Eligibility Standards for Medicare/Medicaid Dual Eligibles: Issues and Options for Reform

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Introduction

In 2003, an estimated 7.5 million aged and disabled Medicare beneficiaries—18% of all beneficiaries—were also covered by Medicaid (Kaiser Commission). Some of these "dual eligibles" receive the full range of Medicaid-covered services, including prescription drugs and long-term care coverage much more extensive than Medicare's. This group, referred to in this report as "full benefit" eligibles, also receives assistance with required Medicare premiums and cost-sharing for Medicare-covered services. Other dual eligibles, usually with slightly higher incomes, are eligible only for the Medicare Savings Programs (MSP), under which Medicaid pays for premiums and/or cost-sharing only.

To these groups have now been added the partially overlapping populations that will be eligible for low-income premium and cost-sharing subsidies under the prescription drug program established by the Medicare Modernization Act (MMA) of 2003. Under final rules issued in January 2005, all current full benefit duals and MSP participants will be deemed eligible for the subsidy program when it begins operations in 2006.[1]

Medicaid eligibility rules are extremely complex. There are many different ways to qualify for benefits, some applicable in all states and some optional. Each eligibility category may have different financial requirements, and states differ in their application procedures and their methodologies for counting available income and resources. Applicants who would be eligible in one state might not qualify in another. Moreover, because people determined by each state to be eligible for Medicaid will be deemed eligible for MMA drug coverage, variations in state policy will be carried over into the new program.

Within a state, beneficiaries have trouble understanding eligibility rules and are often unaware that they could qualify for assistance. And documentation requirements, particularly verification that applicants meet limits on allowable assets, make the application process burdensome and confusing (Perry, Kannel, and Dulio). Uniform and simpler eligibility standards could simplify application and eligibility determination processes, make the program easier to understand, and provide more equitable treatment of similarly situated people.

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[1] Before 2006, low-income people who are not receiving Medicaid drug benefits will receive transitional assistance, including free prescription drug discount cards and an annual subsidy of $600. Because this program will be in effect only briefly, it is not considered in this report.

This report begins with an overview of the current rules under which Medicare beneficiaries may qualify for Medicaid or for the new MMA drug program. It then provides more details on some key issues, including variation among states, cliff effects, and burdensome asset rules. The report concludes with some illustrations of possible reform options and provides estimates of how many more beneficiaries might qualify for assistance under each option, as well as how current participants might be affected.

Data and Methods

Data and estimates in this report are based on the 2001 panel of the Survey of Income and Program Participation (SIPP). The SIPP is a longitudinal household survey conducted by the Census Bureau, collecting data on income and wealth, participation in federal and state programs, and other population characteristics. In the 2001 panel, 36,700 sample units were interviewed 9 times each during the period February 2001 and January 2004. This study uses data from the first six waves of interviews, covering 2001 and 2002. Eligibility estimates are for the month of December 2001 and are limited to people who reported at least 12 continuous months of Medicare coverage beginning at any time in 2001.

The SIPP was chosen for this study because it includes most of the information needed to model the effects of Medicaid eligibility policies. In addition, because it includes state-level data, it allows estimates of variation in the proportion of Medicare beneficiaries potentially qualifying for assistance.[2] Its major limitation is that it covers only noninstitutionalized people, excluding residents of nursing homes or other facilities. In 1999, there were 1.6 million nursing home residents, of whom 86 percent were Medicare beneficiaries and 82 percent were dual eligibles (Jones). All estimates in this report of current or potential eligibility relate only to people living in the community.

Except as noted, counts of Medicare beneficiaries eligible for a given level of Medicaid or MMA benefits are estimates of people who meet the current or revamped financial standards for eligibility. No effort is made to predict how many people would actually apply for benefits if standards were changed, nor of how many more people who are already eligible might apply if the process were simplified. It should also be noted that there were many survey participants in the community who reported receiving Medicaid but who did not meet the financial standards modeled in this study. This is partly because some people with higher income or assets can obtain Medicaid because they have very large

[2] The SIPP sample is too small to allow reporting of state-by-state data, but individual state standards and methodologies were used in all simulations.

bills or need community-based long-term care services; these factors could not be simulated. In addition, some factors in eligibility determinations—such as special treatment of child support income—could not be modeled using the SIPP.

State policies discussed in this report and used in the modeling are those in effect during 2001.[3] Since that time, many states have sought to contain Medicaid spending by reducing benefits, tightening eligibility rules, or cutting provider payment rates. However, it does not appear that many states have made major changes in eligibility rules for the dual eligible groups (Smith et al.).[4]

Appendix A provides a more detailed discussion of data and methodology for this study.

Current Eligibility Standards

Medicaid law and regulations define at least 28 distinct groups of aged and/or disabled beneficiaries, each meeting a different set of requirements for eligibility (Centers for Medicare and Medicaid Services).[5] Some of these groups are mandatory, covered in all states, while others are optional. For each group, applicants must have monthly income below a specified standard and countable resources below a fixed limit. (Resources are most assets other than the applicant's home, such as savings and retirement accounts, other real estate, the cash value of life insurance policies, and so on.)

Full-benefit eligibility

There are four major categories of full-benefit eligibles, those who receive the full scope of Medicaid services:

- Recipients of cash assistance under the Supplemental Security Income (SSI) program. In most states, all beneficiaries who receive SSI are automatically eligible for Medicaid. However, certain states that used more restrictive standards for Medicaid in 1972 have been permitted to go

[3] Except as otherwise noted, all data on state eligibility policies are from the National Association of State Medicaid Directors 2001 Aged, Blind, and Disabled Medicaid Eligibility Survey.
[4] The Census Bureau also reports a drop in the percentage of elderly people in poverty, from 10.2% in 2001 to 9.4% in 2004. (See http://factfinder.census.gov/servlet/MYPTable?_bm=y&-qr_name=ACS_2004_EST_G00_MYP3_15&-geo_id=01000US&-ds_name=ACS_2004_EST_G00_&-_scrollToRow=69.) This would have an insignificant effect on the estimates in this report.
[5] Some of these groups were defined by grandfather clauses enacted in the early 1970s and may no longer have any living members. The count of groups does not include aliens receiving only Medicaid-funded emergency care.

on using those standards (or an intermediate standard) if they choose. There were still 11 such states, known as 209(b) states, in 2001. In 2001, 23 states also furnished Medicaid to participants in state supplement programs (SSP), which provide cash assistance for people with incomes slightly above SSI maximums.

- Medically needy people, covered at state option; 32 states covered medically needy aged or disabled people in 2001. The medically needy must meet an income standard established by the state and have resources within SSI limits. States' medically needy income standards are often lower than SSI/SSP standards. (Louisiana's income limit for a single adult was $100 a month in 2001.) However, people whose income is above the standard may qualify by "spending down," incurring medical bills large enough to bring their countable income below the standard. (People with excess resources may reduce them by spending them on medical care. Many people in nursing homes spend savings for some period and turn to Medicaid when these savings are reduced to the resource limit. Technically, this is not "spend-down.")

- Poverty-related groups, covered at state option. A state may offer full Medicaid benefits to people with family incomes below a state-established limit that may not exceed 100% of the federal poverty guideline (FPG).[6] In 2005, the FPG for a single person is $9,570 per year; for a couple it is $12,830. These optional groups, covered in 19 states in 2001, are distinct from the mandatory poverty-related MSP groups discussed below, who do not receive full benefits.

- People meeting special state income standards for nursing home patients and/or for participants in home and community-based waiver programs, which serve people in the community who need the level of care provided by a nursing home. These special standards, used in 39 states in 2001, may be as high as 300% of the SSI benefit rate.[7] (In the remaining states, nursing home residents typically qualify by spending down to the medically needy standard.)

[6] The FPGs are established each year by DHHS; they are based on, but slightly different from, the "federal poverty levels" established by the Census Bureau.

[7] In many states, people who need nursing home care and whose income exceeds the limit can set aside the excess in a "Miller trust" and qualify for Medicaid; the state can recover Medicaid expenditures from the trust when the beneficiary dies.

Table 1. Major Groups of Full-Benefit Dual Eligibles

	Mandatory or optional	Maximum income	Resource limit	Notes
Cash assistance recipients	Mandatory	In 2004, $564 per month, individual; $846 couple. State may have higher SSP standard.	$2,000 individual, $3,000 couple	209(b) states may have more restrictive standards.
Medically needy	Optional	State-established	State-established, no more restrictive than SSI	Applicant may spend down to income standard
Poverty-related (full benefit)	Optional	State-established, not more than 100% of FPG	State-established, no more than twice SSI standard	
Long-term care standard	Optional	State-established, not more than 300% of SSI	$2,000 individual, $3,000 couple	Only for nursing home resident and participants in home and community-based waiver programs

Eligibility for Medicare Savings Programs

There are four groups of MSP eligibles.[8] Income standards for each group are defined as a percentage of the FPG, with benefits dropping as income rises. Resource standards are all at twice the SSI level. Note that beneficiaries with incomes above the limit cannot spend down by incurring large medical bills. To qualify for Medicaid through spenddown, they would have to be in a state offering medically needy coverage and have bills sufficient to reduce their income to the much lower medically needy limit.

For qualified Medicare beneficiaries (QMBs), with income at or below 100% of the FPG, Medicaid pays the Medicare part B premium and all deductibles and coinsurance for Medicare services.[9] In addition, Medicaid pays the part A premium for people who are not automatically enrolled in Medicare

[8] A fifth group, "qualifying individuals 2," expired at the end of 2002; this group received help with a small share of the Medicare part B premium.

[9] States may limit their payments if the sum of the Medicare payment and the usual Medicare cost-sharing amount would exceed the state Medicaid fee limits for other populations. Providers must accept the reduced Medicaid payment as payment in full.

part A but entitled to buy in. For the other three groups, Medicaid pays part A or part B premiums only.

Table 2. Eligibility and Benefits, Medicare Savings Programs

	Mandatory or optional	Maximum income	Resource limit	What Medicaid pays
Qualified Medicare beneficiaries (QMB)	Mandatory	100% of FPG	$4,000 individual, $6,000 couple	Part B premium (and part A premium if applicable), all deductibles and coinsurance
Specified low-income Medicare beneficiaries (SLMB)	Mandatory	120% of FPG	$4,000 individual, $6,000 couple	Part B premium only
Qualifying individuals (QI)	Mandatory	135% of FPG	$4,000 individual, $6,000 couple	Part B premium only. Subject to appropriated spending cap which may limit number of participants.
Qualified disabled and working individuals (QDWI)	Mandatory	200% of FPG	$4,000 individual, $6,000 couple	Part A premium; only for individuals who have lost automatic part A enrollment because they returned to work.

Estimates in this report are limited to the first three categories; eligibility for QDWI status was not modeled.

Eligibility for MMA low-income drug subsidies

Finally, the Medicare Modernization Act (MMA) of 2003 establishes a new Medicare outpatient prescription drug benefit beginning in 2006. Low-income people, who may or may not also qualify for Medicaid, will receive assistance with required premiums and cost-sharing under the new program. (There is also a transitional assistance program in effect during 2004 and 2005; this temporary program will not be addressed in this report.) Some of the eligibility rules for low-income assistance were left to the discretion of the Centers for Medicare & Medicaid Services (CMS). All discussion and analysis of MMA provisions in this report is based on final rules published in January 2005.[10]

The MMA provided that all people who were already receiving full Medicaid benefits would be deemed automatically eligible for the highest level of MMA premium subsidies. CMS was given the discretion to extend this deeming policy to current MSP participants and has elected to do so. In

[10] *Federal Register*, v. 70, n. 18 (Jan. 28, 2005), p. 4193-4585.

addition, the proposed rule includes some uniform national methods for counting allowable income and assets. These are described below.

Note that the full subsidy income standard for people who are not receiving any Medicaid or MSP benefits is 135% of poverty, the same as the income standard for QI shown in table 2. However, the resource limit is higher; in effect, this group consists of people who passed the QI income test but failed the resource test.

Table 3. Eligibility and Benefits, MMA Low-Income Prescription Drug Subsidies

	Maximum income	Resource limit	Premium	Deductible	Copayment/ coinsurance
Full subsidy					
1. Full-benefit Medicaid enrollees	Deemed eligible	Deemed eligible	None	None	None if in institution; reduced for others, with greater reduction for those <100% of FPG
2. QMB, SLMB, QI, or SSI recipients (without full Medicaid)	Deemed eligible	Deemed eligible	None	None	Reduced, with greater reduction for those <100% of FPG
3. All other	135% of FPG	$6,000/$9,000 in 2006, then updated by CPI	None	None	Reduced
Partial subsidy	150% of FPG	$10,000/$20,000 in 2006, then updated by CPI	Sliding scale	$50	Reduced

Income and resource methodologies

While income and resource limits for different groups may seem straightforward, there are complicated rules for determining how much of an applicant's income and assets are actually counted toward these limits and how much may be "disregarded." There are also rules for deciding who is a member of the applicant's family. Family definition affects income and asset counting; in addition, because the FPGs vary by family size, it determines the applicable income limit for groups with FPG-based limits.

Income and resource methodologies for aged and disabled applicants are generally supposed to follow SSI rules. However, section 1902(r) of the Social Security Act allows states to use "less restrictive" methodologies. For many years, CMS interpreted this provision as meaning that states could use less restrictive methods for resource determination, but had to follow SSI rules for income determination for most Medicaid groups. (SSI/SSP rules must be followed for people actually applying for cash assistance.) A new regulation issued in January 2001 allowed greater flexibility in income determination as well.[11]

Some states with less restrictive methodologies are ignoring certain specific categories of income or resources. Others are allowing larger amounts of income or resources than would otherwise be permitted. They are thus effectively setting higher income or resource limits, even though their policies are referred to as merely methodological changes.

The following is a brief summary of the basic SSI income and resource methods. State exceptions are described in Appendix C.

Income. All of an individual's or couple's income is counted, except for the following disregards: the first $20 of income; an additional $65 of earned income, plus one-half of any earned income above this limit; income from special state and local public assistance programs; educational grants; and one-third of child support. (Only the general and earned income disregards and the exclusion of public assistance are modeled here.) If a married applicant has an ineligible spouse—for example, because the applicant is aged or disabled and the spouse isn't—the spouse's income and resources are deemed available to the applicant, less allowances for the spouse's support and that of any children. If the applicant is living with and receiving support from someone else, such as an adult child, is living with and receiving support from a relative, such as an adult child, the applicant is considered to be receiving in kind income. In such cases, states imputed $177 per month in in-kind income for an individual and $265 for a couple when determining eligibility in 2001. Some states do not make this adjustment for certain groups.

Assets. All financial and other assets, such as property and vehicles, are counted toward resource limits; the major exception is the applicant's principal residence. There are numerous special rules for treatment of certain assets. The following summarizes a few of the more important:

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[11] For a discussion of the changes, see http://www.cms.hhs.gov/medicaid/eligibility/elig0501.pdf.

- **Life insurance**. When a life insurance policy can be turned in for cash, the cash value is counted as a resource, unless the face value of all policies covering an individual is $1,500 or less. As will be seen, this is a major barrier to eligibility. Some states use higher limits for some groups.

- **Income-producing property**. Real property other than the applicant's home is included in resources. Property with a value of less than $6,000 can be excluded from resources, but only if the applicant is receiving rental income equal to 6% of the property's value. Some states allow higher values, but none waives the rental income requirement.

- **Vehicles**. The value of vehicles is included in resources. Under new SSI rules effective March 2005, the value of one car may be excluded if the car is used for transportation of the applicant or any household member.[12] (In the modeling here, all "first cars" are disregarded.) Some states ignore vehicles, and the MMA rules ignore vehicles in determining drug subsidy eligibility.

Family size. For SSI/SSP and medically needy eligibility, there are two income limits, individual and couple. A larger family's income is counted toward these limits, but there are disregards that take into account the fact that more than one or two people are being supported. For poverty-related full benefit or MSP groups, the FPGs establish limits for each family size—one, two, three, and so on. However, there are many states that only use the one- and two-person FPGs, even when there are more people in the family.[13] Most of these states do not use the SSI disregards to adjust the family's income before applying these limits, so that larger families are penalized. The MMA rules for establishing drug subsidy eligibility will use the FPG limits for the full family size, but this does not affect eligibility for MSP applicants.

Key issues in eligibility standards

State differences

[12] *Federal Register*, v. 70, n. 24 (Feb. 7, 2005), p. 6340-6345.

[13] State failure to use full-family FPGs for the MSP groups is clearly contrary to the statutory requirement that the state use the FPG "applicable to a family of the size involved" (section 1905(p)(2)(A) of the Social Security Act). However, a 1999 survey found that almost half of states used one- or two-person standards (Nemore). Some states do not even ascertain family size; see, for example, Maryland's current MSP application form at http://www.dhr.state.md.us/fia/doc/qmbslmb.pdf, accessed Nov. 2005.

Identical individuals and families are treated differently in different states. This problem is most obvious in the case of full-benefit dual eligibles, for whom states have very wide latitude in defining covered populations and setting eligibility standards.

Table 4 groups states according to the proportion of beneficiaries in poverty who are eligible for full Medicaid benefits. Nationally, 45% of poor Medicare beneficiaries are eligible for full Medicaid. However, in the bottom third of states, only 20% are eligible, while, in the top third of states, 65% are eligible.[14] *Note that this, and all full-benefit estimates in this report, are of people who could qualify for SSI, SSP, medically needy, or poverty-related eligibility on the basis of income and resources alone.* The estimates do not include people who might become eligible through spend-down if they had large enough bills, or people who might have long-term care needs and qualify under the special income standards for long-term care.

Table 4. State Variation in Percent of Aged and Disabled Medicare Beneficiaries in Poverty Eligible for Full Medicaid Benefits, 2001

	Beneficiaries in poverty (000s)	Eligible for full Medicaid (000s)	Percent eligible	90% confidence interval
17 states with smallest percentage eligible	909	182	20%	14%-26%
Middle 16 states	2,133	865	41%	36%-46%
17 states with largest percentage eligible	1,535	994	65%	59%-70%
Total	4,577	2,042	45%	41%-48%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period. No data available for New Hampshire.

While eligibility thresholds for the MSP groups are standardized nationally, variation in the ways states count income and resources means that there are still disparities in the way similarly situated families are treated. Moreover, because CMS has decided to deem both full-benefit and MSP

[14] Not all of the variation among states is attributable to differences in eligibility rules. For example, suppose two states both used income standards equal to 80% of the FPG. It could be that, within the set of beneficiaries below 100% of poverty, one state had a larger proportion below 80% than the other, and hence would make more beneficiaries eligible.

enrollees automatically eligible for full MMA drug premium subsidies, the variation will be perpetuated in the new program.

Table 5 shows the proportion of Medicare beneficiaries below 135% of poverty who would potentially have been eligible for full drug premium subsidies if the program had been in effect in 2001. It includes people actually receiving Medicaid or MSP benefits, people meeting state standards for those benefits, and people meeting the MMA standards. In practice, it is unlikely that differences among states would be as large as those shown. The numbers in the table are maximums that would be reached only if everyone who sought the MMA subsidy were screened for Medicaid eligibility, so that applicants in states with more generous Medicaid rules would benefit.

Table 5. State Variation in Percent of Aged and Disabled Medicare Beneficiaries Below 135% of Poverty Potentially Eligible for Full MMA Drug Premium Subsidy

	Beneficiaries below 135% of poverty (000s)	Eligible for full drug subsidy (000s)	Percent eligible	90% confidence interval
18 states with smallest percentage eligible	2,061	1,150	56%	51%-61%
Middle 15 states	4,116	2,991	73%	70%-76%
17 states with largest percentage eligible	2,712	2,332	86%	83%-89%
Total	8,889	6,472	73%	71%-75%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

Finally, the federal poverty guidelines themselves include no adjustment for geographic variation in cost of living (except that the guidelines are higher for Alaska and Hawaii). A 1995 report by the National Academy of Sciences recommended such an adjustment, among other changes in poverty measurement, and experimental measures have been developed. Work by the Census Bureau has shown that an adjustment based on housing prices would raise counts of people in poverty in the Northeast and the West and among people residing in suburban areas (Short et al.). Politically, adoption of a revised

measure might prove difficult, because so many federal programs use the poverty measures to distribute funds to states and localities.

Cliff effects

Under the current system, Medicaid and drug benefits available to Medicare beneficiaries decline with rising income and resources. The benefit reductions occur in discrete steps. A dollar more in monthly income can mean the difference between full-benefit eligibility and QMB-only status, or between any Medicaid benefit and drug subsidies only.

The usual objection to such cliffs is that they create work disincentives, because a sharp reduction in benefits in response to a slight income increase is more or less equivalent to a very high marginal tax rate. This might seem like a less important problem for Medicare beneficiaries, most of whom are retired. However, as table 6 shows, earned income is an important component of beneficiaries' total family income. This is especially true for the disabled, who may often have a spouse still in the workforce. The earned income disregard softens the cliff effect somewhat; for all dual eligible categories, adding a dollar to the spouse's income means adding only 50 cents to countable income. Still, when a small increase in earnings can mean a significant curtailment in Medicaid benefits, the disincentive is quite real.

Table 6. Earned Income, Medicare Beneficiaries, 2001

	Average annual earned income, beneficiaries and families	Earned income as percent of total family income
Aged	$ 5,337	18%
Disabled	$ 7,183	32%
Total	$ 5,548	19%

Source: 2001 Survey of Income and Program Participation (SIPP)

How big are the cliffs? That is, how much do beneficiaries lose as they shift from one category to another? Someone moving from full-benefit eligibility to QMB-only status loses coverage for services that are not covered by Medicare. Currently, the most important of these are long-term care (beyond Medicare's limited coverage of skilled nursing facility and home health care) and outpatient prescription drugs. The MMA low-income drug benefits will largely replace the current Medicaid benefit, although states may choose to offer full-benefit eligibles drugs not included under MMA plan formularies. Beneficiaries needing

long-term care and not meeting the usual standards for full-benefit eligibility can often qualify through special long-term care standards, but only if they are severely disabled. For beneficiaries not needing long-term care, the shift to QMB status may be less important. They would retain Medicaid payment of Medicare premiums and cost-sharing, but would lose some ancillary benefits, such as optical, hearing, transportation, and dental services.

For many beneficiaries, a shift from QMB to SLMB status might be more significant, because the SLMB group receives premium assistance but no help with coinsurance and deductibles. In 2002, estimated average beneficiary cost-sharing liability for Medicare services was $832 (Maxwell, Storeygard, and Moon). For someone at the QMB limit in that year—that is, with countable income of $8,860—one additional dollar of income would have meant sudden exposure to costs averaging 9.4% of income. Moreover, Medicaid pays only part B premiums for SLMBs. For a QMB, Medicaid pays the Medicare part A premium charged to people who don't qualify for part A automatically on the basis of work history. While relatively few beneficiaries are affected, the loss of this benefit could be devastating for those who currently receive it. The part A premium in 2005 can be as high as $375 a month (for people with little or no countable work history), or $4,500 a year.

A shift from SLMB to QI status—that is, from under to over 120% of poverty—has no effect on benefits; both groups receive part B premium payments only. Finally, someone whose income goes above the QI limit of 135% of poverty loses part B premium assistance and goes from full MMA drug subsidies to partial subsidies.

Resource standards

A great many people who meet the income standards for some level of Medicaid eligibility or MMA drug subsidies fail to meet the resource limits. Excess resources may make people ineligible for any benefit or may mean that they receive less extensive assistance; for example, someone might meet income standards for full Medicaid benefits but have assets that qualify him or her only for QMB-only status.

Table 7 shows Medicare beneficiaries meeting income standards and failing resource limits for each level of eligibility in 2001. At each level, the count of potential eligibles excludes people who met the income standards for a higher level of benefits. For example, the estimate of 1.3 million people who met the QMB income standard excludes the 5.7 million people who had income within full benefit standards. (The number of people in the full MMA drug subsidy group is so small because practically no one meets income standards for this

group without meeting standards for an MSP category. The exceptions are beneficiaries with larger families in states that use only one- or two-person FPGs, while MMA rules use full family size.)

Table 7. Medicare Beneficiaries Meeting Income Tests and Failing Asset Tests for Different Benefit Levels, 2001

	Aged		Disabled		Total	
	Meet income standard (000s)	Percent failing asset standard	Meet income standard (000s)	Percent failing asset standard	Meet income standard (000s)	Percent failing asset standard
Full benefits	4,256	53%	1,307	31%	5,563	48%
QMB	1,087	41%	223	25%	1,309	39%
SLMB	1,974	51%	402	31%	2,377	47%
QI	1,450	58%	240	37%	1,690	55%
Rx full	78	65%	117	44%	196	53%
Rx part	1,555	47%	213	37%	1,767	46%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

Resource limits for eligibility have been criticized on a number of grounds:

- The national limits have not been updated since 1989, while income limits increase annually with inflation. As a result, steadily larger numbers of people pass income tests and fail the resource test (Moon, Friedland, and Shirey). This problem is addressed in the MMA drug subsidy rules by having asset limits indexed to inflation, but no such rule is in place for Medicaid.

- Documenting assets makes the application process burdensome, deterring even potential enrollees who might pass the tests.

- Many retired people rely on interest or dividend income to supplement Social Security or pension income. If they are required to spend their savings before receiving Medicaid, a single high-cost medical episode can leave them permanently impoverished.

Four states (Alabama, Arizona, Delaware, and Mississippi) imposed no resource limit for MSP applicants in 2001.[15] Only one state, Massachusetts, has waived resource limits for full-benefit eligibility, and only for the non-elderly disabled under a demonstration waiver. Some people contend that resource limits should be abandoned altogether for all categories, on the grounds that they screen out relatively few applicants while making eligibility determination complicated for everyone.

While it is true that many low-income Medicare beneficiaries have resources only slightly above the limits, there is an appreciable number with substantial assets. Table 8 shows the excess assets of beneficiaries meeting QMB income standards but not resource standards in 2001.[16] Of beneficiaries with countable income below 100% of the FPG, 37% had countable assets less than $5,000 above the applicable resource standard. But nearly a quarter had excess assets of more than $25,000, and 7% had $100,000 or more in excess assets. These figures are subject to considerable error, but two other surveys—the 2000 Health and Retirement Study (HRS) and the 2001 Survey of Consumer Finances (SCF)—show comparable numbers of very low-income people with substantial holdings.[17]

Table 8. Amount of Excess Assets, Medicare Beneficiaries Meeting QMB Income Standard and Failing Asset Standard, 2001

Countable assets above MSP limit	Percent of beneficiaries failing asset test
Under $2,000	21%
$2,000-$4,999	16%
$5,000-$9,999	19%
$10,000-$24,999	21%
$25,000 and over	23%
Total	100%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

[15] Connecticut reported, in the 2001 state survey used for this study, that it used resource limits for QMBs and SLMBs, but not for QIs. This appears to be impermissible; states are supposed to treat all MSP groups alike. For consistency, the state-reported rule is used in the modeling here; only 2 SIPP respondents were affected.
[16] Unlike the previous table, this includes all 2 million beneficiaries who are below poverty and fail to qualify for QMB on the basis of resources.
[17] Author's analysis. The HRS shows 17% of aged people in poverty with assets above $25,000, and 5% with assets above $100,000. In the SCF, 26% of elderly people with family incomes below $15,000 had assets above $25,000, and 6% had assets above $100,000.

It may seem implausible that many people with $100,000 or more in savings could be living in poverty. But assets may not always yield dependable returns. For example, many respondents report "income-producing" (rental) property that is countable toward resource limits but doesn't happen to be producing any income. And elderly people with funds in interest-bearing accounts have received minimal returns from 2001 on.

The existence of even small numbers of poor beneficiaries with substantial assets is likely to make the complete elimination of resource limits politically difficult at the federal level. As the table suggests, however, raising the standards even slightly could make many more people eligible. An alternative is to change some of the rules about which assets are counted.

Table 9 shows how many people who failed the QMB resource test would have passed if specific types of resources had been excluded. The single most important reason for failing is excess life insurance. Again, the cash value of life insurance policies is treated as a countable asset if the sum of all policies is greater than $1,500 per person. Eliminating this one rule would have extended eligibility to 52% of beneficiaries who failed the resource test. Excluding two other classes of assets, income-producing property and vehicles, would make another 13% of failed applicants eligible. Excluding all three of these types of property, along with tax-favored retirement counts, would allow 62% of failed applicants to pass. This would mean that only immediately liquid resources--savings and checking accounts, stocks, bonds, mutual funds, and so on—would be counted. And it is likely that the application and verification process would be greatly simplified, because the value of liquid assets may be more easily documented.

Table 9. Effect of Excluding Specific Assets, Medicare Beneficiaries Meeting QMB Income Standard and Failing Asset Standard, 2001

Exclude:	Percent passing test with resource excluded
Income-producing property	7%
Retirement funds	4%
Life insurance	52%
Vehicles	6%
All of these	62%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

As the table shows, retirement funds were a minor issue in 2001. However, as defined benefit pension plans are becoming increasingly rare, growing numbers of future retirees are likely to be dependent on savings in 401(k) plans, IRAs, or other arrangements. Moon, Friedland, and Shirey point out that, when a person receives a pension from an employer or union retirement fund, the income is considered in determining eligibility, but the amount of the funds held in the person's name is not considered an asset. If a person receives the same income from savings he or she controls, the amount of the savings is counted toward the asset limits. They suggest the possibility of excluding the funds from countable assets and then adding to income the annual amount the fund could be expected to return—that is, treating the asset as if it had been invested in an annuity. This option is considered below.

Options for Reform

The current federal eligibility rules could be revised to encourage greater uniformity in income and resource limits, make the application process simpler, reduce cliff effects, and/or extend subsidies to more people. This report will consider the effects of four illustrative options:

1. Uniform rules for counting certain components of income and assets of MSP and drug subsidy applicants.
2. Replacing the three MSP groups with two (QMB and QI) and aligning income and asset limits for the two groups with those for full and partial MMA drug subsidies. A variant of this option would use higher asset limits for each group. Methodologies would be as in option 1.
3. Annuitization of liquid assets for all benefit levels, with other state-established resource disregards eliminated and no changes in income standards or methods.
4. Uniform national income and asset limits for three coverage levels: full-benefit, QMB, and QI (as redefined in option 2). Methodologies would be as in option 1, extended to full-benefit eligibles.

Option 1: Uniform methodologies for MSP benefits and drug subsidies

This option includes several changes, some based on the methodologies adopted for drug subsidies in the January 2005 rule, others based on MSP policies in various states:

- The FPG used would be the one for the applicant's actual family size; that is, states would no longer have the option of using only a one- or two person standard. The family would consist of the applicant, his or her spouse—whether or not also an applicant—and any dependents.[18]
- Beneficiaries living with adult children or other family members would not be treated as receiving imputed in-kind income.
- Three classes of resources—income-producing property, the cash value of life insurance policies, and vehicles—would not be counted.

States already using less restrictive methods in these or other areas of eligibility determination would be allowed to continue those policies.

Table 10 shows the effect of these changes. There is a slight increase in the number of aged beneficiaries qualifying for some kind of Medicaid or MMA benefit and a much larger increase for disabled beneficiaries. In addition, many people already qualifying for some benefit are shifted to a higher benefit level. The proportion of beneficiaries qualifying for QMB-only benefits doubles.

Table 10. Percent of Medicare Beneficiaries Qualifying for Different Benefit Levels, Current Rules and Option 1

	Aged		Disabled		Total	
	Current	Option	Current	Option	Current	Option
Full benefit	6%	6%	22%	22%	8%	8%
QMB	3%	6%	6%	16%	3%	7%
SLMB	3%	5%	7%	10%	4%	6%
QI	2%	3%	4%	4%	2%	3%
Full drug	2%	1%	4%	0%	2%	1%
Partial drug	5%	5%	5%	5%	5%	5%
Ineligible	78%	74%	52%	43%	75%	70%
Total	100%	100%	100%	100%	100%	100%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

[18] Because it is difficult to establish dependency using the SIPP data, the model here treats only minor children as dependents, although the new federal definition includes anyone for whom the applicant or spouse provides more than one-half of total support.

Option 2: Align MSP categories with MMA drug subsidy categories

Under this option, the three MSP groups would be replaced by two categories, with income and resource standards conforming to those for full and partial MMA drug subsidies, as shown in table 11. Methodologies would be as in option one; eligibility for full benefits would not be affected.

Table 11. Standards and Benefits, Revised MSP Categories

Group	Income limit	Resource limit	Medicaid benefit	Drug benefit
QMB	135% of FPG	$6,000/$9,000 in 2006, then updated by CPI	Medicare Part A and Part B premium and required cost-sharing	Zero premium, reduced cost-sharing
QI	150% of FPG	$10,000/$20,000 in 2006, then updated by CPI	Medicare Part B premium only	Sliding scale premium, reduced cost-sharing

Table 12 shows the results. There would be a dramatic increase in the QMB population, as all SLMBs and current QIs are shifted into this category. People currently eligible for the partial MMA drug subsidy would move into the new QI group and thus receive assistance with the Medicare part B premium.

Table 12. Percent of Medicare Beneficiaries Qualifying for Different Benefit Levels, Current Rules and Option 2

	Aged		Disabled		Total	
	Current	Option	Current	Option	Current	Option
Full benefit	6%	6%	22%	22%	8%	8%
QMB	3%	14%	6%	29%	3%	16%
SLMB	3%	0%	7%	0%	4%	0%
QI	2%	5%	4%	6%	2%	5%
Full drug	2%	0%	4%	0%	2%	0%
Partial drug	5%	0%	5%	0%	5%	0%
Ineligible	78%	74%	52%	44%	75%	71%
Total	100%	100%	100%	100%	100%	100%

Source: 2001 Survey of Income and Program Participation (SIPP)

Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

A variant of this option would use the same income standards but set higher resource standards for the two MSP/drug subsidy groups. While the poverty guidelines originally had some empirical basis, SSI resource standards have simply been set by statute, with limits for MSP and full-subsidy MMA benefits set at fixed multiples of the SSI limits. It is not clear that there is any less arbitrary way of setting resource limits. While it may be possible to say how much income people need to maintain some basic standard of living, there is no equivalent concept for wealth. One possibility would be to set the resource limit at some percentile of the countable resources of single people and couples meeting the income limits for each group. Table 13 shows the distribution in 2001. The option 2 standards are around the 75th percentile of assets for each group.[19]

[19] Note that assets for single people and couples tend to converge at the higher percentile levels. One reason is that couples have much more life insurance than individuals; the exclusion of this asset under option 2 thus produces a greater reduction in countable resources.

Table 13. Countable Resources of People Meeting Option 2 Income Standards, 2001

	QMB		QI	
	Single	Couple	Single	Couple
25th percentile	$ 0	$ 0	$ 0	$ 0
Median	$ 200	$ 900	$ 1,200	$ 2,475
75th percentile	$ 5,000	$ 7,500	$ 20,000	$ 20,100
90th percentile	$ 22,350	$ 33,500	$ 73,000	$ 65,200
Percentile, option 2 standard	76th	77th	68th	73d

Source: 2001 Survey of Income and Program Participation (SIPP)

Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

In the absence of any better basis, resource limits for the high-resource variant of option 2 will simply be set at twice those for the basic option—that is, $12,000/$18,000 for QMB, and $20,000/$40,000. Any further state-specific asset disregards are eliminated.

The results are shown in table 14. Relative to the basic option, the variant produces about a 10% increase in the QMB population. The effect for the QI group is negligible.

Table 14. Percent of Medicare Beneficiaries Qualifying for Different Benefit Levels, Current Rules and High-Resource Variant of Option 2

	Aged		Disabled		Total	
	Current	Option	Current	Option	Current	Option
Full benefit	6%	6%	22%	22%	8%	8%
QMB	3%	16%	6%	30%	3%	17%
SLMB	3%	0%	7%	0%	4%	0%
QI	2%	5%	4%	6%	2%	5%
Full drug	2%	0%	4%	0%	2%	0%
Partial drug	5%	0%	5%	0%	5%	0%
Ineligible	78%	73%	52%	43%	75%	69%
Total	100%	100%	100%	100%	100%	100%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

Option 3: Annuitized liquid assets

This option implements the suggestion by Moon, Friedland, and Shirey, under which financial assets would not be counted toward resource limits, but countable income would be increased by the estimated monthly yield the assets would provide if invested in an annuity.[20] In this illustration, three forms of assets are excluded: liquid assets, retirement funds, and life insurance. The method of computing an annuity value for these financial assets is discussed in appendix A. Other assets—income-producing property and vehicles--are treated as under current rules. State-specific disregards, either for these assets or for resources generally, are eliminated. State income standards and methodologies are unchanged.

This option greatly increases the number of people eligible for full benefits, especially among the aged. Over 20% of the people newly eligible for full benefits were previously ineligible for any benefit. At the same time, almost no one previously receiving full benefits loses them—because annuitizing assets

[20] It would make more sense to add the annuity value to income only if the asset in question is not already providing countable income equal to its annuity value. This might be too complicated in practice; in any event, it was too complicated to model.

that were already limited to $2,000 or $3,000 doesn't produce enough additional income to bring many people from below to above the income limits.

Table 15. Percent of Medicare Beneficiaries Qualifying for Different Benefit Levels, Current Rules and Option 3

	Aged		Disabled		Total	
	Current	Option	Current	Option	Current	Option
Full benefit	6%	11%	22%	27%	8%	13%
QMB	3%	3%	6%	6%	3%	3%
SLMB	3%	5%	7%	9%	4%	5%
QI	2%	3%	4%	5%	2%	4%
Full drug	2%	0%	4%	3%	2%	1%
Partial drug	5%	4%	5%	4%	5%	4%
Ineligible	78%	74%	52%	46%	75%	71%
Total	100%	100%	100%	100%	100%	100%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

Option 4: Combine option 2 with uniform income and asset limits for full benefits

Under this option, the four levels of Medicaid benefits and two levels of MMA subsidies would be replaced by three eligibility categories, using nationally standardized income and resource standards. Methodologies for determining income and assets would be as defined for option 1, except that states would not be allowed to adopt less restrictive rules. This option, then, results in a fully uniform national system. (Eligibility through medically needy spend-down or special long-term care standards would not be affected by the option.)

The new limits are shown in table 16. The income limit for full benefits would be set at 79% of poverty; this level was selected because it leaves the total number of people qualifying for full benefits approximately the same. Standards for the MSP groups would be as in option 2.

Table 16. Income and Resource Limits, Option 4 Eligibility Categories

	Income limit	Resource limits (individual/couple)
Full benefits	79% of FPG	$2,000/$3,000
QMB plus full drug subsidy	135% of FPG	$6,000/$9,000
QI plus partial drug subsidy	150% of FPG	$10,000/$20,000

Table 17. Percent of Medicare Beneficiaries Qualifying for Different Benefit Levels, Current Rules and Option 4

	Aged		Disabled		Total	
	Current	Option	Current	Option	Current	Option
Full benefit	6%	6%	22%	23%	8%	8%
QMB	3%	14%	6%	27%	3%	15%
SLMB	3%	0%	7%	0%	4%	0%
QI	2%	5%	4%	6%	2%	5%
Full drug	2%	0%	4%	0%	2%	0%
Partial drug	5%	0%	5%	0%	5%	0%
Ineligible	78%	75%	52%	44%	75%	71%
Total	100%	100%	100%	100%	100%	100%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

Table 17 shows the overall results. Like option 2, this option substantially increases the QMB population. However, the table masks another important effect. While the total number of people eligible for full benefits goes unchanged, large numbers of people are shifted into or out of this group. Table 18 shows, first, the new eligibility status for people previously eligible for full benefits. Fewer than two-thirds retain full benefits; most of the rest are shifted to QMB status, while a small number lose all benefits. The table then shows the previous status of people made eligible for full benefits under option 4. Most newly eligible for full benefits were previously QMBs, though close to 10% were previously ineligible for any benefit.

Table 18. Changes in Full Benefit Population under Option 4

	Option 2 status for people previously eligible for full benefits		Previous status of people made eligible for full benefits under option 2	
	Beneficiaries (000s)	Percent	Beneficiaries (000s)	Percent
Full benefits	1,881	65%	1,881	65%
QMB	871	30%	411	14%
SLMB	-	0%	30	1%
QI	33	1%	5	0%
Full drug	-	0%	189	6%
Partial drug	-	0%	109	4%
Ineligible	115	4%	283	10%
Total	2,900	100%	2,906	100%

Source: 2001 Survey of Income and Program Participation (SIPP)
Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

What this option illustrates is that any measure that makes eligibility rules more uniform would help people in some states while depriving people in other states of benefits they already enjoy. As suggested earlier, the most important effects of this shift would be felt by people who rely on Medicaid for long-term care services—although many of these people might still qualify under special standards for long-term care recipients, which would not be affected by the proposal. For people who do not require long-term care, a shift from full benefits to QMB status might be less significant. Again, there is a need for research on what people in the different eligibility groups are actually receiving.

There are several ways of preventing large population shifts. New national standards could be treated as a floor, with states allowed—as they are now—to adopt more generous rules. Or states that wished to extend broader benefits might be expected to do so with their own funds. The latter option might be especially likely if new standards were accompanied by some measure to shift more of the financial responsibility for dual eligibles to the federal government.

Conclusion

Each of the four reform options illustrated in this report produces a sizeable increase in the total number of Medicare beneficiaries eligible for some form of Medicaid or MMA assistance. Under current rules, 8.7 million beneficiaries, or 25%, potentially qualified for some benefit in 2001. Under the high-resource variant of option 2, which makes the largest number of beneficiaries newly eligible, 10.8 million beneficiaries, or 31%, could have received some assistance.

Table 19. Percent of Medicare Beneficiaries Qualifying for Different Benefit Levels, Current Rules and Four Options

	Current rules	Option 1	Option 2	Option 2 with higher resource limits	Option 3	Option 4
Full benefit	8%	8%	8%	8%	13%	8%
QMB	3%	7%	16%	17%	3%	15%
SLMB	4%	6%	0%	0%	5%	0%
QI	2%	3%	5%	5%	4%	5%
Full drug subsidy	2%	1%	0%	0%	1%	0%
Partial drug subsidy	5%	5%	0%	0%	4%	0%
Ineligible	75%	70%	71%	69%	71%	71%
Total	100%	100%	100%	100%	100%	100%

Source: 2001 Survey of Income and Program Participation (SIPP)

Note: Includes only people with 12 months of continuous Medicare benefits beginning in calendar year 2001 and with no change in family composition during the 12-month period.

The major differences among the options are in the distribution of beneficiaries by benefit levels. Only option 3, annuitization of assets, has a large effect on the number of people eligible for full Medicaid benefits. The remaining options generally increase eligibility for QMB status. The potential increase in the size of the eligible population is not the only possible criterion for evaluating the options. For example, participation might increase if the application and eligibility determination process were simpler. Options 1, 2, and 4 all promote this goal; option 3 does not, because the calculation of the annuity value of assets requires continuing the current process of verifying the assets' value. If greater

national uniformity is desirable, options 4 would achieve this. The trade-off is that, under this option, as many people lose full benefits as gain them.

Finally, none of the options addresses the problem of cliff effects, sharp declines in benefits after a small increase in income. Nor do the options provide any assistance at all to beneficiaries with incomes above 150% of the poverty guideline—or $14,355 for a single person in 2005. For someone at this level, the Medicare part B premium alone would have consumed 6.5% of income in 2005; adding the deductible for a single inpatient hospital stay would increase out-of-pocket costs to 12.9% of income.

One solution would be to reduce premium and cost-sharing amounts using some form of income-based sliding scale. (A sliding scale will be used for MMA drug premium subsidies for people between 135% and 150% of FPL.) However, this could markedly increase the complexity of the system; applying sliding-scale cost-sharing amounts might be especially troublesome. Another option that might provide at least some relief to modest-income beneficiaries would be a catastrophic limit on cost-sharing for part A and part B benefits, comparable to that established for the new drug benefit. Finally, people could be allowed to spend down to MSP eligibility, thus providing at least some relief for beneficiaries in states without a medically needy program or with extremely low medically needy income standards.

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Appendix A. Methodology

The starting sample for this study consisted of 9,677 SIPP participants who reported receiving Medicare at any time in 2001. Participants who did not report 12 months of continuous Medicare participation beginning at any time in 2001 were dropped, for two reasons. First, given seasonal and other income fluctuations, eligibility testing based on part-year data would have been unreliable. Second, questions about assets are asked only once a year; asset information is unavailable for nearly all the part-year participants. A smaller number of cases were dropped because their family structure changed (e.g., single to married or the reverse) or the count of members changed, making it impossible to use a single income standard and method for 12 months of income data. Table 20 shows the unweighted counts of study units.

Table 20. Dropped Cases, SIPP Participants with Medicare in 2001

	Unweighted count
Fewer than 12 months of data	1,069
Family structure changed	411
Family member count changed	51
Retained	8,146
Total	9,677

For the retained cases, income data are for the 12-month period beginning January 2001 or, if later, the first month in which the individual participated in SIPP and reported Medicare coverage. For individuals whose 12-month period ended after December 2001, income is adjusted using a blend of the 2002 increases in SSI benefit rates and FPGs. Asset data are usually from the third interview round in 2001; if this was unavailable, data from the sixth round in 2002 was used and deflated by the annual change in the CPI.

For the baseline, income and assets for SSI eligibility were determined using the standard method. Certain income disregards, notably the child support disregard, could not be applied. All property used in a business was disregarded. SIPP provides no information on household goods and personal effects, which used to be counted as resources if their value exceeded $2,000; this requirement has been dropped effective March 2005. For vehicles, the most valuable car was assumed to be the one used for the beneficiary's transportation and was disregarded. Under SSI, funds up to $1,500 that are specifically set aside for burial are excluded; this provision was not modeled.

For all categories, income and asset calculations were modified to reflect less restrictive (or, in 209(b) states, more restrictive) state methods whenever possible. These exceptions are outlined in Appendix C. Finally, the net income and resources were compared to the state limits shown in Appendix B or to the national limits for MSP eligibility and MMA drug subsidies. All information on state eligibility policies is from the National Association of State Medicaid Directors 2001 Aged, Blind, and Disabled Medicaid Eligibility Survey. The one exception is MSP family size; states using one- or two-person standards instead of the FPG for the full family size were identified using 1999 data from a survey by the National Senior Citizens Law Center (Nemore). For reasons of sample size, SIPP treats Maine/Vermont as one state and South Dakota/North Dakota/Wyoming as one state. Policies used for these states are, as appropriate, a population-weighted average or the policy of the most populous state.

For the MMA drug subsidy programs, which will not be effective until 2006, the standards used are those that would have been in effect in 2001. For resources, the statute sets limits for 2006; for later years the limits increase with the CPI. It seemed reasonable to set limits for 2001 equal to the 2006 limits *minus* five years of inflation. The limits used in the model are the 2006 limits divided by 1.1.

Finally, Option 3 requires estimates of the annuity value of assets. The annuity income an investment yields depends on three factors. The first is the beneficiary's age: younger people can expect to live longer and receive more annuity payments. The amount of each payment is therefore smaller. For example, a woman aged 65 in 2001 had a life expectancy of 19.4 years and could receive an average of 232 payments, while a woman aged 75 had a life expectancy of 12.4 years and could expect to receive 148 payments. Second, the funds not yet paid out accumulate interest. If there were no interest, a 65 year-old woman with $10,000 invested could receive a monthly payment of $43.10. If her funds earn 5% interest, the monthly annuity goes up to $69.77. Third, annuities are reduced to cover the financial institution's administrative costs and profits. For Option 3, annuity values were calculated using a 5% return and annual mortality tables by age and sex from Arias; no administrative cost was assumed, as it costs nothing to administer a phantom annuity.

Appendix B. State Income Standards, 2001

State	SSI		SSP aged		SSP disabled		Medically needy		Percent of FPG for full benefits	MSP family size standard
	Single	Couple	Single	Couple	Single	Couple	Single	Couple		
Alabama	$ 531	$ 796	*	*	*	*	*	*	*	1 or 2-person
Alaska	$ 531	$ 796	$ 984	$ 1,459	$ 984	$ 1,459	*	*	*	Full family
Arizona	$ 531	$ 796	*	*	*	*	*	*	*	1 or 2-person
Arkansas	$ 531	$ 796	*	*	*	*	$ 108	$ 216	*	1 or 2-person
California	$ 531	$ 796	$ 712	$ 1,265	$ 712	$ 1,265	$ 600	$ 934	100%	Full family
Colorado	$ 531	$ 796	$ 545	$ 817	$ 545	$ 817	*	*	*	1 or 2-person
Connecticut	$ 575	$ 733	$ 747	$ 1,092	$ 747	$ 1,092	$ 575	$ 733	*	Full family
Delaware	$ 531	$ 796	*	*	*	*	*	*	*	1 or 2-person
D.C.	$ 531	$ 796	*	*	*	*	$ 377	$ 397	100%	1 or 2-person
Florida	$ 531	$ 796	*	*	*	*	$ 180	$ 241	90%	1 or 2-person
Georgia	$ 531	$ 796	*	*	*	*	$ 317	$ 375	*	1 or 2-person
Hawaii	$ 825	$ 1,114	$ 536	$ 805	$ 536	$ 805	$ 418	$ 565	100%	Full family
Idaho	$ 531	$ 796	$ 583	$ 816	$ 583	$ 816	*	*	*	Full family
Illinois	$ 531	$ 796	*	*	*	*	$ 283	$ 375	85%	Full family
Indiana	$ 545	$ 817	*	*	*	*	*	*	*	Full family
Iowa	$ 531	$ 796	$ 534	$ 813	$ 534	$ 813	$ 483	$ 483	*	1 or 2-person
Kansas	$ 531	$ 796	*	*	*	*	$ 475	$ 475	*	1 or 2-person
Kentucky	$ 531	$ 796	*	*	*	*	$ 217	$ 267	*	1 or 2-person
Louisiana	$ 531	$ 796	*	*	*	*	$ 100	$ 192	*	1 or 2-person
Maryland	$ 531	$ 796	*	*	*	*	$ 350	$ 392	*	1 or 2-person

State	SSI		SSP aged		SSP disabled		Medically needy		Percent of FPG for full benefits	MSP family size standard
	Single	Couple	Single	Couple	Single	Couple	Single	Couple		
Massachusetts	$ 531	$ 796	$ 660	$ 998	$ 660	$ 998	*	*	100%	Full family
Michigan	$ 531	$ 796	$ 545	$ 824	$ 545	$ 824	$ 408	$ 541	100%	Full family
Minnesota	$ 482	$ 602	$ 592	$ 887	$ 592	$ 887	$ 482	$ 602	95%	Full family
Mississippi	$ 531	$ 796	*	*	*	*	*	*	135%	1 or 2-person
Missouri	$ 545	$ 817	*	*	*	*	*	*	*	Full family
Montana	$ 531	$ 796	*	*	*	*	$ 525	$ 525	*	1 or 2-person
Nebraska	$ 531	$ 796	$ 537	$ 791	$ 537	$ 791	$ 392	$ 392	100%	Full family
Nevada	$ 531	$ 796	$ 581	$ 891	*	*	*	*	*	1 or 2-person
New Hampshire	$ 544	$ 797	$ 544	$ 797	$ 544	$ 797	$ 544	$ 675	*	Full family
New Jersey	$ 531	$ 796	$ 543	$ 794	*	*	$ 367	$ 434	100%	1 or 2-person
New Mexico	$ 531	$ 796	*	*	*	*	*	*	*	1 or 2-person
New York	$ 531	$ 796	$ 618	$ 900	$ 618	$ 900	$ 625	$ 900	*	1 or 2-person
North Carolina	$ 531	$ 796	*	*	*	*	$ 242	$ 317	100%	1 or 2-person
Ohio	$ 460	$ 796	*	*	*	*	*	*	*	1 or 2-person
Oklahoma	$ 584	$ 902	*	*	*	*	$ 1	$ 1	100%	1 or 2-person
Oregon	$ 531	$ 796	$ 532	$ 796	$ 532	$ 796	$ 423	$ 526	*	Full family

State	SSI		SSP aged		SSP disabled		Medically needy		Percent of FPG for full benefits	MSP family size standard
	Single	Couple	Single	Couple	Single	Couple	Single	Couple		
Pennsylvania	$ 531	$ 796	$ 558	$ 840	$ 558	$ 840	$ 425	$ 442	100%	Full family
Rhode Island	$ 531	$ 796	$ 595	$ 917	$ 595	$ 917	$ 625	$ 667	100%	1 or 2-person
South Carolina	$ 531	$ 796	*	*	*	*	*	*	100%	1 or 2-person
Tennessee	$ 531	$ 796	*	*	*	*	$ 241	$ 258	*	Full family
Texas	$ 531	$ 796	*	*	*	*	*	*	*	1 or 2-person
Utah	$ 531	$ 796	*	*	*	*	$ 362	$ 468	100%	1 or 2-person
Virginia	$ 531	$ 796	*	*	*	*	$ 336	$ 406	80%	Full family
Washington	$ 531	$ 796	$ 557	$ 816	$ 557	$ 816	$ 557	$ 592	*	Full family
West Virginia	$ 531	$ 796	*	*	*	*	$ 200	$ 275	*	Full family
Wisconsin	$ 531	$ 796	$ 596	*	*	*	$ 592	$ 592	*	1 or 2-person
Maine, Vermont	$ 531	$ 796	$ 534	$ 828	$ 534	$ 828	$ 417	$ 437	76%	1 or 2-person
North Dakota, South Dakota, Wyoming	$ 531	$ 796	$ 546	$ 811	$ 546	$ 811	*	*	*	Full family

Source: National Association of State Medicaid Directors 2001 Aged, Blind, and Disabled Medicaid Eligibility Survey. Family size policies from Nemore.

*State did not cover this population group in 2001.

Appendix C. Special Eligibility Rules, 2001

	State(s)	Policy
INCOME		
SSI	Indiana, New Hampshire	Reduced general disregard
SSP	Connecticut	Higher general disregard
Medical needy	Connecticut	Higher general disregard
	Georgia, Kansas, Maine/ Vermont	No attribution of in-kind income
	Georgia	No deeming of income from ineligible spouse
	Illinois	Disregards income between medically needy standard and 85% of poverty
	Kansas	25% disregard of self-employment income (not modeled)
Poverty-related	California	Uses more favorable of SSI method or California-specific family member disregards
	Florida, Maine/ Vermont	No attribution of in-kind income
	Mississippi	Higher general disregard
MSP	Alabama, Florida, Kansas, Maine/ Vermont	No attribution of in-kind income
	California	Uses more favorable of SSI method or California-specific family member disregards
	Florida	All earned income excluded
	Kansas	25% disregard of self-employment income (not modeled)
	Louisiana, Maine/ Vermont, South Carolina	Extra $100 disregard per child
	Mississippi	Higher general disregard
ASSETS		
SSI	Hawaii	Include business property (no cases in SIPP data)

	State(s)	Policy
Medically needy	Florida, Georgia, North Carolina	Higher insurance exclusion
	Kentucky	Exclude retirement funds
	Maine/Vermont	Resource limit $8,000/$12,000
	Maine/ Vermont	Exclude two vehicles
	Massachusetts	No resource limit for disabled
	New York	$12,000 income-producing property limit
	North Carolina	No limit on income property if meets 6% rent test
	Tennessee	Allow income property to $6,000 if produces any rental income
Poverty-related		
	Mississippi	No limit on income property if meets 6% rent test
	Mississippi	Exclude two vehicles
	Florida, Georgia, Mississippi, South Carolina, North Carolina	Higher insurance exclusion
MSP		
	Alabama, Arizona, Delaware, Mississippi	No resource limit
	Connecticut	No resource limit for QI only

Source: National Association of State Medicaid Directors 2001 Aged, Blind, and Disabled Medicaid Eligibility Survey.