Medicaid and Supplemental Security Income Eligibility: Time for a Tune-Up

By Georgia Burke, JD, Jennifer Goldberg, JD, and Kate Lang, JD
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Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity and to help them get that protection.¹

Harry S. Truman
November 19, 1945

1. Introduction

While much has improved since President Truman spoke these words, low-income older Americans still need opportunities to improve their health and maintain economic security. But two essential safety net programs are both demonstrating their strengths and showing their age: in 2015 the Supplemental Security Income (SSI) program has celebrated its 40th anniversary and Medicaid its 50th. The number of Americans who are 65 or older (which is expected to rise 120% from 40.2 million in 2010 to 88.5 million by 2050) and 85 or older (which is expected to triple from 5.8 million in 2010 to 19 million by 2050) is growing.² Millions of older adults (an estimated 6.4 million and counting) live in poverty, and those numbers are increasing with the rising population and growing income inequality. As the country strengthens health care coverage and protections through the Affordable Care Act, programs for low-income seniors and persons with disabilities also need to be revitalized.

The Affordable Care Act created a new, more expansive approach to providing health care through the Medicaid system for those under age 65. In the 32 states that have chosen to expand Medicaid,³ new categories of individuals have become eligible for Medicaid. Perhaps as important, the Affordable Care Act introduced radically different — and much simpler — methodologies to determine Medicaid eligibility. Using modified adjusted gross income (MAGI) based on tax filings, Medicaid agencies can determine eligibility without asking most beneficiaries for additional documentation. The income level increased to 138% of the federal poverty level (FPL), and the asset test was eliminated. These more realistic standards and simplified application and documentation procedures encourage low-income individuals and families to get covered and have been critical to the success of MAGI Medicaid.

The Affordable Care Act, however, did not change any of the Medicaid eligibility criteria for those 65 or older. Many individuals who enroll in MAGI Medicaid and then turn 65 will be in for a shock when they encounter the restrictive asset tests, low-income requirements, and complex documentation hurdles common among state Medicaid programs. Many will lose Medicaid eligibility just when they need it most, as they age and their health declines.

The Medicaid program serving seniors and persons with disabilities, frequently called ABD Medicaid because it serves

aged, blind, and disabled beneficiaries, simply has not kept up with the times, leaving many needy seniors without access to this vital benefit. Likewise, the income disregards and asset criteria for the SSI program have not been updated in more than 40 years.

This article looks at SSI and ABD Medicaid’s income and asset limits and methodologies and those of other health insurance benefit programs for low-income older adults. It looks especially at the eligibility rules for Medicare Savings Programs (MSPs) and for the Medicare Part D Low Income Subsidy (LIS) as possible models for change. Both, though not as radical a departure as MAGI Medicaid, include significant improvements in eligibility criteria and methodology that could be models for updating and reforming ABD Medicaid.

What is happening in other programs can provide advocates with comparisons and models not only for potential major state and federal legislative changes that could significantly overhaul the Medicaid and SSI programs, but also for more modest tweaks that can be achieved at the state level through legislation or administrative action by state Medicaid agencies.

II. Background on SSI and ABD Medicaid

The SSI program, operated by the Social Security Administration (SSA), provides monthly cash benefits to low-income individuals who are either age 65 or older or have severe disabilities. Unlike other Social Security benefits, SSI benefits are not based on an individual’s or family member’s work history. SSI is financed through federal general revenue sources, not through the Social Security Trust Funds, and it is meant to provide a basic income to older adults and people with disabilities with no or only limited sources of other income and resources. Some SSI recipients have worked long enough to collect other Social Security benefits, but the amount of these benefits is low enough that they also qualify for SSI.

4 There are four Medicare Savings Programs (MSPs). The Qualified Medicare Beneficiary (QMB) program is a Medicaid benefit that covers Part A premiums (if needed), Part B premiums, and Medicare deductibles, coinsurance, and copayments. The Specified Low-Income Medicare Beneficiary (SLMB) and Qualified Individual (QI) programs provide coverage for Part B premiums only. The Qualified Disabled and Working Individuals (QDWI) program covers Part A premiums only. MSP income limits range from 100% to 200% of the federal poverty level (FPL). Asset limits range from $4,000 for an individual/$6,000 for a couple to $7,280/$10,930. See Medicare.gov, Medicare Savings Programs, https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html (accessed Nov. 8, 2015).

5 The Low Income Subsidy (LIS) provides premium and copayment subsidies for the Medicare Part D prescription drug plan enrollees. Full subsidy recipients pay no premium if they enroll in a “benchmark” plan, pay no deductible, and pay significantly reduced copayments for their Medicare Part D prescription drugs. They do not experience the coverage gap (“donut hole”) and have no copays once they reach the catastrophic coverage stage. Those with a partial subsidy have copays on a sliding scale. Individuals who qualify for Supplemental Security Income (SSI), full-scope Medicaid, or MSPs automatically receive the LIS. Others must apply to the Social Security Administration. The income cutoff for the full LIS is 135% of the FPL; partial subsidies are available for individuals with income below 150% of the FPL.

6 Of the almost 8.4 million individuals who received SSI benefits in December 2013, nearly 2.8 million also received other Social Security benefits. U.S. Soc. Sec. Administration, Off. of Ret. & Disability Policy, An-
The Medicaid program that provides long-term services and supports to low-income older adults and persons with disabilities, ABD Medicaid, is overwhelmingly the largest payer of these services, paying half the costs of all long-term services and supports in the country. It is a workhorse program and a lifeline for the many who cannot afford the high costs of long-term care.

Like SSI, ABD Medicaid is available to individuals 65 or older and individuals with disabilities who are under 65. Everyone must meet asset and income limits to qualify. Most ABD Medicaid beneficiaries, 10.7 million, are dual eligibles, meaning that they qualify for both Medicare and Medicaid benefits. Dual eligibles use Medicaid primarily for long-term services and supports. Some ABD Medicaid beneficiaries, however, only qualify for Medicaid and rely on the program for all their health coverage, including primary and acute care as well as long-term services and supports.

III. Unreasonable Eligibility Limits

The SSI benefit for 2016 is $733 per month, approximately 75% of the FPL. For basic eligibility for state plan services, about half the states set ABD Medicaid income limits at or near the SSI level. Some states, known as “209(b) states,” do not match their income limits to the SSI level. For example, Ohio’s income threshold is approximately 64% of the FPL. Most other states set income eligibility levels for ABD Medicaid at no higher than 100% of the FPL. States also have the option to allow individuals to spend down to the medically needy income level; however, these levels are also very low.


10 The 10 “209(b) states,” named based on that section of the Medicaid law, are Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. All 209(b) states must allow individuals to meet the income threshold by spending down income on health care expenses. See Social Security Program Operations Manual System (POMS) SI 01715.010(A)(1), https://secure.ssa.gov/poms.nsf/lnx/0501715010.


13 Thirty-six states and the District of Columbia use spend down programs. They include the 10 209(b) states that are required to allow individuals to spend down to the state’s income threshold, see supra note 10. The rest use spend down as part of their medically needy programs. For more on spend down, see Kaiser Commn. on Medicaid & the Uninsured, The Medicaid Medically Needy Program: Spending
Monthly SSI benefits are reduced when recipients have other sources of income. In determining a person’s SSI eligibility and benefit levels, SSA exempts the first $20 per month of unearned income, such as other Social Security benefits and pensions (known as the “general income disregard”), as well as the first $65 per month of earnings (known as the “earned income disregard”). Above those thresholds, each dollar of unearned income reduces SSI benefits by a dollar, whereas each dollar of earned income reduces SSI benefits by just 50 cents — a provision that is meant to encourage individuals to work. However, these income disregards have not been adjusted since the SSI program was created in 1972.

The asset limit for SSI is $2,000 for an individual and $3,000 for a couple. This limit has not changed since 1989 and is not indexed for inflation. Almost all state Medicaid programs also use these asset limits.

These income limits, on their face, are staggeringly low. The limits are even worse when viewed in light of the fact that the FPL itself significantly understates the needs of seniors living in poverty. Using a “basket” of goods and services adequate for families in the 1950s and updated only for inflation, the FPL does not reflect current economic realities facing American households, particularly households of older adults. The FPL, among other limitations, fails to take into account the burden of taxes on household budgets and fails to fully reflect the impact of the rapidly rising cost of health care. The federal government itself recognizes these deficiencies, and the U.S. Census Bureau has created the Supplemental Poverty Measure. Under that measure, the percentage of the nation’s seniors living in poverty jumps from 10% to 14.4%. The national Elder Economic Security Standard Index is another yardstick used to measure the income that older adults require to maintain their independence in the community and meet their daily costs of living, including housing and health care. State Elder Economic Security Standard Index programs go deeper, reflecting the different realities within a state. By that measure, a single older adult renting a one-bedroom apartment in Wayne County, Michigan (which includes Detroit), needs $1,906 per month just to meet his or her daily expenses. However, the FPL is set at only slightly more than half of that amount, at $981. Therefore, although Michigan sets ABD Medicaid income limits at 100% of the FPL, many seniors do not qualify for Medicaid, even if they lack sufficient income to meet their health care needs.

Medicaid and SSI asset limits, if anything, are more unrealistic. They also are at cross-purposes with efforts of the Centers for Medicare & Medicaid Services

(CMS) to redesign long-term services and supports to enable more older adults to age in the community and avoid premature placement in an institution. After all, a $2,000 limit on resources makes it virtually impossible to save in order to fix a roof, deal with a plumbing emergency, or repair a car without running afoul of these asset limits. Requiring individuals to spend down virtually all of their resources before they can qualify for needed long-term services and supports takes away the minimal safety net that anyone living in the community requires. It raises the specter that even a small emergency or unplanned expense can cascade into a crisis, potentially forcing an individual to move into an institution or worse, become homeless. The limit also discourages responsible planning. Advocates frequently report cases in which an individual, seeking to do the right thing, saves up from his or her minimal income for an anticipated expense and instead ends up losing coverage or facing an overpayment requirement.

IV. Simplifying Income Eligibility for ABD Medicaid
A. States Can Raise Income Eligibility Limits

Officials at CMS invariably describe Medicaid as a “partnership” between federal and state governments. In that partnership model, CMS allows states considerable flexibility in setting income and asset eligibility rules. Although the Medicaid statute establishes floors for income and asset eligibility, CMS has approved state plans that have significantly expanded eligibility and simplified enrollment. Yet, despite the willingness of CMS to endorse such changes, the number of states that have taken advantage of these opportunities is disappointingly low. Moreover, when states have sought expansion authority, they have frequently done so in the context of particular waiver programs rather than proposing across-the-board easing of eligibility limits. A handful of states, however, go above 100% of the FPL, primarily through income disregards. California, for example, has raised the effective rate to 124% of the FPL. Maine added a $55 state monthly income disregard to its 100% limit.  

B. Income Counting Methods Can Be Simplified

Medicaid programs use SSI’s income counting rules, which are complex and can require the applicant to collect significant supporting materials. Simplifying counting methodologies can allow more individuals to qualify and reduce administrative costs. One model for simplification is the Medicare Part D LIS, which entirely eliminates counting of in-kind support as income. As a result, if a beneficiary lives

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20 42 U.S.C. § 1395w-114(3)(C)(i). This change was enacted by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Pub. L. No. 110-275, 122 Stat. 2494 (2008). The relevant POMS section defines in-kind support as “not cash but … actually food or shelter, or something that can be used to get [food or shelter].” POMS HI 03020.001, https://secure.ssa.gov/poms.nsf/
in his or her daughter’s home and sometimes shares meals provided by family members, the beneficiary can still be eligible for help with paying for prescriptions without having to meet additional reporting requirements. Applying this methodology uniformly to ABD Medicaid would simplify application forms and expand the number of applicants whose income can be verified without additional documentation. It also takes the small supports that friends and families offer to low-income seniors out of the shadows, encouraging rather than discouraging a helping hand.

V. Aiming High for Asset Limits
A. Asset Limits Can Be Modernized

As with income, CMS is open to approving higher limits on assets. New York has taken advantage of that flexibility by effectively raising the asset limit through asset disregards. In New York, the asset limit for ABD Medicaid is $14,850 for a one-person household and $21,750 for a two-person household. Maine uses an asset disregard to create a limit of $10,000 for an individual and $15,000 for a couple. Other states have taken smaller steps. Minnesota, for example, has modestly increased its asset limit to $3,000 for an individual and $6,000 for a couple. The Rhode Island limit is $4,000 for an individual and $6,000 for a couple.

Approaches in other programs also offer models that could be considered in modernizing Medicaid and SSI asset limits. One such approach is indexing. The $2,000/$3,000 asset limit used by SSI and most state Medicaid programs has been the same since 1989. Other programs index their asset limits for inflation. The Medicare Part D LIS asset limits, though originally set at three times the SSI limit, are indexed to the Consumer Price Index. Similarly, the MSPs adjust asset limits for inflation. In 2015, the limits for three of the four MSPs rose to $7,280 for individuals and $10,930 for married couples.

Further, SSI and Medicaid asset limits could be adjusted to decrease the marriage penalty. Now, when a couple get married, they can keep only 75% of the assets that two single individuals are allowed to retain. One model for eliminating this marriage penalty appears in the Medicare Part D LIS asset limit for partial subsidies for a married couple, which is twice the limit for a single person. The limits for 2015 were $13,981 for an individual and $27,250 for a couple.

B. Asset Tests Can Be Eliminated

The District of Columbia and states as diverse as Alabama, Arizona, Connecticut, Mississippi, New York, and Vermont have
totally eliminated the asset test for their MSPs. Elimination of the asset test not only has the effect of expanding the eligible population, it also vastly simplifies the application process and program administration. For example, the MSP application form for New York State requires only one page of information from the applicant and does not ask for supporting documentation, although the state may require support in some cases. The absence of an asset test also is a distinguishing feature of MAGI Medicaid. As more and more individuals in Medicaid expansion states attempt — and fail — to transition from MAGI Medicaid to ABD Medicaid, the problems caused by unrealistically low ABD asset tests in most states will become increasingly apparent.

C. Asset Tests Can Be Simplified — Just Cut the Clutter

If we assume that, at least in the short run, asset tests at some level will continue to be part of the ABD Medicaid eligibility process, other programs offer ways in which those tests can be simplified.

- **Burial Allowance.** The Part D LIS provides for an automatic exclusion of $1,500 for burial expenses without the requirement for an individual to set up a segregated fund for that purpose. The individual only needs to assert that the money has been set aside for those expenses.

- **Life Insurance.** Counting the value of whole life insurance has also created barriers, including the difficulty for individuals to find out the cash value of a policy. The Part D LIS addresses this issue by excluding life insurance cash value entirely from asset counting, a change that was introduced with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

- **Attestation.** The Part D LIS application requires attestation of income and assets only. The SSA compares income and asset information provided on the application with income and asset information the agency obtains through matching agreements with other agencies. If information falls within certain tolerances, no further inquiry is made of the applicant unless non-residence real estate is declared as an asset. MAGI Medicaid, which uses income tax information for determining eligibility, similarly does not generally require additional documentation.

VI. More Options to Modernize Medicaid

A. Eligibility Periods Can Be More Expansive and Predictable

“Cycling” on and off Medicaid because of swings in income and assets creates instability for individuals and increases the
administrative burden on SSA. The Part D LIS provides a model that makes eligibility for the subsidy much more stable and predictable. The Part D LIS eligibility period lasts at least through the calendar year and, for individuals who are deemed eligible because they qualify for SSI or full or partial Medicaid, Part D LIS eligibility can extend for as long as 18 months. If an individual qualifies at any time during the first 6 months of the calendar year, eligibility continues through the end of that year. If an individual is deemed eligible because of SSI or Medicaid eligibility from July 1 forward, Part D LIS eligibility continues through that calendar year and the next calendar year.\footnote{42 C.F.R. 423.773(c)(2) (2015).}

The only event that impacts the Part D LIS midyear is a change in marital status, including death of a spouse.\footnote{POMS HI 03050.005(B)(1), https://secure.ssa.gov/poms.nsf/lnx/0603050005.} And, unlike ABD Medicaid, individuals have no obligation to report the change and thus face no consequences if they fail to do so. Moreover, if an individual loses a subsidy because of the death of a spouse, he or she is given a year’s grace period during which the surviving spouse can continue at the same subsidy level.\footnote{Id.} This deferral of a redetermination allows the surviving spouse more than a year in which to adjust to the financial changes that could ultimately affect eligibility.

The Part D LIS approach is in stark contrast to that used in most ABD Medicaid programs, in which month-to-month fluctuations in income can affect eligibility and failure to report any changes can bring overpayment claims and even result in charges of Medicaid fraud. The President’s Budget for FY 2017, released in February 2016, recognizes this concern and proposes a partial step in the right direction. The budget proposes to give states the option to provide 12-month continuous Medicaid eligibility. The proposal would not mandate changes and does not include all the elements of the Part D eligibility model. It would, however, provide important flexibility not currently available to the states.

B. Medicare Savings Programs: Half a Loaf Is Better Than None

Convincing states to increase full ABD Medicaid eligibility can be a tough sell given the current climate in many statehouses. States, however, may be more open to expanding eligibility for MSPs, particularly the Qualified Medicare Beneficiary (QMB) program. MSP expansion through changes in income or asset limits (or elimination of asset limits) has the added benefit of qualifying more state residents for the Medicare Part D LIS, since any MSP beneficiary is deemed eligible for the LIS. Further, CMS is encouraging MSP expansion by the states to soften the transition when an individual with expansion Medicaid coverage becomes Medicare eligible. CMS asks that states consider disregarding spousal income, disregarding amounts or categories of assets, or eliminating asset tests altogether. The President’s Budget for FY 2017 also includes a proposal that the simplified and less onerous LIS counting rules be mandated for determining eligibility for MSPs. The Budget proposal only addresses how income and assets are counted and would not affect eligibility cut-offs themselves. The counting rules, however, would result in more individuals qualifying for MSPs and bring administrative simplification. Expanding or simplifying MSP criteria is not a substitute for fixing Medicaid eligi-
bility. It is, however, a valuable and important improvement for low-income seniors and a step in the right direction.

VII. SSI: In Desperate Need of Updating

The SSI income disregard amounts have not been updated since President Nixon signed the SSI program into law in 1972. For example, $20 is the general or unearned income disregard whereby a beneficiary is allowed to receive a small amount of income from other sources, such as other Social Security benefits or a pension, without having his or her SSI benefits reduced. The cost of living today is more than 5.5 times what it was in 1972, meaning that $20 today is equivalent in purchasing power to about $3.50 in 1972.\(^{36}\)

To address the need to update and restore the original intent of the SSI program — to protect seniors and people with disabilities from the harms of poverty — Sens. Sherrod Brown (D-Ohio) and Elizabeth Warren (D-Mass.) introduced S. 1387, the Supplemental Security Income Restoration Act of 2015, in the Senate\(^{37}\) and Rep. Raul Grijalva (D-Ariz.) introduced an identical bill, H.R. 2442, in the House.\(^{38}\) Both bills were introduced on May 19, 2015.

Under the Act, several needed updates to the SSI program’s eligibility rules would be made:

- The general income disregard will increase to $112 per month and then be indexed for inflation.
- The earned income disregard will increase to $364 per month and then be indexed for inflation.
- The asset limit will increase to $10,000 for individuals and $15,000 for couples and then be indexed for inflation.
- Individuals who live in households with others, including family members, will no longer have their benefits reduced by one-third, which occurs as a result of the in-kind support and maintenance provision.
- Individuals who transfer assets (even small amounts of money to a family member) will no longer suffer harsh penalties.

For a senior or person with a disability who receives only a small amount in other Social Security benefits each month, an increase in the general income disregard would provide an additional $92 per month in SSI. For example, a widow age 65 or older receiving $550 per month in survivors’ benefits may now be eligible to receive $203 monthly in SSI, which would increase to $295 per month in SSI if the general income disregard were updated from $20 to $112 (which reflects inflation since 1972). This would increase the widow’s income by more than 10%, helping her pay for food, medicine, transportation, and other necessities. The disregards must also be indexed for inflation going forward so that they do not lose their value in the future.

The imposition of the in-kind support and maintenance provision makes an already difficult situation of living on a very low income even worse for those receiving...


SSI. If an elderly parent or sibling with a disability receiving SSI benefits receives assistance of food or shelter from family members, he or she will likely be paid at a lower rate. Thus, an SSI recipient living in the household of another person may be subject to a reduction in benefits equal to one-third the federal benefit level, or $242, reducing his or her SSI benefits to $491 a month. This provision is quite complex and imposes an increased financial burden on SSI recipients and their families, as well as an administrative burden on already stressed local Social Security offices nationwide.

Besides providing these desperately needed improvements to the SSI program, passage of the Supplemental Security Income Restoration Act would have an immediate favorable impact on Medicaid eligibility requirements. SSI reform could jump-start an update of Medicaid eligibility requirements by raising the federal floor and simplifying the counting criteria on which state Medicaid programs are based.

VIII. Conclusion

Low-income seniors need a “reset” of the asset and income eligibility criteria to ensure that the Medicaid and SSI programs meet their needs. Congress has the opportunity to revitalize SSI through the Supplemental Security Income Restoration Act of 2015. The progress in MAGI Medicaid and the reforms in MSPs and the Medicare Part D LIS demonstrate that other approaches are both possible and practical. The inclusion in the President’s Budget of proposals to reform both Medicaid and MSP eligibility gives advocates an additional lever to advocate federally for a redesign of the ABD Medicaid program. There also are opportunities for advocates to work with their states to take advantage of existing federal flexibility to update programs to more effectively reach those experiencing poverty. Putting these long overdue fixes in place will require work at both the federal and state levels. But the need is urgent and the time is ripe.

Of the 10,000 baby boomers aging into Medicare daily, many who benefited from the safety net of MAGI Medicaid will find that the safety net suddenly has giant holes. The vital Medicaid and SSI safety net needs some patching to address 21st century realities.