AGING & DISABILITY
HEALTH POLICY LAB

Streamlining Medicare Savings Programs (MSPs): State Options and Lessons for Change

Panelists

Kim Glaun



Senior Advisor
Aging & Disability Health Policy Lab

Tim Smolen



SHIBA Program Manager
Washington State Office of the Insurance Commissioner

Maiss Mohamed



Health Research Analyst
Aging & Disability Health Policy Lab

Most older adults and people with disabilities are on Medicare, but it's expensive

Part B standard premium	Part A inpatient and Part B deductibles	Other A/B costs
15% of income *($2,435/year premium)*	**13% of income** *($1,736 + $283 deductibles)*	*Part B 20% co-insurance; nursing facility co-insurance, etc.*

28+% of income for Part B premiums and A/B deductibles

*Based on 2026 Medicare rates and 2026 100% federal poverty level income

The Medicare Savings Programs (MSPs) make Medicare affordable for people with low income

Part B standard premium	Part A inpatient & Part B deductibles	Other A/B costs	Medicare Part D Extra Help
COVERED for all	**COVERED for many**	**COVERED for many**	**Automatic enrollment**
($2,435 premium)	*($2,019 deductibles)*	*(20% Part B coinsurance)*	*($5,700)*



$8,000+ saved per year

The MSP eligibility groups include:

	Income*	# / % Participants**	Financing***	Part B Premiums	Part A Premiums	Cost Sharing
Qualified Medicare Beneficiary *(QMB)*	100% FPL	8.5 million 82%	Federal and state	✓	✓	✓
Specified Low-Income Medicare Beneficiary *(SLMB)*	100-120% FPL	1.3 million 12%	Federal and state	✓		
Qualifying Individuals *(QI)*	120-135% FPL	0.6 million 6%	Fully federal	✓		

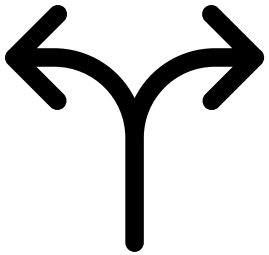
*Federal standard, benefits may be more generous at a state level.
**MMCO enrollment snapshot, March 2025.
***QMB and SLMB financed at standard federal medical assistance percentage.

The federal standard for assets is $9,950 for an individual and $14,910 for a couple.
A few hundred people are enrolled in a separate MSP group called Qualified Disabled Working Individual (QDWI).
Since states do not have the same flexibility over QDWI eligibility, we excluded it from this slide.

Over 40% of eligible people are not enrolled



Extensive documentation including financial documents



Confusing process separate from Medicare, varies by state



Lack of awareness about MSPs or opportunity to apply

Seven reasons to make it easier to enroll (and stay enrolled) in MSPs

1. Better **access** to health care
2. Lower **risk of death**
3. Greater **economic security**
4. **Less red tape** for applicants and their families
5. Lower **administrative burden and costs for states**
6. Lower **error rates**
7. Improved **local economy**

1 Better access to health care

✓ Increased use of preventive care

- *QMBs half as likely as non-MSP enrollees to avoid doctor visits due to costs[1]*
- *Permanent loss of Medicaid at age 65 associated with a lower rate of physician visits and home health care use*[2]*

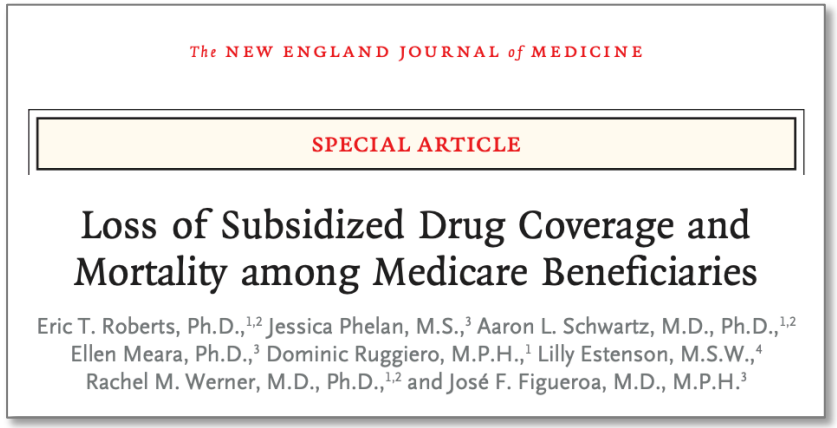
✓ Improved access to treatment[3]

- *Full Part D Extra Help enrollees had higher anti-cancer treatment uptake than partial and non-enrollees*
- *Full Part D enrollees initiated Rx treatment faster than partial and non-enrollees*

*Relative to those who retained Medicaid or regained it after a temporary loss.

[1]Alex D. Federman et al., "Avoidance Of Health Care Services Because Of Cost: Impact Of The Medicare Savings Program," *Health Affairs* 24, no. 1 (2005): 263–70, https://doi.org/10.1377/hlthaff.24.1.263.
[2]Maryssa Pallis et al., "Long-Term Changes in Health Care Use and Outcomes Among Groups Maintaining Versus Losing Medicaid Upon Medicare Enrollment," Milbank Quarterly, 104, no. 2 (February 27, 2026): 7-15, https://doi.org/10.1111/1468-0009.70076.
[3]Yi-Ting Chou et al., "The Association Between Medicare Low-Income Subsidy and Anticancer Treatment Uptake in Advanced Lung Cancer," *Journal of the National Cancer Institute* 112, no. 6 (2020): 637–46, https://doi.org/10.1093/jnci/djz183.

2 Lower risk of death



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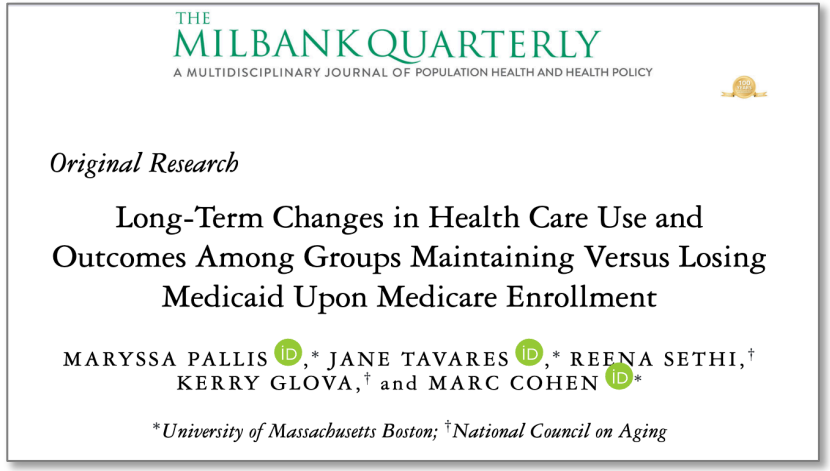
SPECIAL ARTICLE

Loss of Subsidized Drug Coverage and Mortality among Medicare Beneficiaries

Eric T. Roberts, Ph.D.,[1,2] Jessica Phelan, M.S.,[3] Aaron L. Schwartz, M.D., Ph.D.,[1,2] Ellen Meara, Ph.D.,[3] Dominic Ruggiero, M.P.H.,[1] Lilly Estenson, M.S.W.,[4] Rachel M. Werner, M.D., Ph.D.,[1,2] and José F. Figueroa, M.D., M.P.H.[3]

Loss of Part D Extra Help after Medicaid disenrollment was associated with higher mortality among low-income Medicare beneficiaries.[1]

Permanent Medicaid loss after age 65 was associated with higher mortality than those who retained Medicaid or regained it after a temporary loss.[2]



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Original Research

Long-Term Changes in Health Care Use and Outcomes Among Groups Maintaining Versus Losing Medicaid Upon Medicare Enrollment

MARYSSA PALLIS,* JANE TAVARES,* REENA SETHI,† KERRY GLOVA,† and MARC COHEN*

*University of Massachusetts Boston; †National Council on Aging

[1]Eric T. Roberts et al., "Loss of Subsidized Drug Coverage and Mortality among Medicare Beneficiaries," *New England Journal of Medicine* 392, no. 20 (2025): 2025–34, https://doi.org/10.1056/NEJMsa2414435.
[2]Maryssa Pallis et al., "Long-Term Changes in Health Care Use and Outcomes Among Groups Maintaining Versus Losing Medicaid Upon Medicare Enrollment," Milbank Quarterly, 104, no. 2 (February 27, 2026): 7-15, https://doi.org/10.1111/1468-0009.70076.

States have options to address these challenges

Larger-scale opportunities	 Eliminate the asset test  Flatten the benefit cliff from Medicaid to Medicare
Incremental opportunities	 End the MSP family caregiver penalty  Disregard the value of non-liquid assets

Model policies open for public comment through July 10th

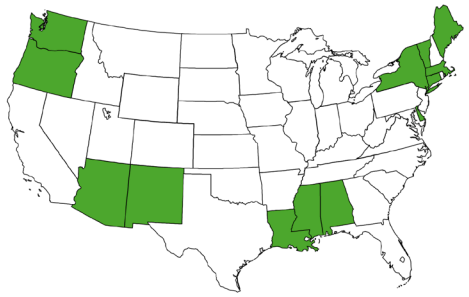
www.ADHealthPolicyLab.org

State Model Policy

Eliminate the Asset Test

Only count income, not assets, to assess MSP eligibility

- **Benefits for older adults & people with disabilities:** Major burden reduction, better access and economic security
- **State benefits:** Major burden reduction and administrative savings, higher *ex parte* renewal rates, lower error rates
- **State costs:** Modest in initial years (around 0.5% increase in spending on Medicare premiums/cost sharing in year 1)



13 states have eliminated the asset test

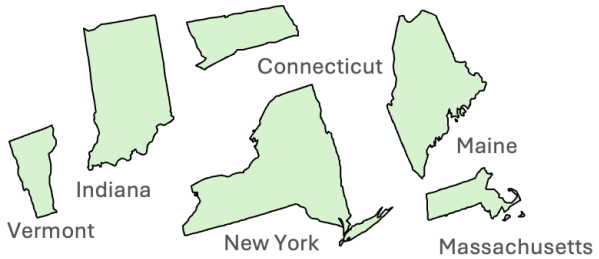
including Alabama, Arizona, Connecticut, Delaware, Louisiana, Maine, Massachusetts, Mississippi, New Mexico, New York, Oregon, Vermont, and Washington, as well as the District of Columbia.

State Model Policy

Flatten Benefit Cliff from Medicaid to Medicare

Eliminate premiums and cost sharing for Medicare beneficiaries with incomes up to 138% FPL and cover Part B premium using 100% federal funding for people with incomes up to 186% FPL

- **Benefits for older adults & people with disabilities:** Major improvement in access and economic security, current SLMBs and QIs newly protected from cost liability, lower mortality, elimination of financial shocks when new to Medicare
- **State benefits:** Maximize federal funding
- **State costs:** Increased Medicaid spending to cover Medicare cost sharing for people with incomes up to 138%



6 states have flattened the benefit cliff
including Maine, New York, Connecticut, Indiana, Massachusetts, and the District of Columbia.

State Model Policy

End the MSP Family Caregiver Penalty

Increase MSP income eligibility thresholds by expanding the definition of family size, beyond just spouse, to include household dependents

- **Benefits for older adults & people with disabilities:** For family caregivers like grandparents raising grandchildren, better access and economic security
- **State benefits:** Stability and fairness for family caregivers who are experiencing economic hardship
- **State costs:** Low and temporary new Medicaid costs



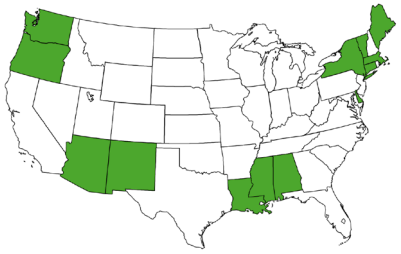
Florida has implemented this policy

State Model Policy

Disregard the Value of Non-Liquid Assets

Exclude the value of non-liquid assets from the MSP asset test

- **Benefits for older adults & people with disabilities:** Burden reduction, especially in rural areas
- **State benefits:** Burden reduction and administrative savings
- **State costs:** Low new Medicaid costs



13 states disregard all assets, but we are not aware of any other that have specifically excluded all non-liquid resources

MSPs in Washington State

Asset test eliminated for MSPs (QMB, SLMB, and QI) in 2023



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ADHealthPolicyLab.org

Info@ADHealthPolicyLab.org

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