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REPORT

# Estimates of Potential Eligibility for Low-Income Subsidies Under Medicare Part D

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Sponsored by the Social Security Administration



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## Summary

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The 2003 Medicare Prescription Drug, Improvement, and Modernization Act (Pub. L. No. 108-173) added a new prescription drug benefit to the Medicare program known as Part D (prescription drug coverage), as well as the Low-Income Subsidy (LIS) program to provide “extra help” with premiums, deductibles, and copayments for Medicare Part D beneficiaries with low income and limited assets. This study was designed to provide the Social Security Administration (SSA) and other policymakers with an independent estimate of the population potentially eligible for the extra help available through the LIS. Specifically, the study had four objectives:

- to generate a credible, independent estimate of the LIS-eligible population as of 2006 based on the best currently available data, both in aggregate and for relevant groups
- to assess the robustness of the estimates of the LIS-eligible population
- to examine the characteristics of the LIS-eligible population
- to generate a projection of the LIS-eligible population in 2008.

To accomplish these objectives, we had to confront a number of methodological challenges that arise because of who is eligible for the LIS and the eligibility criteria, as well as how those factors accord with available data. In this way, we sought to improve on prior estimates provided by the Congressional Budget Office (CBO), the Centers for Medicare and Medicaid Services (CMS), and other independent researchers. In particular, our study employed the following approaches, many of which represent advances over previous studies:

- employing both the Survey of Income and Program Participation (SIPP) and the Health and Retirement Study (HRS) to cover the potentially LIS-eligible noninstitutionalized and institutionalized populations of all ages
- constructing measures of income and resources that replicate as closely as possible the constructs used to determine LIS eligibility
- using matched administrative data to improve on potentially error-ridden survey measures of income and program participation

- adjusting sample weights to account for panel data attrition and selective matching of survey and administrative data
- performing extensive sensitivity analyses to determine how robust results are to variation in the methodology.

In the remainder of this summary, we highlight key findings with respect to the four study objectives.

## Size of the LIS-Eligible Population in 2006 and Sensitivity Analysis

Our preferred methodology used to derive baseline estimates for 2006 combines results from the SIPP and the HRS with equal weights for the overlapping population (the noninstitutionalized age 53 and above) and otherwise uses estimates from either the SIPP or the HRS for the other population subgroups. The baseline estimates use the matched SIPP-SSA data and impute Medicaid/Medicare Savings participation for the HRS. We also use attrition-adjusted and matching-adjusted (SIPP only) weights and rescale the weights to match known marginal distributions for the population.

Our results can be considered estimates of the *potentially* LIS-eligible population because we count as eligible those individuals who are not enrolled in Medicare Part D but are otherwise eligible for the LIS, even though Part D enrollment is a prerequisite to LIS eligibility. In addition, we distinguish between (1) *automatic eligibility* for the LIS—those who are potentially eligible because they are enrolled in the Supplemental Security Income (SSI) program, enrolled in Medicaid (the dual eligibles), or enrolled in a Medicare Savings program—and (2) *nonautomatic eligibility* for the LIS—those who qualify for a full or partial subsidy based only on meeting income and resource (asset) criteria (known as *direct eligibility*).

Using this method, we generate the following baseline results for 2006:

- An estimated 12.2 million persons, or 29 percent of Medicare beneficiaries, were potentially eligible for the LIS in 2006. Accounting for sampling error, the 95-percent confidence interval is from 11.4 million to 13.1 million. The error band would be wider if we also accounted for modeling uncertainty.
- Estimates by age show that 4.3 million of the potentially LIS-eligible population are under age 65 and 7.9 million are age 65 and older. The

eligibility rate is higher for the under-age-65 population (68 percent versus 22 percent for those 65 and older).

- The potentially eligible population consists of 11.6 million noninstitutionalized persons, while the remaining 0.6 million persons are in nursing homes. The eligibility rate is higher for those in nursing homes (50 versus 29 percent).
- Of those estimated to be LIS eligible, most would be eligible for the full subsidy either through automatic eligibility (6.9 million) or by meeting the lower income and resource thresholds (3.8 million). The remainder (1.5 million) would qualify for the partial subsidy.
- Of those who are estimated to be ineligible for the LIS, most have both income and resources too high (47 percent out of 71 percent), followed by only income too high (15 percent out of 71 percent) and then only resources too high (9 percent out of 71 percent).
- These baseline estimates are most sensitive to the weight we place on the estimates derived from the SIPP versus the HRS. Our baseline method gives them equal weight. If we instead give preference to the SIPP-based estimates and use the HRS only when it is the sole source of data for a subpopulation, the estimated number of LIS eligibles increases from the baseline of 12.2 million to 13.4 million. If we instead give preference to HRS-based estimates, the estimate falls to 11.1 million. Accounting for sampling error alone, the confidence intervals around these three estimates range from a lower bound (based on the HRS-preference result) of 10.3 million LIS eligibles to an upper bound (based on the SIPP-preference result) of 14.6 million eligibles.
- This wide range reflects significant distributional differences between the SIPP and the HRS, especially in the distribution of resources. As part of the sensitivity analyses, we rescaled the SIPP wealth distribution for the entire SIPP population using a scaling factor that matched the median of the SIPP distribution to the median of the HRS distribution for the population where they overlap. The result was a reduction from the baseline estimate of 12.2 million LIS eligibles to 11.5 million. Using an external benchmark from CMS of the number of Medicare beneficiaries automatically eligible for the LIS, we further refined our estimate to 11.8 million. Again, a reasonably large band of uncertainty still remains around this point estimate.

- Rescaling the SIPP wealth distribution was the methodological variant that generated the largest change in the estimate of LIS eligibles. All the other methodological choices we examined in the sensitivity analyses showed little to no effect on our estimates—differences were on the order of 1 to 2 percent. Thus, our results are more sensitive to the relative weight we place on the two data sources than to the choice of methods we apply to either data source. Given the mixed evidence regarding the quality of the measures of income, resources, and program participation in the two data sources, as well as the representativeness of the SIPP and HRS samples, it is not possible to definitively conclude that one data source is more accurate than the other.
- Even with this uncertainty, our estimates suggest that prior estimates of the size of the LIS-eligible population by CBO, CMS, and other independent researchers likely overstate the true number of eligibles. Our baseline estimate of 12.2 million and our refined estimate of 11.8 million in 2006 are both below the CMS estimate of 13.2 million, for example.

### **Characteristics of Populations Eligible and Not Eligible for the LIS**

Using both the HRS and the SIPP, we examined the characteristics of the population estimated to be eligible for the LIS under the baseline model versus those estimated to be ineligible. Among those eligible, we considered differences between those we estimated to be automatically eligible and those estimated to be nonautomatically eligible (i.e., they have direct eligibility but are not automatically eligible). Finally, we examined differences based on the SIPP data matched to LIS application records between those classified as nonautomatically eligible who do not apply for the LIS and those who applied for and were awarded the subsidy. In the HRS, we considered differences between those who were classified as nonautomatically eligible and self-reported being enrolled in Part D and those who said they did not have Part D coverage. There were some differences between the SIPP and the HRS in terms of measures of prescription drug usage and insurance coverage, and the two surveys provide results for different population groups. Nevertheless, they showed very consistent patterns, including the following:

- As expected, those not eligible for the LIS are disproportionately from sociodemographically more advantaged groups, such as males, non-Hispanic whites, those with higher education levels and better health status, and those with employer-based health insurance coverage.

Eligibility did not vary with prescription drug usage in the last year (SIPP) or with the combination of prescription drug use and creditable coverage (HRS).

- Among those who are estimated to be LIS eligible, the differences in the demographic characteristics of those who are automatically eligible and those who are nonautomatically eligible are modest. The automatically eligible are slightly more likely to be Hispanic or African American, have less than a high school diploma, and be in poor health. Based on the SIPP, the automatically eligible group is a little more likely to have used prescription drugs and to have health insurance coverage through Medicare or Medicaid. The HRS data show that the automatically eligible are overrepresented among those with regular prescription drug use and creditable coverage and among those with drug coverage through Medicaid. Again, these are the expected patterns, as automatic eligibility for the LIS applies to those who are already participating in means-tested programs that require low income and low assets.
- Among those who are nonautomatically eligible for the LIS, there is less than full take-up of the benefit. Based on the SIPP, among those who are estimated to be eligible for the LIS but are nonautomatically eligible, only about one in four is estimated to have applied for the LIS according to the administrative data, and the administrative data show awards for just under 20 percent of those estimated to have nonautomatic eligibility. According to the HRS self-reports, the Medicare beneficiaries who have nonautomatic eligibility for the LIS are nearly equally divided between those who have Part D coverage and those who do not.
- Among the group that we estimate would be eligible for the LIS based on estimated income and resources, those who do not apply for the LIS (SIPP) or report that they do not have Part D coverage (HRS) are a group that is selectively somewhat more advantaged in terms of their health status. They also report lower rates of use of prescription drug coverage and greater access to other creditable coverage. This suggests that the lack of take-up may result from a lower level of expected need for the subsidy than those who do participate. On the other hand, the group that does not apply for the LIS or have Part D coverage is also less likely to have more than a high school education (more noticeably so in the SIPP). This suggests that there may be barriers to seeking coverage, associated with a

lack of knowledge of the program's existence, the LIS eligibility rules, or the application process.

## **Size of the LIS-Eligible Population in 2008**

Using the observed survey and administrative data as of 2006, we made a parallel set of projections for 2008 to match the results we reported for 2006. Key findings include the following:

- The number of LIS eligibles, using the baseline methodology, is projected to increase from an estimated 12.2 million in 2006 to 12.7 million in 2008, with a 95-percent confidence interval (accounting only for sampling error) that ranges from 11.8 million to 13.6 million. The eligibility rate is estimated to remain the same at 29 percent. The LIS eligibility rate by age also is projected to remain close to the 2006 rate.
- There is also little change in the rate of eligibility by the different pathways. A somewhat smaller fraction of the 2008 population is estimated to have income or resources that exceed the thresholds than was estimated for 2006 (e.g., 61 versus 63 percent with income too high and 55 versus 57 percent with resources too high).
- We estimate a total of 12.1 million noninstitutionalized LIS eligibles in 2008 (compared with 11.6 in 2006) and 600,000 institutionalized LIS eligibles (almost unchanged from 2006). The eligibility rates by institutionalization status and rates of eligibility by pathway are projected to remain effectively unchanged.
- The same pattern of differences in estimates by data source found for 2006 is also evident for the 2008 projections. Thus, we again have a wide range of estimates for total LIS eligibles if we consider alternative weighting schemes for the two data sources. Giving preference to the SIPP results in an estimate of 13.9 million LIS eligibles in 2008 compared with 11.5 million when preference is given to the HRS. Taking into account the confidence intervals, the range is from 10.6 million LIS eligibles in 2008 as a lower bound (based on the HRS-preference estimate) and 15.2 million as an upper bound (based on the SIPP-preference estimate).