ISSUE BRIEF

Rising MSP Participation Signals Progress, but Significant Enrollment Gaps Remain

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May 2026

Introduction

Medicare Savings Programs (MSPs) are critical to ensuring older adults can afford the health care they need. MSPs reduce out-of-pocket Medicare expenses for eligible low-income individuals by covering Medicare premiums and cost-sharing that might otherwise impede access to care.[1] Despite the value MSPs provide, participation has historically lagged, with many eligible individuals not enrolled.

New analysis shows that MSP participation has improved in recent years. However, enrollment remains well below full participation. More than one in three eligible individuals are still not enrolled, underscoring the need for continued state and federal action.

West Health Policy Center (West Health) recently partnered with Aurrera Health Group (Aurrera Health) and the Urban Institute (Urban) to provide new insights on MSP participation. This brief summarizes findings from Urban's analysis – Medicaid Participation Among Medicare Savings Program Eligibles – and provides considerations for policymakers, advocates, and other stakeholders to support more robust MSP participation.[i]

i Urban's analysis uses Medicaid participation as a stand in for MSP enrollment among those eligible due to limited administrative data availability.

Background

MSPs help cover out-of-pocket Medicare expenses for eligible low-income individuals and are administered by state Medicaid agencies. There are four types of MSPs, each with distinct coverage and eligibility levels (see Table 1).[2]

Table 1. Medicare Savings Program Types and Eligibility Levels

Medicare Savings Program Type	Assistance with Medicare Cost-Sharing	Federal Income Limit* (% Federal Poverty Level)	Federal Asset Limit* (Single/ Married)
Qualified Medicare Beneficiary (QMB) Program	• Part A premiums • Part B premiums • Deductibles, coinsurance, copayments	Up to 100%	$9,660/$14,470
Specified Low-Income Medicare Beneficiary (SLMB) Program	• Part B premiums	101 – 120%	$9,660/$14,470
Qualifying Individual (QI) Program	• Part B premiums	121 – 135%	$9,660/$14,470
Qualified Disabled & Working Individual (QDWI) Program	• Part A premiums	Up to 400%	$4,000/$6,000

Note: States may apply income and asset limits that are more generous than federal standards.
Source: Centers for Medicare & Medicaid Services, 2026.

The largest share of MSP enrollment is in the Qualified Medicare Beneficiary (QMB) program, which offers the most generous coverage, including Medicare Part A and Part B premiums, deductibles, copayments, and coinsurance.[3] Other MSPs offer more limited coverage, for example the Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI) programs only cover Part B premiums.

To qualify for MSPs, individuals must have incomes and assets that fall below defined limits. The federal government sets minimum income and asset limits for MSPs, but states have flexibility to adopt more generous eligibility requirements.[4] As of 2023, 18 states and the District of Columbia have MSP income and asset levels that are more generous than the federal minimum.[5]

Approximately 10 million individuals were enrolled in MSPs nationwide in 2021. Earlier research, including a prior Urban analysis, suggests that many others may be eligible but not enrolled.[6] However, those analyses relied on older data, posing a challenge for policymakers in understanding the scope of the problem today and where there may be disparities in access that require tailored solutions.

Urban Analysis: MSP Enrollment Levels and Enrollee Characteristics

Urban conducted analyses using data from the Survey of Income and Program Participation, a nationally representative household survey conducted by the U.S. Census Bureau, to assess Medicaid participation among those eligible for MSPs from 2021 to 2023. Medicaid participation among MSP-eligible individuals was used as a proxy for MSP enrollment among those eligible due to data limitations. We refer to these findings as "MSP participation" for simplicity. Key findings of this work and considerations for policymakers are described below.

FINDING: MSP participation has increased but remains incomplete.

Estimated participation in each MSP type exceeded 55 percent from 2021 to 2023, which was considerably higher than those found in earlier Urban estimates from 2009-2010. Although the analyses use somewhat different data, findings suggest meaningful progress over the past decade (Table 2).[7]

Table 2. Comparison of MSP Participation Estimates, 2009–10 and 2021–23

Medicare Savings Program Participation Type	2009–10 Urban Analysis	2021–23 Urban Analysis
QMB participation	53.1%	64.3%
SLMB participation	32.2%	62.5%
QI participation	15.1%	55.9%

Note: MSP participation estimates are based on different data (i.e., self-reported Medicaid compared with administrative MSP enrollment data).
Sources: Urban analysis of the Survey of Income and Program Participation (SIPP), 2026, and Urban analysis of SIPP data for the Medicaid and CHIP Payment and Access Commission, 2017.

Considerations for policymakers

While estimated gains in MSP enrollment are encouraging, participation remains below 65 percent across programs, meaning more than one in three eligible individuals are still not enrolled.

Although the analysis cannot identify the precise drivers of increased enrollment over the past decade, estimated increases may reflect state efforts over the past decade to expand and streamline MSP eligibility, such as raising or eliminating asset limits, simplifying applications, and aligning MSP enrollment with other benefit programs. These strategies are often coupled with robust outreach efforts to help further spur enrollment. As outlined in a previous policy brief by West Health and Aurrera Health, an array of strategies have been implemented in a subset of states, suggesting that broader adoption across more states could help further improve participation.[8] At the same time, the suspension of eligibility redetermination during the COVID-19 Public Health Emergency (PHE), which was in place for most of the study period, may have had a very modest impact on higher enrollment by reducing coverage loss and churn that can occur during the year. Data show that during the PHE Medicaid coverage loss declined significantly among those eligible for both Medicare and Medicaid (including those enrolled in MSPs), underscoring the importance of administrative simplifications now that states have returned to normal operations.[9,10]

FINDING: MSP participation is higher when enrollment processes are less burdensome.

MSP participation was greater among those who participate in other means-tested programs such as Supplemental Security Income (SSI) or the Supplemental Nutrition Assistance Program (SNAP). SSI beneficiaries were 33.4 percent more likely to enroll in MSPs than non-SSI beneficiaries and SNAP beneficiaries were 38.5 percent more likely to enroll than non-SNAP beneficiaries.

Considerations for policymakers

Aligning and automating MSP enrollment with programs such as SSI or SNAP could meaningfully increase MSP participation by reducing application burden and some of this work is already underway at federal and state levels. In September 2023, the Centers for Medicare & Medicaid Services issued a final rule to facilitate more efficient MSP enrollment through automatic enrollment of those receiving SSI who are eligible for Medicare into the QMB program and requiring that states use data from Medicare Part D Low Income Subsidy (LIS) program to enroll individuals in MSPs. While implementation of the rule was delayed until 2034 under budget reconciliation legislation (H.R.1) enacted in July 2025, states can and many already have proceeded independently with automated enrollment and other streamlining efforts that can significantly improve access to MSPs.[11,12]

FINDING: MSP participation is lower among adults age 65 and older.

Individuals ages 65 and older were 18.3 percent less likely to enroll in MSPs compared with younger adults ages 18 to 64.

Considerations for policymakers

Findings highlight the importance of targeted outreach and education strategies that are tailored to populations

that face distinct barriers to enrollment. Both older adults (those age 65 and older) and individuals under age 65 may qualify for Medicare and for MSPs, but they enter Medicare through different pathways. Older adults qualify for Medicare based on age, while individuals under 65 typically qualify due to disability or certain medical conditions. Younger Medicare beneficiaries are often more likely to be connected to public benefits systems (e.g., through Medicaid or Social Security Disability Insurance), which can create more established avenues for outreach and enrollment into MSPs. Outreach to older adults may be more challenging due to more limited awareness of MSPs and understanding of eligibility. In addition, some older adults face barriers such as limited proficiency with or access to certain technologies and heightened concerns about potential scams that necessitate well-coordinated, in-person assistance and support. Tailored outreach through trusted community partners, aging services organizations, and hands-on application support could meaningfully improve enrollment among eligible older adults.

> **FINDING: MSP participation is higher among individuals who reside in states with more generous asset limits.**

Those who live in states with more generous MSP asset requirements were 11.8 percent more likely to enroll in MSPs compared with those residing in states that use federal asset standards.

Considerations for policymakers

Establishing more generous asset limits can both expand MSP eligibility and increase participation among those who are eligible by reducing confusing and burdensome verification requirements that deter participation. As of 2023, only 17 states have raised or eliminated asset limits for MSPs, leaving ample opportunity for broader adoption.[13]

> **FINDING: MSP participation is lower among individuals who are at the upper end of eligibility thresholds, have more education, or have private health insurance.**

Those with assets at the upper end of eligibility thresholds ($5,000 - $9,090 for an individual in 2023) were 20.3 percent less likely to enroll in MSPs compared to those with $0 to $150 in assets. College graduates were 11.3 percent less likely to enroll in MSPs compared with those with less than a high-school education. Those enrolled in a private plan were 19.2 percent less likely to enroll in MSPs.

Considerations for policymakers

Lower participation among those at the upper end of eligibility thresholds or who have other sources of coverage may reflect confusion about eligibility and benefits. All individuals who qualify for MSPs meet established income and resource criteria. Even those at the upper end of MSP eligibility thresholds have limited financial capacity and remain likely to benefit from the program. Clear, targeted communications that clarify who qualifies for MSPs and how the program supplements other coverage may support improved enrollment among these individuals. Raising or eliminating asset requirements may also reduce confusion and administrative burden for those with higher assets.

Looking Forward

Urban's analysis shows meaningful progress in MSP participation while underscoring persistent barriers that leave many eligible individuals unenrolled. Increasing participation further will require continued action at both the state and federal levels. The evidence points most strongly to strategies that reduce administrative burden, automate enrollment wherever possible, and tailor outreach to older adults. These findings build on and reinforce prior work by West Health and Aurrera Health, which identified key state policy approaches to expand MSP access, including simplifying enrollment processes, aligning MSPs with other public benefit programs, and expanding financial eligibility.[14]

States can take several steps to strengthen enrollment among eligible individuals:

Adjust financial eligibility policies to reduce barriers. Raising income and asset limits can broaden overall access to MSPs. At the same time, Urban's findings suggest that raising or eliminating asset limits may also be effective in increasing participation among those who are already eligible but not enrolled, as doing so reduces documentation requirements and eases verification burdens for beneficiaries and states.

Simplify and streamline enrollment processes. Shortening applications, adopting multi-program applications, and aligning eligibility systems can reduce friction and make it easier for eligible individuals to complete enrollment.

Leverage existing federal data to automate enrollment. Using data from SSI and the LIS program to initiate or complete MSP enrollment—rather than requiring a separate application—can substantially close participation gaps.

Coordinate targeted outreach. Partnering with trusted entities such as State Health Insurance Assistance Programs (SHIPs), community-based organizations, and managed care plans can improve awareness and support enrollment among older adults, particularly those who may be less connected to public benefits systems.

Federal leadership remains central to advancing these strategies. While implementation of CMS's final rule requiring automatic enrollment of SSI recipients into QMB and clarifying requirements to use LIS data has been delayed until 2034, opportunities remain for federal support and guidance as states explore and implement new strategies. Continued federal-state coordination can help build on recent gains and continue moving the needle on MSP participation and access to care.

ENDNOTES

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13 Johnson, et al, December 2024

14 Johnson, et al, December 2024