medicaid benefits and/or Medicare Savings Programs (MSPs) that will reduce their costs. This "Insight on the Issues" discusses how Medicare beneficiaries can qualify for traditional Medicaid and MSPs. It also provides new state data on the number and characteristics of eligible individuals and discusses the potential impact of expanding traditional Medicaid income and asset rules in the Medicaid expansion states. Finally, the report outlines policy options that would make it easier for Medicare beneficiaries to qualify for traditional Medicaid benefits and MSPs.

Introduction

The Affordable Care Act (ACA) allows states to offer Medicaid coverage to low-income adults—ages 19 and older—who would not have been eligible under rules that predated the law.[1] However, the ACA does *not* let people continue Medicaid expansion coverage once they are eligible for Medicare.[2]

As a result, many individuals will transition from the Medicaid-expansion program, where they face very low out-of-pocket costs, to Medicare, where their basic costs will start at $1,495.80 per year in 2014 and 2015. This amount does not include the thousands of dollars in potential additional cost sharing associated with service use, including inpatient hospital services and prescription drugs.[3] These costs place a tremendous burden on low-income people (see case study in box 1). However, there are programs that can help low-income people with these new costs as they move from the Medicaid expansion to Medicare.

This report:

- Describes programs that could help low-income Medicare beneficiaries access traditional Medicaid-covered services and/or get help with their Medicare costs after they are no longer enrolled in the Medicaid expansion.
- Describes the rules in the Medicaid expansion states that qualify Medicare beneficiaries for traditional Medicaid-covered services and/or help with their Medicare costs.
- Estimates the number and characteristics of people turning 65 in Medicaid expansion states who will be eligible for help with their Medicare costs after they transition to Medicare between 2015 and

Box 1. Case Study

Gail Goodrich is a single woman with no children. She works part time as a server at the local diner and makes around $13,000 a year. She would like to work more hours, but complications from diabetes make that impossible. The diner does not offer health insurance to its employees, so Gail has been uninsured for the last several years. She was thrilled when her state adopted the Medicaid expansion, and wasted no time signing up because she desperately needed help paying for her diabetes medication. Gail feels lucky to be in the Medicaid program where she pays very little out of her own pocket to get the care she needs. This was a tremendous help, because she barely makes ends meet after paying her rent and buying food.

Gail was 64 years old when she signed up for Medicaid, so next year she will have to give up her Medicaid expansion coverage and transition to Medicare. The good news is she has worked long enough to qualify for Medicare. The bad news is that when she transitions to Medicare, Gail's health care costs will increase significantly. She also might lose access to certain services that Medicare does not pay for, such as transportation and dental care.

There are programs that can help low-income people like Gail get help with their Medicare premiums and, in some cases, other cost-sharing. And if she qualifies, Gail, and others like her, might also qualify for Medicaid under traditional rules that do not apply to the Medicaid expansion. The most important thing for Gail and others like her is to learn about these programs and enroll.

2016 (data constraints do not allow for later estimates).

- Discusses the impact of eliminating or broadening certain qualifiers for getting help with Medicare in the Medicaid expansion states.
- Offers policy options that may help maximize the number of people who get help with their Medicare costs after they transition from the Medicaid expansion to Medicare.

Programs That Help Low-Income People with Their Medicare Costs

As of November 2014, 28 states and the District of Columbia have expanded their Medicaid programs.[4] States use modified adjusted gross income rules and do *not* consider assets to determine eligibility for the Medicaid expansion.[5] In contrast, traditional Medicaid eligibility rules count income differently and sometimes consider assets.[6]

Many of those transitioning from Medicaid expansion coverage to Medicare will qualify for full Medicaid benefits under traditional Medicaid eligibility rules *and* receive help with Medicare premiums, deductibles, and cost-sharing. These "full dual eligibles" are the poorest and sickest Medicare beneficiaries and need this financial help to access their benefits. Because they are eligible for the full Medicaid benefit package, they may also get dental care, transportation services, and other important benefits that Medicare does not cover.

Low-income people who do not qualify as full dual eligibles and are transitioning from the Medicaid expansion to Medicare may qualify for one of three programs—collectively called the Medicare Savings Programs (MSPs)—that help with Medicare premiums and, in one instance, cost-sharing. People who meet the traditional income and asset requirements may receive MSP benefits (described

more fully below)[7] *in addition* to their Medicare coverage. Like the aid given to full dual eligibles, this financial help can mean the difference between accessing and forgoing needed health care. Every state Medicaid program must provide this assistance.

Eligibility Rules for Programs That Help Low-Income Medicare Beneficiaries

Full Medicaid Coverage

Receipt of Supplemental Security Income (SSI) automatically qualifies people for full Medicaid benefits (full dual eligibility) under traditional rules.[8,9] SSI is a government program that provides financial support to people with very low incomes and resources who are 65 or older, blind, or disabled.

In general, the 2014 income eligibility limit for SSI is $721 per month for an individual and $1,082 per month for a couple.[10] Assets are limited to $2,000 for an individual and $3,000 for a couple. Federal law allows states to use more restrictive eligibility criteria when determining eligibility for full Medicaid benefits. Ten states have elected this option.[11] States also have the option to make more people eligible for traditional Medicaid through special pathways.

This report *does not* estimate the number of people who would be eligible for traditional Medicaid or MSPs using these optional pathways.[12]

Medicare Savings Programs

There are three Medicare Savings Programs: the Qualified Medicare Beneficiary Program (QMB), the Specified Low-Income Medicare Beneficiary Program (SLMB), and the Qualifying Individual (QI) Program.[13] The federal government sets minimum eligibility guidelines for MSP eligibility and benefits and defines the MSP benefit structure (table 1). States may increase income or asset standards to allow more people to become eligible for the programs (table 2).

Estimating Medicaid or MSP Eligibility for Medicare Beneficiaries Transitioning from the Medicaid Expansion by 2016

To estimate the number and characteristics of people in Medicaid expansion states who were potentially eligible for the 2014 ACA-related Medicaid expansion who will turn age 65 by 2016, we used pooled 2009–2011 data from the Urban Institute's Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS).[14] This sample was aged forward to

Table 1
Minimum Federal Guidelines for MSP Eligibility and Benefits for Majority of Medicaid Expansion States, 2014

	Income[a]	Assets		Benefits
		Individual[b]	Couple[b]	
QMB	Up to 100% FPL[c]	$7,160	$10,750	Pays Part A and B premiums and cost-sharing
SLMB	100–120% FPL	$7,160	$10,750	Pays Part B premium
QI	120–135% FPL	$7,160	$10,750	Pays Part B premium, with total payments capped by federal appropriations

Source: http://www.medicare.gov.

[a] Income threshold includes a $20/month SSI general income exclusion and a 50 percent earned income disregard.

[b] Countable resources for the asset test include money in checking and savings accounts, stocks, and bonds; they do not include home, one car, burial plot, up to $1,500 for burial expenses, furniture, or certain other household and personal items.

[c] The federal poverty level (FPL) is the minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. Public assistance programs such as Medicaid define eligibility income limits as a percentage of FPL.

2014 to identify the relevant population (i.e., people turning age 65 by 2016) for the Medicaid expansion. (Appendix A provides a more detailed description of the HIPSM-ACS model and methods used in this report.)

Next, we projected the 2016 income and assets of the chosen population (i.e., people who are potentially eligible for Medicaid expansion in 2014 and will turn age 65 by 2016). To do this, we relied on the Census Bureau's Survey of Income and Program Participation (SIPP), which collected data from the same people from 2008 to 2010. We then aged these data so that they would correspond to the period of 2014 to 2016, and statistically matched income and assets to the 2014 HIPSM-ACS data. Because we had only 2 years of available SIPP data, we could not estimate eligibility for traditional Medicaid or MSPs beyond 2016.

Finally, we simulated each state's current eligibility rules for Medicaid and MSPs and applied them to the Medicaid income and asset expansion data from the SIPP. This allowed us to determine the number and characteristics of people who would be eligible for Medicaid as full dual eligibles or for MSPs in 2015 and 2016.

Limitations

This report has two significant limitations. First, the data do not include people who become eligible for Medicaid due to large medical expenses. Nor do they include those who qualify for Medicaid under special program rules that make them eligible for institutional care. People in both of these groups are likely to have household incomes above the level that would qualify them for the Medicaid expansion in 2014.

Second, the data used to predict income and assets in 2016 are from surveys conducted from 2008 to 2010. The general economic trends during those years differ from economic predictions for 2014 through 2016. However, most of those represented by the data would have retired between 2014 and 2016, and retirement generally has a larger impact on income and assets than changes in general economic trends.

Table 2
MSP Eligibility Rules for Medicaid Expansion States Not Using Federal Guidelines for MSP Eligibility, 2014

State	Asset Test	Income Threshold if Different from Federal
Arizona	No	Federal Income Threshold
Colorado	Yes, more generous[a]	Federal Income Threshold
Connecticut	No	Up to 211% FPL for QMB, 231% FPL for SLMB, 246% FPL for ALMB (QI)
Delaware	No	Federal Income Threshold
District of Columbia	No	Up to 300% FPL for QMB[b]
Maryland	Yes, more generous[c]	Federal Income Threshold
Minnesota	Yes, more generous[d]	Federal Income Threshold
New Mexico	Yes, more generous[e]	Federal Income Threshold
New York	No	Federal Income Threshold
Vermont	No	Federal Income Threshold

Source: Urban Institute compilation of eligibility information posted on state Medicaid department web sites.

[a] Colorado has a higher resource limit: in 2014 it is $8,660 for individuals and $13,750 for couples.

[b] DC has expanded QMB, so SLMB eligibility applies only to the month of application and 3 months prior to the month of application. It also covers those with 100–300% FPL.

[c] Maryland has higher asset limits: $8,660 for individuals and $13,750 for couples.

[d] Minnesota has higher asset limits: $10,000 for individuals and $18,000 for couples.

[e] New Mexico has higher asset limits: $8,660 for individuals and $13,750 for couples.

Majority of Study Population Would Qualify for Medicaid or MSPs

An estimated 57 percent (442,100) of the low-income people ages 63 or 64 who qualify for the Medicaid expansion in 2014 would subsequently qualify as full dual eligibles or be eligible for one of the MSPs when they transition to the Medicare program over the next 2 years (table 3).

Nearly one-third (32 percent) of this population are so poor that they would qualify for full Medicaid benefits *in addition* to help with their Medicare cost-sharing (i.e., full dual eligible). The majority of those in this group are non-white; 25 percent are Hispanic, 19 percent are non-Hispanic black, and 8 percent are Asian/Pacific Islanders (table 4). A majority (58 percent) are female, and 48 percent report fair or poor health status. The top five states

Table 3
People Ages 63 and 64 Eligible for Full Medicaid or MSPs between 2015 and 2016 in Medicaid Expansion States

State	Full Benefit Dual Eligibles		QMB		SLMB		QI		Any MSP		Overall Population
	N	% Eligible	N	% Eligible	N	% Eligible	N	% Eligible	N	% Eligible	N
Total	**250,436**	**32.0%**	**81,141**	**10.4%**	**78,443**	**10.0%**	**32,078**	**4.1%**	**442,099**	**56.5%**	**782,208**
Arizona	13,452	45.2%	-	0.0%	3,112	10.5%	2,062	6.9%	18,626	62.6%	29,759
Arkansas	4,619	25.6%	2,112	11.7%	2,326	12.9%	1,187	6.6%	10,244	56.8%	18,040
California	68,681	38.2%	4,150	2.3%	13,010	7.2%	7,555	4.2%	93,395	51.9%	179,787
Colorado	2,676	14.9%	4,308	23.9%	1,645	9.1%	359	2.0%	8,988	50.0%	17,991
Connecticut	1,928	15.9%	7,581	62.4%	47	0.4%	271	2.2%	9,827	80.9%	12,151
Delaware	923	27.0%	803	23.5%	465	13.6%	57	1.7%	2,249	65.7%	3,421
District of Columbia	1,507	43.6%	1,439	41.7%	-	0.0%	-	0.0%	2,946	85.3%	3,454
Hawaii	2,396	30.7%	26	0.3%	836	10.7%	202	2.6%	3,461	44.3%	7,810
Illinois	18,460	37.1%	1,082	2.2%	5,371	10.8%	1,840	3.7%	26,752	53.8%	49,745
Iowa	1,351	13.0%	2,079	20.0%	762	7.3%	249	2.4%	4,442	42.8%	10,382
Kentucky	5,232	21.2%	4,360	17.6%	2,180	8.8%	825	3.3%	12,597	51.0%	24,705
Maryland	4,314	23.9%	2,514	13.9%	2,394	13.2%	346	1.9%	9,567	52.9%	18,073
Massachusetts	10,178	36.4%	844	3.0%	2,179	7.8%	856	3.1%	14,057	50.2%	27,980
Michigan	14,329	33.8%	3,081	7.3%	3,794	8.9%	1,733	4.1%	22,937	54.1%	42,395
Minnesota	4,925	31.8%	462	3.0%	2,067	13.3%	890	5.7%	8,344	53.9%	15,493
Nevada	1,937	16.9%	2,146	18.7%	1,264	11.0%	374	3.3%	5,720	49.9%	11,460
New Hampshire	572	16.8%	928	27.2%	385	11.3%	104	3.1%	1,989	58.4%	3,408
New Jersey	10,860	37.7%	1,364	4.7%	2,932	10.2%	1,056	3.7%	16,212	56.3%	28,774
New Mexico	2,545	17.9%	4,052	28.6%	1,059	7.5%	501	3.5%	8,157	57.5%	14,191
New York	38,320	40.4%	14,456	15.2%	7,932	8.4%	4,220	4.5%	64,927	68.5%	94,816
North Dakota	613	31.7%	241	12.4%	335	17.3%	-	0.0%	1,188	61.5%	1,933
Ohio	7,942	16.0%	12,989	26.2%	6,362	12.8%	1,721	3.5%	29,014	58.6%	49,517
Oregon	2,881	17.0%	2,847	16.8%	2,782	16.5%	335	2.0%	8,845	52.3%	16,909
Pennsylvania	21,526	39.9%	1,552	2.9%	8,274	15.3%	2,018	3.7%	33,370	61.9%	53,950
Rhode Island	2,024	34.9%	129	2.2%	668	11.5%	592	10.2%	3,414	58.8%	5,803
Vermont	137	8.5%	221	13.8%	287	17.9%	34	2.1%	679	42.4%	1,600
Washington	4,003	15.7%	2,998	11.8%	3,661	14.4%	1,355	5.3%	12,017	47.2%	25,480
West Virginia	2,107	16.0%	2,376	18.0%	2,316	17.6%	1,336	10.1%	8,135	61.7%	13,180

Source: Health Insurance Policy Simulation Model-American Community Survey 2014.

% eligible = percentage of all people turning age 65 by 2016 in Medicaid expansion states who would qualify for full dual eligibility or for one of the MSPs by 2016.

with the highest percentages of people qualifying as full dual eligibles were Arizona (45 percent), the District of Columbia (44 percent), New York (40 percent), Pennsylvania (40 percent), and California (38 percent) (table 3).

Among those who would qualify for an MSP, roughly equal numbers would be eligible as QMBs (81,100) and SLMBs (78,400); 32,100 would be eligible as QIs (table 3). Nearly a fifth of QMB eligibles (19 percent) would be employed compared with 9 percent of SLMB eligibles and only 3 percent of QI eligibles (table 4).

In contrast to full dual eligibles, more that 60 percent of MSP eligibles would be white, non-Hispanic (table 4). Most would be female, unemployed, and in better than fair health (table 4). States with the highest percentages of people qualifying as QMB eligibles are Connecticut (62 percent), the District of Columbia (42 percent), New Mexico (29 percent), New Hampshire (27 percent), and Ohio (26 percent). States with the highest percentages of people qualifying as SLMB-eligible are Vermont (18 percent), West Virginia (18 percent), North Dakota (17 percent), Oregon (17 percent), and Pennsylvania (15 percent) (table 3).

State Policy Decisions Affect Eligibility for Traditional Medicaid or Medicare Savings Programs in Expansion States

Policy decisions in Medicaid expansion states make a difference in the number

Table 4
Characteristics of People Ages 63 and 64 Eligible for Full Medicaid or MSPs between 2015 and 2016 in Medicaid Expansion States

Characteristic		Full-Benefit Dual Eligibles	QMB	SLMB	QI	Any MSP
	Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Current Income (as a percent of Federal Poverty Level)	Up to 0% FPL	28.5%	13.9%	8.8%	0.0%	20.3%
	1–50% FPL	17.4%	20.1%	13.4%	5.5%	16.3%
	51–100% FPL	36.6%	41.6%	27.1%	12.3%	34.1%
	100–138% FPL	17.5%	24.5%	50.6%	82.1%	29.3%
Employment Status	Employed	16.0%	19.1%	9.2%	2.9%	14.4%
	Not Employed	84.0%	80.9%	90.8%	97.1%	85.6%
Health Status	Better than Fair	51.8%	56.3%	55.4%	57.4%	53.7%
	Fair or Poor	48.2%	43.7%	44.6%	42.6%	46.3%
Sex	Male	42.5%	39.0%	42.7%	45.0%	42.1%
	Female	57.5%	61.0%	57.3%	55.0%	57.9%
Race/ Ethnicity	White, Non-Hispanic	46.8%	61.1%	63.9%	61.8%	53.5%
	Black, Non-Hispanic	19.2%	11.2%	17.5%	15.7%	17.2%
	Hispanic	25.2%	21.0%	7.9%	13.5%	20.5%
	Asian/Pacific Islander, Non-Hispanic	7.9%	4.6%	10.5%	9.0%	7.8%
	American Indian/ Alaskan Native	0.9%	1.4%	0.1%	0.0%	0.8%
	Other, Non-Hispanic	0.1%	0.7%	0.2%	0.0%	0.2%

Source: Health Insurance Policy Simulation Model-American Community Survey 2014.

of people who would be eligible as full dual eligibles or for MSPs in 2016 (figure 1).[15] State expansions of eligibility for MSPs beyond the federal minimum make a much higher share of people eligible for assistance. For example, in expansion states that have eliminated the asset test *and* raised income eligibility thresholds (e.g., Connecticut and the District of Columbia), more than 80 percent of low-income people ages 63 and 64 who qualify for the Medicaid expansion in 2014 would qualify as full dual eligible or for MSPs when they transition to the Medicare program by 2016.

In states that have eliminated the asset test but *kept* the federal income test (e.g., Arizona, Delaware, New York, and Vermont), two-thirds (67 percent) would qualify. In the remaining expansion states—those that have kept the federal income and asset test—just over half (54 percent) would be eligible for Medicaid assistance when they transition to the Medicare program by 2016.[16]

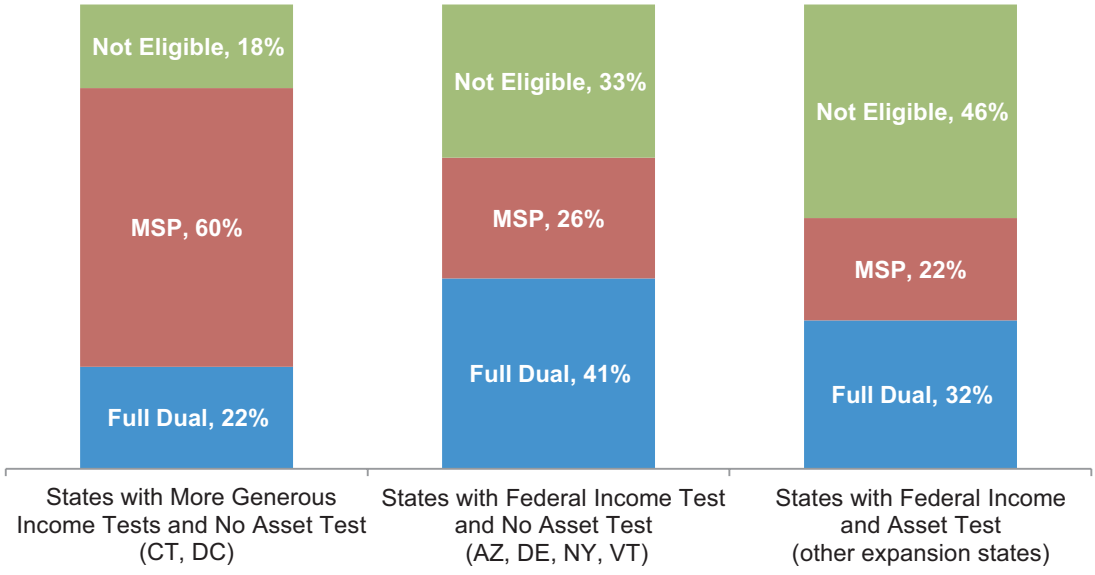
Discussion

The number of people who would qualify as full duals after transitioning to Medicare is significant. Because they have little or no income, they cannot afford their Medicare premiums and cost-sharing responsibilities. Without help from the traditional Medicaid program, they are less likely to have a usual source of care and more likely to visit an emergency room when their unattended health conditions worsen. Helping these people gain access to traditional Medicaid and providing assistance with Medicare cost-sharing could increase their access to primary care and improve their overall health. That, in turn, would reduce costly emergency room use and uncompensated care costs.

Although not as vulnerable as those who would be eligible as full duals, low-income adults who are only eligible for an MSP after they transition to Medicare should still be the focus of intense outreach and enrollment efforts. These relatively low-income individuals could apply the money they would otherwise

Figure 1

State Policy Decisions Affect Eligibility for Traditional Medicaid or Medicare Savings Programs among Those in Expansion States Who Are Turning Age 65 by 2016



Source: Health Insurance Policy Simulation Model-American Community Survey 2014.

pay in Medicare premiums to other critical needs.

Asset tests for MSP eligibility can be a barrier to enrollment because they are intrusive and force people to endure the stigma of interacting with the welfare system. Moreover, they require applicants to submit large amounts of paperwork to their state Medicaid agency, which can be burdensome and time-consuming for state administrative staffs.[17]

In addition to making more low-income people eligible for financial help, states that eliminate the asset test could potentially save enough in administrative costs to offset some of the additional expense of expanding MSP coverage.[18] States that can afford to do so should consider increasing income limits to make more people eligible for help paying their Medicare premiums and cost-sharing.

Many low-income people who will turn age 65 by 2016 are unaware that federal law does *not* let them continue to receive Medicaid expansion coverage after they become eligible for Medicare. They also may not know of their possible eligibility for Medicaid or one of the MSPs under traditional Medicaid rules.

Policy Options

Federal and state governments can help ease the financial burden that low-income people face as they transition from Medicaid expansion coverage to Medicare. Some options include the following:

- making people aware that they are no longer eligible for the Medicaid expansion subsidy after they turn 65;
- informing people that they may qualify for traditional Medicaid or an MSP to help with the Medicare cost-sharing after they become eligible for Medicare, and telling them how to apply;
- automatically assessing Medicare beneficiaries transitioning from Medicaid expansion coverage for eligibility for traditional Medicaid and/or MSPs and the Medicare Part D low-income subsidy;
- streamlining the application process by eliminating certain documentation;
- training Navigators[19] and other consumer assisters about the transition policy and the availability of alternative coverage;
- ensuring that outreach workers and enrollment assisters can meet the needs of non-English speakers;
- eliminating the asset test for MSPs, which is a potential barrier to enrollment; and
- increasing income limits for MSPs in states that see the benefit in doing so.

Conclusion

Federal law recognized the financial vulnerability of low-income Medicare beneficiaries by creating programs to help them access a fuller benefit package and/or benefit from financial help with their Medicare costs. Enrolling in these important programs allows low-income Medicare beneficiaries to use their limited financial resources on necessities like food, shelter, and electricity. Enrollment can also make it easier for them to access health care because their Medicare premiums—and in some cases their deductibles and cost-sharing—are covered. The results in this report can help states set targeted goals for ensuring that low-income Medicare beneficiaries do not fall through the cracks and miss important post-transition benefits. Finally, our results demonstrate how eliminating or broadening asset tests and raising income limits for MSP eligibility can make even more low-income people eligible for help with their Medicare premiums and, in some cases, their cost-sharing.[20]

Appendix A: Methodology

General Approach to This Research

For this work, we:

- estimated the number and characteristics of 2014 Medicaid eligibles in each expansion state who would turn 65 by 2016;
- projected the income and assets that each 2014 Medicaid eligible would have in 2016; and
- determined each individual's eligibility for full dual Medicaid or MSPs in 2016.

2014 Medicaid Eligibles Turning 65 by 2016

Data on the number and characteristics of 2014 Medicaid eligibles are not currently available. Therefore, we used the HIPSM-ACS. We based the model on 3 years of data (2009–2011) from the American Community Survey (ACS). Because the ACS is the largest household survey administered by the Census Bureau, we were able to generate a large enough sample of 63- and 64-year-olds to produce state-level estimates. Those who are age 63 or 64 in 2014 would turn 65 by 2016. The ACS data were then aged to 2014 using Census population targets and projections of income and wage growth from the Bureau of Labor Statistics.

Medicaid eligibility in 2014 was determined using Modified Adjusted Gross Income (MAGI) for a taxable unit. MAGI adds nontaxable social security income to the Adjusted Gross Income (AGI). Tax unit MAGI is computed by summing the individual MAGI of the tax unit head, the spouse (if married), and any qualifying children with an individual AGI *above* the single tax filing threshold. The income of other qualifying children and qualifying relatives (below the threshold) is not included. We then use the sum of the tax unit MAGI to calculate a ratio of MAGI to the applicable federal poverty level (FPL) of the tax unit. We used special prorating of units that include undocumented parents or childless spouses to scale the total AGI (including that of the undocumented family members) by a ratio of the FPLs including and excluding the undocumented family members.

This project only included adults gaining eligibility under the Medicaid expansion. Therefore, we did not consider other types of Medicaid eligibility, such as eligibility based on disability status. We applied each state's Medicaid expansion decisions as of October 2014, including Pennsylvania as an expansion state, even though expansion will not take effect until January 2015. Current thresholds are available at http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf.

2016 Income and Assets

We then projected the 2016 income and assets of those eligible for Medicaid in 2014 and turning 65 by 2016. To do this, we needed survey data that followed people over time. The only major Census Bureau survey that does so is the SIPP. The SIPP is a far smaller survey than the ACS and it does not produce representative state-level estimates, so we needed to combine information from the two surveys (SIPP and ACS). The most recent SIPP round began in 2008, so we looked at people who entered the survey ages 63 or 64 who were still in the survey 2 years later. We did not have data past 2010, so we projected only 2 years into the future. We aged the SIPP data to 2014 so that it would be compatible with the 2014 ACS data. To impute the 2016 income and assets of 2014 ACS observations, we statistically matched the SIPP data with the 2014 Medicaid eligibles in the ACS data.

2016 Full Medicaid and MSP Eligibility

Finally, we compiled current state rules for full-benefit dual Medicaid-Medicare eligibility and for each MSP (tables 1 and 2). While the Centers for Medicare and Medicaid Services[21] regularly publishes income eligibility criteria by state for full duals, MSP eligibility rules are not available in a single place. We obtained them from the websites of each state's Medicaid agency. For this report, we assumed that current eligibility rules would be applicable in 2016. We then applied each state's income and asset tests (if any) to determine how many of those who were eligible for the Medicaid expansion in 2014 would be eligible for full-benefit Medicaid and for each MSP in 2015 and 2016.

Endnotes

[1] Eligibility for ACA-related Medicaid expansion (i.e., the Medicaid expansion) ranges from zero to 138 percent of the federal poverty level ($0 to $21,707 for a family of two in 2014).

[2] People can become eligible for Medicare Part B because they turn age 65 and meet all federal requirements (e.g., worked long enough to be eligible for Social Security by having earned 40 qualifying credits after working for about 10 years), or because they have a disability that allows them to qualify for Medicare after a 2-year waiting period. This "Insight on the Issues" deals with the former group and does not provide state-level data on how many people would qualify based on disability status. It also does not estimate the number of people who would be eligible for the Medicare Part D Low Income Prescription Drug Subsidy.

[3] The annual Medicare Part B (medical insurance) premium for 2014 and 2015 is $1,258.80. The annual Part B deductible for those years is $147. Medicare typically charges people 20 percent of the cost of physician and other Part B services. If people incur a hospitalization, they also pay the Part A (hospital insurance) inpatient deductible costs. *Medicare 2014 & 2015 Costs at a Glance*. Accessed at http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html.

[4] Expansion states include Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. Of these, only Arizona, Iowa, and Michigan did not expand their traditional Medicaid programs. Those states are using the Medicaid waiver process to enroll people into qualified health plans (QHPs) in the health care Marketplace. Pennsylvania will not implement its Medicaid expansion until January 2015. Smith, V., et al., *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015* (Menlo Park, CA: Kaiser Family Foundation, October 2014). Accessed at http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/?utm_campaign=KFF%3A+The+Latest&utm_source=hs_email&utm_medium=email&utm_content=14517546&_hsenc=p2ANqtz--6eBqCbXw3JHJDeqPCntjTR5SA9Jta_Pihu-o7CBee6UllT5oqCRhrW8_fXyRwKvOWnbm45eb0VmCbyxZS_HgLjWwgDQ&_hsmi=14517546. Families USA, A 50-State Look at Medicaid Expansion. (Updated November 24, 2014). Accessed at http://familiesusa.org/product/50-state-look-medicaid-expansion.

[5] MAGI is defined as an individual's or a couple's (or a tax unit's) adjusted gross income (for federal tax purposes), with nontaxable Social Security income added in. Other adjustments add in foreign income and tax-exempt interest.

[6] Under traditional Medicaid income eligibility rules, states set both a dollar amount (called the income standard) at which the person may qualify and an income counting methodology under which certain types or amounts of income may be disregarded to determine if the person meets the income standard. States vary in both their income standards and their income counting methodologies. States also set standards and methodologies for counting assets. These also vary among states. Schneider, A., et al., *The Medicaid Resource Book* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2002).

[7] The Medicare Savings Programs help people pay their Medicare premiums. In some cases, MSPs may also pay Medicare Part A (Hospital Insurance) and Medicare Part B (medical insurance) deductibles, coinsurance, and copayments. For more details on MSPs, see: http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html.

[8] This report models the following income eligibility criteria for full Medicaid: (a) Section 1634 criteria under which the federal eligibility determination process for SSI automatically qualifies a person for Medicaid; (b) Supplemental Security Income (SSI) criteria, under which individuals must apply separately for SSI-related

Medicaid; (c) eligibility under section 209(b) of the Social Security Act, which allows states to use more restrictive income eligibility criteria than SSI-related income eligibility criteria; and (d) poverty level criteria, which allows states to provide full Medicaid coverage to older adults and people with disabilities whose income is above the SSI or 209(b) level, but at or below 100 percent of the federal poverty level. MACPAC Report to the Congress on Medicaid and CHIP March 2014, Table 11. Accessed at 2014-03-14_Macpac_Report.pdf.

[9] Younger people with disabilities also qualify if they have very low income and few assets. However, this report *does not* include them in its estimates.

[10] Not all income is countable income. Thus, one could earn more than $721 per month and still qualify for SSI because the SSI program disregards certain items from income.

[11] The more restrictive states are Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. MACPAC Report to the Congress on Medicaid and CHIP March 2014, Table 11. Accessed at 2014-03-14_Macpac_Report.pdf.

[12] These optional pathways include medically needy and eligibility under the 300 percent rule. Under the medically needy option, people with higher incomes can spend down to a state-specified medically needy income level by deducting medical expenses from countable income for Medicaid eligibility. Under the special income option, states may provide Medicaid to people who need at least 30 days of nursing home or other institutional care and who have income at or below 300 percent of the SSI income eligibility rate (approximately 222 percent of the federal poverty level in 2014). MACPAC Report to the Congress on Medicaid and CHIP March 2014, Table 11. Accessed at 2014-03-14_Macpac_Report.pdf. This Issue Brief does not estimate eligibility for individuals who might qualify under medically needy criteria or under special income rules.

[13] The QMB and SLMB programs are entitlements, meaning that states must enroll everyone who qualifies. The QI program is not an entitlement, meaning the availability of federal funding limits the number of people who can enroll.

[14] The American Community Survey (ACS) is the largest household survey administered by the Census Bureau. The basis of the HIPSM-ACS model is 3 years (2009–2011) of data from the ACS. Because the SIPP is a smaller survey than the ACS and does not produce representative state-level estimates, we combined data from two surveys to produce reliable state-level estimates.

[15] The impact of state policy decisions also applies to non-Medicaid expansion states, but our data do not include these impacts for purposes of this report. A subsequent report will show impact in all states.

[16] In the next report in this series, we will show how eligibility for full dual eligibility and MSPs changes in the remaining states that eliminate their asset test. The resulting eligibility rates are very close to those for states that have already dropped the asset test, suggesting that the difference appears to be due to the change in policy rather than to any underlying difference in income distribution.

[17] Summer, L., and Thompson, L., *Issue Brief: How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits* (New York, New York: The Commonwealth Fund, May 2004).

[18] Dorn, S., and Shang, B., "Spurring Enrollment in Medicare Savings Programs through a Substitute for the Asset Test Focused on Investment Income," *Health Affairs* 31(2): 367–375 (Washington, DC: Project Hope, 2012); Tiedemann, A. M., and Fox, K., *Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements* (New Brunswick, NJ: Rutgers Center for State Health Policy, 2005).

[19] The ACA created a Navigator function to help people who get health insurance through their state Exchange learn about their options and assist them with enrollment.

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[21] The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for oversight of the Medicare and Medicaid programs.

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