Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Costs and Benefits of Expanding Medicare Savings Programs and Classic Medicaid Programs to Promote Affordable Care, Premiums, and Cost Sharing for Medicare Enrollees

As required per Engrossed Substitute Senate Bill 5693, Section 208(7)
(Chapter 297, Laws of 2022)

December 2022

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RDA Report Number 9.124

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Executive Summary

Engrossed Substitute Senate Bill 5693, passed by the 67th Washington State Legislature on March 10, 2022, directed the Department of Social and Health Services (DSHS) to study options to expand Medicare Savings Programs and classic Medicaid programs to promote affordable health care for Medicare enrollees. To meet this requirement, the DSHS Research and Data Analysis Division, in collaboration with the Health Care Authority (HCA), the DSHS Aging and Long-Term Support Administration (ALTSA), the DSHS Developmental Disabilities Administration (DDA), and Northwest Health Law Advocates (NOHLA), examined a set of eligibility expansion options. Cost estimates reported below focus on "full implementation" State Fiscal Year (SFY) 2025 projections, under the assumption that any changes implemented in the 2023 Legislative Session would not achieve full effect until SFY 2025.

Key Findings

- For the options examined for expanding SSI-related CN Medicaid coverage, full-implementation HCA medical, behavioral health, and Part D clawback cost estimates for SFY 2025 ranged from $310.3 million to $374.8 million GF-S. Medicare Part D clawback costs represented nearly two-thirds of total GF-S costs. In addition to HCA costs, ALTSA and DDA LTSS cost estimates associated with expanding SSI-related CN Medicaid coverage ranged from $22.6 to $76.5 million GF-S at full implementation in SFY 2025.
- The Medicare savings program option examined is associated with GF-S costs of $54.9 million at full implementation in SFY 2025.
- The impact on Medicaid coverage rates of raising income eligibility to 138 percent FPL and maintaining current asset limits is greater than the impact of removing the asset limit while maintaining the current income limits. This is because few Medicare beneficiaries with incomes below 75 percent FPL have significant assets.
- We examined equity effects by age, gender, and race/ethnicity. All demographic groups would experience an increase in eligibility rates under the proposed options. We also provide a demographic profile of current beneficiaries and proposed expansion groups to understand how the characteristics of persons who would benefit from the expansion options relate to the characteristics of persons covered under current rules.

BUDGET PROVISO LANGUAGE

$75,000 of the general fund-state appropriation for fiscal year 2023 is provided solely for the department, in collaboration with the Washington state health care authority, to study the cost and benefit of adopting available options to expand Medicare savings programs and classic Medicaid programs, including categorically needy and medically needy, to promote affordable care, premiums, and cost sharing for Medicare enrollees. The cost analysis must identify available federal funding for each option. The department shall consider options that create affordability comparable to affordable care act programs available to adults without Medicare, as well as intermediate options that move toward comparability. The study must analyze equity impacts of each option, considering gender, race, and ethnicity. The department shall submit the study and recommendations to the fiscal and health care committees of the legislature, as well as the joint legislative-executive committee on planning for aging and disability issues, by November 1, 2022.

Background

For over half a century, the poverty-reducing effects of programs such as Social Security, Medicare, and Medicaid have been dramatic, keeping tens of millions of people nationwide out of poverty.[1] In the first 50 years of operation of the Medicare and Social Security programs, the poverty rate among Americans 65 and older dropped from 28.5 percent to 9.1 percent, compared to relatively modest changes in poverty rates for persons under 65.[2] However, critical gaps in Medicare's coverage of health care expenses persist for elders who are poor or near poor. Further, women and persons from BIPOC communities are disproportionately represented among elders who are poor or near poor, for whom health care expenses create more significant economic challenges.

Before residents are eligible for Medicare, Washington State offers a fairly generous Medicaid program, with coverage for behavioral health care, dental care, non-emergency medical transportation, and other benefits with no requirement for co-pays and deductibles. Once on Medicare, Medicaid acts as a supplemental insurance to Medicare for those who are eligible for continued "full dual" coverage. However, stricter asset and income tests are applied which results in tens of thousands of persons losing their eligibility for full Medicaid benefits.

Supplemental coverage is unaffordable for most low-income people, who are faced with out-of-pocket costs such as an inpatient hospital deductible of $1,484 and daily coinsurance of $186 for skilled nursing facility stays lasting 21–100 days. Part B includes an annual deductible and 20 percent coinsurance for most services.[3] Expenditures for those on Medicare are projected to increase in the future. One study projects that "Medicare beneficiaries' average out-of-pocket health care spending is projected to rise as a share of average per capita Social Security income, from 41 percent in 2013 to 50 percent in 2030."[4] These challenges disproportionately affect women, people over 85, those with lower income and those in poorer health.

The loss of Medicaid supplemental coverage due to stricter income and asset tests for Medicare beneficiaries is a phenomenon referred to as the "Medicare Cliff". Roberts et al found that "Among partial Medicaid recipients, the rate of disenrollment was 40 percent lower (AHR: 0.60) in states with less restrictive asset limits for partial Medicaid compared to federal standards."[5]

The consequences of the loss of cost-sharing coverage were studied by Roberts et al (2021) using a regression discontinuity design. They found that, compared to those who maintained Medicaid coverage, "near-poor beneficiaries exposed to this coverage cliff incurred $2,288 in additional out-of-pocket spending (over two years) and were 33.1 percentage points more likely to incur catastrophic spending."[6] In addition, those who lost Medicaid used fewer outpatient services and filled fewer prescriptions for chronic conditions. In another study, the loss of

[1] Consumer Affairs article, found at Elderly Poverty Statistics (2022): Senior Poverty Rate | ConsumerAffairs.
[2] Who's poor in America? 50 years into the 'War on Poverty,' a data portrait | Pew Research Center.
[3] Medicaid Coverage 'Cliff' Increases Expenses and Decreases Care for Near-Poor Medicare Beneficiaries, Eric T. Roberts, Alexandra Glynn, Noelle Cornelio, Julie M. Donohue, Walid F. Gellad, J. Michael McWilliams, and Lindsay M. Sabik, Health Affairs 40, NO. 4 (2021): 552–561.
[4] Kaiser Family Foundation, January 2018, Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future, Prepared by: Juliette Cubanski, Tricia Neuman, Karen E. Smith, Anthony Damico.
[5] Roberts et al, 2019. Association of State Policies with Medicaid Disenrollment Among Low-Income Medicare Beneficiaries, Health Affairs 38, NO. 7 (2019): 1153–1162. The term "partial Medicaid" is synonymous with the "MSP-only" term defined later in this report.
[6] Roberts et al, 2021.

prescription drug coverage (under the Medicare "donut hole") was linked to missed refills of medication and increases in mortality.[7] Increasing out-of-pocket costs have real adverse impacts on poor and "near-poor" individuals.

All states have implemented programs to assist low-income residents with out-of-pocket costs for Medicare, such as Medicare Savings Programs. These approaches are described in a Kaiser Family Foundation survey of 50 states.[8] Although the "floor" is to enroll people on Supplemental Security Income (SSI) in Medicaid, several states have expanded access to Medicaid for low-income seniors. Of note, 21 states cover seniors and people with disabilities up to 100 percent of the Federal Poverty Limit (FPL), whereas Washington currently relies on the SSI standard of approximately 74 percent FPL.

Medicaid Eligibility in Washington State

Income Eligibility

Adults under the age of 65 who are not eligible for Medicare qualify for Modified Adjusted Gross Income (MAGI) Medicaid expansion programs with income up to 138 percent FPL. However, the income limit for SSI-related Medicaid programs for low-income seniors and individuals with a disability is only approximately 74 percent FPL. In Washington, we refer to SSI-related Medicaid coverage (medical programs for individuals who are aged, blind, or disabled) as Classic Apple Health (Medicaid). Because individuals 65 and over or those who have Medicare coverage are not eligible for Apple Health for Adults, they are required to meet the lower income limits associated with Classic Apple Health. This results in many of the most vulnerable adults losing access to free or low-cost health care coverage options. While Medicare Savings Programs (MSPs) may help to alleviate some of the financial burden by assisting with out-of-pocket costs such as premiums and co-pays, MSP income limits are lower than those for MAGI Apple Health, leaving this population at risk of losing Apple Health and being forced to pay potentially high out-of-pocket Medicare costs.

Asset Eligibility

While MAGI Apple Health for Adults does not require an asset test, Classic Apple Health programs maintain low asset limits that match those of the SSI program. Currently, allowable assets are limited to $2,000 for an individual and $3,000 for a couple in Aged, Blind, or Disabled (ABD), Long Term Support Services (LTSS), and Medically Needy (MN) programs, and $8,400 for an individual and $12,600 for a couple in MSP (MSP asset limits will be eliminated in January 2023). Spousal impoverishment protections do permit a household where only one member of a married couple is seeking LTSS to have a higher asset test to protect the community spouse. However, with such low limits, those who meet other eligibility requirements are often faced with the decision to either remain ineligible for essential health coverage or liquidate and spend down assets to meet the allowable limits. Several states including California, New York, and Illinois have made recent updates to their asset test policies. New

[7] The Health Costs of Cost-Sharing, Amitabh Chandra, Evan Flack, Ziad Obermeyer; Working Paper 28439 http://www.nber.org/papers/w28439, National Bureau of Economic Research, February 2021.

[8] KFF Issue Brief June 2019, Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey, MaryBeth Musumeci and Priya Chidambaram, Kaiser Family Foundation, and Molly O'Malley Watts, Watts Health Policy Consulting.

York significantly increased limits for all programs, providing access to coverage for most who are otherwise eligible. California is eliminating the asset test for ABD programs effective January 2024.

The Washington State Health and Human Services (HHS) Coalition has been working for several years to develop an integrated eligibility and enrollment solution for health and human services. The HHS Coalition Integrated Eligibility and Enrollment (IE&E) roadmap vision was published in January 2022 in the Integrated Eligibility and Enrollment Modernization Report to the Washington State Legislature, as required by Engrossed Substitute Senate Bill 5092 (2021). To ensure the HHS Coalition IE&E roadmap vision is realized within the roadmap schedule, eligibility criteria for both the MAGI and Classic Medicaid programs would need further alignment. The options laid out in this report reflect alignment strategies that are consistent with the IE&E roadmap vision.

Alignment of income standards and reduction or elimination of resource tests for Classic programs would move DSHS and HCA closer to a simplified, single application portal for client benefit enrollment, and are actions aligned with the future vision of streamlined eligibility. These policy changes would reduce existing biases and inequities in Medicaid eligibility for individuals who are aged, blind, or have a disability. Advancing alignment in eligibility standards between MAGI and Classic Medicaid programs supports modernization of technologies used in determining eligibility and automating enrollments and renewals, and will improve client and staff experiences.

Policy Options

Policy options were developed by a workgroup of staff from the Department of Social and Health Services and the Health Care Authority, along with health policy experts with Northwest Health Law associates. Estimates of the number of potentially eligible Medicare beneficiaries associated with the options benefited from models developed by Hunter Plumer, MHA. State agency staff identified the following set of policy options for financial modeling:

1. **Raise the income eligibility thresholds for all non-institutional Categorically Needy SSI-related programs under Classic Apple Health programs to 138 percent FPL, and align the Medically Needy Income Level (MNIL) to this standard.** This change would align adult Apple Health medical programs to the same income limit, including programs serving persons aged 65 and older.
2. **Raise asset/resource limits for Classic Apple Health Categorically Needy SSI-related programs, in combination with the increase in income eligibility to 138 percent FPL, according to the following options:**
    a. **Low asset limit option**: increase the resource limit for SSI-related Medicaid coverage to $10,000 for individuals and $20,000 for married couples, for both institutional and non-institutional coverage groups.
    b. **Middle asset limit option**: increase the resource limit for SSI-related Medicaid coverage to $25,000 for both individuals and married couples, for both institutional and non-institutional coverage groups.
    c. **High asset limit option**: eliminate the asset test for non-institutional SSI-related Medicaid coverage while maintaining a $25,000 asset limit for institutional coverage

groups related to eligibility for ALTSA- and DDA-funded long-term services and supports.

3. **Raise Medicare Savings Program income eligibility thresholds as follows:**
    a. **Qualified Medicare Beneficiary (QMB) Program**: increase the QMB income eligibility threshold to 138 percent FPL.
    b. **Specified Low-Income Medicare Beneficiary (SLMB) Program**: increase the SLMB income eligibility range to 139 to 150 percent FPL.
    c. **Qualifying Individual (QI-1) Program**: raise the income eligibility limit above 150 percent FPL to the maximum extent allowed with available federal funds.

Table 2 below summarizes the SSI-Related Categorically Needy Medicaid expansion options for which costs estimates were developed. Table 12 below summarizes current and proposed Medicare Savings Program income options.

This report is organized as follows. The next section examines the impact of SSI-related CN Medicaid coverage expansion options on HCA medical costs, behavioral health costs, and Part D "clawback" costs.[9] The subsequent section examines the impact of SSI-related Medicaid coverage expansion options on ALTSA and DDA LTSS costs. We then turn to examine costs associated with the proposed Medicare Savings Program eligibility expansions. Next, we examine the differential impacts of the proposed eligibility expansions by race/ethnicity, gender, and age. We close with a summary of the main findings.

Categorically Needy SSI-related Program Options: HCA Cost Estimates

Estimating the impact of proposed changes in income and asset limits for Medicaid coverage for Medicare beneficiaries requires data on the income and asset levels of Medicare beneficiaries in Washington State. We rely on modeling developed by Hunter Plumer, under contract with Northwest Health Law Advocates, to estimate the number of Medicare beneficiaries eligible under the proposed expansion scenarios. This modeling is based on the integration of American Community Survey, Medicare Beneficiary Survey (a key resource for asset data), and CMS Medicare program data. We acknowledge the significant investment made by Northwest Health Law Advocates and Hunter Plumer in the development of this sophisticated modeling tool, which provides the essential population demographic building blocks for the financial and equity modeling that follows. We note that estimates are limited to the Medicare population; we do not attempt to estimate potential impacts on coverage rates and costs for persons not enrolled in Medicare. It is also important to note that throughout this study, financial impacts are estimated in terms of full-implementation costs. We do not attempt to model the exact timing of implementation and potential ramp-up window to full implementation.

Table 1 provides data on the estimated number of Medicare beneficiaries eligible for SSI-related CN Aged or Disabled Medicaid under current eligibility criteria (75 percent FPL income limit and

[9] The Part D clawback is a mechanism through which states will help finance the Medicare Part D drug benefit. The clawback is a monthly payment made by each state to the federal Medicare program roughly reflecting the state-fund expenditures the state would make for Medicaid-funded prescription drug coverage for full-benefit dual eligibles (elderly or disabled persons enrolled in both Medicare and Medicaid).

$2,000/$3,000 resource limits). The table also provides the estimated number of eligibles under a variety of expansion scenarios, from which we draw the following conclusions:

- The impact of raising the income eligibility threshold to 138 percent FPL and maintaining current asset limits is greater than the impact of removing the asset limit while maintaining the current income limits. This is because relatively few Medicare beneficiaries with incomes below 75 percent FPL have significant assets. For example, removing the asset limit while maintaining current income limits would increase the number of Medicare beneficiaries eligible for SSI-related CN Medicaid by only 20,937 (from 95,887 to 116,824 persons). In contrast, increasing the income limit to 138 percent FPL while maintaining current asset limits would increase the number of Medicare beneficiaries eligible for SSI-related CN Medicaid by 121,293 (from 95,887 to 217,180 persons).
- The effect of increasing or removing asset limits is greater if the change is coupled with an increase in income limits. This is because at higher income levels, there are more Medicare beneficiaries with assets above current eligibility limits.

The most important information to be inferred from Table 1 is the increase in the number of persons who would be financially eligible for Medicaid through the expansion options under consideration. Those options are summarized in Table 2. The increase in Medicaid eligibles associated with each option is reflected in the “eligible” column in Table 3, for our calendar year 2022 baseline. We apply a take-up rate parameter of 50 percent to the estimated number of increased eligibles to project increased enrollment, assuming half of the population newly eligible for Medicaid under the proposed expansion options would actually enroll in Medicaid.

Current “partial dual” MSP enrollment provides a benchmark for assessing the reasonableness of the 50 percent take-up rate assumption. Partial duals are persons enrolled in QMB, SLMB, or QI-1 coverage but not enrolled in Categorically Needy or Medically Needy Medicaid coverage. This group is also referred to as the “Medicare Savings Program only” (MSP-only) population. The income and resource limits for MSP-only coverage are slightly less generous than the proposed limits for our “Low” expansion option. Specifically, the MSP program income limit is currently 135 percent FPL, with resource limits of $8,400 for an individual and $12,600 for a couple. (Resource limits will be eliminated in January 2023.)

In December 2021, there were 66,780 partial dual (MSP-only) Medicare beneficiaries in Washington State. This aligns well with the projected SSI-related Medicaid expansion of 76,075 persons associated with our “Low” option. We would expect our Low option to generate higher enrollment than current MSP-only coverage because it has somewhat higher income and resource standards and would present eligible Medicare beneficiaries with stronger financial incentives to enroll in Medicaid, relative to the incentives provided through the Medicare premium and cost-sharing assistance received through Medicare Savings Programs. Based on this assessment, we maintain the 50 percent take-up rate assumption throughout our analysis of the impact of the proposed expansion options on HCA program costs. Table 3 summarizes the additional number of annual SSI-related CN Medicaid coverage months associated with each expansion option under these assumptions, for our CY 2022 baseline period.

Table 4 provides information about the per cap cost assumptions associated with the projected increase in enrollment. HCA medical per caps are based on CY 2021 per cap data for fee-for-service CN Aged and Disabled clients, with a three percent annual trend factor. HCA behavioral

health per caps are based on SFY 2023 Behavioral Health Services Only (BHSO) per caps, also trended forward to SFY 2025 with a three percent annual trend factor. We applied a case mix adjustment factor of 68 percent to these per caps, to reflect the expected lower acuity in the proposed expansion populations. This adjustment factor reflects the relative non-pharmacy Medicare PMPM expenditures levels of FFS Washington State partial and full duals in calendar year 2018 (the most recent year for which these data were available). After trending and case mix adjustment, the blended medical and behavioral health per cap for the expansion populations are estimated to be $215.69 in SFY 2024 and $222.16 in SFY 2025. We assume a 50 percent General Fund State (GF-S) share of these costs.

In addition to the GF-S share of Medicaid medical and behavioral health costs is the impact of the Medicare Part D clawback. Projected PMPM GF-S costs associated with the Part D clawback were provided by HCA fiscal staff. The GF-S cost of the Part D clawback is substantially larger than the GF-S share of medical and behavioral health service costs for the expansion populations, and reflects a cost shift from federal to state funds for existing Medicare Part D coverage. These estimates assume 100 percent Part D take up; to the extent Part D enrollment would be less than 100 percent, costs would be lower than projected here.

Combining forecast increased coverage months with associated per cap costs produces the overall expenditure estimates presented in Table 5. In SFY 2025, GF-S costs range from $310.3 million for the Low option to $374.8 million for the High option. Again, it is important to note that financial impacts are estimated in terms of full-implementation costs. We do not attempt to model implementation timing and the scaling up of costs over time to full implementation.

TABLE 1.

Estimated Number of Washington State Medicare Beneficiaries

By income and resource threshold, Calendar Year 2022

	Resource Limit		
Income Limit Percent FPL	**Individual**	**Married**	**Medicare Beneficiaries**
75%	$2,000	$3,000	95,887
75%	$10,000	$20,000	105,409
75%	$25,000	$25,000	107,818
75%	No limit	No limit	116,824
138%	$2,000	$3,000	217,180
138%	$10,000	$20,000	248,037
138%	$25,000	$25,000	255,927
138%	No limit	No limit	285,589

SOURCE: Medicare Cliff Analysis prepared for Northwest Health Law Advocates by Hunter Plumer, MHA.

TABLE 2.

SSI-Related Categorically Needy Medicaid Expansion Options

Option	**Income Limit Percent FPL**	**Resource Limit Non-Institutional**		**Resource Limit Institutional**		**Additionally Eligible Medicare Beneficiaries** (CY 2022 Baseline)
		Individual	**Married**	**Individual**	**Married**	
Low	138%	$10,000	$20,000	$10,000	$20,000	152,150
Middle	138%	$25,000	$25,000	$25,000	$25,000	160,040
High	138%	No limit	No limit	$25,000	$25,000	183,770

TABLE 3.

Projected Full Implementation Enrollment, CY 2022 Population Baseline

Excludes project DSHS ALTSA and DDA costs (see below)

Option	Eligible	Take Up	Enrolled	Annual Member Months (At Full Implementation)
Low	152,150	50%	76,075	912,900
Middle	160,040	50%	80,020	960,240
High	183,770	50%	91,885	1,102,618

TABLE 4.

Caseload and Per Cap Trend Factors for HCA Medical and Behavioral Health Costs

Excludes LTSS Costs

SFY	Caseload Trend Factor	Total Medical and BHSO Per Cap (All Funds)	GF-S Share of Medical and BHSO Per Cap	GF-S Part D Clawback	GF-S Total
SFY 2023	1.34%	$210.52	$105.26	$183.00	$288.26
SFY 2024	4.07%	$215.69	$107.85	$207.00	$314.85
SFY 2025	6.87%	$222.16	$111.08	$207.00	$318.08

TABLE 5.

Full Implementation Estimates by Option, HCA Medical and Behavioral Health Costs

Excludes LTSS Costs

	Low		Middle		High	
SFY	All Funds	GF-S	All Funds	GF-S	All Funds	GF-S
SFY 2023	$364,069,455	$266,687,873	$382,948,903	$280,517,431	$439,729,860	$322,110,573
SFY 2024	$401,577,378	$299,118,123	$422,401,864	$314,629,408	$485,032,626	$361,280,433
SFY 2025	$418,686,017	$310,315,885	$440,397,701	$326,407,849	$505,696,759	$374,805,298

Categorically Needy SSI-related Program Options: ALTSA and DDA LTSS Estimates

In this section we estimate the impacts on ALTSA and DDA expenditures for in-home personal care and community residential services. The options applicable to these Medicaid program areas are reflected in Table 6. Note that the “High” option maintains resource limits at $25,000 for Medicaid coverage groups related to receipt of ALTSA and DDA LTSS services.

Because persons with income at or above 138 percent FPL are already eligible for ALTSA and DDA LTSS services through a variety of waiver programs, we do not anticipate a significant effect on program costs associated with the proposed changes to income-related eligibility criteria. To estimate the effect of raising asset limits, we examined Asset Verification System data from applications for LTSS services in the first six months of CY 2022. We used data from applications identified with excess resources up to $10,000 to extrapolate the potential number of eligibles in the $10,000 to $25,000 asset range, under the assumption that the observed volume of applications with assets in $10,000-$25,000 range would significantly underestimate the true number of eligibles in that range. Table 7 provides the estimated number of additional approved applications associated with potential coverage expansion options in our SFY 2022 baseline period.

We assumed a 70/30 split between in-home personal care and community residential services for the expansion population, and applied SFY 2023 per cap forecasts from the Summer 2022 per cap forecast cycle. Total all funds baseline expenditures by option, program, and modality are reflected in Table 8. Note that these “baseline” expenditures represent a mix of SFY 2023 per caps and SFY 2022 utilization.

Table 9 provides a critical parameter linking the projected increase in approved applications (that would otherwise have been denied due to excess resources) to increased ALTSA and DDA program costs. This parameter is the average number of additional months of LTSS utilization associated with a newly approved application. At the $10,000 resource limit option, the average number of additional service months per newly approved application will be relatively small (1.29), because newly approved applicants would likely have exhausted their limited resources relatively quickly and become financially eligible for ALTSA or DDA services under existing rules. As the resource limit is increased to $25,000, the average number of additional service months per newly approved application increases to 2.86 months, as persons with greater resources would have required more time to exhaust their assets and become eligible for services under existing rules.

Caseload trend, per cap trend, and federal cost share (FMAP) assumptions are provided in Table 10. Applying these factors to the baseline expenditure estimates in Table 8 produces the cost estimates reported in Table 11, and the underlying caseload impacts reflected in Tables 11a and 11b. In SFY 2025, we estimate that the “Low” option would cost $22.6 million GF-S, while the Middle/High option would cost $76.5 million GF-S. These costs are in addition to the HCA medical, behavioral health, and Part D clawback costs described in the previous section. Again, it is important to note that financial impacts are estimated in terms of full-implementation costs. We do not attempt to model implementation timing and cost ramp-up to full implementation. Finally, we note that LTSS costs are based on caseload impacts and do not include costs for additional FTEs for Area Agency on Aging case management.

We close this section by noting that the proposed SSI-related Medicaid expansion options would have offsetting cost impacts on the Medically Needy (MN) Medicaid program. Most current MN Medicaid beneficiaries would shift to SSI-related CN Aged or Disabled Medicaid coverage under these options, which would result in GF-S offsets (savings). Further, there would be GF-S offsets due to the reduction in state dollars used to fund the state buy-in program for MN Medicaid beneficiaries with income above the current QMB standard who currently have their Part B premiums paid using state-only dollars when they meet their spenddown.

Offsetting these savings would be increased eligibility for MN Medicaid coverage at higher income and asset levels, and an increased GF-S share of costs for persons remaining on the MN caseload, as they would be required to spend less out of pocket to reach a higher spend-down threshold. We would expect the net impact of these partially offsetting effects to produce some net savings, which we have not separately modeled.

TABLE 6.

SSI-Related Categorically Needy Medicaid Expansion Options for Coverage Groups Related to Eligibility for ALTSA and DDA LTSS Services

Option	Income Limit Percent FPL	Resource Limit Institutional	
		Individual	Married
Low	138%	$10,000	$20,000
Middle/High	138%	$25,000	$25,000

TABLE 7.

Unduplicated Annualized Count of LTSS Applications Denied Due to Excess Resources

Estimated based on applications from the 1/1/2022 – 6/30/2022 time period

SFY 2022	Under $4000 (Observed)	Under $6000 (Observed)	Under $10000 (Observed)	Under $25000 (Extrapolated)
ALTSA	5,538	6,996	8,232	12,867
DDA	1,164	1,342	1,478	1,988
TOTAL	**6,702**	**8,338**	**9,710**	**14,855**

TABLE 8.

Full Implementation Baseline Combined ALTSA and DDA Cost Estimates by Option

Option	Modality	ALTSA	DDA	Total - All Funds
Low	In-Home	$24,038,000	$4,746,000	$28,784,000
	Residential	$11,631,000	$2,283,000	$13,914,000
Middle	In-Home	$83,391,000	$14,167,000	$97,558,000
	Residential	$40,349,000	$6,815,000	$47,164,000

TABLE 9.

Additional LTSS Benefit Months Per Newly Eligible Applicant

Option	Additional Benefit Months
Low	1.29
Middle	2.86

TABLE 10.

ALTSA and DDA Caseload and Per Cap Trend Factors and FMAP Assumptions

SFY	June 2022 Caseload Forecast Council HCBS Caseload	Caseload Trend Factor	Per Cap Trend Factor	FMAP
SFY 2022	63,450			
SFY 2023	65,723	3.58%	N/A	56%
SFY 2024	68,564	8.06%	3.50%	56%
SFY 2025	71,203	12.22%	7.12%	56%

TABLE 11.

Full Implementation Combined ALTSA and DDA Cost Estimates by Option

	Low		Middle	
SFY	All Funds	GF-S	All Funds	GF-S
SFY 2023	$44,227,655	$19,460,168	$149,906,663	$65,958,932
SFY 2024	$47,754,320	$21,011,901	$161,860,058	$71,218,425
SFY 2025	$51,327,678	$22,584,178	$173,971,714	$76,547,554

TABLE 11a.
Low Option: ALTSA and DDA Monthly Caseload Impacts at Full Implementation

	ALTSA		DDA	
SFY	**In-Home**	**Residential**	**In-Home**	**Residential**
SFY 2023	642	275	115	49
SFY 2024	670	287	120	52
SFY 2025	695	298	125	54

TABLE 11b.
Middle Option: ALTSA and DDA Monthly Caseload Impacts at Full Implementation

	ALTSA		DDA	
SFY	**In-Home**	**Residential**	**In-Home**	**Residential**
SFY 2023	2,226	954	344	147
SFY 2024	2,323	995	359	154
SFY 2025	2,412	1,034	373	160

Medicare Savings Program Cost Estimates

Estimates of the impact of proposed changes in income limits for Medicare Savings Programs rely on modeling developed by Hunter Plumer, under contract with Northwest Health Law Advocates. Table 12 compares current and proposed QMB, SLMB, and QI-1 income thresholds. Options are modeled under the assumption that the asset test for MSP has been eliminated. QMB helps pay Medicare Part A premiums, Part B premiums, and deductibles, coinsurance, and copayments. The SLMB and QI-1 programs help pay for Part B premiums only.

Note that the proposed upper limit for the QI-1 program would be in the 165-200% FPL range, with the exact upper limit depending on available federal funds. We do not attempt to estimate a precise QI-1 income threshold. We note that QI-1 coverage is entirely federally funded, and therefore we do not examine QI-1 program costs in the modeling that follows.

There are three sources of increased GF-S costs associated with the proposed MSP option:

- Increasing the QMB limit to 138%FPL and the SLMB limit to 150% FPL will increase the number of Medicare beneficiaries receiving assistance with Part B premiums (Table 14);
- Replacing QI-1 coverage with QMB coverage in the 120-135 percent FPL income range will increase GF-S costs for assistance with Part B premiums (Table 14); and
- Expanding QMB coverage to 138 percent FPL will increase the number of Medicare beneficiaries receiving assistance with Part A and Part B cost sharing (Table 15).

Taken together, the proposed changes in income limits for Medicare Savings Programs are associated with increased GF-S costs of $47.7 million in the CY 2022 baseline period (Table 16). Trending caseloads at the rate projected in Table 4, and trending per caps at three percent per year, GF-S costs are estimated to increase to $54.9 million in SFY 2025 (Table 17). Again, it is important to note that financial impacts are estimated in terms of full-implementation costs. We do not attempt to model implementation timing.

Table 17a also provides estimates for the option of raising the QMB income limit to 138 percent FPL, without the additional increase in the SLMB income limit to 150 percent FPL. The

estimated GF-S cost associated with this alternative is $37.3 million GF-S in SFY 2025, assuming full implementation in that fiscal year.

TABLE 12.
Current and Proposed Medicare Savings Program Income

Poverty Level	Current	Proposed
0 to 100%	QMB	QMB
101 to 120%	SLMB	QMB
121 to 135%	QI-1	QMB
136 to 138%	No MSP	QMB
139 to 150%	No MSP	SLMB
151 to 200%	No MSP	QI-1*

*Upper limit depends on federal funding formula.

TABLE 13.
Estimated CY 2022 Washington State Medicare Beneficiaries Eligible Under Current and Proposed Income and Resource Limits

Poverty Level	Current	Proposed	Estimated Medicare Beneficiaries	Estimated Eligible Under Current Limits	Estimated Eligible Under Proposed Limits	Enrollment Assumption	Incremental Enrolled Count
0 to 75%	QMB	QMB	116,824	116,824	116,824	50%	0
76 to 100%	QMB	QMB	68,712	68,712	68,712	50%	0
101 to 120%	SLMB	QMB	51,582	51,582	51,582	50%	0
121 to 135%	QI	QMB	40,719	40,719	40,719	50%	0
136 to 138%	No MSP	QMB	7,752	0	7,752	50%	3,876
139 to 150%	No MSP	SLMB	31,007	0	31,007	50%	15,504

TABLE 14.
Incremental Medicare Part B Premiums Under Proposed Expansion, CY 2022 Baseline

Poverty Level	Current	Proposed	Part B Premiums (PMPM)	WA State Share of Premiums	Incremental Washington Part B Premium Cost
0 to 100%	QMB	QMB	$164.90	50%	$0
101 to 120%	SLMB	QMB	$164.90	50%	$0
121 to 135%	QI	QMB	$164.90	50%	$20,143,689
136 to 138%	No MSP	QMB	$164.90	50%	$3,834,914
139 to 150%	No MSP	SLMB	$164.90	50%	$15,339,163

SOURCE: Medicare Cliff Analysis prepared for Northwest Health Law Advocates by Hunter Plumer, MHA.

TABLE 15.
Incremental Medicare Cost Sharing Under Proposed Expansion, CY 2022 Baseline

Poverty Level	Current	Proposed	Washington Cost Share (PMPM)	Incremental Cost Sharing Count	Incremental Washington Cost Sharing Cost
0 to 75%	QMB	QMB	$14.00	0	$0
76 to 100%	QMB	QMB	$14.00	0	$0
101 to 120%	SLMB	QMB	$14.00	25,791	$4,332,888
121 to 135%	QI	QMB	$14.00	20,360	$3,420,396
136 to 138%	No MSP	QMB	$14.00	3,876	$651,168

SOURCE: Medicare Cliff Analysis prepared for Northwest Health Law Advocates by Hunter Plumer, MHA.
NOTE: Incremental cost sharing count for poverty levels above 100 percent FPL with QMB is higher than incremental count reflected in Table 13 because current rules only cover Medicare Part B premiums. Under the proposed expansion, all persons newly enrolled in QMB above 100 percent FPL are considered 'incremental' with respect to cost sharing.

TABLE 16.
Summary Estimates of Washington State MSP Enrollment and Cost Under Proposed Expansion, by Federal Poverty Level, CY 2022 Baseline

Poverty Level	Current	Proposed	Premium Assistance Incremental Enrollment	Cost Sharing Incremental Enrollment	Incremental Total Cost
0 to 75%	QMB	QMB	0	0	$0
76 to 100%	QMB	QMB	0	0	$0
101 to 120%	SLMB	QMB	0	25,791	$4,332,888
121 to 135%	QI	QMB	0	20,360	$23,564,085
136 to 138%	No MSP	QMB	3,876	3,876	$4,486,082
139 to 150%	No MSP	SLMB	15,504	0	$15,339,163
TOTAL			19,380	50,027	$47,722,219

SOURCE: Medicare Cliff Analysis prepared for Northwest Health Law Advocates by Hunter Plumer, MHA.

TABLE 17.
Full Implementation Medicare Savings Program Expansion Cost Estimates

SFY	All Funds	GF-S
SFY 2023	$98,178,289	$49,089,145
SFY 2024	$103,842,198	$51,921,099
SFY 2025	$109,832,858	$54,916,429

TABLE 17a.
Estimated Cost Associated with Expanding QMB to 138 Percent FPL

SFY	All Funds	GF-S
SFY 2023	$66,621,232	$33,310,616
SFY 2024	$70,464,613	$35,232,307
SFY 2025	$74,529,719	$37,264,860

Disparities Analysis for SSI-related Categorically Needy Medicaid and Medicare Savings Program Expansion Options

Our examination of equity effects associated with the SSI-related CN Medicaid expansion options is based on an assessment of the demographic composition of the following three coverage groups in December 2021:

1. Full dual eligible SSI-related CN Medicaid beneficiaries,
2. All (dual and non-dual) SSI-related CN Medicaid beneficiaries, and
3. MSP-only beneficiaries with income between 75 and 138 percent FPL.

As previously discussed, current MSP program income and asset limits are relatively close to the parameters reflected in the “Low” SSI-related CN Medicaid expansion option. Therefore, we would expect existing MSP-only beneficiaries to make up the vast majority of the expansion population under this option. Comparing the characteristics of current MSP-only beneficiaries with current SSI-related CN Medicaid (Aged and Disabled) beneficiaries is relevant from an equity perspective because it informs our understanding of how the characteristics of persons who would benefit from the expansion options relate to the characteristics of persons covered under current rules.

Slide 18 reports the race/ethnicity distribution of the three populations noted above. Compared to the population of CN Aged and Disabled full benefit duals, the MSP-only population expected to reflect most persons gaining Medicaid coverage under the “Low” expansion option is:

- More likely to be White, American Indian or Alaska Native, or Hispanic;
- Comparably likely to be Black or African American; and
- Less likely to be Asian or Native Hawaiian or Other Pacific Islander.

Relative to the broader population of CN Aged and Disabled beneficiaries (including both duals and non-duals), the MSP-only population is:

- More likely to be White;
- Comparably likely to be Hispanic, American Indian or Alaska Native or Native Hawaiian or Other Pacific Islander; and
- Less likely to be Asian or Black or African American.

Slide 19 compares the age distribution of the three populations. Compared to the population of CN Aged and Disabled full benefit duals, the MSP-only beneficiaries are more likely to be persons with disabilities aged 45 to 64 or seniors aged 65 to 74, and less likely to be younger persons with disabilities under the age of 45 or seniors aged 75 or above. Relative to the broader population of CN Aged and Disabled beneficiaries (including both duals and non-duals), MSP-only beneficiaries are more likely to be aged 65 to 84 and far less likely to be younger persons with disabilities under the age of 45.

Table 20 compares the gender distribution of our three populations. Compared to the population of CN Aged and Disabled full benefit duals, the MSP-only population is slightly more likely to be male. Relative to the broader population of CN Aged and Disabled beneficiaries (including both duals and non-duals), the MSP-only population is slightly less likely to be male.

We leverage data from the online modeling tool developed by Hunter Plumer, under contract with Northwest Health Law Advocates, to draw inferences about the equity effects associated with increasing asset limits from the “Low” option to the “Middle” and “High” asset-limit options. The tool provides estimates of the demographic composition of Washington State Medicare beneficiaries with incomes at or above 100 percent FPL at the relevant asset levels. The survey-based online tool projects that in the 100-138 percent FPL income range, raising asset limits for SSI-related CN Medicaid programs (or removing them altogether) would result in significant gains in Medicaid coverage across all race/ethnicity, age, and gender groups. In this income range, gains relative to existing coverage rates would be greatest for White beneficiaries and beneficiaries aged 65 or above.

Inferences from this survey-based modeling tool regarding the equity effects of the proposed options should be interpreted with a degree of caution. Based on actual MSP-only enrollment data, the survey-based tool appears to underestimate the relative increase in coverage that would be observed under the “Low” option for American Indian and Alaska Native beneficiaries and persons with disabilities aged 45 to 64, while overestimating coverage increases among persons aged 75 and above.

TABLE 18.

Demographic Comparison of Current SSI-Related Medicaid and MSP Coverage Groups by Race and Ethnicity

	December 2021 Enrollment		
Race/Ethnicity	**CN SSI-Related Full Dual**	**CN SSI-Related All**	**MSP-only 75% to 138% FPL**
American Indian or Alaska Native	2.6%	3.5%	3.7%
Asian	11.8%	8.4%	6.1%
Black or African American	6.8%	8.7%	6.3%
Hispanic	8.7%	10.3%	9.8%
Native Hawaiian or Other Pacific Islander	3.1%	2.8%	2.5%
White alone, non-Hispanic	60.8%	60.4%	70.7%
Other/unknown race, non-Hispanic	7.1%	7.1%	2.1%
Total Population	136,542	233,260	57,807

NOTE: With the exception of “White alone, non-Hispanic” and “Other/unknown race, non-Hispanic” groups, other race/ethnicity groups are not mutually exclusive and persons with more than one race/ethnicity are reflected in each group. The MSP-only population is approximately equivalent to the “Low” SSI-related CN Medicaid expansion option.

TABLE 19.

Demographic Comparison of Current SSI-Related Medicaid and MSP Coverage Groups by Age

	December 2021 Enrollment		
Age Group	**CN SSI-Related Full Dual**	**CN SSI-Related All**	**MSP-only 75% to 138% FPL**
Under 45	14.0%	30.7%	7.7%
45 to 64	22.7%	30.4%	31.9%
65 to 74	34.5%	21.3%	40.6%
75 to 84	19.0%	11.5%	16.3%
85 and Older	8.5%	5.1%	2.9%
Unknown	1.4%	0.8%	0.7%
Total Population	136,542	233,260	57,807

NOTE: The MSP-only population is approximately equivalent to the “Low” SSI-related CN Medicaid expansion option.

TABLE 20.

Demographic Comparison of Current SSI-Related Medicaid and MSP Coverage Groups by Gender

	December 2021 MSP Population		
Gender	**CN SSI-Related Full Dual**	**CN SSI-Related All**	**MSP-only 75% to 138% FPL**
Female	59.2%	53.9%	57.0%
Male	40.8%	46.1%	43.0%
Total Population	136,542	233,260	57,807

NOTE: The MSP-only population is approximately equivalent to the “Low” SSI-related CN Medicaid expansion option.

Next, we examine the equity effects associated with the proposed Medicare Savings Program expansion option (Tables 21-23). Again, we rely on the modeling tool developed by Hunter Plumer, under contract with Northwest Health Law Advocates. Because we were not able to identify the maximum feasible income threshold for the QI-1 program, we modeled coverage gains in the Medicare population with income up to 150 percent FPL. This approach has the effect of understating eligibility gains across all groups, and likely dampening differentials in relative gains by race/ethnicity and age.

Table 21 reports absolute and relative gains in MSP eligibility by race and ethnicity associated with the proposed expansion option. American Indian or Alaska Native and Hispanic Medicare beneficiaries experience the greatest absolute increase in MSP eligibility. Non-Hispanic White Medicare beneficiaries experience the greatest relative increase in MSP eligibility. Although eligibility levels are high for Black or African American Medicare beneficiaries, coverage gains relative to current program rules are smallest for this group.

Table 22 reports absolute and relative gains in MSP eligibility by age associated with the proposed expansion option. Absolute eligibility gains are greatest for disabled Medicare beneficiaries under the age of 65 and elders aged 85 and above. Relative gains are greatest among Medicare beneficiaries aged 65 and above.

Table 23 reports absolute and relative gains in MSP eligibility by gender associated with the proposed expansion option. Absolute and relative gains are slightly greater for women than for men.

TABLE 21.

Eligibility Rate Per 1,000 Medicare Beneficiaries Under Current and Proposed MSP Options, by Race and Ethnicity

Race Ethnicity	Current	Proposed	Expansion Gain	Percent Gain
Asian	225	247	22	9.8%
Black or African American	345	364	20	5.8%
Hispanic	285	326	41	14.4%
American Indian or Alaska Native	332	374	42	12.7%
Other/Unknown	234	270	36	15.4%
White, non-Hispanic	159	183	24	15.1%

NOTE: These data pertain to the proposed MSP expansion option.
SOURCE: Analysis prepared for Northwest Health Law Advocates by Hunter Plumer, MHA.

TABLE 22.

Eligibility Rate Per 1,000 Medicare Beneficiaries Under Current and Proposed MSP Options, by Age

Age Group	Current	Proposed	Expansion Gain	Percent Gain
Under 45	458	498	40	8.7%
45 to 64	403	444	41	10.2%
65 to 74	123	142	18	14.6%
75 to 84	146	170	24	16.4%
85 and Older	224	262	38	17.0%

NOTE: These data pertain to the proposed MSP expansion option.
SOURCE: Analysis prepared for Northwest Health Law Advocates by Hunter Plumer, MHA.

TABLE 23.

Eligibility Rate Per 1,000 Medicare Beneficiaries Under Current and Proposed MSP Options, by Gender

Sex	Current	Proposed	Expansion Gain	Percent Gain
Female	195	222	28	14.4%
Male	154	175	21	13.6%

NOTE: These data pertain to the proposed MSP expansion option.
SOURCE: Analysis prepared for Northwest Health Law Advocates by Hunter Plumer, MHA.

Summary

We modeled the cost and equity effects associated with options for increasing eligibility for SSI-related CN Medicaid coverage (Table 2) and Medicare Savings Programs (Table 12). Key findings are summarized below.

Cost estimates. Full-implementation HCA medical, behavioral health, and Part D clawback cost estimates for SFY 2025 for the options examined for expanding SSI-related CN Medicaid coverage ranged from $310.3 million to $374.8 million GF-S. Medicare Part D clawback costs represented roughly two-thirds of total GF-S costs. In addition, ALTSA and DDA LTSS cost estimates ranged from $22.6 to $76.5 million GF-S at full implementation in SFY 2025. The Medicare savings program option examined is associated with GF-S costs of $54.9 million at full implementation in SFY 2025.

Eligibility effects of income and asset limit increases. The impact of raising the income eligibility threshold to 138 percent FPL and maintaining current asset limits is greater than the impact of removing the asset limit while maintaining the current income limits. This is because relatively few Medicare beneficiaries with incomes below 75 percent FPL have significant assets. The effect of increasing or removing asset limits is greater if the change is coupled with an increase in income limits. This is because at higher income levels there are more Medicare beneficiaries with assets above current eligibility limits.

Equity effects. We examined equity effects by age, gender, and race/ethnicity. All demographic groups would experience an *absolute* increase in eligibility under the proposed options. We also provided a demographic profile of current beneficiaries and proposed expansion groups to understand how the characteristics of persons who would benefit from the expansion options relate to the characteristics of persons covered under current rules.