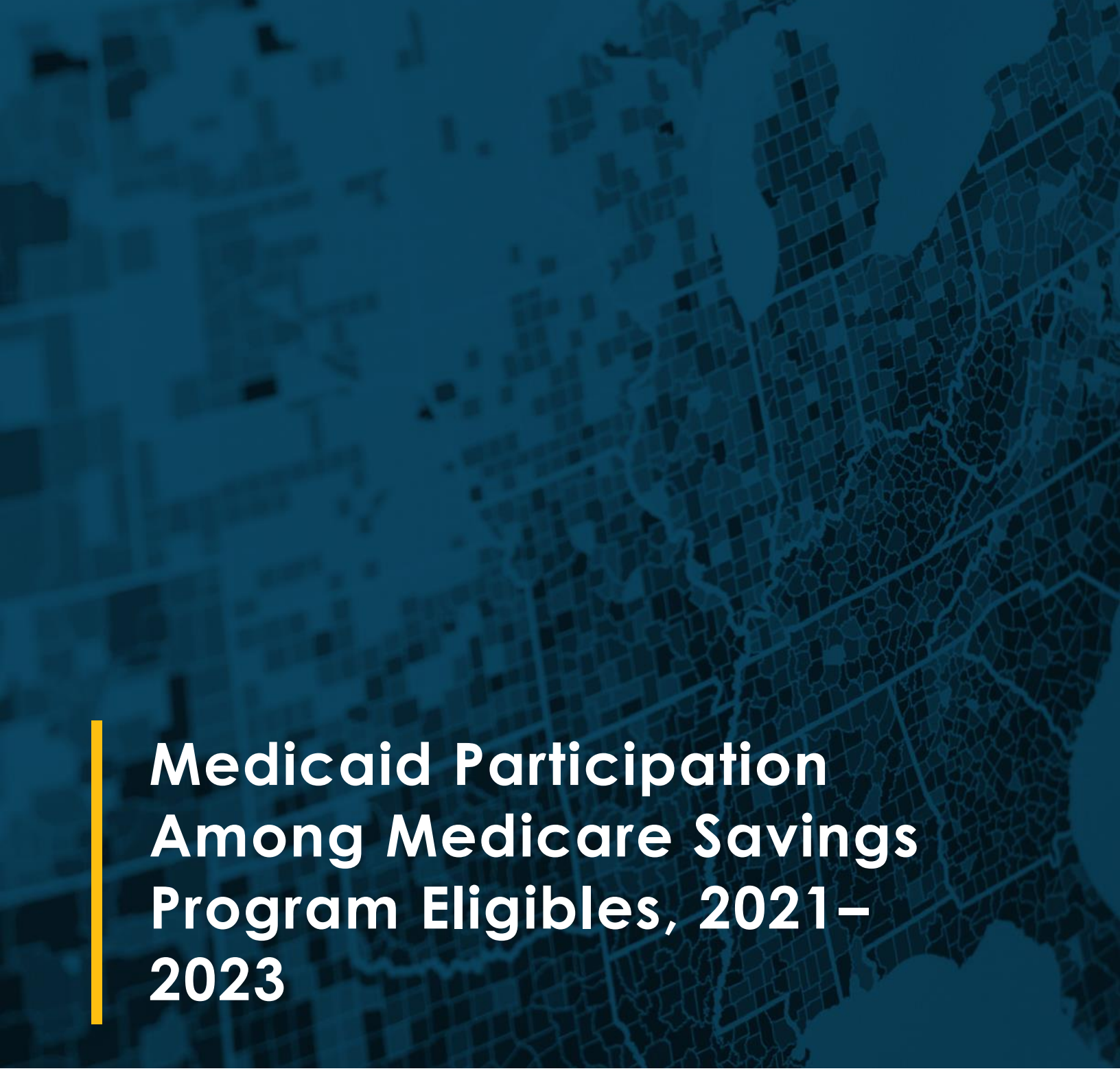

Medicaid Participation Among Medicare Savings Program Eligibles, 2021–2023

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Executive Summary

Participation in Medicare Savings Programs (MSPs) remains incomplete, potentially leaving low-income Medicare beneficiaries exposed to avoidable cost sharing. This study provides updated national estimates of Medicaid participation among individuals eligible for MSPs and identifies factors associated with enrollment. Using the 2022–24 panels of the Survey of Income and Program Participation, we simulate eligibility for the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs and measure self-reported Medicaid coverage as a proxy for MSP participation. Averaged over December 2021–23, Medicaid participation among MSP-eligible adults was 64.3 percent for QMB eligibles, 62.5 percent for SLMB eligibles, and 55.9 percent for QI eligibles; differences across programs are not statistically significant. Participation is higher among individuals receiving Supplemental Security Income (SSI) and Supplemental Nutrition Assistance Program (SNAP) benefits and in states with more generous asset rules, and lower among those with greater assets, higher education, private insurance, and who are age 65 or older—patterns consistent with greater participation among individuals with higher financial need. Overall participation appears higher than estimates from a decade earlier, though substantial gaps in participation for those who may benefit remain, suggesting both individual circumstances and state policy design influence take-up.

Medicaid Participation Among Medicare Savings Program Eligibles, 2021–2023

Introduction and Background

Participation in Medicare Savings Programs (MSPs) is well below 100 percent, potentially leaving many individuals with limited resources exposed to Medicare-related expenses that Medicaid would otherwise cover. MSPs are a form of Medicaid that reduces Medicare cost sharing for eligible Medicare enrollees with limited resources. There are multiple programs for which Medicare beneficiaries can be eligible. The Qualified Medicare Beneficiary (QMB) program is the most generous, paying enrollees' Medicare Part B premiums, deductibles, and copayments. By contrast, the Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI) programs cover only Medicare Part B premiums. Additionally, in some cases, individuals may also be eligible for full Medicaid benefits, referred to as QMB-Plus or SLMB-Plus, which varies by state. MSP enrollees are also commonly referred to as "dual enrollees" or "dual Medicare-Medicaid enrollees," although alternative pathways to dual Medicare-Medicaid enrollment exist beyond MSPs.

Early work by the Social Security Administration estimated a 63 percent participation rate in 1999 for the QMB and SLMB programs combined (Rupp and Sears 2000). More recent research reflecting an average over calendar years 2009 and 2010 measured lower participation rates—namely, 53.1 percent for the QMB program, 32.2 percent for the SLMB program, and 15.1 percent for the QI program (Caswell and Waidmann 2017). More recent work suggests that, as of December 2013, the participation rate was 68 percent for the QMB program, 55 percent for the SLMB program, and 45 percent for QI (Niedzwiecki et al. 2025).

In this paper, we offer timely estimates of Medicaid participation among those eligible for MSPs spanning December 2021, 2022, and 2023, and identify features correlated with Medicaid participation, using the Survey of Income and Program Participation (SIPP). We consider this a very close proxy for MSP participation, interpreting self-reported Medicaid participation in this context to include both full- and partial-benefit duals.[1] Specifically, we investigate the relationship between participation and demographic characteristics, other public program participation, resource levels,

private health insurance enrollment, geographic region of residence, and residence in states with more generous income- and/or asset-eligibility requirements for Medicaid. The reference period covers the period when the "Medicaid continuous coverage" provision during the COVID-19 public health emergency was in effect, and immediately after it ended. Continuous coverage increased Medicaid enrollment and may also have influenced MSP participation.

Our main results, which average across December 2021, 2022, and 2023, suggest that Medicaid participation was 64.3 percent among QMB-eligible adults, 62.5 percent among SLMB-eligibles, and 55.9 percent among QI-eligibles, although the estimates across the three programs are statistically indistinguishable from one another. That said, these results suggest that participation may have increased compared with the earlier studies from 2009, 2010, and 2013. We also find that MSP-eligible individuals receiving Supplemental Security Income (SSI) and Supplemental Nutrition Assistance Program (SNAP) benefits, and those in states with more generous asset-eligibility requirements, are consistently and significantly more likely to enroll in Medicaid. Conversely, we find that those who are eligible for MSPs and have greater assets, higher levels of education, and private insurance are less likely to participate. Much of the evidence supports the hypothesis that people with the greatest financial need are more likely to participate, though substantial gaps in participation from those who may benefit remain. Additionally, higher participation in states with more generous asset requirements suggests a role for state policy in increasing MSP participation.

Methods

Data

We used data from SIPP, collected during calendar years 2022, 2023, and 2024, for this research. The SIPP is a nationally representative household survey conducted by the US Census Bureau. The data collected during the SIPP interviews largely reflects the entire previous calendar year (i.e., 2021, 2022, and 2023). Much of the information in the SIPP is collected for each month of the calendar year, such as income and government program participation. The SIPP is a longitudinal survey in which the same individuals are interviewed across multiple survey years; however, the data can also be analyzed cross-sectionally, as is done in this work. We focus on individuals ages 18 and older, as well as December, because asset information is collected for December only, and assets are a key feature used to measure respondents' MSP eligibility (discussed below). Reported statistics are most appropriately interpreted

as averages over December 2021, 2022, and 2023. Our final sample, combining survey data spanning the 2022–24 interviews, includes 2,902 person-month observations for 2,253 unique individuals.[2]

MSP Eligibility Simulation

We developed an MSP-eligibility simulation and applied it to the SIPP data to determine which respondents are eligible for the QMB, SLMB, and QI programs. The key features of the simulation include monthly MSP eligibility unit income, assets, and state of residence.

We first identified MSP eligibility units by month using SIPP's data on intrahousehold relationships and created unique MSP unit IDs. This is important in that MSP income and asset eligibility are functions of MSP units' size. Specifically, we identified and defined monthly MSP eligibility units as cohabiting married couples and single individuals using the SIPP's information on personal relationships across household members (SSA 2025a, sec. 2122, 2123), which can change from month to month. We aggregated countable resources (income and assets) by MSP units, applied income and asset disregards (discussed below), and ultimately compared unit income with federal or state-specific rules to determine eligibility.

To quantify MSP unit income, we first disregarded the following sources from respondents' total reported income and set the floor equal to $0 for all income categories, per the federal eligibility rules (SSA 2025a, secs. 2128–47):

- SSI
- Temporary Assistance for Needy Families
- general assistance
- foster care payments
- child support payments (one-third of total payments)

After applying the categorical income disregards above, earned and unearned income were aggregated by MSP unit, and the following amounts were further disregarded from earned and unearned MSP unit income per federal rules (SSA 2025a, sec. 2135):

- $65 of monthly earned income
- $20 of monthly unearned income
- any remaining portion of the $20 monthly unearned income deduction (above) to earned income
- 50 percent of any remaining earned income

To quantify countable MSP unit assets, we first disregarded the following asset categories/amounts and set the floor equal to $0 for all (secured) asset categories: (SSA 2025b, sec. SI01130.120; 2025a, secs. 2148–66):

- life insurance, valued up to $1,500
- net equity of one vehicle (the highest net equity vehicle in the MSP unit)
- net equity of the primary residence

Eligibility was determined by comparing total MSP income post disregards as a percent of the Federal Poverty Guidelines, and assets post disregards, with federal income and asset limits or state-specific limits where applicable (MedPAC and MACPAC 2022, table 2; 2023, table 2; 2024, table 2).

Medicaid Enrollment Among the MSP-Eligible

We measured Medicaid participation among those simulated to be eligible for MSPs using respondents' self-reported Medicaid enrollment responses, combined with the eligibility simulation described above. We consider this a very close proxy for MSP enrollment, including full- and partial-benefit duals among those MSP-eligible, with distinctions that we summarize here and discuss further in the appendix.

Limiting the sample to the MSP-eligible population excludes those not eligible for MSPs—including those who could be eligible and enrolled in Medicaid with full benefits through pathways with more generous enrollment requirements (e.g., spend down or medically needy). Yet, because of the possibility of overlap between states' Medicaid and MSP eligibility requirements, some individuals may be enrolled in Medicaid with full benefits, be MSP-eligible, but not enrolled in an MSP, which is a limitation.

Medicaid participation measured in the SIPP data makes no distinction between partial and full Medicaid benefits. Throughout this report, we interpret Medicaid enrollment among the MSP eligible as including those with either full or partial Medicaid benefits, although we acknowledge some uncertainty on this point. The appendix offers additional discussion on these conceptual and data measurement considerations for interested readers.

Empirical Approach

First, we present summary statistics on Medicaid participation by MSP eligibility group (any MSP, as well as QMB, SLMB, and QI, in turn). We then present descriptive summary statistics on the characteristics of MSP-eligible Medicaid-enrolled individuals, compared with MSP-eligible but not Medicaid-enrolled individuals, by MSP program eligibility group.

We further estimated the relationship between Medicaid participation and individual characteristics among the MSP-eligible population using a multivariate model. Specifically, we estimated logit models for each eligibility category, where the dependent variable identified self-reported Medicaid enrollment, and the independent variables included: age, sex, race and ethnicity, highest educational attainment, household composition, MSP unit income and assets, government program participation (SSI, SNAP), private health insurance coverage, survey reference year, residence in a state with more generous income and/or asset requirements, and census division.

We estimated and reported average marginal effects (AME) using the logit model's parameter estimates. Results are interpreted as percentage-point differences in the rate of Medicaid participation associated with a given characteristic compared with a stated reference group. All independent variables are binary and are therefore interpreted in this way. To aid interpretation, we also report the AME in relative terms, divided by the dependent variable mean.

All statistical hypothesis tests and variance estimates account for the survey's complex design by using its replicate weights and Fay's balanced repeated replication method (US Census Bureau 2025).

Limitations

This work has several limitations. One is that we measured Medicaid participation generally, not Medicaid enrollment by program type. As discussed above, limiting the sample to those MSP-eligible should conceptually exclude most non-MSP duals. However, errors in reporting income and/or assets may result in the inclusion of some non-MSP Medicaid enrollees in the analysis. Another limitation is that it is not possible to distinguish between full and partial Medicaid benefits, a policy-relevant distinction. For example, the prospect of enrolling in an MSP in a state that offers full Medicaid benefits to those eligible for MSPs may be more appealing and could lead to higher participation.

Another limitation arises from survey respondent errors in reporting Medicaid enrollment. It is well established that household surveys "undercount" Medicaid enrollees. That is, there are more survey respondents enrolled in Medicaid who fail to report Medicaid enrollment (false-negative responses) than respondents not enrolled in Medicaid who report Medicaid enrollment (false-positive responses). There is also evidence that individuals with partial Medicaid benefits are less likely to report Medicaid enrollment in household surveys. Although it's unclear if this evidence applies to partial-benefit MSP programs, compared with other forms of partial or restricted Medicaid benefits, such as those specific to family planning or emergency services (Noon, Fernandez, and Porter 2019). These errors may result in lower-than-actual participation rates.

Errors in survey respondents' reporting of income and/or assets are a limitation common to all survey data. Overreporting income and/or assets could result in an underestimation of the true size of the MSP-eligible population, and underreporting income and/or assets may result in overestimating the size of the MSP-eligible population. As discussed above, there are errors in Medicaid reporting. Finally, item nonresponse and the subsequent imputation of missing data introduce additional sources of error.

The SIPP only interviews those who are not institutionalized. Consequently, our results are interpreted excluding those in nursing homes, a population that includes dual enrollees.

We cannot incorporate some income and asset rules because of data limitations. For example, net equity of business property is excluded from assets for MSP eligibility (SSA 2025a, sec. 2158). However, the SIPP does not collect data on the value of business property distinct from nonproperty assets. Although this is a limitation, we consider the SIPP the best survey of many options for this exercise because of the variety of detailed asset and income information it collects, its sample size, and its broad representation (e.g., across all ages).

Results

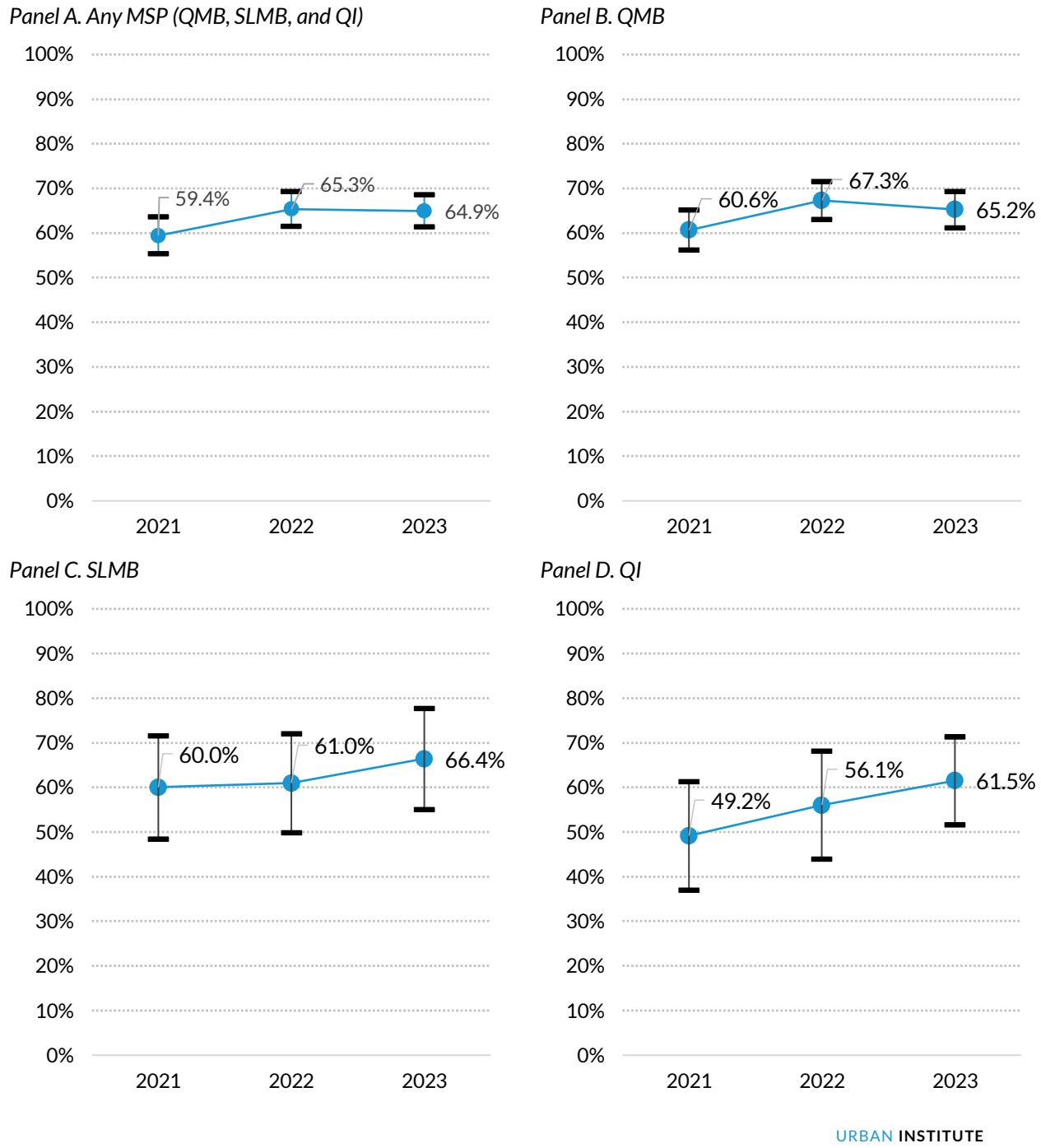
Medicaid Participation by Year

Figure 1 reports Medicaid participation by calendar year among those our simulation deemed eligible for the QMB, SLMB, and QI programs, in turn, as well as any MSP (all three programs combined). The Medicaid participation rate among all MSP-eligibles was 59.4 percent in December 2021, which increased to 65.3 percent in December 2022 (p-value = 0.0353), and marginally decreased to 64.9 percent in December 2023, yet is not statistically different from 2022 (panel A). For the QMB-eligible population, the pattern is similar, where estimated participation increased from 60.6 percent in 2021 to 67.3 percent in 2022 (p-value = 0.0357), and marginally decreased to 65.2 percent in 2023, but the change between 2022 and 2023 is again statistically insignificant (panel B).

Estimated SLMB participation was 60.0 percent in 2021, 61.0 percent in 2022, and 66.4 percent in 2023, although the three estimates are statistically indistinguishable from one another (panel C). Finally, estimated QI participation was 49.2 percent in 2021, 56.1 percent in 2022, and 65.1 percent in 2023, but again, the estimates are statistically indistinguishable from one another (panel D). The SLMB and QI eligible groups are relatively small, resulting in less precise estimates compared with the QMB eligible group, as seen by the wider confidence intervals for these two groups.

FIGURE 1

Medicaid Participation Rates with 95 Percent Confidence Intervals Among MSP-Eligibles Ages 18 and Older by MSP Program, 2021–23



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Source: Authors' calculations using the 2022, 2023, and 2024 Survey of Income and Program Participation files.
Notes: MSP = Medicare Savings Program; QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-Income Medicare Beneficiary; QI = Qualifying Individual.

Medicaid Participation by Age Group

Table 1 reports Medicaid participation by MSP-eligible category and any MSP (all three programs combined). The top panel reports results for adults ages 18 and older, and the bottom two panels present results by age group: ages 65 and older and ages 18 to 64. Statistics are averages over December 2021, 2022, and 2023 combined to increase the sample size and produce more precise estimates.

We estimate that 63.2 percent of adults eligible for any MSP participate in Medicaid (table 1). Medicaid participation among QMB eligibles is slightly greater (64.3 percent) but not statistically different from that for SLMB eligibles (62.5 percent), which is, in turn, greater but again not statistically different than that for QI eligibles (55.9 percent). Medicaid participation among the QMB eligible is greater and statistically different than that for QI eligibles (p-value = 0.0217).

Results by age group suggest that Medicaid participation among the MSP-eligible is greater for adults ages 18 to 64 than for those ages 65 and older (middle and bottom panels of table 1). For example, among those ages 65 and older and eligible for any MSP, 57.1 percent participated in Medicaid, compared with 69.6 percent of MSP-eligibles ages 18 to 64 (p-value < 0.0000). That said, the subsample sizes by age group are relatively small, resulting in larger confidence intervals (less precise estimates).

TABLE 1

Medicaid Enrollment by MSP-Eligible Category and Age Group, Average December 2021, 2022, and 2023

Eligible Population	Percent enrolled in Medicaid	Standard error	95 percent confidence interval (% enrolled)		Total eligible sample size
Ages 18 and older					
Any MSP-eligible	63.2%	0.012	60.9%	65.5%	2,902
QMB-eligible	64.3%	0.012	61.9%	66.8%	2,260
SLMB-eligible	62.5%	0.035	55.6%	69.4%	309
QI-eligible	55.9%	0.034	49.2%	62.7%	333
Ages 65 and older					
Any MSP-eligible	57.1%	0.018	53.6%	60.7%	1,797
QMB-eligible	59.5%	0.019	55.7%	63.2%	1,377
SLMB-eligible	53.4%	0.044	44.7%	62.1%	194
QI-eligible	46.6%	0.044	37.9%	55.3%	226
Ages 18 to 64					
Any MSP-eligible	69.6%	0.016	66.5%	72.7%	1,105
QMB-eligible	69.1%	0.018	65.4%	72.7%	883
SLMB-eligible	72.6%	0.048	63.1%	82.1%	115
QI-eligible	71.2%	0.051	61.3%	81.2%	107

Source: Authors' calculations using the 2022, 2023, and 2024 Survey of Income and Program Participation (SIPP) files.
Notes: MSP = Medicare Savings Program; QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-Income Medicare Beneficiary; QI = Qualifying Individual. Statistics represent averages over December 2021, 2022, and 2023 combined. December

is reported as it is the month when asset data are collected in the SIPP. See the methods section for more details about data and sample used in this analysis.

Characteristics of the Enrolled and Eligible but Not Enrolled

Table 2 reports results on the differences in characteristics among Medicaid-enrolled MSP-eligibles compared with those eligible for an MSP but not enrolled in Medicaid. Several distinct and consistent patterns emerge.

Among adults eligible for any type of MSP, those not enrolled in Medicaid are more likely than those enrolled to be older (ages 65 and older), white, non-Hispanic, not married, to have higher levels of education, reside in a household with more adults, have higher income and wealth, and have private health insurance. MSP-eligible adults, not enrolled in Medicaid, are less likely to participate in SSI and/or SNAP. There is no statistical evidence of differences among Medicaid enrollees and MSP-eligible nonenrollees by sex, multiple race and ethnicity groups (Black, non-Hispanic; other non-Hispanic; Hispanic), or the number of children in the household. There is evidence that the share of the eligible population enrolled increased between 2021 and 2022, but we find no change between 2022 and 2023, as shown in figure 1. Finally, we find evidence that those who reside in states with more generous income and asset requirements are more likely to enroll. And there is limited evidence of geographic variation in participation by census division, with those enrolled more likely to reside in the Middle Atlantic, and, conversely, those in the East South Central and West South Central less likely to enroll.

The general patterns described above are almost the same for the QMB-eligible subpopulation, which is the largest among the three subpopulations. There is less statistical evidence of differences among the smaller SLMB- and QI-eligible subpopulations by race and ethnicity, education, number of adults in the household, income, wealth (QI), and survey year. This could, in part, reflect less statistical power resulting from the smaller subsample sizes, underscoring the value of the multivariate approach presented below.

TABLE 2

Characteristics of Medicaid-Enrolled and Eligible but Not Enrolled, by MSP-Eligibility Group

	MSP-Eligible			QMB-Eligible			SLMB-Eligible			QI-Eligible		
	Not enrolled	Enrolled		Not enrolled	Enrolled		Not enrolled	Enrolled		Not enrolled	Enrolled	
Demographics												
Younger than age 65	40.5%	53.9%	**	44.0%	54.4%	**	34.7%	55.1%	**	24.7%	48.3%	**
Age 65 and older	59.5%	46.1%	**	56.0%	45.6%	**	65.3%	44.9%	**	75.3%	51.7%	**
Male	40.8%	42.3%		40.9%	42.4%		44.9%	39.2%		36.9%	45.6%	
Female	59.2%	57.7%		59.1%	57.6%		55.1%	60.8%		63.1%	54.4%	
White, non-Hispanic	46.3%	40.8%	*	46.2%	41.0%	+	52.7%	39.4%	+	41.7%	39.8%	
Black, non-Hispanic	22.2%	24.9%		22.2%	25.3%		19.1%	27.0%		25.1%	19.3%	
Hispanic	22.8%	23.2%		22.4%	21.9%		25.3%	27.8%		23.3%	29.1%	
Other, non-Hispanic	8.7%	11.1%		9.3%	11.7%		2.9%	5.8%		9.9%	11.8%	
Not married	24.1%	16.7%	**	20.7%	16.3%	+	34.5%	16.1%	**	36.1%	20.8%	*
Married	75.9%	83.3%	**	79.3%	83.7%	+	65.5%	83.9%	**	63.9%	79.2%	*
Less than high school	25.4%	34.3%	**	24.1%	35.0%	**	26.5%	29.1%		32.2%	33.9%	
High school and less than a college degree	61.8%	56.0%	*	62.3%	54.9%	*	65.8%	64.8%		55.1%	56.0%	
College graduate	12.8%	9.6%	+	13.5%	10.0%		7.7%	6.0%		12.7%	10.1%	
Number of adults in household	2.2	2.0	**	2.2	2.0	*	2.2	2.0		2.4	2.2	
Number of children in household	0.3	0.3		0.3	0.3		0.2	0.2		0.2	0.3	
MSP unit income after deductions												
Average income as a percent of FPG	61.7%	53.7%	**	42.1%	36.0%	*	118.2%	116.3%		132.6%	136.9%	
MSP unit assets after deductions												
$0–150	41.2%	54.4%	**	42.8%	54.9%	**	26.8%	54.7%	**	43.4%	50.1%	
$150–1,500	22.6%	29.1%	**	23.0%	28.8%	*	20.6%	28.7%		21.6%	31.4%	+
$1,500–5000	17.5%	10.6%	**	16.5%	10.9%	**	29.8%	10.8%	**	13.4%	7.8%	
Above $5,000	18.8%	6.0%	**	17.8%	5.5%	**	22.8%	5.8%	**	21.7%	10.7%	*
Government program participation												
SSI	19.0%	54.8%	**	22.1%	59.1%	**	7.5%	46.0%	**	9.5%	27.4%	**
SNAP	22.8%	63.1%	**	23.5%	64.6%	**	19.0%	56.9%	**	21.3%	57.5%	**
Private health insurance	26.2%	9.9%	**	26.0%	9.2%	**	25.6%	16.2%		27.5%	8.9%	**
Survey reference year												
2023	33.6%	36.2%		34.3%	35.7%		29.9%	35.5%		32.3%	40.7%	
2022	29.7%	32.6%		28.3%	32.3%	+	37.7%	35.3%		31.7%	31.9%	
2021	36.7%	31.2%	*	37.4%	31.9%	*	32.4%	29.2%		36.0%	27.5%	

	MSP-Eligible			QMB-Eligible			SLMB-Eligible			QI-Eligible		
	Not enrolled	Enrolled		Not enrolled	Enrolled		Not enrolled	Enrolled		Not enrolled	Enrolled	
State eligibility generosity												
More generous income requirement	11.3%	15.1%	*	11.5%	15.1%	+	8.9%	10.1%		12.0%	20.7%	+
More generous asset requirement	36.1%	42.2%	*	36.6%	43.5%	*	30.5%	29.4%		37.5%	45.3%	
Census division												
New England	5.6%	6.8%		6.0%	6.8%		5.0%	7.7%		4.1%	5.7%	
Middle Atlantic	12.6%	19.2%	**	13.0%	19.4%	**	6.6%	10.7%		15.1%	26.9%	*
East North Central	10.9%	12.8%		11.7%	13.4%		12.3%	11.0%		5.0%	9.3%	
West North Central	4.4%	5.3%		4.1%	4.6%		8.7%	11.8%		2.8%	4.3%	
South Atlantic	18.6%	18.5%		17.1%	17.5%		25.9%	26.1%		21.0%	18.7%	
East South Central	9.3%	6.2%	*	9.6%	6.2%	*	6.4%	4.3%		10.0%	7.8%	
West South Central	16.2%	10.2%	**	15.7%	10.0%	**	17.8%	12.3%		17.5%	9.4%	+
Mountain	5.9%	6.0%		6.1%	5.8%		5.1%	8.7%		4.8%	4.1%	
Pacific	16.6%	15.1%		16.6%	16.2%		12.2%	7.3%		19.7%	13.7%	
N	1,164	1,738		881	1,379		125	184		158	175	

Source: Authors' calculations using the 2022, 2023, and 2024 Survey of Income and Program Participation (SIPP) files.

Notes: MSP = Medicare Savings Program; QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-income Beneficiary, QI = Qualifying Individual; FPG = federal poverty guidelines; SSI = Supplemental Security Income; SNAP = Supplemental Nutrition Assistance Program. Statistics represent averages over December 2021, 2022, and 2023 combined. December is reported as it is the month when asset data are collected in the SIPP. See the methods section for more details about data and sample used in this analysis. **, *, + indicate statistical significance at the 0.01, 0.05, and 0.10 levels, respectively. The null hypothesis is that a given row statistic is equal for enrollees and nonenrollees.

Multivariate Regression Model Results—Medicaid Participation by MSP Eligibility Group

Table 3 reports AMEs from four logit model specifications, one for each MSP eligibility grouping (any MSP, QMB, SLMB, and QI). Results are interpreted as the percentage point difference in the probability of Medicaid enrollment associated with each characteristic compared with the reference group.

Among all MSP-eligibles, for example, the AME for those ages 65 and older is –0.116, meaning they are 11.6 percentage points less likely to enroll in Medicaid than younger adults ages 18 to 64 (the reference group) eligible for MSPs. The estimate is statistically significant at conventional levels (*p*-value < 0.000), and in relative terms, it represents an 18.3 percent difference (11.6 percentage points divided by the dependent variable mean equal to 63.2 percent). Along with age, the following characteristics relate to the likelihood of enrolling in Medicaid among all MSP-eligibles.

- Education is negatively associated with Medicaid participation. College graduates are 7.1 percentage points (11.3 percent) less likely to enroll, and those with a high school education are 4.4 percentage points (7.0 percent) less likely to enroll, compared with those with less than a high school education.
- Having children in the household is associated with higher Medicaid take-up compared with those with no children (4.9 percentage points or 7.7 percent).
- Income above the group median is associated with greater Medicaid take-up (3.4 percentage points or 5.3 percent).
- Assets are associated with lower Medicaid take-up. Those with more than $5,000 in countable assets are 12.8 percentage points less likely to enroll in Medicaid (–20.3 percent), and those with $1,500 to $5,000 in assets are 5.7 percentage points less likely to participate (–9.1 percent) than those with $0 to $100 in countable assets.
- Government program participation is positively related to Medicaid participation.
    - » SSI beneficiaries are 21.1 percentage points (33.4 percent) more likely to enroll in Medicaid than non-SSI beneficiaries.
    - » SNAP beneficiaries are 24.3 percentage points (38.5 percent) more likely to enroll in Medicaid than non-SNAP beneficiaries.
- Private health insurance is negatively related to Medicaid participation. Those enrolled in a private plan are 12.1 percentage points (–19.2 percent) less likely to enroll.
- Those who live in states with more generous asset requirements were 7.4 percentage points (11.8 percent) more likely to enroll compared with those in states with the federal asset test requirements.

TABLE 3

Average Marginal Effects Predicting Medicaid Enrollment Among MSP-Eligible Groups

	MSP-Eligible			QMB-Eligible			SLMB-Eligible			QI-Eligible		
	AME	SE	% Δ	AME	SE	% Δ	AME	SE	% Δ	AME	SE	% Δ
Demographics												
Younger than age 65 (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
Age 65 and older	-0.116**	0.022	-18.3%	-0.109**	0.025	-17.0%	-0.208**	0.050	-0.333	-0.144+	0.074	-0.258
Male (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
Female	-0.005	0.021	-0.8%	-0.004	0.022	-0.5%	0.050	0.054	0.080	-0.056	0.058	-0.099
White, non-Hispanic (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
Black, non-Hispanic	-0.025	0.028	-4.0%	-0.036	0.034	-5.6%	0.125	0.078	0.201	-0.096	0.084	-0.171
Other, non-Hispanic	0.044	0.037	7.0%	0.021	0.040	3.3%	0.322**	0.091	0.515	0.023	0.101	0.042
Hispanic	-0.011	0.028	-1.8%	-0.052+	0.031	-8.0%	0.146*	0.069	0.234	0.102	0.077	0.182
Not married (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
Married	-0.034	0.027	-5.4%	-0.021	0.032	-3.2%	-0.067	0.066	-0.108	-0.113	0.091	-0.203
Less than high school (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
High school and less than a college degree	-0.044+	0.023	-7.0%	-0.056+	0.025	-8.7%	-0.013	0.061	-0.020	-0.016	0.056	-0.028
College graduate	-0.071+	0.040	-11.3%	-0.085*	0.041	-13.2%	0.102	0.118	0.163	-0.138	0.139	-0.247
One adult in household (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
Two or more adults in household	-0.006	0.025	-1.0%	-0.008	0.026	-1.3%	-0.020	0.067	-0.032	0.034	0.072	0.062
No children in household (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
One or more children in household	0.049+	0.028	7.7%	0.041	0.029	6.4%	-0.002	0.102	-0.003	0.115	0.089	0.206
MSP unit income above median	0.034+	0.019	5.3%	0.034	0.021	5.3%	-0.047	0.060	-0.075	0.079	0.065	0.141
MSP unit assets after deductions												
$0–150 (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
$150–1,500	0.039	0.026	6.1%	0.042	0.030	6.5%	0.004	0.059	0.007	0.070	0.074	0.126
$1,500–5000	-0.057+	0.029	-9.1%	-0.040	0.035	-6.2%	-0.254**	0.086	-0.407	-0.073	0.089	-0.131
Above $5,000	-0.128**	0.037	-20.3%	-0.116**	0.043	-18.0%	-0.281**	0.106	-0.449	-0.156+	0.088	-0.279
Government program participation												
SSI	0.211**	0.027	33.4%	0.196**	0.028	30.5%	0.310**	0.057	0.496	0.173*	0.082	0.310
SNAP	0.243**	0.027	38.5%	0.263**	0.029	40.9%	0.179**	0.067	0.286	0.237**	0.079	0.423
Private health insurance	-0.121**	0.030	-19.2%	-0.145**	0.033	-22.5%	-0.114	0.083	-0.182	-0.128	0.085	-0.229
Survey reference year												
2021	-0.037	0.026	-5.9%	-0.020	0.028	-3.1%	-0.233**	0.062	-0.372	0.032	0.070	0.057

	MSP-Eligible			QMB-Eligible			SLMB-Eligible			QI-Eligible		
	AME	SE	% Δ	AME	SE	% Δ	AME	SE	% Δ	AME	SE	% Δ
2022	-0.010	0.021	-1.5%	0.010	0.024	1.6%	-0.143**	0.051	-0.229	0.000	0.080	0.000
2023 (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
State eligibility generosity												
More generous income requirement	0.042	0.036	6.7%	0.060	0.047	9.3%	0.131	0.102	0.210	0.007	0.136	0.012
More generous asset requirement	0.074**	0.028	11.8%	0.093**	0.030	14.4%	0.067	0.067	0.107	0.051	0.085	0.091
Census division												
New England (reference group)	--	--	--	--	--	--	--	--	--	--	--	--
Middle Atlantic	0.067	0.061	10.6%	0.110	0.074	17.2%	-0.021	0.141	-0.034	0.060	0.151	0.108
East North Central	0.069	0.067	11.0%	0.138	0.085	21.4%	-0.141	0.120	-0.225	0.044	0.179	0.079
West North Central	0.073	0.078	11.6%	0.124	0.101	19.3%	-0.132	0.181	-0.211	0.002	0.237	0.004
South Atlantic	0.040	0.068	6.3%	0.113	0.087	17.6%	-0.108	0.150	-0.172	-0.045	0.184	-0.081
East South Central	-0.054	0.064	-8.5%	-0.013	0.086	-2.0%	-0.251	0.178	-0.401	0.001	0.191	0.002
West South Central	-0.070	0.065	-11.0%	0.008	0.084	1.2%	-0.259+	0.147	-0.415	-0.219	0.173	-0.393
Mountain	0.060	0.070	9.5%	0.084	0.088	13.0%	0.017	0.141	0.028	-0.007	0.197	-0.013
Pacific	0.007	0.062	1.1%	0.091	0.082	14.1%	-0.259+	0.153	-0.414	-0.192	0.170	-0.344
N	2,902			2,260			309			333		

Source: Authors' calculations using the 2022, 2023, and 2024 Survey of Income and Program Participation files.

Notes: MSP = Medicare Savings Program; QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-Income Medicare Beneficiary; QI = Qualifying Individual; AME = average marginal effects; SSI = Supplemental Security Income; SNAP = Supplemental Nutrition Assistance Program. "—" indicates not applicable. "AME" columns report the estimated average percentage point difference in MSP enrollment corresponding to a given row characteristic with respect to a stated reference group, which are average marginal effects based on the coefficient estimates from a logit model (not reported) and observable sample characteristics. The overall rate of MSP enrollment corresponding to a given model is reported in each column heading, and the column "% Δ" reports the AME as a percentage of the enrollment rate. See the methods section for more details on the survey data, criteria applied to determine MSP eligibility, and regression model specifications.

**, *, + indicate statistical significance at the 0.01, 0.05, and 0.10 levels, respectively. The null hypothesis is that a given AME is equal to zero.

Finally, there is no statistical evidence of a relationship between Medicaid take-up among all MSP-eligibles for the following characteristics: sex, race and ethnicity, marital status, the number of adults in the household, calendar year, and census geographic region are not associated with Medicaid take-up among all MSP-eligibles.

Results for the QMB-eligible subpopulation are qualitatively and quantitatively very similar to those for all MSP-eligibles outlined above, with a few exceptions. There is less statistical evidence of a relationship between Medicaid participation and MSP unit income, assets, and children in the household. QMB-eligible Hispanics are less likely to enroll in Medicaid compared with white, non-Hispanics. Similarity in results is somewhat anticipated given that the QMB-eligible subsample represents almost 78 percent of the overall (unweighted) MSP-eligible sample.

Qualitatively, results for the SLMB-eligible population are somewhat different than those described above for the QMB-eligible population. There is evidence that Hispanics are 14.6 percentage points (23.4 percent) more likely to participate in Medicaid, and other non-Hispanics are 32.2 percentage points (51.5 percent) more likely to participate than non-Hispanic whites. Additionally, West South Central and Pacific residents are significantly less likely to enroll in Medicaid (8.4 and 8.2 percentage points, respectively), compared with those in New England. Some evidence also shows variation in participation over time, unlike the QMB-eligible population. Finally, several characteristics associated with Medicaid participation among QMB-eligibles are not significant for SLMB-eligibles: education, children in the household, income, private health insurance, and more generous income or asset requirements.

Among QI eligibles, characteristics associated with Medicaid participation are limited to age, assets, and government program participation (SSI and SNAP).

Conclusion and Discussion

This analysis suggests that MSP participation was higher in 2021–23 compared with a decade earlier (Caswell and Waidmann 2017). Although the empirical approach is different across the two analyses (i.e., measurement of MSP enrollment from linked administrative data compared with self-reported Medicaid enrollment among MSP-eligibles), both use the same survey (SIPP) for the eligibility simulation, with updated state-specific eligibility criteria. QMB participation in the more recent period was 64.3 percent compared with 53.3 percent in the earlier period; SLMB participation was 62.5

percent compared with 32.2 percent; and QI participation was 55.9 percent compared with 15.1 percent in the earlier period.

In another recent analysis of the earlier period, researchers estimated rates even larger than those estimated here (Niedzwiecki et al. 2025). However, as described in the appendix, the method used in that report to estimate MSP participation was substantively different than the method described above, so a comparison with those results is not particularly informative about trends over time. Arithmetically, the method used in that report will consistently produce higher participation estimates than the method used in this analysis because those authors include those enrolled but not eligible in the numerator and denominator of their measure of participation, while we do not include individuals deemed ineligible in this analysis.

Taken together, the multivariate analyses in this paper identify several themes among the factors predicting Medicaid participation among those eligible for MSPs. First, multiple findings are consistent with the strong association between individual needs and participation in one of these programs. For example, MSP-eligible individuals with more than $5,000 in assets are 12.8 percentage points (20.3 percent) less likely to enroll relative to those with less than $150 in countable assets (table 3). Second, we found that individuals with some form of private health insurance, which offers some of the same out-of-pocket cost relief as MSPs, had lower participation. Additionally, there was higher participation among those with dependents in their household. Third, participation in SSI and SNAP are strongly associated with Medicaid participation. Finally, although SSI and SNAP participation may also reflect a correlation in program awareness or the ease and/or coordination of application processes across states, correlation in relative needs is a plausible explanation for these findings.

On the other hand, and somewhat surprisingly, having monthly income greater than the median (of each eligibility group) was associated with 3.4 percentage points higher participation in MSPs overall (table 3). The lack of a statistically significant association for QMB, SLMB, and QI participation and income above the group median likely reflects the relatively narrow bands of eligible income for those programs.

Across the three years studied, participation rates were lower in 2021 than in 2022 or 2023. However, except for the SLMB-eligible group, these differences were not statistically significant after controlling for other covariates. Although the pandemic-era moratorium on eligibility redetermination may have reduced enrollment churn, eligibility determination processes may also have been streamlined during this period. Before the passage of the One Big Beautiful Bill Act in July 2025, states would have been required to streamline eligibility determination for MSPs, but that requirement was

suspended (Schubel 2025).[3] Some states, however, had already made changes to their systems, such as aligning eligibility criteria with Medicare Part D low-income subsidy provisions by removing asset tests.[4] This may explain some of the increases in participation since the 2009–10 period. Although these types of system changes are not required, some states may make voluntary changes. As a recent report has highlighted, states have a range of policy and administrative tools to increase participation and enrollment in MSPs. For example, several states have recently expanded eligibility by raising income and asset limits or by eliminating asset requirements entirely (Johnson et al. 2025).

States' efforts to expand eligibility likely increase enrollment by increasing the number of people eligible. However, it is unclear whether the participation rate among this expanded population would also increase. When we test for participation differences correlated with state resource limits—the first such test we are aware of in the literature—we find evidence that participation rates were higher in states with more generous asset requirements, but participation in states with higher income limits was not statistically different from states with the lower federal standards. These findings may reflect pent-up demand for MSP benefits among those with somewhat higher asset levels and may point to different potential effects of raising asset limits versus income limits. However, they may also reflect other differences across states, such as differences in administrative simplicity or outreach to potentially eligible individuals.

The findings in this analysis can be of use to policymakers in estimating enrollment and cost impacts of potential policy and system changes intended to ensure that eligible individuals can access the out-of-pocket spending relief that MSPs offer. Specifically, while we do not produce estimates of state-specific participation, a state could use the model estimates along with knowledge of its own policies and populations to estimate the maximum additional cost of the MSP program if eligibility determination were streamlined and all eligible-but-not-enrolled persons took up MSPs. In an average state using federal asset limits, if the 35.7 percent of persons QMB-eligible but not enrolled began receiving benefits and had spending profiles similar to those enrolled, QMB program costs could increase by roughly 55 percent (0.357/0.643). Any actual increase in state outlays resulting from streamlining eligibility would be no greater than this amount. Conversely, if a state already has higher asset limits, the results in table 3 suggest there would be a smaller cost increase predicted from additional streamlining efforts. The findings may also point to subpopulations, defined by age, geography, and economic and social circumstances, where they may want to target outreach, such as those ages 65 and older.

Appendix A. Medicaid Participation Among the MSP-Eligible

Conceptual and Measurement Considerations

In this appendix, we discuss conceptual and measurement considerations of our approach that reports Medicaid participation among the MSP-eligible using self-reported survey data. This metric is distinct from MSP enrollment among the MSP-eligible used in previous studies, which is discussed below. The complexity and uncertainty of these considerations make it impossible to offer a simplified explanation of how they, in total, influence our measure of Medicaid enrollment among the MSP-eligible and to interpret it as a strict proxy for MSP participation. Rather, this discussion is intended to lay out important considerations specific to this analysis for initiated readers.

Medicaid Enrollment Interpretation—Full/Partial Benefits

The SIPP questions presented to survey respondents related to Medicaid enrollment do not make the distinction between partial and full Medicaid benefits (US Census Bureau 2025). Relatedly, to our knowledge, no research has examined whether partial-benefit dual enrollees report Medicaid coverage in the SIPP. Indeed, existing research on the "Medicaid undercount," which links survey respondents to administrative enrollment data to assess the degree to which surveys undercount Medicaid enrollees, benchmarks survey responses with full-benefit Medicaid enrollment only (Noon, Fernandez, and Porter 2019). In other words, it does not consider the case of partial-benefit MSP duals, or cases of partial Medicaid-only enrollment (e.g., pregnancy-related benefits).

As a result, it is reasonable to postulate that respondents enrolled in Medicare with partial Medicaid coverage through MSPs report Medicaid enrollment. It is also reasonable to postulate that they may not report Medicaid coverage at the same rate as those with full Medicaid benefits, given that partial benefits are limited to Medicare premium assistance and cost sharing. Nonetheless, these are unknown features of the SIPP and other Census surveys.

For the reasons discussed above, the estimates in this work are presented as any reported Medicaid enrollment, as the SIPP does not distinguish partial from full benefits. Still, the absence of evidence on reporting patterns among MSP participants, combined with general Medicaid underreporting in survey

data, introduces some level of unquantifiable uncertainty (using available data) into the measure of Medicaid participation among the MSP-eligible we report.

Medicaid Enrolled, MSP Eligible but Not Enrolled

It is conceptually possible that our measure of Medicaid participation among those eligible for an MSP includes some individuals who are enrolled in Medicaid with full benefits and are also eligible for but not enrolled in an MSP. Further, some portion of these individuals may be required to pay Medicare premiums, depending on whether they reside in a "buy-in" state or not. This is relevant insofar as some small number of individuals we measure as MSP-eligible Medicaid participants may not benefit from the more complete financial protection that MSPs offer.

This can occur because of overlaps in states' eligibility rules for full Medicaid benefits (some categories) and MSP eligibility rules, no MSP take-up, and state buy-in participation. These dimensions vary by state. Full-benefit Medicaid and MSP eligibility overlap is more likely in states with relatively generous eligibility criteria—e.g., spend down Medicaid eligibility rules and MSP. It is not possible to quantify the extent to which this occurs in our study sample. However, analysis of administrative Medicare enrollment data provides some insight into the maximum size of this group in aggregate.

The Master Beneficiary Summary File includes data that address this issue: the dual-eligibility code and the Medicare entitlement buy-in indicator. The former includes the category "Other Dual Eligibles with full Medicaid benefits," representing non-MSP-enrolled dual enrollees, which conceptually may include both MSP-eligible and non-MSP-eligible individuals. Historically, this group represents roughly 17 percent of all dual enrollees in recent years, of which roughly 60 percent benefit from state buy-in, suggesting that roughly six to seven percent of all full benefit duals not enrolled in MSPs must pay Medicare premiums. This works out to roughly three-quarters of a million individuals, depending on the year. Some unknown fraction of this group could be MSP eligible.

Finally, there are no non-MSP partial benefit dual enrollees. Therefore, the discussion above is limited to full-benefit dual enrollees.

MSP Ineligible and the Continuous Coverage Provision

Excluding those deemed ineligible for MSPs limits our study's focus to the subpopulation of interest to the extent possible. (See the discussion above on the Medicaid-enrolled, MSP-eligible but not enrolled.) The reference period we study overlaps with the period when the COVID-19 public health emergency

continuous coverage provision was in effect, during which some individuals enrolled in MSPs may have experienced income and/or asset increases that would normally have made them ineligible. However, our income and asset eligibility simulation determines eligibility based on federal and state-specific rules, and excludes those with resources above these thresholds, conceptually excluding individuals who, during normal circumstances, would be ineligible for MSP.

It is possible that the continuous coverage provision may have increased our measure of participation. If so, participation could increase through including individuals who: (1) were eligible and enrolled in an MSP; (2) at some point during the provision, had higher/ineligible levels of income and/or assets that would have triggered ineligibility and disenrollment if not for the continuous coverage provision; and (3) later became MSP eligible again in the year, but would have otherwise not re-enrolled. (Recall from the methods section that our participation rates are based on December of a given calendar year). Although we acknowledge this possibility, we infer that the provision's effect on participation, as measured in this work, is likely very modest.

Comparison of the Empirical Approach with Previous Studies

Our approach in reporting self-reported Medicaid participation among those deemed eligible for MSPs is distinct from previous work that directly measures MSP enrollment among those deemed MSP-eligible (Caswell and Waidmann 2017; Niedzwiecki et al. 2025). These previous studies incorporate administrative data that directly measure MSP enrollment with survey data linked to individual respondents capable of measuring MSP eligibility. Our approach limits the subpopulation of interest in a similar way by using survey data to identify MSP-eligibles. However, we are unable to further limit our attention to MSP enrollees or distinguish between those enrolled in an MSP with full Medicaid benefits and those with partial benefits using publicly available data. Relatedly, we are unable to completely remove some likely small number of individuals who may have full Medicaid benefits, but are not enrolled in an MSP (discussed above). There are also opportunities for misreporting Medicaid and measurement error inherent to survey data, which are not considered using administrative data (discussed in more detail below).

In addition, the work by Niedzwiecki et al. (2025) is distinct from this work and our previous report in that they assume all people enrolled in an MSP in their analysis are eligible regardless of whether their survey responses are consistent with that assumption. That is, if their MSP eligibility simulation deemed a respondent MSP ineligible, but the linked administrative data identified them as enrolled, they are included in the analysis. This design decision effectively increases the numerator and denominator of their reported participation rate, thereby increasing measured participation.

Below, we enumerate multiple reasons why it's possible to observe self-reported Medicaid enrollment among those deemed ineligible for MSPs.

1. ***Respondent correctly reports Medicaid coverage and correctly reports income and/or assets above the eligibility thresholds.***

   The survey respondent could be enrolled in Medicaid through a category with more generous eligibility requirements than MSPs, such as spend down or medically needy pathways, which vary by state.

   Specifically for the first two years of this study, the continuous enrollment provision mandated that Medicaid enrollees who become ineligible be allowed to continue their Medicaid coverage. (See the subsection above on the continuous coverage provision).

   A final possibility could be inaccuracy in reporting income and/or assets when applying for Medicaid benefits.

2. ***Respondent correctly reports Medicaid and incorrectly reports income and/or asset values that are above the eligibility threshold.***

   This could simply be the result of respondent error, which may result in resources that are above (or below) the MSP thresholds.

3. ***Respondent correctly reports Medicaid but did not respond to [all] the income and/or asset questions used to determine eligibility, and the imputed values are above the income/asset thresholds.***

   We expect imputation errors, which may result in resources that are above (or below) the MSP thresholds.

4. ***US Census Bureau inaccurately imputes missing Medicaid participation data, and respondents correctly reported income and/or assets above the MSP thresholds (similar to scenario 2).***
5. ***US Census Bureau inaccurately imputes missing Medicaid participation data and inaccurately imputes higher incomes.***

Notes

[1] A complete discussion on the merits and limitations of this approach is presented in the methods section and the appendix.

[2] There were a limited number of respondents interviewed in multiple years, including 124 individuals interviewed in all three years, and 401 individuals interviewed in two of the three possible survey years.

[3] "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," *Federal Register* 88 (182) September 21, 2023.

[4] Advancing States, "Memorandum: Streamlining Medicaid; MSPs Eligibility Final Rule Summary," November 3, 2023.

References

Caswell, Kyle J., and Timothy Waidmann. 2017. *Medicare Savings Program Enrollees and Eligible Non-Enrollees.* Washington, DC: Urban Institute.

CMS. 1999. "List and Definition of Dual Eligibles." April. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/downloads/Buy-InDefinitions.pdf

Johnson, Kate, Sophie Leruth, Kristal Vardaman, Sasha Hulsey, and Caroline Picher. 2025. "Expanding Medicare Savings Programs (MSPs) to Increase Healthcare Affordability and Accessibility for Medicare Beneficiaries with Limited Financial Resources." Sacramento, CA: Aurrera Health Group and Washington, DC: West Health Policy Center.

MedPAC and MACPAC. 2022. *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.* Washington, DC: MedPAC and MACPAC.

———. 2023. Data *Book: Beneficiaries Dually Eligible for Medicare and Medicaid*. Washington, DC: MedPAC and MACPAC.

———. 2024. *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*. Washington, DC: MedPAC and MACPAC.

Niedzwiecki, Matthew, Evelyn Cody, and Andrea Wysocki. 2025. *Medicare Savings Programs: Eligibility and Enrollment Trends*. Washington, DC: ASPE.

Noon, James M., Leticia E. Fernandez, and Sonya R. Porter. 2019. "Response Error and the Medicaid Undercount in the Current Population Survey." *Health Services Research* 54 (1): 34–43. https://doi.org/10.1111/1475-6773.13058.

Rupp, Kalman, and James Sears. 2000. "Eligibility for the Medicare Buy-in Programs, Based on a Survey of Income and Program Participation Simulation." *Social Security Bulletin* 63 (3): 13–25.

Schubel, Jessica. 2025. "Rolling Back Biden-Era Medicaid Rules Would Hurt Beneficiaries and Increase Costs." *Health Affairs Forefront*.

SSA (Social Security Administration). 2025a. "Chapter 21: Supplemental Security Income." *Social Security Handbook*. Baltimore, MD: Social Security Administration.

———. 2025b. "SSA Program Operations Manual System." Baltimore, MD: Social Security Administration.

US Census Bureau. 2025. *2024 Survey of Income and Program Participation Users' Guide*. Washington, DC: US Census Bureau.

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