Chapter 3:

Medicare Savings Programs: Enrollment Trends

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Key Points

- The Medicare Savings Programs (MSPs), which provide Medicaid coverage of Medicare premiums and cost sharing, have the potential to improve access to care for low-income Medicare beneficiaries. State Medicaid programs administer the MSPs. Most MSP enrollees are also eligible for full Medicaid benefits, known as "full-benefit dually eligible beneficiaries." MSP enrollees are considered dually eligible even if their only Medicaid benefit is coverage under the MSPs. These individuals are considered "partial-benefit dually eligible beneficiaries."
- In 2020, the Commission made recommendations aimed at improving participation in the MSPs. Those recommendations were based on an analysis of MSP participation in 2009 and 2010 that found relatively low rates of participation in the Qualified Medicare Beneficiary (QMB) eligibility group, the largest of the four MSPs.
- The Centers for Medicare & Medicaid Services subsequently addressed aspects of our recommendations in rulemaking aimed at streamlining eligibility and enrollment policies in Medicaid, including better aligning state MSP eligibility policies with those of the Medicare Part D Low-Income Subsidy program.
- The policy landscape has changed since our study of MSP participation. Major health care policy changes have occurred that have likely increased MSP enrollment. For example, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) was enacted in 2010 and gave states the option, in 2014, to expand to a new adult population. Since then, most states have adopted that expansion, leading to millions of new Medicaid enrollees. Although these new adult enrollees are not eligible for Medicare and would lose Medicaid eligibility upon becoming eligible for Medicare, some of them would likely become eligible for an MSP.
- Our new analysis found that about 10 million dually eligible beneficiaries were enrolled in an MSP in 2021, representing a majority of the 12.8 million dually eligible beneficiaries. Of those, 8 million were enrolled in the QMB group. Our analysis did not estimate participation in the MSPs. We also found higher MSP enrollment growth among partial-benefit dually eligible beneficiaries than the full-benefit population.
- Looking ahead, the disparate enrollment patterns we identified between full- and partial-benefit populations may represent areas for further research.

CHAPTER 3: Medicare Savings Programs: Enrollment Trends

Dually eligible beneficiaries, people who are eligible for both Medicare and Medicaid, may be eligible to receive Medicaid assistance with their Medicare premiums and cost sharing through the Medicare Savings Programs (MSPs). State Medicaid programs administer the MSPs, including determining eligibility and enrolling beneficiaries. Most MSP enrollees are also eligible for full Medicaid benefits and are considered full-benefit dually eligible beneficiaries (CMS 2024a). MSP enrollees are also considered dually eligible beneficiaries even if their only Medicaid benefit is coverage under the MSPs. These individuals are considered partial-benefit dually eligible beneficiaries.

The Commission has had a long-standing interest in the MSPs because of their potential to improve access to care for low-income Medicare beneficiaries. In 2020, the Commission made recommendations tied to increasing participation in the MSPs (MACPAC 2020). The Centers for Medicare & Medicaid Services (CMS) subsequently addressed aspects of the Commission's recommendations through proposed rulemaking aimed at streamlining eligibility and enrollment policies in Medicaid, including better aligning MSP eligibility policies with those of the Medicare Part D Low-Income Subsidy (LIS) program, which is administered by the Social Security Administration (SSA) (CMS 2022). After publishing the proposed rule in 2022, CMS indicated plans to publish the final rule in two parts with the first part focused on the MSPs. In that final rule, published in September 2023, CMS addressed many of the misalignments between state and SSA eligibility policies for MSPs and the LIS program (CMS 2023a). Additional changes streamlining eligibility and enrollment in Medicaid by aligning requirements for non-modified adjusted gross income (non-MAGI) populations with those of MAGI groups were included in the second part of the rule, which was recently finalized (CMS 2024b).

Our 2020 recommendations were based on an analysis of MSP participation that we did under contract with the Urban Institute and published in 2017 (Caswell and Waidmann 2017). In that study, we found relatively low rates of participation: 53 percent of people eligible for the Qualified Medicare Beneficiary (QMB) group and 32 percent of people eligible for the Specified Low-income Medicare Beneficiary (SLMB) group. We also previously found that assistance with cost sharing, which is available under the QMB eligibility group, could have a positive effect on access to care (Haber et al. 2014). Although payment policies are just one of several factors that could affect access, we found that as the Medicaid contribution toward Medicare cost sharing increases, beneficiaries are more likely to use selected outpatient services (Haber et al. 2014).

The policy landscape has changed since our study of MSP participation, particularly when considering the data we used represented the latter parts of calendar years 2009 and 2010. Participation rates in those years would not have accounted for several major health care policy changes that have occurred since then and that have likely contributed to increased MSP enrollment. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) was enacted in 2010 and gave states the option to expand Medicaid coverage to a new adult population beginning in 2014. The new adult population was not eligible in 2009 and 2010, the data years represented in our study of MSP participation. Since then, most states have adopted the Medicaid expansion under the ACA. Adults in the expansion population are not eligible for Medicare, and when they become eligible for Medicare, they lose their Medicaid coverage. However, states are required through federal regulation to determine if someone losing coverage in their original eligibility group is eligible under any other eligibility group included in the state plan. This procedure can result in MSP enrollment for individuals who became eligible for Medicare while enrolled in the new adult group—people who before 2014 would not have applied for Medicaid. Given the number of adults who gained Medicaid coverage in those states and the propensity those states showed to extend coverage to eligible groups by adopting the expansion, expansion adults who turned age 65 and became eligible for Medicare may have contributed to an increase in MSP enrollment.

Enrollment in the Medicare Advantage program has increased substantially in the last decade. From 2011 to 2022, the number of eligible Medicare beneficiaries enrolled in Medicare Advantage plans increased from 26 percent to 49 percent (Serna and Johnson 2023). Medicare Advantage plans have an incentive to make sure their enrollees are getting available Medicaid assistance with their Medicare premiums and cost sharing because that assistance conveys dually eligible status on the Medicare Advantage enrollee, and CMS's risk adjustment system pays higher capitation rates for dually eligible individuals than for individuals who are not dually eligible because of the higher risk scores associated with the dually eligible population.

To better understand MSP policy in today's changed landscape, we contracted with the Urban Institute to revisit the MSPs, this time by analyzing enrollment for calendar years 2010–2021 using Medicare administrative data from the Medicare Master Beneficiary Summary File. We set out to describe enrollment trends across the MSPs over a 12-year period with a focus on the QMB plus group, for individuals who meet the QMB eligibility criteria and also qualify for full Medicaid benefits, which accounts for more than 60 percent of all MSP enrollees (Table 3-3). Our findings indicate that a majority of dually eligible beneficiaries are enrolled in an MSP. In 2021, around 80 percent of dually eligible beneficiaries, or about 10 million people, were enrolled in an MSP. Of these, 6.3 million were enrolled in the QMB plus group and were eligible for full Medicaid benefits. Our analysis did not estimate MSP participation rates and instead focused on actual enrollment using administrative data.

This chapter begins with an overview of each of the four MSPs, including eligibility criteria and benefits covered. It reviews our prior work estimating participation rates and describes recent federal and state efforts to streamline enrollment into the MSPs. Finally, it describes findings from our analysis of MSP enrollment trends over a 12-year period, including comparisons of enrollment in the QMB plus group by demographic characteristic such as age, sex, and urban or rural residence.[1]

Overview of the MSPs

The MSPs provide Medicaid coverage of Medicare premiums and cost sharing to eligible low-income Medicare beneficiaries. Once Medicare beneficiaries enroll in an MSP, they are considered dually eligible. States receive their regular federal medical assistance percentage (FMAP) for MSP expenditures.[2] Four mandatory MSP eligibility pathways provide varying levels of assistance and have different eligibility criteria (Table 3-1). They include the QMB group, the SLMB group, the Qualifying Individual (QI) group, and the Qualified Disabled and Working Individual (QDWI) group. When individuals are enrolled only in MSP benefits, without being simultaneously enrolled in full Medicaid benefits, they are considered partial-benefit dually eligible beneficiaries. For example, people who are enrolled only in the QMB eligibility group, without full Medicaid benefits, are known as "QMB only enrollees." This is a partial-benefit category of dual eligibility. People who are enrolled in both the QMB eligibility group and full Medicaid are known as "QMB plus enrollees" and are considered full-benefit dually eligible beneficiaries. The QI and QDWI groups cover only Medicare premiums. Few people are enrolled in the QDWI group because it serves a limited population: individuals with disabilities who have returned to work and are no longer eligible for premium-free Medicare Part A coverage. Because enrollment in QDWI is so low, we excluded it from our MSP enrollment analysis.

Benefits, eligibility, and structure

The QMB eligibility group was enacted in 1986 and is the most expansive of the MSPs in terms of the number of enrollees it covers and the benefits it provides. Originally a state option, Congress subsequently made the QMB group mandatory in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) (Rosenbach and Lamphere 1999). For QMB-eligible individuals, Medicaid pays for Medicare Part A (hospital insurance) premiums as well as Medicare Part B (supplementary medical insurance) premiums and Medicare coinsurance, deductibles, and copayments. To qualify for QMB, individuals must typically have income at or below 100 percent of the federal poverty level (FPL) and limited assets.[3]

TABLE 3-1. Medicare Savings Program Eligibility and Benefits, CY 2024

Medicare Savings Program (MSP) beneficiaries		Enrolled in full Medicaid benefits	Dual eligibility type	MSP income threshold as % of FPL	Qualify for Medicaid payment of:	Federal asset limits, 2024	
						Individual	Couple
QMB	Only	No	Partial	At or below 100%	Medicare Part A premiums (if needed); Medicare Part B premiums; Medicare coinsurance, deductibles, and copayments	$9,430	$14,130
	Plus	Yes	Full		Medicare Part A premiums (if needed); Medicare Part B premiums; Medicare coinsurance, deductibles, and copayments; all Medicaid-covered services under the state plan	2,000	3,000[1]
SLMB	Only	No	Partial	101–120	Medicare Part B premiums	9,430	14,130
	Plus	Yes	Full		Medicare Part B premiums[2]; all Medicaid-covered services under the state plan	2,000[1]	3,000[1]
QI		No	Partial	121–135	Medicare Part B premiums	9,430	14,130
QDWI		No	Partial	At or below 200	Medicare Part A premiums	4,000	6,000

Notes: CY is calendar year. MSP is Medicare Savings Program. FPL is federal poverty level. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-income Medicare Beneficiary. QI is Qualifying Individual. QDWI is Qualified Disabled and Working Individual.

[1] Many states have spenddown programs in place that enable older adults and people with disabilities to qualify for full Medicaid benefits even if they have assets above these limits through a medically needy pathway (KFF 2022).

[2] States may choose to pay for Medicare Parts A and B coinsurance, deductibles, and copayments in their state plans.

Sources: MACPAC and MedPAC 2024 and CMS 2023b.

There are two types of QMB enrollees: those who receive only QMB benefits (QMB only) and those who are enrolled in both QMB and full Medicaid benefits (QMB plus). QMB only enrollees are considered partial-benefit dually eligible beneficiaries because they are eligible only for Medicaid payment of Medicare premiums and cost sharing through the QMB eligibility group. QMB plus enrollees receive assistance with their Medicare premiums and cost sharing plus full Medicaid benefits through eligibility pathways that include receipt of Supplemental Security Income benefits and the aged, blind, and disabled pathway for individuals who are low income and age 65 or older or who have a qualifying disability.

The SLMB eligibility group was enacted as part of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508); it originally covered beneficiaries with incomes between 101 percent and 110 percent of the FPL and was later expanded to cover individuals with incomes up to 120 percent of the FPL (MACPAC 2017, GAO 2012, Rosenbach and Lamphere 1999). Medicaid pays Medicare Part B premiums only for eligible

enrollees. As with the QMB group, individuals with SLMB benefits are categorized as SLMB only or SLMB plus based on whether they are enrolled only in SLMB or are also enrolled in full Medicaid benefits.

The QI eligibility group was enacted in the Balanced Budget Act of 1997 (P.L. 105-33). It initially was authorized to provide Medicaid assistance with Medicare Part B premiums for beneficiaries with incomes between 120 and 175 percent of the FPL, but the upper income eligibility limit was effectively lowered to 135 percent of the FPL in 2002 (GAO 2004).[4] Unlike the QMB and SLMB groups, QI funding is provided to states through a federal allotment that is set at a specific amount each year. States receive 100 percent federal match up to the amount of the allotment. To qualify for QI benefits, an individual may not be enrolled in any other Medicaid eligibility group (CMS 2024c).

The QDWI group was enacted as part of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). It is the smallest of the MSPs. QDWI is designed to help pay the Part A premium for people who are disabled and younger than age 65 who have lost premium-free Part A coverage because they returned to work—a relatively small population (CMS 2024c, Merlis 2005).

Eligibility linkage with Medicare Part D LIS program

An automatic eligibility link exists between the MSPs and the Medicare Part D LIS program, which is administered by the SSA. The MSPs and LIS program are designed to serve similar populations. The LIS program provides subsidized coverage of Medicare Part D premiums and cost sharing for low-income Medicare beneficiaries up to 150 percent of the FPL.[5] Starting in 2024, some people who are eligible for the LIS program will not be eligible for the MSPs because the LIS income threshold is higher than the MSP standard of 135 percent of the FPL. Anyone eligible for or enrolled in the MSPs is automatically eligible for the LIS program. However, people eligible for the LIS program are not automatically eligible for the MSPs. MSP participation rates are also generally lower than participation in the LIS program, perhaps because most LIS program enrollees are deemed eligible for the LIS program because they are enrolled in Medicaid (Fung et al. 2024, CMS 2023a). CMS has worked to ease enrollment into the MSPs by establishing requirements for states to better align their MSP eligibility policies with those of the LIS program. Most recently, CMS finalized rulemaking in September 2023 to streamline eligibility and enrollment by codifying policies designed to ease enrollment into the MSPs (CMS 2023a). For more details on the final rule, see the section on CMS rulemaking.

State flexibility

States must use income and asset thresholds for the MSPs that are no more restrictive than the federal standards, but states have the flexibility under Section 1902(r)(2) to adopt more generous levels (Table 3-1). In 2023, 18 states and the District of Columbia opted to use more generous income and asset levels (MACPAC and MedPAC 2024). States choosing to make changes to their eligibility criteria may need to submit a state plan amendment to CMS for approval.

Prior MACPAC Work on MSP Participation Rates

The Commission previously reviewed barriers to participation in the MSPs and made recommendations to Congress on ways to increase MSP enrollment. In June 2020, the Commission recommended that Congress amend the Medicaid statute to require that states align their MSP eligibility determination policies with those that the SSA uses to determine eligibility for the LIS program. The Commission also recommended that the SSA transfer continuing LIS program eligibility data to states annually to help enrollees whose circumstances have not changed maintain their enrollment in the MSPs (Box 3-1) (MACPAC 2020).

States have discretion over how they administer their MSPs, and in some cases, state eligibility policies for MSPs do not align with those the SSA uses for the LIS program. This complicates states' ability to use just the SSA data to determine MSP eligibility. Because the LIS program and the MSPs are both designed to provide financial assistance to low-income Medicare beneficiaries to cover out-of-pocket Medicare costs, policymakers have looked for opportunities to further align the two programs where possible. CMS estimated that over 1 million individuals who were receiving the full

BOX 3-1. MACPAC Recommendation from June 2020 Report to Congress

Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

LIS subsidy were not enrolled in an MSP, even though the eligibility criteria for the two programs is so closely aligned that they would have probably been eligible for an MSP (CMS 2023a). In rulemaking that CMS finalized in September 2023, the agency largely addressed the misalignments between state and SSA eligibility policies, with a few exceptions, including the treatment of burial funds (CMS 2023a). Some states require that individuals set aside at least $1,500 intended to offset the cost of burial in a separate account, without which the state will not disregard them as assets. In contrast, the SSA disregards burial funds up to $1,500 for an individual when calculating assets for purposes of eligibility for the LIS program.

Policymakers have also raised concerns that people eligible for the MSPs might lose their MSP coverage during regular Medicaid benefit renewals because of the need to resubmit paperwork. Although dually eligible beneficiaries typically do not have big fluctuations in income that are likely to make them ineligible for Medicaid, individuals have been dropped from the MSPs for failure to produce paperwork that verifies that their situations have not changed. Studies have found that almost 30 percent of new full-benefit dually eligible beneficiaries lost Medicaid coverage for at least 1 month during the 12 months after they became dually eligible (Chidambaram and Burns 2022, Feng et al. 2019). Of the people who lost coverage, nearly 30 percent had short breaks in coverage of one to three months, likely for administrative reasons such as lack of familiarity with Medicaid policies and eligibility verification procedures (Feng et al. 2019, Riley et al. 2014).

In 2017, we set out to estimate rates of participation in each of the MSPs and to better understand the population eligible for an MSP but not enrolled.[6] Prior studies on MSP eligibility and enrollment were difficult to conduct because household surveys do not collect information on MSP participation, and administrative data sources do not identify the universe of individuals eligible but not enrolled in MSPs. Our study linked Medicaid administrative data from the Medicaid Statistical Information System (MSIS), which we used to capture MSP enrollment, with data from the Survey of Income and Program Participation. The linked survey data enabled us to study the entire MSP-eligible population—those eligible and enrolled as well as those eligible but not enrolled—and rates of MSP participation. Previous studies also linked administrative data with survey data but did not estimate participation rates for each of the MSPs, instead presenting one combined participation rate across all MSPs (Sears 2002, Rupp and Sears 2000). One study found that about 63 percent of non-institutionalized eligible individuals had enrolled in the QMB and SLMB groups in 1999 (Rupp and Sears 2000). Another study estimated a combined participation rate of 64 percent in 2001 (Haber et al. 2003).

We estimated that 53 percent of MSP-eligible individuals participated in the QMB group and that 32 percent participated in the SLMB group. These participation rates are best interpreted as representing the latter parts of calendar years 2009 and 2010. We also found that adults eligible for but not enrolled in the QMB group, compared to QMB enrollees, had the following characteristics:

- more likely to be 65 and older;
- more likely to be white, non-Hispanic;
- more likely to report excellent or very good health; and
- less likely to report limitations in activities of daily living.

Moreover, about 45 percent of adults who enrolled in the QMB group were also enrolled in other public programs such as the Supplemental Nutrition Assistance Program or the Supplemental Security Income program.

Federal and State Efforts to Increase Enrollment

The federal government and states have been engaged over the years in efforts to align MSP enrollment policies with those the SSA uses for the LIS program because of similarities between the two programs. They provide similar benefits, namely assistance with Medicare premiums and cost sharing, to individuals with similar levels of income and assets.

CMS has provided ongoing guidance to states about ways to align state MSP eligibility policies with those used by the SSA for the LIS program with the goal of streamlining enrollment across the MSPs and LIS program. For example, in 2010, CMS published a state Medicaid director's letter explaining how states could use the data from the SSA as an application for the MSPs (CMS 2010). CMS reiterated this guidance in 2020 in chapter 1 of the *Manual for State Payment of Medicare Premiums* and again in 2021 in a CMS informational bulletin (CMS 2024d, 2021).

CMS rulemaking. In September 2023, CMS finalized the portions of a 2022 proposed rule on Medicaid eligibility and enrollment that pertain to better aligning MSP policies with those of the SSA (CMS 2023a, 2022). In that final rule, CMS codified existing policies related to facilitating enrollment in the MSPs, including the requirement enacted in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) that mandates states use data from LIS applications, referred to as "leads data," from the SSA to initiate an MSP application (CMS 2023a). States receive leads data from the SSA every business day (CMS 2023a). Although this requirement was enacted in MIPPA in 2008, CMS indicated concern that not all states were using the leads data and were instead requiring beneficiaries to complete a new MSP application (CMS 2023a). This process often includes providing information that the beneficiary has already shared with the SSA in their LIS application.

The final rule also encourages states to align their eligibility policies with those that the SSA uses so that states can more easily use the LIS leads data to determine MSP eligibility (CMS 2023a). For example, Medicaid policies differ from SSA policies in how certain assets are treated, such as burial funds and life insurance policies. States have the option under current law to align MSP eligibility criteria with those that the SSA uses, but not all states have done so. Under the 2023 final rule, states that have not aligned their policies with the SSA will be required to accept self-attestation from beneficiaries for income and assets that the MSPs count but the LIS program does not unless the state already has other recent information with which the self-attestation is not reasonably compatible. States that observe discrepancies between self-reported information and state data that are not reasonably compatible can require additional information from beneficiaries (Burns 2023). Under the final rule, states also retain the option to conduct a post-enrollment verification of income, such as interest or dividends, and request additional information from beneficiaries.

CMS notes in the final rule that feedback from states on the proposed rule indicated a lack of familiarity with the LIS leads data (CMS 2023a). CMS also acknowledged the burden on states of additional requirements while states are responding to the unwinding of the public health emergency. As a result, CMS extended the deadline for state compliance with most of the provisions of the rule to April 1, 2026.

The second part of the 2022 proposed rule was recently finalized and included changes to streamline eligibility, including enrollment and renewal procedures, by better aligning non-MAGI groups with MAGI groups (CMS 2024b). In the final rule, CMS acknowledged the relative stability of income for the non-MAGI populations relative to the MAGI groups and noted that changes to align the two groups promote equity across Medicaid beneficiaries (CMS 2024b).

MSP enrollees can benefit from these changes to the extent those policies prevent instability in their Medicaid eligibility and help them avoid potential Medicare coverage gaps as a result of a loss of Medicaid assistance with Medicare premiums and cost sharing. Currently, states are required to redetermine Medicaid eligibility at least every 12 months for Medicaid

enrollees, such as dually eligible beneficiaries, whose eligibility is determined on a basis other than MAGI (42 CFR 435.916(b)).[7] States must attempt an ex parte renewal for all Medicaid beneficiaries, which means using information available to the state Medicaid agency, including information from electronic data sources, to renew eligibility without requiring additional beneficiary action (MACPAC 2023).[8] Although many dually eligible beneficiaries may not have fluctuations in income that are likely to make them ineligible for Medicaid, as of January 2023, about half of states successfully completed ex parte renewals for about 50 percent or more of their Medicaid eligibility renewals, and only six states reported conducting more than 50 percent of Medicaid eligibility renewals for non-MAGI eligibility groups in July 2022 (Brooks et al. 2023, Musumeci et al. 2022). In the same survey, 28 states reported adopting at least 1 new strategy to increase the share of non-MAGI renewals completed using ex parte (Musumeci et al. 2022).

Some states have exercised their statutory flexibility to expand MSP income and asset thresholds beyond the federal standards, making more individuals eligible. As of November 2023, 18 states plus the District of Columbia have expanded income and asset thresholds above the federal standards (MACPAC and MedPAC 2024). Some states have also restructured their MSP eligibility policies to reduce confusion for beneficiaries and for the people administering the programs.

Interviews with states. To get a sense of state activity around the MSPs in light of CMS rulemaking, we talked to three states that made recent changes to the MSPs or are otherwise engaged in enrolling eligible beneficiaries. One state told us that the SSA LIS leads data transfer is not streamlined and requires a fair amount of work to use. We were told data arrive in a format that the state has had difficulty integrating into its existing eligibility systems. Another state told us that asset tests are a barrier to MSP enrollment and that other efforts, such as outreach, have brought in few new enrollees. We also heard that the structure of the MSPs could be more streamlined. Finally, we heard that while states are supportive of the recent CMS rulemaking, expectations around implementation time frames are challenging as states are still making their way through the unwinding of the public health emergency.

MSP Enrollment Trends from 2010 to 2021

To better understand current MSP policy and to contribute to the renewed national conversation about the MSPs prompted by CMS rulemaking, we set out to describe MSP enrollment trends using the most recent available data. We contracted once again with the Urban Institute. Our prior work estimating participation rates was cited in the recent CMS rulemaking, but because of the challenges associated with obtaining the data needed to estimate those rates, we could not easily update our prior work (CMS 2023a). Instead, we pivoted to readily available monthly MSP enrollment data for calendar years 2010–2021 and analyzed MSP enrollment trends over that period. The final two years of the study period, 2020 and 2021, were affected by the COVID-19 public health emergency and the Medicaid continuous coverage requirement that was enacted, which paused Medicaid redeterminations in both years.

We used administrative data from the Medicare Master Beneficiary Summary File to analyze enrollment in each MSP and compare enrollment patterns across MSPs. We also compared enrollees in different MSPs by demographic characteristics, including age, sex, and urban or rural residence.[9] In these comparisons, we focused on the QMB plus group because it has the most enrollees and offers the most comprehensive benefits. We describe the enrollment patterns below, but we are not able to draw conclusions or explain the take-up rates among eligible beneficiaries. We did not engage in comparisons of MSP enrollment patterns relative to the broader dually eligible population or attempt to place the MSP trends we identified into a larger programmatic context. Those elements were outside the scope of our project.

Enrollment. MSP enrollment steadily increased over the study period. In 2021, of the 12.8 million dually eligible beneficiaries in the country, 10 million were enrolled in an MSP (Table 3-2) (MACPAC and MedPAC 2024). Enrollment increased in all of the MSPs since 2010 at an average annual growth rate of 3.0 percent. This growth is slightly higher than the 2.4 percent average annual growth in the Medicare program from 2013 to 2022 (CMS 2023c).

TABLE 3-2. Medicare Savings Program Enrollment, CY 2010–2021 (millions)

Type of MSP	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Average annual growth, 2010–2021
All MSPs	**7.2**	**7.5**	**7.9**	**8.1**	**8.3**	**8.5**	**8.7**	**8.9**	**9.1**	**9.3**	**9.7**	**10.0**	**3.0%**
QMB plus	4.8	4.8	5.0	5.1	5.3	5.3	5.4	5.6	5.6	5.8	6.1	6.3	**2.6**
QMB only	1.0	1.2	1.2	1.3	1.4	1.4	1.5	1.5	1.6	1.5	1.7	1.7	**4.7**
SLMB plus	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	**4.0**
SLMB only	0.8	0.9	0.9	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	**2.6**
QI	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	**3.0**

Notes: CY is calendar year. MSP is Medicare Savings Program. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-income Medicare Beneficiary. QI is Qualifying Individual. CYs 2020 and 2021 were affected by the COVID-19 public health emergency and the enactment of the Medicaid continuous coverage requirement, which paused Medicaid redeterminations in both years.

Source: MACPAC, 2023, analysis of administrative data from the Medicare Master Beneficiary Summary File, under contract with the Urban Institute.

Most MSP enrollees, 6.3 million people in 2021, were enrolled in both QMB benefits and full Medicaid benefits, therefore qualifying as QMB plus enrollees (Table 3-2, Figure 3-1). QMB plus is the dual eligibility category with the highest levels of enrollment in any year. This group is also the most comprehensive in terms of the benefits offered, which include payment of both Medicare Part A and Part B premiums as well as coverage of Medicare cost sharing and full Medicaid benefits to pay for Medicaid-covered services that Medicare does not cover.

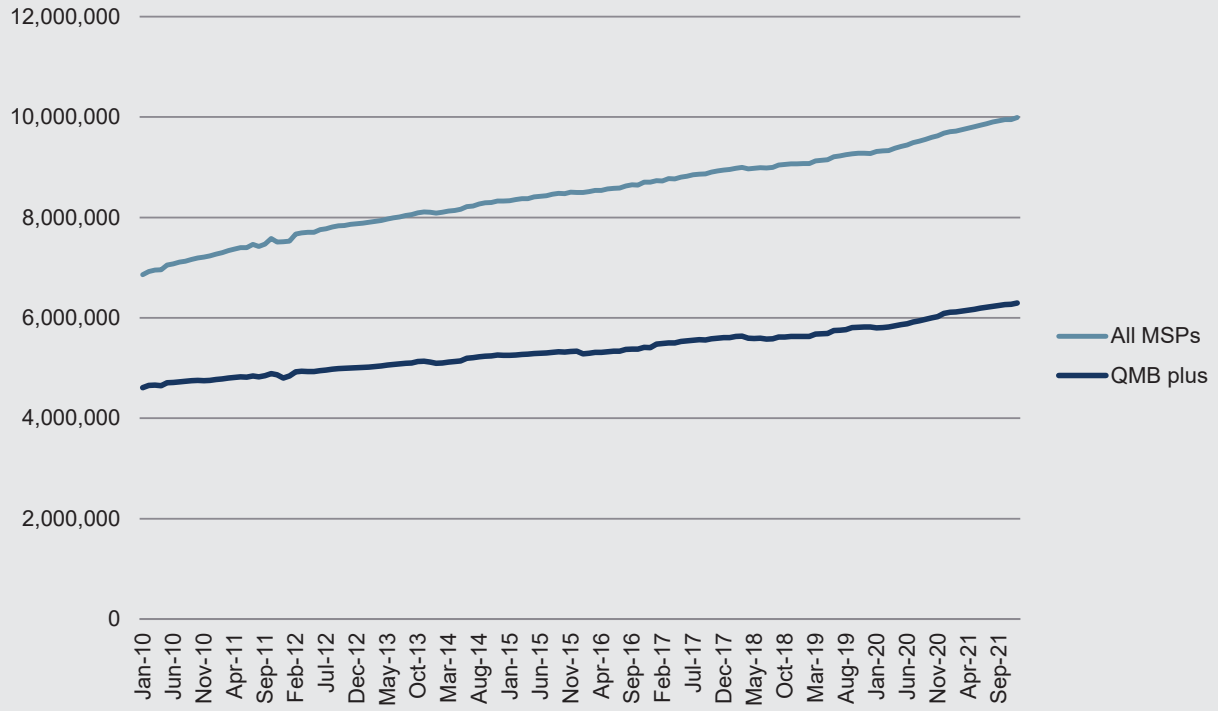
The SLMB plus group, in contrast, had the lowest enrollment of any of the categories (Table 3-2, Figure 3-2). To be eligible for SLMB benefits, beneficiaries must have incomes that fall between 101 percent and 120 percent of the FPL, a range within which most people will not qualify for full Medicaid benefits except through a medically needy pathway. Further, SLMB plus enrollees receive coverage for Medicare Part B premiums and full Medicaid benefits, and states can opt to cover Medicare cost sharing for these individuals as a state plan benefit. They are not eligible for Medicaid assistance with Medicare Part A premiums.

More analysis is needed to understand the differences in enrollment patterns between the full-benefit and partial-benefit groups. Enrollment in the QMB plus group is higher in every year than the QMB only group, but the opposite is true in the SLMB group (Table 3-2). SLMB only enrollment exceeds SLMB plus enrollment in every year. There could be a smaller share of SLMB enrollees in the SLMB plus group because effective state income limits for the aged, blind, and disabled pathways, through which many SLMB plus individuals receive full Medicaid benefits, are generally less than the SLMB income limits. QMB plus enrollment grew at a slower average annual rate, 2.6 percent, than QMB only enrollment, for which the rate was 4.7 percent. In contrast, SLMB plus enrollment had higher average annual growth (4.0 percent) than SLMB only enrollment (2.6 percent).

The QI eligibility group had lower enrollment levels than the other MSPs and dual eligibility categories, with the exception of enrollment in SLMB plus (Table 3-2). The income eligibility range for the QI group, between 121 percent and 135 percent of the FPL, is narrower and higher than the range used for the SLMB group.

Share of enrollment. Enrollment was not distributed evenly across the MSPs. Although enrollment increased across the study period, the composition of enrollment by MSP did not change much. QMB plus, the dual eligibility category that offers the most comprehensive benefits to people with the lowest income, accounted for the largest share of MSP enrollment across the 12-year period, making up almost 63 percent of dually eligible beneficiaries with MSP benefits in 2021 (Table 3-3). The SLMB plus category had the lowest share of total enrollment across all years.

FIGURE 3-1. Comparison of Monthly Enrollment in All Medicare Savings Programs with Enrollment in the Qualified Medicare Beneficiary Plus Group, CYs 2010–2021



Notes: CY is calendar year. MSP is Medicare Savings Program. QMB is Qualified Medicare Beneficiary. CYs 2020 and 2021 were affected by the COVID-19 public health emergency and the enactment of the Medicaid continuous coverage requirement, which paused Medicaid redeterminations in both years.

Source: MACPAC, 2023, analysis of monthly administrative data from the Medicare Master Beneficiary Summary File, under contract with the Urban Institute.

The share of enrollment that each dual eligibility category comprised was fairly consistent over the 12-year period, with the exception of a steadier increase in QMB only enrollees as a share of total enrollment (Table 3-3). The QMB only group saw its share of enrollment increase in every year of the study period, with the exception of 2019. These steady increases could be related to the enactment of the ACA in 2010 and the subsequent implementation in 2014, which may have increased awareness of available coverage options, leading more people to enroll in those years (Table 3-3). In addition, MIPPA included increased federal funding for outreach to individuals eligible for the MSPs, which may have led to increased enrollment. Further analysis is needed to better understand the different enrollment patterns for partial-benefit dually eligible beneficiaries relative to full-benefit individuals.

Enrollment growth. QMB only enrollment experienced the highest rates of growth year over year with several years experiencing growth of 5 percent or higher, exceeding the growth in other dual eligibility categories in most years (Table 3-4, Figure 3-2). In addition, over the 12-year window, the QMB only group had the highest average annual enrollment growth at 4.7 percent relative to 2.6 percent in the QMB plus group and 4.0 percent in the SLMB plus group. We also noted the differing growth rates among partial-benefit dually eligible categories in comparison to growth rates among full-benefit dually eligible categories. Further research in these areas will help us better understand the reasons for higher enrollment growth rates among partial-benefit dually eligible beneficiaries, primarily QMB only, and the underlying causes of variation among growth rates.

SLMB enrollment experienced flatter growth than the other MSPs for most of the 12-year period, with enrollment in the SLMB only and SLMB plus categories growing at less than 1 percent in some years (Table 3-4). SLMB enrollment levels also were relatively low compared to the other MSPs. The District of Columbia and New York have changed the structure of their MSPs by effectively combining the SLMB group with the QMB group to simplify and reduce confusion for beneficiaries.[10] Beneficiaries and states may find the current MSP structure confusing because it has multiple programs, each offering coverage of different benefits at different income and asset thresholds.

QMB plus group enrollment by demographic characteristics

In this section, we examine enrollment in the QMB plus group by demographic characteristics including sex, age, and urban or rural residence. We focus on the QMB plus group because it accounts for more than 60 percent of all MSP enrollees (Table 3-4). QMB plus enrollees are more likely to be women, to be age 65 or older, and to live in an urban area.

Sex. In 2021, 3.8 million QMB plus enrollees, or about 60 percent, were women (Figure 3-2). The average annual growth rate for female QMB plus enrollees was 3.2 percent compared to 2.2 percent among male enrollees.

TABLE 3-3. Share of Enrollment by Type of Medicare Savings Program, CYs 2010–2021

MSP	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
QMB plus	65.7	63.9	63.6	63.2	63.1	62.8	62.1	62.7	62.1	62.8	62.9	63.0
QMB only	14.4	15.4	15.4	15.9	16.4	16.5	17.1	17.2	17.2	16.7	17.4	17.2
SLMB plus	3.1	3.2	3.1	3.1	3.0	3.1	3.0	3.1	3.2	3.1	3.3	3.4
SLMB only	10.9	11.3	11.4	11.4	11.1	11.2	11.2	11.0	11.2	11.1	10.6	10.4
QI	5.9	6.2	6.5	6.4	6.4	6.4	6.2	6.0	6.3	6.3	5.9	5.9

Notes: CY is calendar year. MSP is Medicare Savings Program. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-income Medicare Beneficiary. QI is Qualifying Individual. CYs 2020 and 2021 were affected by the COVID-19 public health emergency and the enactment of the Medicaid continuous coverage requirement, which paused Medicaid redeterminations in both years.

Source: MACPAC, 2023, analysis of monthly administrative data from the Medicare Master Beneficiary Summary File, under contract with the Urban Institute.

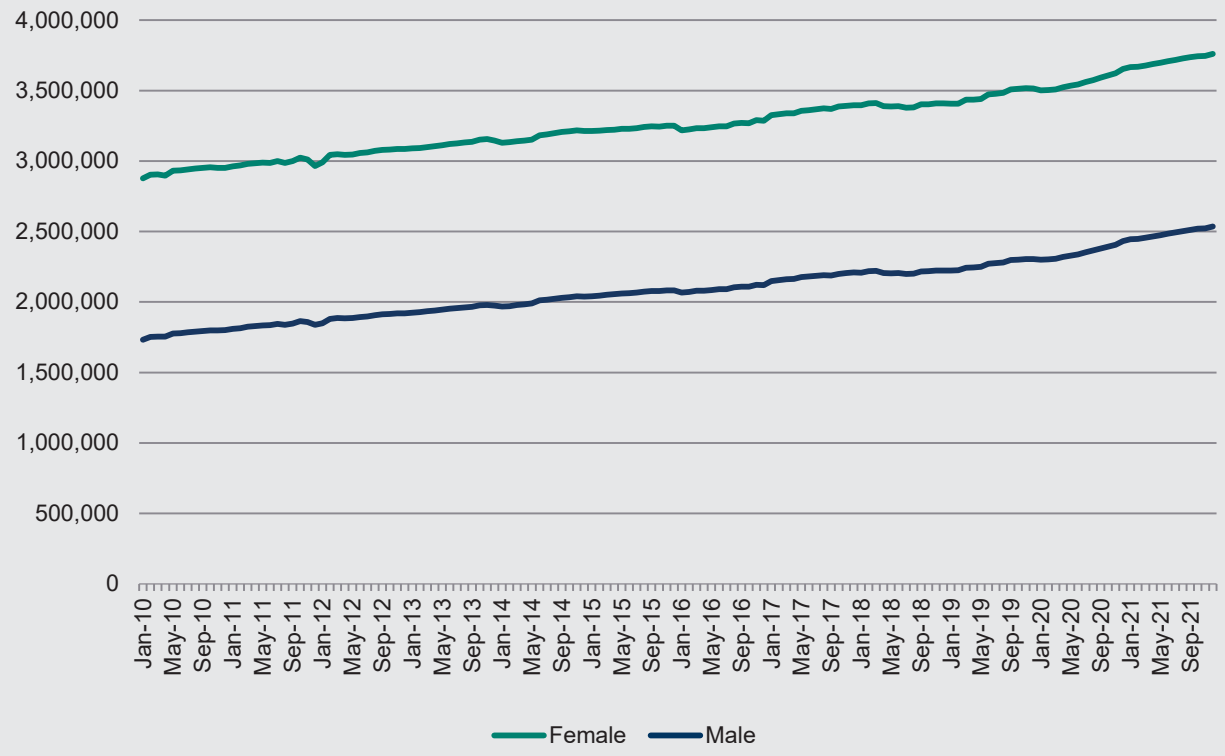
TABLE 3-4. Annual Medicare Savings Program Enrollment Growth Rates, CYs 2011–2021

MSP	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
All MSPs	**4.0%**	**4.7%**	**2.9%**	**2.8%**	**2.0%**	**2.2%**	**3.0%**	**1.4%**	**2.3%**	**4.4%**	**3.2%**
QMB plus	1.1	4.2	2.3	2.6	1.6	1.3	3.7	0.4	3.4	4.6	3.4
QMB only	11.4	4.3	6.9	5.4	2.7	6.6	3.3	1.2	-0.8	8.6	2.2
SLMB plus	5.6	3.1	2.2	1.6	3.7	1.0	4.9	3.4	0.7	9.0	8.7
SLMB only	8.2	5.6	2.2	0.4	3.1	2.7	0.4	3.5	1.3	-0.4	1.7
QI	9.4	10.3	1.3	2.7	1.8	-1.3	-0.4	6.9	2.1	-2.6	3.8

Notes: CY is calendar year. MSP is Medicare Savings Program. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-income Medicare Beneficiary. QI is Qualifying Individual. This table excludes the Qualified Disabled and Working Individual group because enrollment is too small to report. CYs 2020 and 2021 were affected by the COVID-19 public health emergency and the enactment of the Medicaid continuous coverage requirement, which paused Medicaid redeterminations in both years.

Source: MACPAC, 2023, analysis of monthly administrative data from the Medicare Master Beneficiary Summary File, under contract with the Urban Institute.

FIGURE 3-2. Qualified Medicare Beneficiary Plus Monthly Enrollment by Sex, CYs 2010–2021

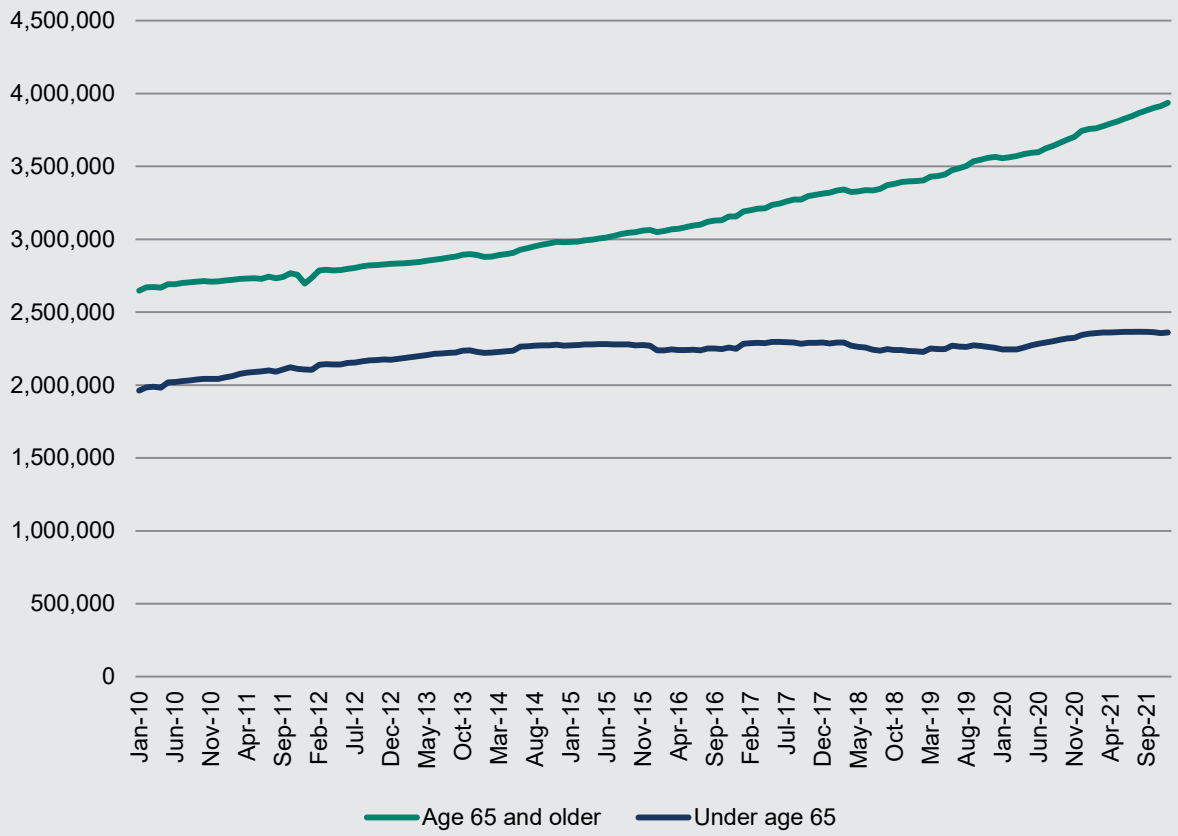


Note: CY is calendar year. CYs 2020 and 2021 were affected by the COVID-19 public health emergency and the enactment of the Medicaid continuous coverage requirement, which paused Medicaid redeterminations in both years.

Source: MACPAC, 2023, analysis of monthly administrative data from the Medicare Master Beneficiary Summary File, under contract with the Urban Institute.

Age. Among QMB plus enrollees, 62.5 percent were age 65 or older and 37.5 percent were younger than age 65 (Figure 3-3). Among all Medicare beneficiaries, the age split was different, with a larger share of the population (87 percent) older than 65 in 2021 (CMS 2023d). This indicates that a greater share of the younger dually eligible population (37.5 percent) is enrolled in the QMB plus group than we would have assumed (13.0 percent) if the proportions were aligned with Medicare (CMS 2023d). We found different growth patterns among people younger than age 65 and people who are 65 years old or older. Enrollment grew steadily among QMB plus enrollees age 65 or older (3.4 percent), which is consistent with overall Medicare enrollment growth rates among the same age group (3.2 percent) (CMS 2023c). Among younger QMB plus enrollees, enrollment growth has been relatively flat (1.3 percent) but higher than average for Medicare beneficiaries who are disabled (-0.9 percent) (CMS 2023c). The differences between age groups may reflect the aging of the population, particularly among people born between 1946 and 1964 who are turning age 65 between the years 2011 and 2029, often referred to as the “baby boom generation.” This demographic shift may explain the upward trend among people age 65 and older and the flatter growth among the younger population (Figure 3-3).

FIGURE 3-3. Qualified Medicare Beneficiary Plus Monthly Enrollment by Age, CYs 2010–2021



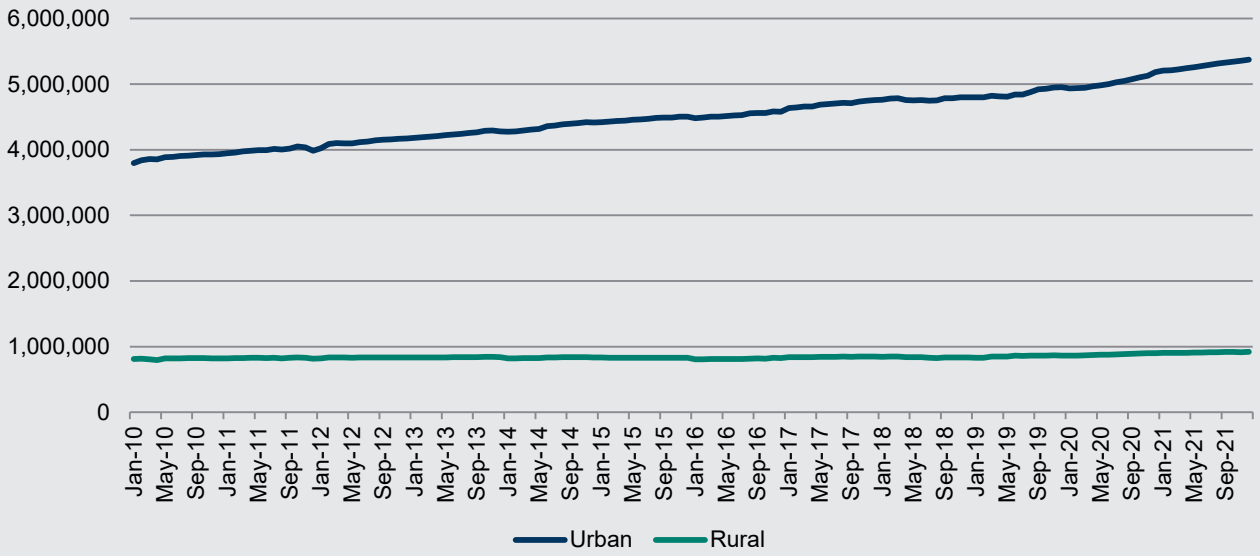
Note: CY is calendar year. CYs 2020 and 2021 were affected by the COVID-19 public health emergency and the enactment of the Medicaid continuous coverage requirement, which paused Medicaid redeterminations in both years.

Source: MACPAC, 2023, analysis of monthly administrative data from the Medicare Master Beneficiary Summary File, under contract with the Urban Institute.

Urban or rural residence. QMB plus enrollees lived primarily in urban areas (85 percent) rather than in rural areas (15 percent) in 2021 (Figure 3-4). This trend is consistent with the overall Medicare population, 83 percent of which lived in an urban area in 2021 (CMS 2024a). QMB plus enrollment grew steadily among people living in urban areas at an average annual growth rate of about 3 percent, but enrollment growth among people living in rural areas was relatively flat across the study period at 1 percent. This flat growth may indicate an area for more focused outreach efforts. Future work could explore whether a gap exists between the eligible but not enrolled populations in rural areas as compared to urban areas, perhaps indicating that more eligible people are enrolling in rural areas than in urban ones.

Race and ethnicity. The Medicare Master Beneficiary Summary File data on race and ethnicity were not of sufficient quality to use in this analysis, but in a prior analysis of calendar year 2020 data from the Transformed Medicaid Statistical Information System (T-MSIS), around 20 percent of QMB enrollees were Black or Hispanic, compared to 9 percent or less among non-dually eligible Medicare beneficiaries (Table 3-5). Efforts to increase enrollment in the MSPs may therefore have a disproportionate effect on these subpopulations, creating an opportunity to address potential health disparities. More research is needed to identify potential differences among subpopulations.

FIGURE 3-4. Qualified Medicare Beneficiary Plus Monthly Enrollment by Urban or Rural Residence, CYs 2010–2021



Note: CY is calendar year. CYs 2020 and 2021 were affected by the COVID-19 public health emergency and the enactment of the Medicaid continuous coverage requirement, which paused Medicaid redeterminations in both years.

Source: MACPAC, 2023, analysis of monthly administrative data from the Medicare Master Beneficiary Summary File, under contract with the Urban Institute.

Conclusions and Next Steps

The landscape of coverage for MSP-eligible individuals has changed since our prior work in ways that have likely increased enrollment in the MSPs, such as states opting to expand MSP eligibility beyond the federal standards. Our analysis of Medicare administrative data found that MSP enrollment increased from 2010 to 2021 across all categories of dual eligibility, with the majority of dually eligible beneficiaries enrolled in an MSP. These findings indicate that state and federal efforts over the last decade to increase awareness of the MSPs among eligible low-income Medicare beneficiaries have made substantial progress. The Commission applauds these efforts.

The enrollment analysis described in this chapter may indicate opportunities for further research to continue the progress toward enrolling MSP-eligible people in an MSP and to explain some of the enrollment patterns we found. For example, higher enrollment growth rates among partial-benefit dually eligible beneficiaries, primarily among the QMB only group, differed from those of the full-benefit groups, but the reasons for those differences are unclear. Another study found similar differences between the full- and partial-benefit groups, identifying lower rates of disenrollment among partial-benefit dually eligible beneficiaries (Chidambaram and Burns 2022). Perhaps state and federal efforts to conduct MSP outreach had a greater effect on enrollment of QMB only beneficiaries because, unlike full-benefit individuals, they would not have contact with Medicaid agencies otherwise. More research is needed to understand these differing enrollment patterns, but given the relative stability of income among the non-MAGI groups, a more automatic enrollment mechanism could be worth exploring to address the disparity in enrollment between the full- and partial-benefit populations.

TABLE 3-5. Transformed Medicaid Statistical Information System (T-MSIS) Data on Race and Ethnicity among Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary Groups, CY 2020

Race and ethnicity	All dually eligible	QMB		SLMB		Non-dually eligible Medicare beneficiaries[1]
		QMB only	QMB plus	SLMB only	SLMB plus	
White, non-Hispanic	52%	53%	45%	61%	70%	82%
African American, non-Hispanic	21	24	20	23	18	9
Hispanic	17	18	20	12	8	6
Other	10	6	14	4	4	3

Notes: CY is calendar year. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-income Medicare Beneficiary.

[1] Data on non-dually eligible Medicare beneficiaries is from the MACPAC and Medicare Payment Advisory Commission (MedPAC) analysis of spending and utilization among dually eligible beneficiaries for CY 2020 (MACPAC and MedPAC 2024).

Sources: MACPAC, 2023, analysis of T-MSIS data for CY 2020, and MACPAC and MedPAC 2024.

MACPAC plans to monitor state efforts to come into compliance with the CMS final rule ahead of the April 1, 2026, deadline.[11] We are interested to see how states approach the new requirements. Some states may choose to use the final rule as an opportunity to consider more comprehensive changes to reduce confusion and make enrollment easier, which could include adopting more automatic enrollment procedures. For example, CMS approved the use of passive enrollment with an opt-out in states participating in the Financial Alignment Initiative demonstrations. Some stakeholders raised concerns at the time about limiting beneficiary choice, but we found passive enrollment to be a key factor in enrolling and retaining eligible individuals (MACPAC 2019). The Medicare Payment Advisory Commission described passive enrollment as a policy that would encourage the development of integrated plans and found that it was a key factor in plan decisions to participate in the Financial Alignment Initiative demonstration (MedPAC 2018).

It may also be useful for researchers to consider ways to communicate with beneficiaries about the MSPs and to collect their feedback on barriers to enrollment, including potential confusion around eligibility and benefits. MACPAC has found that although beneficiary communication preferences and ability to access technology vary, providing multiple avenues to connect with Medicaid ensures that individuals complete processes in a way that best meets their needs (MACPAC 2022). Beneficiaries could highlight opportunities for policymakers interested in streamlining and simplifying MSP enrollment and marketing.

In the coming years, MACPAC will remain attentive to state and federal efforts to increase enrollment in the MSPs, particularly in the lead up to the 2026 deadline for the CMS final rule (CMS 2023a). MACPAC looks forward to opportunities to collaborate with researchers on the topic and share information we have gathered through our work on the MSPs.

Endnotes

[1] The Medicare Master Beneficiary Summary File data on race and ethnicity were not of sufficient quality to include in our study.

[2] The exception is the qualifying individual group, which is fully federally funded through annual allotments to states (CMS 2023b).

[3] States have the option under Section 1902(r)(2) of the Social Security Act to use more generous income and asset criteria for MSPs than the federal standards. In 2023, 19 states did so (MACPAC and MedPAC 2024).

[4] Originally, the QI program had two parts: QI-1 for individuals with incomes of at least 120 percent but less than 135 percent of the FPL and QI-2 for individuals with incomes of at least 135 percent but less than 175 percent FPL (GAO 2004). In December 2002, the QI-2 program was allowed to expire, but the QI-1 program was reauthorized. It was subsequently reauthorized a number of times before being made permanent with the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10). That legislation funded the QI program through 2016 and established a formula for calculating funding allocations for all future years (CRS 2015).

[5] With enactment of the Inflation Reduction Act of 2022 (P.L. 117-169), beginning in calendar year 2024, individuals with incomes up to 150 percent of the FPL are now eligible for the full subsidy under the LIS program (Feyman et al. 2024). Before enactment of the Inflation Reduction Act, the full subsidy was available to people with incomes up to 135 percent of the FPL.

[6] The QDWI program was excluded from our study because enrollment in the program at less than 1,000 individuals was too small with respect to the data and methods we were using.

[7] MAGI-based methods are used to determine income eligibility for most Medicaid beneficiaries, including children, pregnant people, parents, and adults younger than age 65 without dependent children. Eligibility groups for whom income eligibility is determined using other (non-MAGI) methods include those who are eligible based on age or disability; those whose eligibility for Medicaid does not require a Medicaid determination of income, such as individuals receiving Supplemental Security Income or Title IV-E child welfare assistance; those in need of long-term services and supports; and those applying for assistance with Medicare cost sharing or through medically needy pathways (42 CFR 435.603).

[8] When the state lacks sufficient information to renew eligibility or has information that would result in a loss of eligibility, it may send beneficiaries a prepopulated form containing the information available to the agency with instructions to provide any requested information and report relevant changes (42 CFR 435.916(b)).

[9] The Medicare Master Beneficiary Summary File data on race and ethnicity were not of sufficient quality to include in our study.

[10] The District of Columbia offers just one MSP group, the QMB group, at an expanded income level of 300 percent of the FPL. New York subsumed its SLMB group in its QMB group by increasing the QMB income threshold from 100 to 138 percent of the FPL and expanding QI income eligibility from 135 percent to 186 percent of the FPL (NCOA 2024). States can make this type of change through a state plan amendment using authority under Section 1902(r)(2).

[11] The CMS final rule includes one earlier deadline of October 1, 2024, for automatically enrolling Supplemental Security Income recipients into the QMB group (CMS 2023a). States must deem enrolled in the QMB group anyone in the mandatory Supplemental Security Income recipients group or the 209(b) group. CMS notes that people receiving Supplemental Security Income are already eligible for the QMB group. Also, states have processes in place for Medicare Part A buy-in programs that they can build on to comply with this requirement (CMS 2023a).

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