Reforming Access: Trends in Medicaid Enrollment for New Medicare Beneficiaries, 2008–2011

Laura M. Keohane, Momotazur Rahman, and Vincent Mor

Objective. To evaluate whether aligning the Part D low-income subsidy and Medicaid program enrollment pathways in 2010 increased Medicaid participation among new Medicare beneficiaries.

Data Sources. Medicare enrollment records for years 2007–2011.

Study Design. We used a multinomial logistic model with state fixed effects to examine the annual change in limited and full Medicaid enrollment among new Medicare beneficiaries for 2 years before and after the reforms (2008–2011).

Data Extraction Methods. We identified new Medicare beneficiaries in the years 2008–2011 and their participation in Medicaid based on Medicare enrollment records.

Principal Findings. The percentage of beneficiaries enrolling in limited Medicaid at the start of Medicare coverage increased in 2010 by 0.3 percentage points for individuals aging into Medicare and by 1.3 percentage points for those qualifying due to disability ($p < .001$). There was no significant difference in the size of enrollment increases between states with and without concurrent limited Medicaid eligibility expansions.

Conclusions. Our findings suggest that streamlining financial assistance programs may improve Medicare beneficiaries' access to benefits.

Key Words. Medicare, Medicaid, Medicare Savings Programs, evaluation design and research, state health policies

For low-income Medicare beneficiaries, the Medicare Savings Programs provide limited Medicaid coverage of Medicare premiums and, for beneficiaries with income below the federal poverty level (FPL), Medicare cost-sharing. Unlike full Medicaid benefits, these programs do not finance long-term care or other services that are not at least partially insured by Medicare. Historically, few eligible Medicare beneficiaries actually participate (Moon, Brennan, and Segal 1998). Only a third of Medicare beneficiaries who qualify for cost-sharing benefits enroll in limited Medicaid. Uptake drops to 13 percent for members who only qualify for Part B premium subsidies (Congressional

Budget Office 2004). Failing to enroll may influence beneficiaries' access to care: individuals who were eligible for Medicaid cost-sharing coverage but do not enroll were more likely to report avoiding physician visits due to cost than individuals enrolled in limited Medicaid (Federman, Vladeck, and Siu 2005).

Obstacles to limited Medicaid enrollment include eligible beneficiaries' lack of awareness about the availability of financial assistance and a complicated application process (Perry, Kannel, and Dulio 2002; Haber et al. 2003). Turning age 65 qualifies most individuals for Medicare and, because Medicaid eligibility rules vary by age, may also change access to Medicaid. However, it can be difficult to simultaneously enroll in Medicare and limited Medicaid benefits. The application processes are separate. The Social Security Administration (SSA) handles Medicare enrollment, whereas applications for limited Medicaid must be processed through each state's Medicaid program.

In contrast, applications for the needs-based Medicare Part D low-income subsidy (LIS) can be processed directly by the SSA. Aside from dual-eligible individuals who are automatically enrolled in the Part D LIS, about 30 percent of eligible Medicare beneficiaries enroll in the program and receive aid with prescription drug costs (Shoemaker et al. 2012). Several policy analysts suggested that better alignment between the eligibility criteria and application processes for Medicaid and Part D LIS could help low-income individuals access benefits (Ebeler, Van der Water, and Demchak 2006; Nemore, Bender, and Kwok 2006; Medicare Payment Advisory Commission [MedPAC] 2008). One study projected that raising limited Medicaid income and asset thresholds to meet those of the Part D LIS program could increase limited Medicaid eligibility from about 8 percent up to 10 percent of all elderly Medicare beneficiaries (Zuckerman, Shang, and Waidmann 2009).

To encourage enrollment in limited Medicaid, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 mandated national changes in 2010. First, MIPPA raised the federal guidelines for limited Medicaid asset thresholds to be consistent with those of the Part D full LIS. Except for Medicaid programs that already had more generous asset requirements prior to 2010, this reform expanded eligibility for limited Medicaid in most states. Second, MIPPA required state Medicaid programs to initiate

Address correspondence to Laura M. Keohane, M.S., Department of Health Policy, Vanderbilt University School of Medicine, 1500 21st Avenue South, Nashville, TN 37212; e-mail: laura.keohane@vanderbilt.edu. Momotazur Rahman, Ph.D., and Vincent Mor, Ph.D., are with the Department of Health Services, Policy, and Practice, Brown University School of Public Health, Providence, RI. Vincent Mor, Ph.D., is also with the Providence Veterans Administration Medical Center, Health Services Research Program, Providence, RI.

applications for beneficiaries referred by SSA (Government Accountability Office [GAO] 2012). With application data transferred from SSA, the Medicaid application process could have been faster for new Medicare beneficiaries. Uptake of full and limited Medicaid benefits could have also improved among beneficiaries who might have not been aware of their eligibility for Medicaid or might not have otherwise started a Medicaid application.

In a Government Accountability Office (GAO) survey, the majority of states reported an increase in the number of new limited Medicaid enrollees following the 2010 reforms (GAO 2012). GAO also reported that aggregate limited Medicaid enrollment increased in 2010, but to date there has been no detailed analysis of individuals' enrollment changes. Using Medicare enrollment records, we compare the rates of new Medicare beneficiaries joining Medicaid from 2008 to 2011, 2 years prior and after the reforms. We focus on this population because they may have some contact with the SSA when starting Medicare and are likely to benefit from the changes to Medicaid application coordination. We present unadjusted changes in limited and full Medicaid enrollment over time, as well as results from multivariate models that predict changes in enrollment after adjusting for beneficiaries' demographic characteristics, state of residence, and area poverty. To see if enrollment gains were larger in states that simultaneously increased their asset thresholds, we match states with no limited Medicaid eligibility changes to states with eligibility expansions and compare the differences in their Medicaid participation rates.

Background: Limited Medicaid Eligibility and 2010 Reforms

Depending on income level, Medicare beneficiaries can qualify for one of the Medicare Savings Programs that provide limited Medicaid coverage: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI). MIPPA did not change income thresholds for these programs. Individuals with income between 100 and 135 percent FPL are eligible for Medicaid coverage of the Part B premium (SLMB and QI). In addition to this benefit, individuals with income below 100 percent FPL can qualify for Medicaid coverage of Part A and B cost-sharing, as well as any charges for the Part A premium (QMB) (GAO 2012). Maine, Connecticut, and the District of Columbia have elected to exceed the federal eligibility requirements and offer limited Medicaid to individuals with higher incomes (Kaiser Commission on Medicaid and the Uninsured 2010).

Individuals with income less than 75 percent FPL are categorically eligible for full Medicaid, which includes all the benefits of limited Medicaid plus coverage of services that are not insured by Medicare, such as long-term care. States can also elect to offer full Medicaid benefits to individuals with income below 100 percent FPL. Eleven states, referred to as 209(b) states, can have more restrictive eligibility criteria than current federal guidelines as long as their benefits are at least as generous as their 1972 criteria. Alternative pathways into full Medicaid include medically needy programs for individuals with high medical expenses and different income limits for individuals requiring long-term care (Kaiser Commission on Medicaid and the Uninsured 2010).

Table 1 outlines the key changes in federal guidelines for Medicaid under MIPPA. At the start of our study period in 2008, the asset thresholds for limited Medicaid benefits were \$4,000 for an individual and \$6,600 for a couple (excluding homes) in most states. MIPPA required states to raise these asset limits in 2010 to meet those of Part D LIS: \$6,600 for an individual and \$9,910 for a couple with future annual adjustments for inflation (Dorn and

Table 1: Federal Guidelines for Categorical Medicaid Eligibility for Individuals Who Are Disabled or Age 65+

	<i>Income Limit (% FPL)</i>	<i>Asset Limits</i>		<i>SSA to State Medicaid Program Application Transfers</i>	
		<i>2008–2011</i>	<i>2008–2009</i> <i>2010 Changes</i>	<i>2008–2009</i>	<i>2010 Changes</i>
Full Medicaid*	75 Optional: 100	\$2,000	No change	SSI recipients automatically enrolled in Medicaid (32 states)	Information for Part D low-income subsidy applicants forwarded to states to start Medicaid application unless individual opts out
Limited Medicaid	135	\$4,000	Raised to \$6,600 [†] Annual inflation adjustment	SSA can refer beneficiaries to state Medicaid program, can notify states of potentially eligible residents	

Notes. *209(b) states are allowed to have more restrictive Medicaid eligibility criteria than current federal guidelines (Kaiser Commission on Medicaid and the Uninsured 2010).

[†]Eight states and Washington, DC, had no changes to their asset limits because they had already waived asset tests prior to 2010; Minnesota has no changes to asset limits because their pre-2010 threshold was higher than new federal minimum (GAO 2012).

Shang 2012; GAO 2012). Prior to 2010, eight states and Washington, DC, had waived asset tests, and Minnesota had set asset limits to be higher than the new federal minimum. These states had no changes to their asset limits in 2010 (GAO 2012). The asset limits for full Medicaid benefits (\$2,000 for an individual, \$3,000 for a couple in most states) (Kaiser Commission on Medicaid and the Uninsured 2010) were not affected by MIPPA.

MIPPA also mandated that states and the SSA restructure application referrals for beneficiaries potentially eligible for Medicaid. Starting in 2010, all individuals who apply for the Part D LIS program through SSA are automatically forwarded to state Medicaid programs to start Medicaid applications unless the beneficiary opts out (GAO 2012). This change represented a significant change in coordination between the SSA and states. Other than contracts with 32 states and Washington, DC, to automatically enroll Supplemental Security Income beneficiaries in full Medicaid (Medicaid and CHIP Payment and Access Commission 2013), SSA does not process Medicaid applications. Prior to this reform, SSA could refer individuals to their states' Medicaid program and could notify states of potentially eligible beneficiaries (GAO 2004; Cusick and Nibali 2005; Ebeler, Van der Water, and Demchak 2006).

Finally, MIPPA also changed some features that were potential barriers to Medicaid enrollment. Limited Medicaid benefits provided after January 1, 2010, can no longer be subject to estate recovery after a Medicaid enrollee's death, a rule that was already in place for Part D LIS benefits. States were also given more flexibility about whether to count certain resources, such as insurance policies, toward the limited Medicaid asset limit (GAO 2012).

Although MIPPA required these changes to be effective at the start of 2010, CMS did not send guidance to states detailing their responsibilities under the federal guidelines until February 2010 (Centers for Medicare and Medicaid Services [CMS] 2010). This timing could have impacted when states actually adjusted their Medicaid eligibility and application processes.

METHODS

Study Data and Population

Our main data sources were Medicare enrollment records for beneficiaries over age 21 for the years 2007–2011. We identified new Medicare beneficiaries as individuals who have a Medicare enrollment record for the first time

in the years 2008–2011, looking back to the beginning of 2007. For each new Medicare beneficiary, we identified whether they enrolled in either limited or full Medicaid in their first month of Medicare coverage. Limited Medicaid enrollees include beneficiaries who participate in the QMB, SLMB, and QI programs without receiving full Medicaid benefits. Full Medicaid beneficiaries include individuals classified as receiving other Medicaid benefits or have full Medicaid coverage in addition to QMB and SLMB benefits (Chronic Conditions Data Warehouse 2014). We analyzed results separately for beneficiaries who age into Medicare and beneficiaries qualifying due to disability.

We identified beneficiaries' age, gender, and race from the enrollment file. After linking individuals' residential zip code to census summary data, we categorized beneficiaries as living in zip codes with less than 10 percent, 10–20 percent, and greater than 20 percent of residents age 65 and above living in poverty. We classified residents' counties as urban based on metropolitan statistical areas. We excluded beneficiaries who qualified for Medicare due to end-stage renal disease, lived outside of the 50 states, had missing or invalid Medicaid enrollment information in the first 12 months of Medicare benefits, or left and rejoined Medicare in the first 12 months of benefits. We also excluded beneficiaries whose zip codes could not be linked to poverty rates or urban indicators. Because Connecticut increased its limited Medicaid income thresholds and waived asset tests in 2009 under its own initiative (Becker 2010), we excluded Connecticut residents to avoid misattributing any increases in that state's enrollment to the new federal 2010 Medicaid requirements. Our final sample was 8,728,921 new Medicare beneficiaries qualifying due to age and 2,711,848 Medicare beneficiaries qualifying due to disability in the years 2008–2011.

Analysis

We employed a multinomial logistic model to predict beneficiaries' likelihood of enrolling in limited or full Medicaid after controlling for these demographic covariates and fixed effects for state, year, and quarter of enrollment. Our standard errors are clustered at the state level to account for state-wide similarities in Medicaid criteria. To estimate the adjusted annual change in Medicare enrollment, we predicted the average marginal effects for a 1-year change in the categorical variable for year. We tested whether the adjusted annual change in Medicaid enrollment from the previous year was significantly

different in 2009 compared to 2010, the year the reforms were implemented. Given the large number of individuals aging into Medicare, we randomly sampled 50 percent of that population for our models to enable computation of marginal effects. We considered performing an interrupted time series model but rejected this approach because we were concerned about establishing a reliable estimate of trends with the limited number of time points before and after the MIPPA reforms.

We examined the percentage of new Medicare beneficiaries enrolling in limited or full Medicaid at two additional time points: within the first 3 and 12 months of Medicare benefits. For these analyses, we did not include beneficiaries who started in the calendar year 2011 because we cannot observe their Medicaid enrollment beyond December 2011.

The reform of Medicaid application procedures coincided with a significant economic downturn in the U.S. economy, which could have depleted beneficiaries' financial resources and increased their likelihood of enrolling in Medicaid independent of the policy change we are studying (GAO 2012). We present Medicaid enrollment rates by quarter to demonstrate shifts in enrollment patterns relative to the timing of the 2010 reforms. We also conducted a sensitivity analysis that added state unemployment rates to our model to partially control for economic conditions.

To assess if Medicaid enrollment changes differed between states with and without limited Medicaid eligibility expansions, we performed a second analysis. We limited our sample to seven states with no limited Medicaid eligibility changes in 2010 matched to neighboring states that raised their asset limits. We attempted to match states with similar eligibility criteria for full Medicaid benefits. State pairs included (states with no eligibility expansion listed first): Alabama–Tennessee, Arizona–Utah, Delaware–Maryland, Minnesota–Wisconsin, Mississippi–Louisiana, New York–Pennsylvania, and Vermont–New Hampshire. Even though Maine and Washington, DC, also had no limited Medicaid eligibility changes in 2010, they have limited Medicaid income thresholds that are higher than the federal standard so we excluded them. For this analysis, our model included fixed effects for each pair and an interaction term between an indicator variable for whether a state increased their asset limits in 2010 and an indicator variable for the time period following January 1, 2010 (Karaca-Mandic, Norton, and Dowd 2012). As a sensitivity analysis, we also compared states without Medicaid eligibility changes in 2010 to all states. Because these results were similar, we present only the analysis using pairs of neighboring states.

RESULTS

Beneficiaries Aging into Medicare

From the first quarter of 2008 through the first quarter of 2010, the quarterly percent of individuals aging into Medicare who joined limited Medicaid in their first month of Medicare benefits ranged from 0.6 to 0.8 percent (Figure 1). This percentage increased to 1.1 percent in the second quarter of 2010 and stayed between 1.1 and 1.2 percent until the end of 2011. This change represents a 56 percent relative increase in the proportion of new Medicare beneficiaries joining limited Medicaid from the prereform period to the postreform period.

Enrollment in full Medicaid benefits fluctuated more. From the first quarter of 2008 to the first quarter of 2009, about 4.3–4.5 percent of beneficiaries aging into Medicare also enrolled in full Medicaid. This rate started to shift upward in the second quarter of 2009 to hover around 5.0 percent and spiked in the first quarter of 2010 to 6.5 percent. Rates were fairly constant for the rest

Figure 1: Percent of Medicare Beneficiaries Qualifying Due to Age Enrolling in Medicaid in First Month of Medicare Coverage, 2008–2011

Notes: Percent enrolling in limited or full Medicaid includes beneficiaries who are enrolled in Medicaid within their first month of Medicare benefits. Connecticut residents are excluded.

Source: Authors' analysis of Medicare enrollment records.

of 2010 at 5.2–5.3 percent and spiked again in the first quarter of 2011 to 6.0 percent. The proportion dropped over the remainder of 2011, ending at 4.7 percent in the fourth quarter.

Beneficiaries Who Qualify for Medicare Due to Disability

Beneficiaries who qualify for Medicare due to disability had greater initial participation in limited and full Medicaid (Figure 2), most likely because these individuals have high rates of Medicaid participation before Medicare enrollment (Rupp and Riley 2012). Prior to the reforms, quarterly limited Medicaid enrollment rates ranged from 3.0 to 3.6 percent in 2008 and from 2.5 to 4.1 percent in 2009. Starting in the second quarter of 2010, these proportions increased to a range of 5.2–5.8 percent in 2010 and 5.5–6.3 percent in 2011. From the prereform period to the postreform period, this population had a 60 percent relative increase in the proportion of beneficiaries joining limited Medicaid in their first month of Medicare benefits.

The percentage of new beneficiaries simultaneously enrolling in full Medicaid was more variable over the study period. This share ranged from

Figure 2: Percent of Medicare Beneficiaries Qualifying Due to Disability Enrolling in Medicaid in First Month of Medicare Coverage, 2008–2011

Notes: Percent enrolling in limited or full Medicaid includes beneficiaries who are enrolled in Medicaid within their first month of Medicare benefits. Connecticut residents are excluded.

Source: Authors' analysis of Medicare enrollment records.

22.3 to 25.8 percent for the first quarter of 2008 through the third quarter of 2009. Full Medicaid enrollment rates started to increase slightly in the fourth quarter of 2009 and ranged from 26.4 to 27.8 percent through the end of 2010. In the first quarter of 2011, over 28 percent of new Medicare beneficiaries enrolled in full Medicaid in their first month of Medicare, but this percentage dropped off throughout the rest of 2011 to end at 25.5 percent.

Limited Medicaid Enrollment: Adjusted Results and Longer Term Effects

Limited Medicaid participation results are largely unchanged after adjusting for beneficiaries' demographic characteristics, state, and quarter of enrollment. Table 2 presents the predicted annual change in the percent of new Medicare beneficiaries enrolling in Medicaid. Prior to the reform from the years 2008 to 2009, there was not a significant increase in the proportion of new Medicare beneficiaries enrolling in limited Medicaid in their first month of Medicare. In contrast, there was a significant increase from 2009 to 2010. The adjusted enrollment rate increased by 0.34 percentage points (95 percent CI: 0.19, 0.48) for individuals aging in Medicare and by 1.32 percentage points (95 percent CI: 0.75, 1.90) for individuals joining Medicare due to disability. These 2010 changes in annual enrollment rates after the reform are significantly larger than the 2009 changes in Medicaid enrollment prior to the reform ($p < .001$). From 2010 to 2011, there was no significant change in limited Medicaid enrollment for individuals aging into Medicaid. There was still a significant increase for individuals qualifying for Medicare due to disability: 1.03 percentage points (95 percent CI: 0.60, 1.47).

When we extended our analysis to consider limited Medicaid enrollment within the first 3 or 12 months of Medicare benefits, there are similar results. Compared to 2009, limited Medicaid enrollment rates in 2010 for beneficiaries qualifying due to age were 0.43 percentage points higher (95 percent CI: 0.28, 0.58) at the end of 3 months of Medicare participation and 0.45 percentage points higher (95 percent CI: 0.30, 0.59) at the end of 12 months of Medicare participation. The corresponding increases for Medicare beneficiaries eligible due to disability were 1.68 percentage points (95 percent CI: 1.11, 2.26) and 1.71 percentage points (95 percent CI: 1.17, 2.26). For all of these measures, the size of the enrollment increases in 2010 is significantly larger than the size of the enrollment increases in 2009 ($p < .001$). These findings are consistent with the theory that the 2010 reforms not only sped up how quickly limited Medicaid applications were processed but they also expanded the number of beneficiaries who joined limited Medicaid.

Table 2: Adjusted Annual Change in Percent of New Medicare Beneficiaries Enrolling in Medicaid by Number of Months of Medicare Benefits

Number of Months in Medicare	Adjusted Annual Change from Previous Year in Percent of New Medicare Beneficiaries Enrolling in Medicaid			Difference in Adjusted Annual Change 2009 versus 2010
	Prereform: 2009	Postreform: 2010	Postreform: 2011	
Beneficiaries qualifying for Medicare due to age				
Limited Medicaid				
First month	0.05 (−0.05, 0.15)	0.34*** (0.19, 0.48)		0.29*** (0.17, 0.41)
3 months	0.08 (−0.02, 0.18)	0.43*** (0.28, 0.58)	0.07 (−0.02, 0.16)	0.35*** (0.20, 0.50)
12 months	0.14** (0.05, 0.22)	0.45*** (0.30, 0.59)		0.31*** (0.20, 0.42)
Full Medicaid				
First month	0.28* (0.05, 0.51)	0.61*** (0.32, 0.90)	−0.06 (−0.42, 0.30)	0.33 (−0.02, 0.68)
3 months	0.24* (0.04, 0.44)	0.38** (0.15, 0.61)		0.14 (−0.18, 0.46)
12 months	0.11 (−0.09, 0.32)	0.43*** (0.23, 0.63)		0.31 (−0.06, 0.69)
Beneficiaries qualifying for Medicare due to disability				
Limited Medicaid				
First month	0.18 (−0.17, 0.54)	1.32*** (0.75, 1.90)	1.03*** (0.60, 1.47)	1.14*** (0.69, 1.59)
3 months	0.31 (−0.04, 0.66)	1.68*** (1.11, 2.26)		1.37*** (0.89, 1.85)
12 months	0.77*** (0.43, 1.11)	1.71*** (1.17, 2.26)		0.94*** (0.59, 1.30)
Full Medicaid				
First month	−0.12 (−0.83, 0.59)	2.25*** (1.12, 3.39)	0.35 (−0.35, 1.04)	2.37*** (0.81, 3.94)
3 months	1.11** (0.44, 1.78)	0.75 (−0.15, 1.66)		−0.36 (−1.52, 0.80)
12 months	1.39*** (0.87, 1.92)	0.12 (−0.49, 0.74)		−1.27*** (−1.83, −0.71)

Notes: Estimates are based on a multinomial model that adjusted for beneficiaries' gender, age, race, state, residence in an urban county, zip code level poverty rate of elderly individuals, and quarter and year of Medicare enrollment. Standard errors clustered at the state level. To estimate the adjusted annual change in Medicare enrollment, we predicted the average marginal effects for a 1-year increase in the categorical variable for year.

* $p < .05$, ** $p < .01$, *** $p < .001$.

Source: Authors' analysis of Medicare enrollment record.

A sensitivity analysis that controlled for a state's unemployment rate in a beneficiary's month of Medicare enrollment and 12 months prior found mixed results. For beneficiaries aging into Medicare, the estimated annual increase in limited Medicaid enrollment in 2010 was smaller but still significant (0.21 percentage points, 95 percent CI: 0.09, 0.32, Appendix Table SA2). Results for the population qualifying due to disability were no longer significant in 2010.

Full Medicaid Enrollment: Adjusted Results and Longer Term Effects

Even before the reforms were implemented, there was a significant increase from 2008 to 2009 in the proportion of new beneficiaries aging into Medicare who also simultaneously enrolled in full Medicaid (0.28 percentage points, 95 percent CI: 0.05, 0.51). The size of the annual increase doubled to 0.61 percentage points in 2010 (95 percent CI: 0.32, 0.90), but this annual increase is not significantly different than the increase in 2009. When comparing full Medicaid enrollment participation within 3 and 13 months of joining Medicare, there were smaller increases from 2009 to 2010 (0.38, 95 percent CI: 0.15, 0.61 and 0.43, 95 percent CI: 0.22, 0.63, respectively). These increases were not significantly larger than the changes seen from 2008 to 2009 in these measures.

For new beneficiaries qualifying for Medicare due to disability, there was a significant increase from 2009 to 2010 in the proportion participating in full Medicaid in their first month of Medicare (2.25 percentage points, 95 percent CI: 1.12, 3.39). This increase in 2010 was significantly larger than the increase in 2009 ($p < .01$). However, there was not a significant increase when measuring full Medicaid enrollment within the first 3 or 12 months of Medicare benefits. One possible interpretation is that the reforms sped up how quickly Medicaid applications were processed for this population but did not necessarily increase the number of beneficiaries who would have enrolled in full Medicaid by the end of their first year.

After controlling for unemployment rates, there was no significant increase in full Medicaid enrollment in the first month of Medicare benefits among either population (Appendix Table SA2).

Expanding Limited Medicaid Eligibility

To determine if states that simultaneously expanded eligibility for limited Medicaid had larger increases in Medicaid enrollment, we compared two

groups of states: (1) seven states with no eligibility changes because they had already raised or eliminated asset limits prior to 2010 and (2) seven neighboring states that raised their asset thresholds to meet the new 2010 federal guidelines. At baseline, each group had similar proportions of individuals aging into Medicare who joined limited Medicaid in the same month (0.80 and 0.76 percent, respectively, Table 3). Following the 2010 reforms, states with less restrictive asset tests at baseline had 1.16 percent of new Medicare beneficiaries enrolling in limited Medicaid compared to 1.36 percent of new Medicare beneficiaries in states with asset limit increases. After adjusting these results for demographic covariates, there are no indications that states that expanded limited Medicaid eligibility had a statistically significant greater increase in limited Medicaid enrollment than states with no eligibility changes in 2010. Other than higher baseline rates of limited Medicaid participation, the results were similar for individuals qualifying for Medicare due to disability.¹

DISCUSSION

Following changes to application processing in 2010, we found a significant increase in the percentage of new Medicare beneficiaries enrolling in limited Medicaid. This gain was present for both beneficiaries who age into Medicare and who qualify due to a disability. Although the reforms did not target full Medicaid participation, more new beneficiaries who aged into Medicare simultaneously enrolled in full Medicaid in 2010. However, full Medicaid enrollment was already increasing prior to the 2010 reform, so other underlying trends may explain that finding. States that did not expand their limited Medicaid eligibility had similar increases in limited Medicaid enrollment as states that also raised their limited Medicaid asset thresholds in 2010. This combination of results suggests that the improved application coordination between SSA and the states was a key factor in higher enrollment rates.

The MIPPA policy changes reinforce previous interventions to simplify the Medicaid application process for Medicare beneficiaries. States have implemented shorter application forms for limited Medicaid, allowed mail-in applications, and reduced documentation requirements for income and assets (Glaun 2002; Hoover et al. 2002; Tiedemann and Fox 2005). An SSA pilot program demonstrated that Medicaid participation increased when SSA offices screened beneficiaries for eligibility and assisted beneficiaries in filling out Medicaid applications (Nadel et al. 2000).

Table 3: Percent of New Medicare Beneficiaries Enrolling in Medicaid among States with and without Asset Limit Increases

	States with No Asset Limit Changes			States with Asset Limit Increases			Difference in Size of Enrollment Increase	
	Prereform	Postreform	Change	Prereform	Postreform	Change	Unadjusted	Adjusted
Beneficiaries qualifying for Medicare due to age								
Limited	0.80	1.16	+0.36	0.76	1.36	+0.60	+0.24	+0.20 (−0.18, 0.59)
Full	6.79	8.64	+1.85	3.67	4.42	+0.74	−1.11	−0.39 (−1.07, 0.28)
Beneficiaries qualifying for Medicare due to disability								
Limited	3.28	4.92	+1.63	2.92	5.67	+2.75	+1.12	+1.11 (−0.55, 2.77)
Full	26.98	30.55	+3.57	30.09	31.57	+1.48	−2.09	−1.85 (−6.15, 2.44)

Notes: State pairs included (states with no asset limit increases listed first): Alabama–Tennessee, Arizona–Utah, Delaware–Maryland, Minnesota–Wisconsin, Mississippi–Louisiana, New York–Pennsylvania, and Vermont–New Hampshire. Adjusted for beneficiaries' gender, age, race, state, residence in an urban county, zip code level poverty rate of elderly individuals, quarter and year of Medicare enrollment, and fixed effect for each matched pair. Standard errors clustered at the state level.

Source: Authors' analysis of Medicare enrollment records.

Isolating the effect of asset limit changes has been difficult in previous expansions. States report success with this strategy. Arizona removed asset tests for limited Medicaid after predicting that any costs from a larger pool of eligible beneficiaries would be offset by reduced administrative spending on verifying asset amounts (Glaun 2002; Tiedemann and Fox 2005). Medicaid participation increased in Minnesota when the state increased its asset limits and initiated multiple outreach efforts to Medicare beneficiaries (Hoover et al. 2002). The number of beneficiaries enrolled in Maine's limited Medicaid programs tripled after the state increased its income limits and eliminated asset tests (MedPAC 2008).

Ideally, our study would be able to compare states that expanded their eligibility to states that had the same baseline eligibility criteria and did not expand. Because that scenario did not exist, we compared states that raised their asset limits to states that had previously expanded eligibility. A higher proportion of the beneficiaries referred by SSA in the states with more generous eligibility criteria could have been found to be eligible for Medicaid. These states may also have other initiatives, such as outreach programs, to ensure uptake among eligible beneficiaries. Both these factors could bias our results for this comparison toward a null finding.

Several factors limit the interpretation of our study results. We have no data on beneficiaries' participation in Medicaid prior to enrolling in Medicare, so we cannot distinguish between beneficiaries who are carrying over previous Medicaid enrollment and beneficiaries who are initiating Medicaid benefits for the first time. Beneficiaries who qualify for Medicare due to disability may be more likely to continue previous Medicaid enrollment than beneficiaries qualifying due to age. We also lack data on beneficiaries' financial resources and therefore we cannot determine whether Medicare beneficiaries are eligible for Medicaid. Our study did not consider several other aspects of state Medicaid policy that could influence beneficiaries' enrollment in Medicaid, such as whether SSI beneficiaries are automatically enrolled in full Medicaid. Finally, our definition of beneficiaries' Medicare start date may be imprecisely measured. It may capture some beneficiaries who discontinued Medicare prior to 2007 and rejoined during the study period, or it could inaccurately identify Medicare start dates for beneficiaries with retroactively awarded Medicare benefits.

Our study has several implications for improving participation in limited Medicaid among eligible beneficiaries. First, our findings highlight the importance of "no wrong door" policies for need-based programs. Previous

analyses have highlighted beneficiaries' lack of awareness about limited Medicaid benefits and the difficulty of the application process as barriers (Perry, Kannel, and Dulio 2002; Haber et al. 2003). Requiring states to initiate a Medicaid application for Part D LIS applicants referred by SSA can simplify the application process for beneficiaries. Our results are consistent with findings that states increased Medicaid enrollment by using application information from other needs-based programs, such as the Supplemental Nutritional Assistance Program, to target potentially eligible children (Blavin, Kenney, and Huntress 2014).

Second, addressing discrepancies that still exist between financial assistance programs for health costs could further increase participation. The fact that enrollment rates in Medicaid are still relatively low even after these reforms suggests that there are still eligible Medicare beneficiaries who are not participating in Medicaid. Without individual-level data on financial resources, we cannot directly measure changes in Medicaid uptake among eligible beneficiaries in this study. Among the entire Medicare population, enrollment rates would have to at least triple for complete participation in limited Medicaid among eligible beneficiaries. Because Medicare beneficiaries over age 75 have fewer financial resources (Jacobson et al. 2013), that estimate is probably too high for new Medicare beneficiaries at age 65. Still, the approximately 56–60 percent relative increases in limited Medicaid enrollment are modest compared to the likely levels of eligibility for the program.

Several options could further strengthen alignment with the Part D LIS program and simplify the determination and application process. MedPAC has recommended allowing the SSA to directly process limited Medicaid applications (MedPAC 2008). As an alternative, more states could accept the information transferred by SSA about Part D LIS applicants' financial resources as the basis for a Medicaid determination. Thirty-five states require additional verification or information from beneficiaries (GAO 2012), which could deter eligible individuals. MedPAC has also recommended raising the income limits for Part B premium support to match the criteria for Part D LIS (150 percent FPL) (MedPAC 2008). One analysis suggests that if states simplified limited Medicaid asset requirements, the number of eligible beneficiaries would only modestly increase and applications would be easier to process (Dorn and Shang 2012).

Finally, our study captures Medicaid enrollment rates for new Medicare beneficiaries prior to major Affordable Care Act (ACA) measures implemented in 2014. Patterns of dual Medicare–Medicaid enrollment are likely to change as individuals under the age of 65 with insurance subsidies or Medi-

caid coverage transition to Medicare. However, some ACA measures to ensure coordination between Medicaid and federally administered subsidies are limited to individuals under the age of 65. For example, states were required to change their Medicaid applications and eligibility determinations for this population to increase alignment with eligibility criteria for federal health insurance subsidies (Artiga, Musumeci, and Rudowitz 2012). As beneficiaries age into different financial assistance programs, one challenge will be ensuring continuity of benefits.

Our study found significant gains in the percentage of new Medicare enrollees enrolling in Medicaid following changes in Medicaid enrollment pathways. These findings underscore the importance of streamlining financial assistance applications to ensure low-income Medicare beneficiaries can access benefits.

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Disclaimers: None.

NOTE

1. Prior to April 2008, New York had imposed asset limits for limited Medicaid coverage of Part A and B cost-sharing but had no asset tests for limited Medicaid coverage of the Part B premium. It eliminated asset tests for all forms of limited Medicaid in April 2008. This change mostly affected what type of limited Medicaid coverage New York beneficiaries received, not necessarily whether they were eligible for any form of limited Medicaid (Arnold 2008). Accordingly, we kept New York and Pennsylvania, its matching state with 2010 asset limit increases, in our reported results for this analysis. If we exclude these states, the adjusted result for the difference in the size of the enrollment increase between states with and without asset limit increases changes slightly. Among beneficiaries who qualified due to age, it is 0.4 percentage points (95 percent CI: 0.0, 0.7) and is marginally significant ($p = .04$). Among beneficiaries who qualified due to disability, the estimate is 1.9 percentage points (95 percent CI: $-0.4, 4.2$).

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.

Table SA2: Change in Percent of New Medicare Beneficiaries Enrolling in Medicaid, by Year and Number of Months of Medicare Benefits (Adjusted for State Unemployment).