

## Insight on the Issues

# Medicare Savings Program Enrollment Increases When States Expand Financial Eligibility Criteria

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### Key Takeaways

- ✓ States set financial eligibility criteria for Medicare Savings Programs (MSPs). Many states have more generous eligibility criteria than the federal minimum standards require.
- ✓ In four states (Indiana, Louisiana, Massachusetts, and Oregon) that expanded MSP eligibility criteria, MSP enrollment rates increased after the change.
- ✓ In the states analyzed, MSP enrollment rates increased immediately when states increased the income levels for MSP eligibility, whereas in states that eliminated asset limits, enrollment increases took longer to materialize.
- ✓ All states experienced long-term growth in MSP enrollment rates after their policy changes. By the end of 2022, the actual enrollment rates were 54 percent, 14 percent, 28 percent, and 10 percent higher than would have been expected in Indiana, Louisiana, Massachusetts, and Oregon, respectively, if the state's enrollment had continued with the trajectory before the policy change.

Medicare Savings Programs (MSPs) can help individuals with low incomes by paying their Medicare premiums and, in some cases, out-of-pocket costs like deductibles and cost sharing.<sup>1</sup> Most individuals who enroll in MSPs can save approximately \$2,000 or more in out-of-pocket costs each year.<sup>2</sup> Those determined eligible for MSPs are also automatically enrolled in the federal Low-Income Subsidy program, which helps pay for enrollees' Medicare Part D drug costs. Increasing access to these important programs can improve individuals' overall financial stability and—by alleviating costs—may also lead to better health outcomes, thus helping maintain health and well-being.

Given these benefits, many states have expanded access to MSPs to take advantage of state authority to set more generous financial eligibility thresholds than what federal law requires. States have done so in three ways:

increasing the income limits used for one or more MSPs, changing how they assess assets, and eliminating the consideration of assets entirely when determining MSP eligibility.

The outcomes of these actions are particularly relevant at a time when additional states are considering changes to MSP financial eligibility criteria. Yet information has remained limited on how eligibility criteria changes have affected enrollment.<sup>3</sup>

Insights on how these policy decisions have affected MSP enrollment can help policymakers evaluate the potential costs and benefits of expanding financial eligibility. Mathematica, working with the AARP Public Policy Institute, analyzed MSP enrollment patterns in a sample of four states before and after they expanded MSP eligibility criteria. The findings show that these changes led to enrollment growth and suggest multiple potential benefits to states.

### States set financial eligibility criteria

Federal law sets minimum standards for MSP eligibility, but states can use more generous eligibility criteria for each of the four MSPs (table 1). For example, under the Qualified Medicare Beneficiary (QMB) program, one of the four MSPs, all states must at least cover Medicare beneficiaries who earn up to 100 percent of the federal poverty level (FPL) in income.<sup>4</sup> For 2023, this equates to about \$14,820 annually for an individual.<sup>5</sup> Individuals can also have a maximum of \$9,090 in assets. The QMB program pays for enrollees' Medicare Parts A and B premiums and Medicare cost sharing.

To date, 17 states have chosen to use more generous income and/or asset criteria for MSPs than the federal standards described in table 1, including six states that use more generous income limits for one or more of the MSPs, and 16 states that have increased or eliminated the asset limit completely.<sup>6</sup>

### A look at the states analyzed

The four sample states represent several types of financial eligibility criteria changes (changes to income criteria, asset criteria, or both). These four states also made their eligibility criteria changes sufficiently long ago to allow for examination of the policy changes' effects on MSP enrollment but not so long ago as to make the data less reliable.<sup>7</sup> Following are the states analyzed, including the eligibility changes they made:

- Indiana raised the income limit for its QMB program from 100 percent to 150 percent of the FPL and raised SLMB and QI income limits to 170 percent and 185 percent of the FPL, respectively, in 2014.<sup>8</sup>
- Louisiana eliminated the asset test for all MSPs (meaning they do not look at assets at all in determining MSP eligibility) as of 2019.

TABLE 1  
2023 Federal MSP Eligibility Criteria

Medicare savings program	Monthly income limits (for individuals/ married couples)	Asset limits (for individuals/ married couple)	Costs covered
<b>Qualified Medicare Beneficiary (QMB)</b>	Less than 100% federal poverty level (FPL) (\$1,235/\$1,663)	\$9,090/\$13,630	Medicare Part A premium (when applicable); Medicare Part B premium; and Medicare Parts A and B deductibles, coinsurance, and copayments
<b>Specified Low-Income Medicare Beneficiary (SLMB)</b>	100%–120% FPL (\$1,478/\$1,992)	\$9,090/\$13,630	Medicare Part B premium
<b>Qualifying Individual (QI)</b>	120%–135% FPL (\$1,660/\$2,239)	\$9,090/\$13,630	Medicare Part B premium
<b>Qualified Disabled and Working Individual (QDWI)*</b>	Less than 200% FPL (\$4,945/\$6,659)	\$4,000/6,000	Medicare Part A premiums only

**Notes:** Federal MSP eligibility criteria are codified in Section 1902(a)(10)(E) of the Social Security Act. Alaska and Hawaii have slightly higher federal income limits. Section 1902(r)(2) of the Social Security Act grants all states the ability to use more generous income and asset criteria for these programs than the federal minimum standards listed in this table. The monthly income limits listed in this table include a \$20 per month income disregard.

**Source:** The National Council On Aging (NCOA), Medicare Savings Programs (MSPs): Eligibility and Coverage (2023), <https://www.ncoa.org/article/medicare-savings-programs-eligibility-coverage>.

\* The analysis described here did not include QDWI. Enrollment in the QDWI program is small, so state policy changes to eligibility criteria are likely to have a limited effect on QDWI enrollment.

- Massachusetts raised its income limits for the QMB program to 130 percent of the FPL, for the SLMB program to 150 percent of the FPL, and for QI to 165 percent of the FPL (with a \$20 disregard for all three) in 2020. The state also increased its MSP asset limits that year to \$15,720 for an individual and \$23,600 for a couple.<sup>9</sup>
- Oregon eliminated the asset test for all MSPs as of 2016.

### Findings: enrollment effects

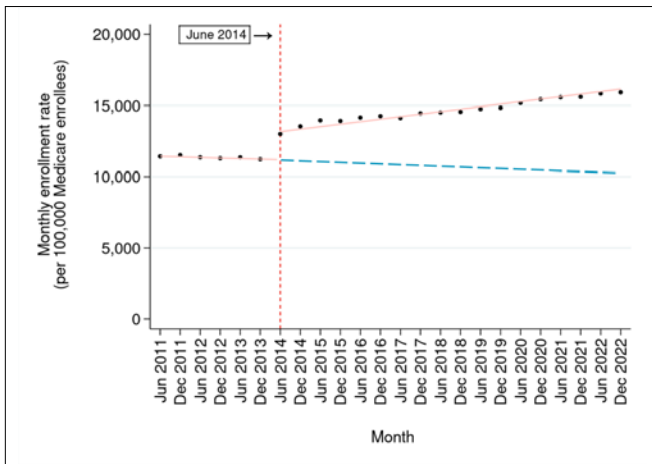
The analysis showed the following:

1. Overall MSP enrollment rates (per 100,000 Medicare beneficiaries) increased in all states after they made changes to their income or asset limits. That trend came after MSP enrollment rates in all four states either remained flat or declined slightly (exhibits 1-4) before making their MSP eligibility criteria changes.<sup>10</sup> By December 2022,
    - a. About eight years after the policy change, Indiana's actual MSP enrollment rate was about 16,160 (per 100,000 Medicare beneficiaries), whereas the state's enrollment rate would have been around 10,501 (per 100,000 beneficiaries) if enrollment had continued the trajectory before the policy change, an approximately 54 percent change (exhibit 1).
    - b. About three years after the policy change, Louisiana's actual MSP enrollment rate was about 25,715 (per 100,000 Medicare beneficiaries), whereas the state's enrollment rate would have been around 22,606 (per 100,000 beneficiaries) if enrollment had continued the trajectory before the policy change, an approximately 14 percent change (exhibit 2).
    - c. About two years after the policy change, Massachusetts's actual MSP enrollment rate was about 20,689 (per 100,000 Medicare beneficiaries), whereas the state's enrollment rate would have been around 16,200 (per 100,000 beneficiaries) if enrollment had continued the trajectory before the policy change, an approximately 28 percent change (exhibit 3).
    - d. About six years after the policy change, Oregon's actual MSP enrollment rate was about 15,159 (per 100,000 Medicare beneficiaries), whereas the state's enrollment rate would have been around 13,796 (per 100,000 beneficiaries) if enrollment had continued the trajectory before the policy change, an approximately 10 percent change (exhibit 4).
  2. How quickly enrollment rates began to increase differed among the four states:<sup>11</sup>
    - a. In Indiana and Massachusetts, where income limits changed, the overall MSP enrollment rate increased immediately after the policy change took effect and continued to increase over time (exhibits 1 and 3).
    - b. In Louisiana and Oregon, states that eliminated MSP asset limits, the overall MSP enrollment rate declined immediately after the policy implementation but later began to increase (exhibits 2 and 4).
  3. Enrollment growth after eligibility changes was largely in QMB programs (appendix exhibits B.1-B.4). Enrollment rates in the SLMB and QI programs remained flat or declined slightly in three of the four states—Indiana, Massachusetts, and Oregon—and increased slightly in Louisiana after the eligibility criteria changes.
- These differences remained even after controlling for time-varying, state-level characteristics that could have affected MSP enrollment, including state-year demographic and socioeconomic characteristics.<sup>12</sup>

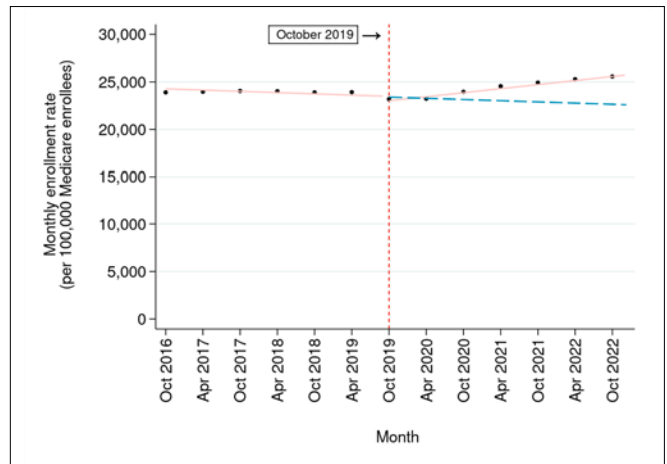
### Monthly Enrollment Rate Graph Notes

- Enrollment rates are per 100,000 Medicare beneficiaries, before and after the state’s eligibility criteria change.
- The dots represent actual monthly enrollment rates for MSPs (QMB, SLMB, and QI programs combined) in each state before and after the state’s eligibility criteria change, for the months labeled on the x-axis (with the remaining monthly enrollment data points suppressed for readability).
- The solid orange lines show the actual enrollment trend, whereas the blue dotted line shows the expected enrollment trend in the absence of the eligibility criteria change.
- MSP = Medicare Savings Program; QI = Qualifying Individual; QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-Income Medicare Beneficiary.

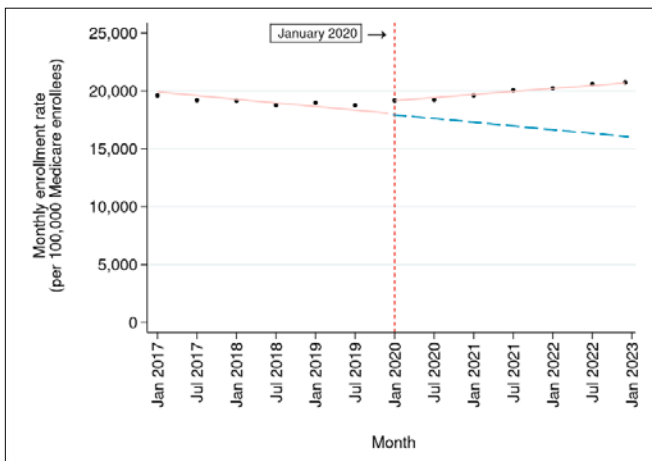
**EXHIBIT 1**  
**Indiana Overall MSP Monthly Enrollment Rates<sup>13</sup>**



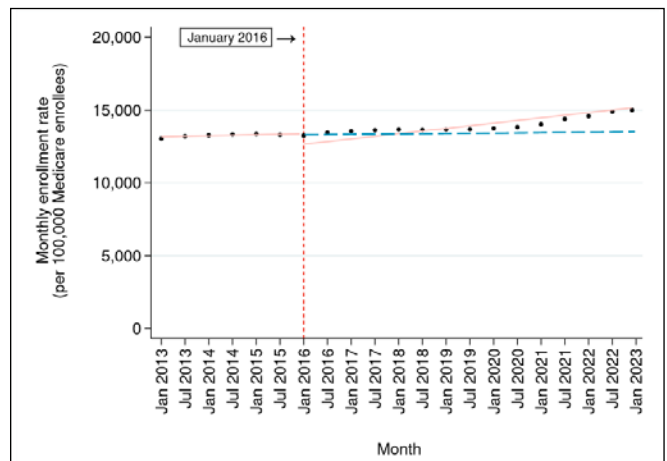
**EXHIBIT 2**  
**Louisiana Overall MSP Monthly Enrollment Rates<sup>14</sup>**



**EXHIBIT 3**  
**Massachusetts Overall MSP Monthly Enrollment Rates<sup>15</sup>**



**EXHIBIT 4**  
**Oregon Overall MSP Monthly Enrollment Rates<sup>16</sup>**



### Policy implications: eligibility changes lead to enrollment changes

Based on the four states examined, our findings suggest that MSP enrollment will increase, especially in the QMB program, after states expand financial eligibility criteria and that enrollment increases are likely to happen more quickly in states with income eligibility criteria changes (Indiana and Massachusetts), compared with states with only asset test changes (Louisiana and Oregon).

The more significant initial enrollment bumps from income criteria changes may stem from those changes possibly being easier to convey in outreach messaging and easier for potential enrollees to understand in the context of their own financial situation. Changes to asset limits, on the other hand, may be more complicated to explain and less tangible for potential enrollees, leading to a slower uptake in enrollment.

In our analysis, some of the differences observed in SLMB and QMB enrollment after the policy change could be due to people shifting from SLMB into QMB. Once a state expanded QMB eligibility, some SLMB enrollees who became newly eligible for QMB likely moved for QMB's more generous benefits (table 1). Even accounting for new SLMB enrollees, overall SLMB enrollment remained relatively flat. The relative lack of enrollment increases in the QI program could reflect the general underenrollment in that program. A 2017 Medicaid and CHIP Payment and Access Commission (MACPAC) analysis found the QI program to be the most underenrolled of the MSPs, with only a 15 percent participation rate.<sup>17</sup> Thus, even if enrollment increased in the QI program as states expanded eligibility, program enrollment rates would likely remain low.

### Takeaways: benefits to residents, state

Many variables may affect states' decisions to change financial eligibility for MSP programs. States thinking about expanding eligibility for

MSPs will likely need to consider the following factors, among others:

1. How many state residents could be helped,
2. Whether the changes could affect the state budget, and
3. Whether the eligibility criteria changes and/or expanded MSP enrollment could result in financial savings for the state in other areas.

Potential state savings could come from eliminating MSP asset limits by reducing administrative burden for both beneficiaries and state eligibility staff because there would no longer be a need to review asset documentation during initial and annual eligibility determinations. Additionally, expanding MSP eligibility criteria could help more low-income Medicare beneficiaries access preventive and community-based care, thus helping reduce the need for states to cover higher-cost long-term services and supports through their Medicaid programs.

These study results can help states plan for changes to financial eligibility criteria. The results provide evidence that state policy efforts to change MSP eligibility achieve their intended effect of helping additional state residents access benefits that make health care more affordable. Increased enrollment in most MSPs will mean factoring in an accompanying state cost. States pay a share of the costs of each MSP, generally the state's federal medical assistance percentage for Medicaid, except the QI program (which is fully funded by the federal government).<sup>18</sup> However, increasing MSP enrollment will also ease the financial burden of accessing needed health care for residents who are newly able to enroll, which could play a role in reducing other state costs (for example, Medicaid costs) in the long run.

Research has long shown that individuals are prone to delay health care because of cost. Delays in care can detrimentally affect health, which can lead to higher health care costs over time, lost productivity, and other consequences that may have wider, indirect economic

effects in the state.<sup>19,20</sup> Additionally, providing individuals financial support for necessary expenses, like health care and food, can allow them to spend extra funds in other ways, having wide-reaching economic effects.<sup>21</sup>

In light of these findings, states should continue to consider expanding MSP eligibility criteria to increase enrollment in these important programs. States looking to make the quickest boost to enrollment may want to

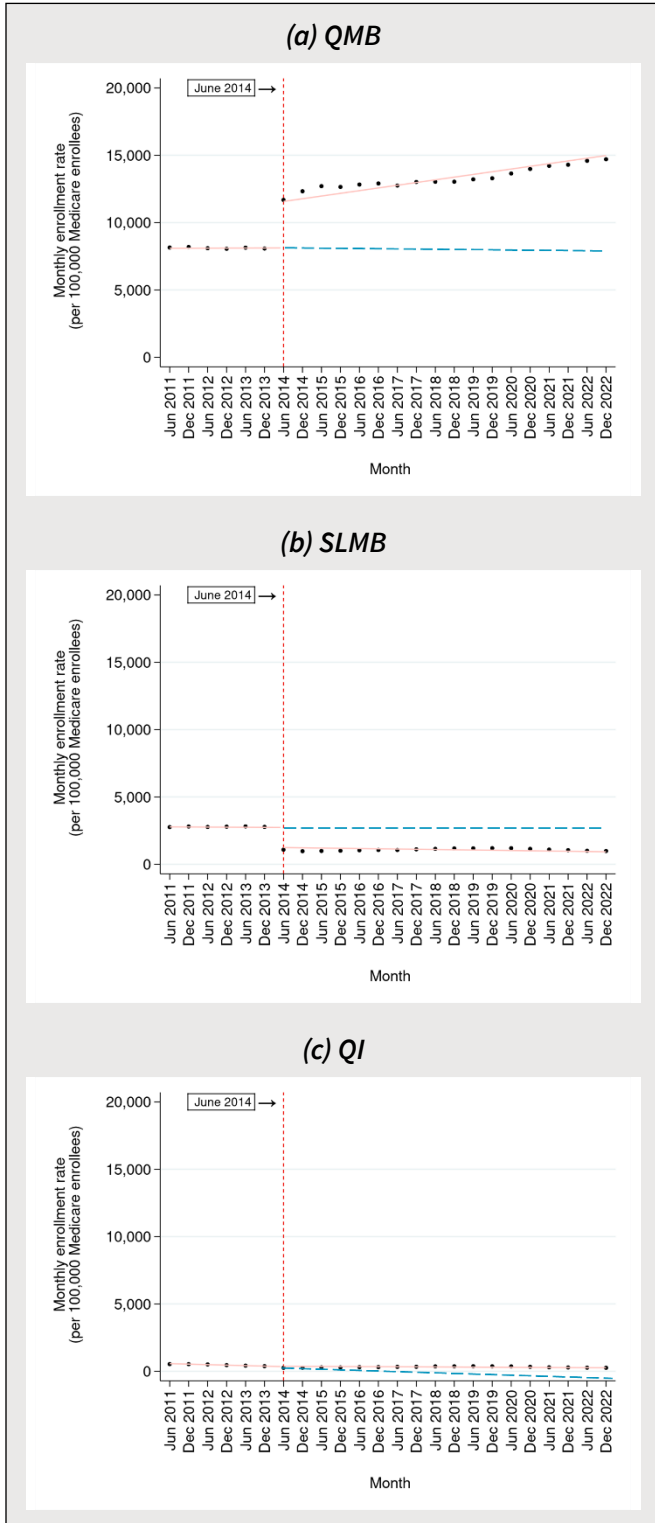
consider changes to income eligibility criteria. Meanwhile, although asset test changes may require more time and effort to explain, states that make those changes can gain a return on investment in the form of reduced burden and time savings from staff who will no longer need to review and process asset documentation. Regardless of the specific change(s) made, increasing MSP enrollment to help low-income residents afford their health care can benefit both the residents and the state overall.

## Appendix A: Supplemental Exhibits

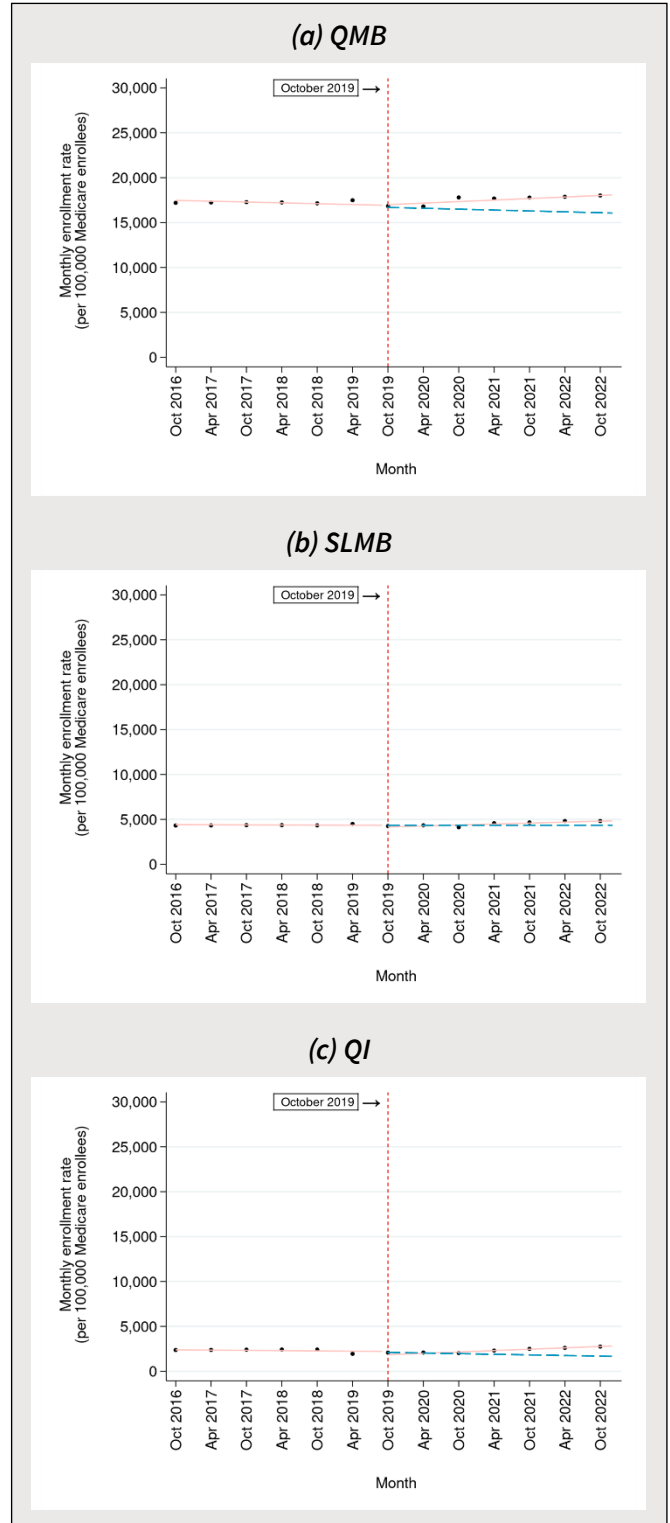
### Appendix A Graph Notes

- Graphs show monthly enrollment rates (per 100,000 Medicare beneficiaries) before and after the state's eligibility criteria change.
- The dots represent actual monthly enrollment rates for QMB, SLMB, and QI programs in each state before and after the state's eligibility criteria change, for the months labeled on the x-axis (with the remaining monthly enrollment data points suppressed for readability).
- The solid orange lines show the actual enrollment trend, whereas the blue dotted line shows the expected enrollment trend in the absence of the eligibility criteria change.
- MSP = Medicare Savings Program; QI = Qualifying Individual; QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-Income Medicare Beneficiary.

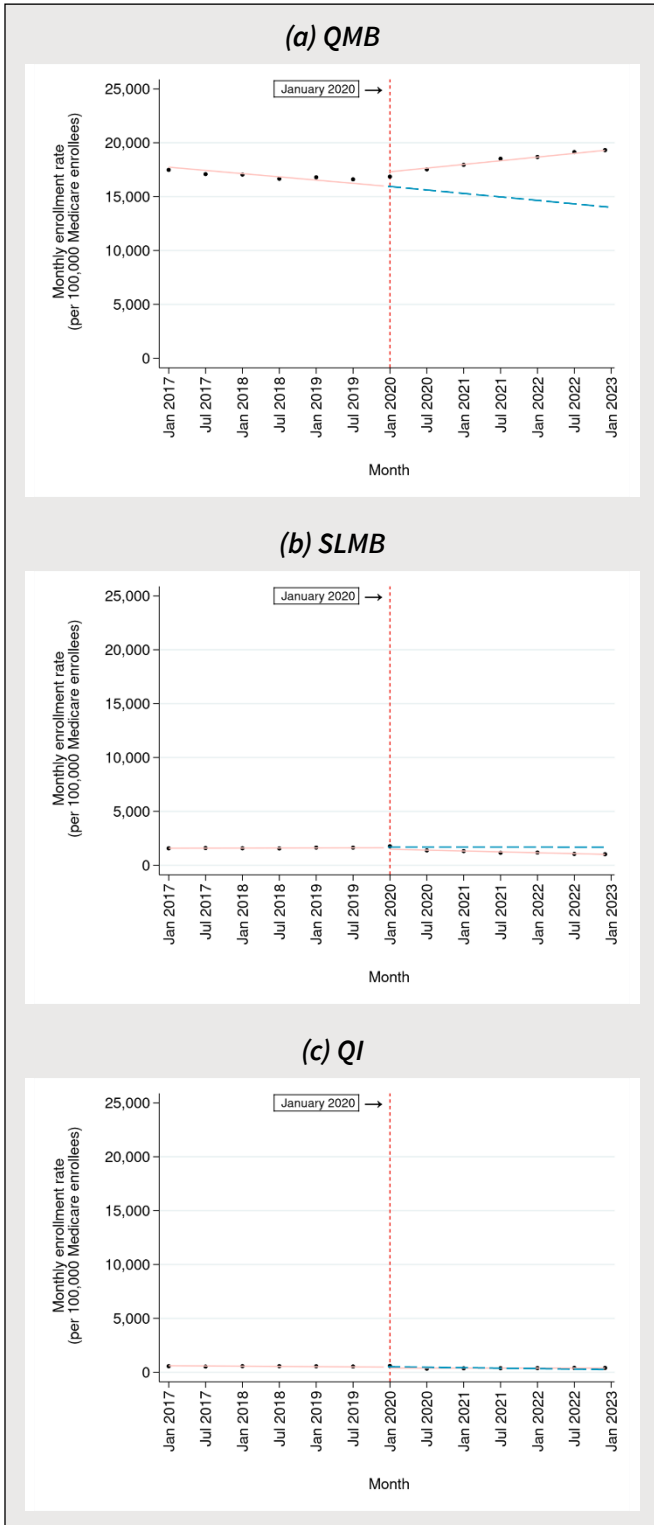
**EXHIBIT A.1**  
**Indiana QMB, SLMB, and QI Monthly Enrollment Rates<sup>22</sup>**



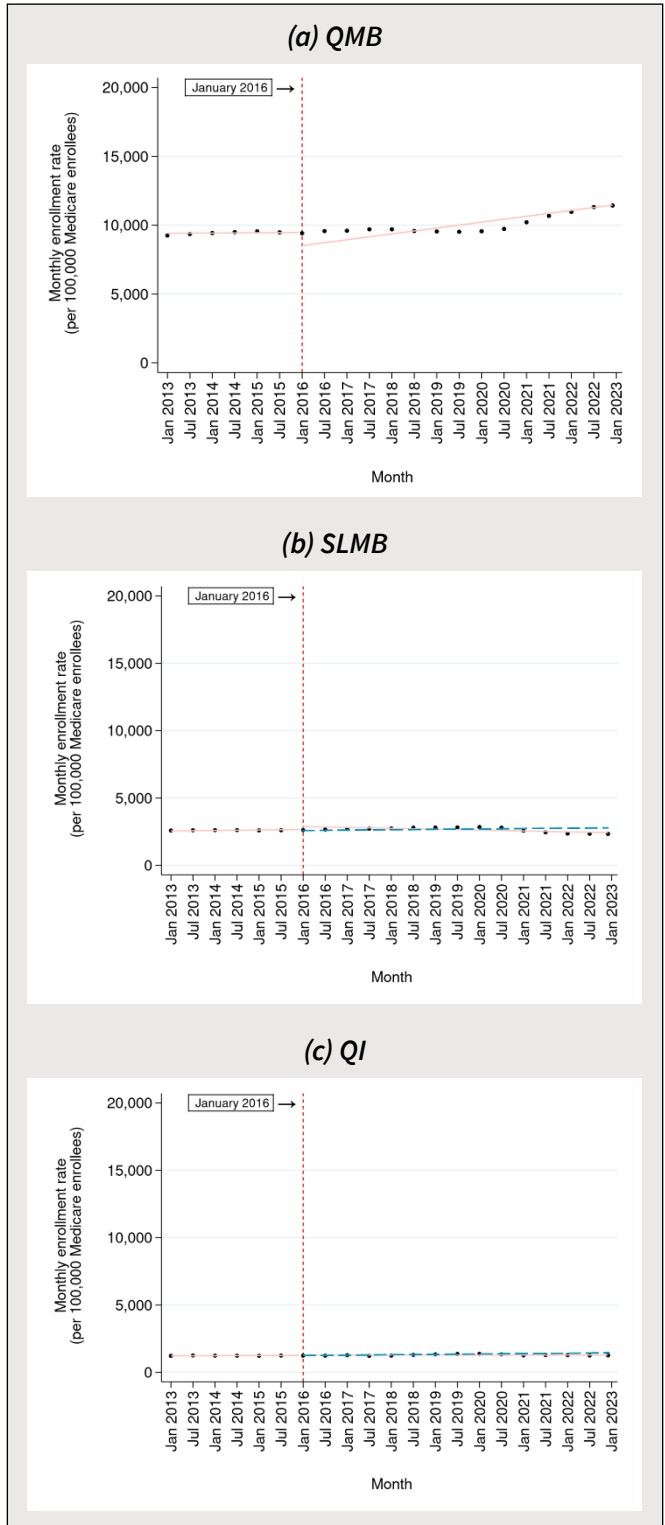
**EXHIBIT A.2**  
**Louisiana QMB, SLMB, and QI Monthly Enrollment Rates<sup>23</sup>**



**EXHIBIT A.3**  
**Massachusetts QMB, SLMB, and QI Monthly Enrollment Rates<sup>24</sup>**



**EXHIBIT A.4**  
**Oregon QMB, SLMB, and QI Monthly Enrollment Rates<sup>25</sup>**





## Appendix B: Methodology

1. Data
  - a. Medicare Beneficiary Summary File data used to obtain state-month enrollment in MSPs and Medicare (used to construct outcome measures)
  - b. US Census data used to obtain state-year demographic and socioeconomic characteristics used to adjust for factors outside of the MSP policy change that may affect MSP enrollment rates over time
2. Sample
  - a. We included all Medicare beneficiaries residing in each of the four states that made changes to MSP eligibility criteria between 2014 and 2020 for the relevant analysis period.
    - i. Indiana: June 2011-December 2022
    - ii. Louisiana: October 2016-December 2022
    - iii. Massachusetts: January 2017-December 2022
    - iv. Oregon: January 2013-December 2022
  - b. We then aggregated data to the state-month level.
3. Outcomes
  - a. We calculated state-month level rates of overall MSP enrollment per 100,000 Medicare beneficiaries as well as enrollment rates for each MSP of interest, including QMB, SLMB, and QI.
  - b. Because MSP enrollment can be driven by changes in the Medicare population, we adjusted MSP enrollment by the number of Medicare beneficiaries to make it easier to compare MSP enrollment across time and in different states.
4. Analyses
  - a. We conducted analyses separately by state.
    - i. We did the following for each state:
    - ii. Plotted monthly trend graphs to understand how MSP enrollment rates have changed over time in the state
    - iii. Ran Interrupted Time Series regressions to estimate whether and the extent to which the state eligibility expansion policy affected MSP enrollment rates in the short and long term
  - b. All regressions were adjusted for time-varying, state-level characteristics that could be potential confounders, including state-year demographic characteristics (percentage of the state's population that was age 65 and above, percentage of the state's population that was female, and the state's race and ethnicity distribution), and socioeconomic characteristics (percentage of the state's population below the poverty level and the state's unemployment rate).

### Study Limitations

- This analysis included information only on individuals who are enrolled in MSPs in each state, not on individuals who are eligible for (but not enrolled in) MSPs in each state based on MSP income and asset rules. The study therefore does not address how MSP eligibility criteria changes have affected MSP participation rates—that is, the proportion of eligible people who are enrolled in the programs.
- Although the analysis controlled for overall demographic and socioeconomic characteristics within states over time, other state factors that change over time (for example, enrollment outreach and support) could have affected MSP enrollment rates during our study period.
- Massachusetts has continued to incrementally increase its MSP asset limits since the state first increased those limits in 2020. Therefore, some of the estimated changes in MSP enrollment rates in the post-2020 period may be attributed to those subsequent changes in eligibility criteria rather than to the initial change in 2020.
- The conclusions may not necessarily apply to other states—either those that made changes to MSP eligibility policies before or after 2020 or those that have not made changes but are considering doing so in the future—because of the many contextual factors unique to each state.

- 1 The four MSPs are Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI). Each has different benefits and eligibility requirements.
- 2 For QMB, SLMB, and QI enrollees, MSPs at minimum cover the cost of Part B premiums, which, for 2023, is \$1,979 annually. “2023 Medicare Parts A & B Premiums and Deductibles 2023 Medicare Part D Income-Related Monthly Adjustment Amounts,” Centers for Medicare & Medicaid Services, September 27, 2022, <https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023-medicare-part-d-income-related-monthly>.
- 3 State Medicaid officials interviewed in the early 2000s reported that they did not think changes to the asset tests made a significant difference in enrollment. In 2001, Arizona’s Medicaid staff projected that if the state eliminated its asset test, enrollment would increase by only 475. Amy M. Tiedemann et al., “Promising Strategies for Medicare Savings Program Enrollment: State Solutions Project: An Initiative to Improve Enrollment in Medicare Savings Programs,” Rutgers University, Center for State Health Policy, May 2005, <http://www.cshp.rutgers.edu/Downloads/5300.pdf>.
- 4 Sections 1905(p)(1) and 1902(a)(10)(E) of the Social Security Act.
- 5 This annualized amount includes a \$20 per month general income disregard. “Medicare Savings Programs,” Centers for Medicare & Medicaid Services, <https://www.medicare.gov/medicare-savings-programs>.
- 6 “Medicare Savings Programs (MSPs): Eligibility and Coverage,” National Council on Aging, February 3, 2023, <https://www.ncoa.org/article/medicare-savings-programs-eligibility-coverage>.
- 7 The dual status codes necessary for this analysis have been present in Medicare Beneficiary Summary File data only since 2005, the first year that states began exchanging Medicare Modernization Act (MMA) files with the Centers for Medicare & Medicaid Services. MMA files are used to identify individuals who are dually eligible for Medicare and Medicaid. Because states’ ability to accurately identify different types of dually eligible individuals (including MSP enrollees) in MMA files has improved in accuracy in recent years, the accuracy of dual status code information in Medicare Beneficiary Summary File data has also improved.
- 8 Indiana’s QMB, SLMB, and QI income limits have been 150 percent, 170 percent, and 185 percent of the federal poverty level, respectively, since the state increased them in 2014.
- 9 In the years since, the state has continued to incrementally increase the asset limits (to \$15,940/\$23,920 in 2021, \$16,800/\$25,200 in 2022, and \$18,180/\$27,260 in 2023). Massachusetts also increased its QMB, SLMB, and QI income limits again in 2023 to 190 percent, 210 percent, and 220 percent of the federal poverty level, respectively. “Medicare Savings Programs (MSPs): Eligibility and Coverage,” National Council on Aging, 2020.

- 10 This pattern reflects the fact that the Medicare beneficiary populations in these four states grew during these periods, but MSP enrollment either remained flat or increased at a slower rate than the growth in the state's Medicare beneficiary population (data not shown).
- 11 This reflects the fact that states varied in how quickly their overall MSP enrollment counts responded to the policy changes. By contrast, in all states, Medicare beneficiary population growth trended smoothly before and after the policy changes (data not shown).
- 12 State-year demographic characteristics were measured by the percentage of the state's population that was age 65 and older, the percentage of the state's population that was female, and the state's race and ethnicity distribution. Socioeconomic characteristics were measured by the percentage of the state's population below the poverty level and the state's unemployment rate.
- 13 Using an ITS model, we estimated that the level of the monthly enrollment rate decreased by 473.5 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 94.3 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period. The level estimate was not statistically significant at  $p \leq 0.05$  and the slope estimate was statistically significant at  $p \leq 0.001$ .
- 14 Using an ITS model, we estimated that the level of the monthly enrollment rate increased by 1,986.1 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 36.0 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period. Both estimates were statistically significant at  $p \leq 0.001$ .
- 15 Using an ITS model, we estimated that the level of the monthly enrollment rate increased by 1,146.5 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 95.5 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period. Both estimates were statistically significant at  $p \leq 0.001$ .
- 16 Using an ITS model, we estimated that the level of the monthly enrollment rate decreased by 703.7 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 24.9 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period. Both estimates were statistically significant at  $p \leq 0.001$ .
- 17 "Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled," Medicaid and CHIP Payment and Access Commission (MACPAC), August 2017, <https://www.macpac.gov/publication/medicare-savings-programs-new-estimates-continue-to-show-many-eligible-individuals-not-enrolled/>.
- 18 QMB, SLMB, and QDWI programs are partially funded by federal dollars using the Federal Medical Assistance Percentage. See MACPAC Chapter 3: Improving Participation in the Medicare Savings Programs, p. 67, <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-3-Improving-Participation-in-the-Medicare-Savings-Programs.pdf>.
- 19 Autumn H. Gertz et al., "Delayed Medical Care and Underlying Health in the United States During the COVID-19 Pandemic: A Cross-Sectional Study," *Preventive Medicine Reports* (August 28, 2022): 101882, <https://doi.org/10.1016/j.pmedr.2022.101882>.
- 20 Reed Abelson, "Higher Bills Are Leading Americans to Delay Medical Care," *The New York Times*, February 16, 2023, <https://www.nytimes.com/2023/02/16/health/inflation-delayed-health-care.html>.
- 21 Stephen Vogel et al., "Impact of USDA's Supplemental Nutrition Assistance Program (SNAP) on Rural and Urban Economies in the Aftermath of the Great Recession," US Department of Agriculture, Economic Research Service, Report No. 296, October 2021, <https://www.ers.usda.gov/webdocs/publications/102287/err-296.pdf?v=715.6>; "The Supplemental Nutrition Assistance Program (SNAP) and the Economy: New Estimates of the SNAP Multiplier," US Department of Agriculture, Economic Research Service, July 2019, <https://healthyeatingresearch.org/wp-content/uploads/2020/04/HER-SNAP-Brief-042220.pdf>.
- 22 Using an ITS model, we estimated that the level of the QMB monthly enrollment rate increased by 3,449.9 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 32.8 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; both estimates were statistically significant at  $p \leq 0.001$ . Additionally, we estimated that the level of the SLMB monthly enrollment rate decreased by 1,490.1 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend decreased by 1.9 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; the level estimate was statistically significant at  $p \leq 0.001$  and the slope estimate was not statistically significant at  $p \leq 0.05$ . Finally, we estimated that the level of the QI monthly enrollment rate increased by 26.2 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 5.1 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; the level estimate was not statistically significant at  $p \leq 0.05$  and the slope estimate was statistically significant at  $p \leq 0.001$ .

- 23 Using an ITS model, we estimated that the level of the QMB monthly enrollment rate increased by 78.0 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 43.7 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; the level estimate was not statistically significant at  $p \leq 0.05$  and the slope estimate was statistically significant at  $p \leq 0.001$ . Additionally, we estimated that the level of the SLMB monthly enrollment rate decreased by 186.8 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 19.9 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; the level estimate was not statistically significant at  $p \leq 0.05$  and the slope estimate was statistically significant at  $p \leq 0.01$ . Finally, we estimated that the level of the QI monthly enrollment rate decreased by 364.6 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 30.6 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; both estimates were statistically significant at  $p \leq 0.001$ .
- 24 Using an ITS model, we estimated that the level of the QMB monthly enrollment rate increased by 1,371.3 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 106.8 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; both estimates were statistically significant at  $p \leq 0.001$ . Additionally, we estimated that the level of the SLMB monthly enrollment rate decreased by 135.1 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend decreased by 14.8 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; the level estimate was statistically significant at  $p \leq 0.01$  and the slope estimate was statistically significant at  $p \leq 0.001$ . Finally, we estimated that the level of the QI monthly enrollment rate decreased by 89.7 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 3.6 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; both estimates were statistically significant at  $p \leq 0.05$ .
- 25 Using an ITS model, we estimated that the level of the QMB monthly enrollment rate decreased by 951.8 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend increased by 33.8 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; both estimates were statistically significant at  $p \leq 0.001$ . Additionally, we estimated that the level of the SLMB monthly enrollment rate increased by 215.2 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend decreased by 8.2 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; both estimates were statistically significant at  $p \leq 0.001$ . Finally, we estimated that the level of the QI monthly enrollment rate increased by 32.9 (per 100,000 Medicare beneficiaries) upon the policy change and the slope of the enrollment trend decreased by 0.7 (per 100,000 Medicare beneficiaries) after the policy change compared to the pre-policy period; the estimates were not statistically significant at  $p \leq 0.05$ .

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Insight on the Issues 1749900, November 2023

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