United States General Accounting Office

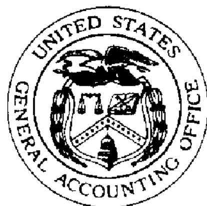
GAO

Report to Congressional Requesters

January 1994

MEDICARE AND MEDICAID

Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program



GAO/HEHS-94-52

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-255554

January 20, 1994

The Honorable Joseph R. Biden, Jr.
United States Senate

The Honorable William S. Cohen
United States Senate

The Honorable John Glenn
United States Senate

The Honorable David H. Pryor
United States Senate

The Honorable Donald W. Riegle, Jr.
United States Senate

In January 1989, a new benefit became available to low-income Medicare beneficiaries. Under the Qualified Medicare Beneficiary (QMB) program, people eligible for Medicare whose incomes are at or below 100 percent of the poverty level but are not low enough to qualify them for regular Medicaid benefits can have their Medicare premiums, deductibles, and coinsurance paid by the Medicaid program. Having these normally out-of-pocket expenses paid by Medicaid results in a significant increase in the beneficiary's disposable income—the national average actuarial value in 1993 is $950. The minimum benefit to a QMB is $439, the annual part B premium amount paid for a QMB who receives no services during the year. Out-of-pocket costs would be reduced by over $2,300 for a beneficiary who has a typical hospitalization and skilled nursing facility stay during the year.

In 1991, Families USA, Inc., a consumer advocacy group, estimated that almost half of the senior citizens eligible for the QMB program were not enrolled in it. Families USA attributed the low enrollment to the failure of federal and state governments to make senior citizens aware of the program. The group's report showed large differences in the estimated enrollment rates across states, ranging from no enrollment in some states to as much as 78 percent in one state.

Subsequent to the Families USA report, you asked us to answer a number of questions about government efforts to publicize the QMB program and for suggestions for ways to increase enrollment in it.

Results in Brief

Families USA's 1993 national estimate that 1.8 million senior citizens were eligible for but not enrolled in the QMB program is a reasonable estimate. However, the hypothesis that low enrollment is due to a failure to publicize the program and a lack of outreach highlights what is probably not the only, or even the main, reason. The federal government has taken a number of actions to alert potentially eligible people about the program and so have the states. Our analysis of enrollment data shows, however, that the two main federal efforts did not affect the enrollment trend and that the number of different efforts undertaken by individual states do not appear to have affected enrollment rates significantly.

State and federal officials responsible for the QMB program gave us many reasons why they believe that more people have not enrolled. These reasons include such factors as eligible people perceiving a welfare stigma attached to being a QMB, the complicated application process, and eligible people believing that the benefit is not worth much in monetary terms. Reasons such as these contribute to the significant number of eligibles who have not enrolled. Moreover, these kinds of reasons are relatively hard to overcome because they deal with perceptions and with the inherent nature of means-tested programs.

One action that has been proposed to increase enrollment is to authorize the Social Security Administration (SSA) to determine QMB eligibility. The rationale behind this proposal is that senior citizens are more familiar with SSA and less intimidated by it than by the local welfare agencies responsible for Medicaid eligibility determinations. However, SSA has opposed this option for a number of reasons, including insufficient resources to carry out the function. Also, we have reported that SSA had limited success in taking food stamp applications after it was given authority to perform that function.[1] We believe it would be prudent to have SSA pilot test making QMB determinations so that its effectiveness can be judged. Such a test would also permit SSA to determine what additional resources it would need to perform the function nationally.

A small percentage of QMBs are required to pay a premium in order to gain part A Medicare coverage for hospital services. We identified problems with the way some state Medicaid programs enroll these QMBs in part A, which can result in their not being covered for up to 15 months after they are determined to be eligible.

[1] Social Security: Need for Better Coordination of Food Stamp Services for Social Security Clients (GAO/HRD-92-92, Sept. 1992).

Background

Medicare is a federal health insurance program that covers almost all people 65 years of age or older, all people who have received Social Security disability benefits for 24 months or longer, and most people who suffer from kidney failure. Medicare, authorized by title XVIII of the Social Security Act, consists of two parts. Part A, which is financed primarily by a payroll tax, covers inpatient hospital, skilled nursing facility, home health, and hospice services and is free to those who are eligible. Persons 65 or older who are not eligible for free part A can purchase it by paying a monthly premium ($221 in 1993).[2] Part A requires the beneficiary to pay a deductible for inpatient hospital stays ($676 in 1993) and coinsurance on hospital stays in excess of 60 days and skilled nursing facility stays over 20 days.[3]

Part B is a voluntary program under which anyone age 65 or older and all persons eligible for part A can purchase coverage by paying a monthly premium ($36.60 in 1993). Premiums cover 25 percent of part B costs and federal general revenues are used for the remainder. Part B covers physician services and a wide range of other services, including diagnostic laboratory tests, medical equipment used in the home, and physical therapy. Beneficiaries must meet a $100 annual deductible and after that pay 20 percent coinsurance for most services.

Medicaid is a federal/state program authorized by title XIX of the Social Security Act under which the federal government pays for 50 to nearly 80 percent (depending on state per capita income) of the states' costs of paying for health services for low-income people. States must cover a number of services, including hospital, physician, and clinic services, and can elect to cover almost any health service. Under Medicaid, states must cover persons who receive cash assistance under one of the welfare programs and can choose to cover other low-income aged, blind, and disabled individuals and members of families with dependent children.

Low-income elderly and disabled people can be eligible for both Medicare and Medicaid, and currently about 4 million are. Most of these dual eligibles qualify for Medicaid because they receive cash assistance from

[2]Before 1994, eligible individuals with fewer than 40 quarters of Social Security coverage were required to pay the full premium to receive part A coverage. Beginning in 1994, the monthly premium for people with at least 30 quarters of coverage will be reduced by 25 percent. This percentage increases by 5 percent a year until 1998. In 1998 and subsequent years, the reduction will be 45 percent.

[3]Hospital coinsurance is $169 per day for 1993 for stays between 61 and 90 days. Beneficiaries have a lifetime reserve of 60 days that can be used for stays exceeding 90 days, and coinsurance is $338 per day for reserve days. For the 21st through the 100th day of a skilled nursing facility stay, coinsurance is $84.50 per day. The benefit ends after 100 days.

the Supplemental Security Income (SSI) program of title XVI of the Social Security Act.[4] Others qualify by being in a nursing home without sufficient income and assets to pay for care or by having medical expenses that reduce their income below the Medicaid eligibility level. However, a significant portion of Medicare beneficiaries with incomes below the poverty level do not qualify for regular Medicaid benefits.

In 1988, the Congress amended Medicaid to require states to pay the Medicare premiums, deductibles, and coinsurance for beneficiaries who do not qualify for regular Medicaid but have incomes at or below the poverty level and assets of no more than twice the eligibility level for SSI. These people make up the population of potential QMBs.

Objectives, Scope, and Methodology

In 1991, Families USA reported that over half of the people eligible for the QMB program were not enrolled in it. It issued similar reports in 1992 and 1993.[5] This led you to ask us to evaluate why so many people have not signed up for the program and to make suggestions for improving the enrollment process. To address your questions, we met with Medicaid officials in California, Delaware, Georgia, Michigan, Oklahoma, Texas, and Washington and discussed their QMB programs, including their efforts to disseminate information about their programs and encourage eligible people to enroll. We held similar discussions with officials of the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services (HHS) that administers Medicare and Medicaid. We also obtained and analyzed data about the QMB program from HCFA and the states. The objectives, scope, and methodology of our study are presented in detail in appendix I.

Many Eligible People Have Not Enrolled as QMBs

Families USA's 1991 estimate that 2 million people eligible for the QMB program have not enrolled is reasonable. HCFA also estimated the number of persons eligible for the QMB program in 1991 but not enrolled in it. The Families USA estimate fell within the range that HCFA estimated. Families USA's 1993 estimate of 1.8 million people eligible but not enrolled is based on their 1991 estimate, adjusted for changes in QMB enrollees and other factors.

[4]To qualify for SSI, an individual must be 65 or older, blind or disabled, have an income of less than $454 per month in 1993, and have no more than $2,000 in assets, excluding a home and certain other items.

[5]The Secret Benefit: The Failure to Provide the Medicare Buy-in to Poor Seniors, (1991); The Medicare Buy-in: Still a Government Secret, (1992); and The Medicare Buy-in: A Promise Unfulfilled, (1993). Families USA Foundation, Inc., Washington, D.C.

Families USA broke its national estimate down by state and these state estimates are less reliable than the national estimate. This is because a number of the data elements necessary to make an estimate of eligible but unenrolled people are derived from national samples that do not always have sufficient numbers of cases in individual states to make precise statewide estimates. Consequently, state estimates should be used with caution in assessing the success of individual states in enrolling QMBS. Virtually all the states we visited questioned the accuracy of Families USA's estimates of their enrollment rates. This was true for states with both high and low enrollment estimates.

How Effective Were Efforts to Notify Eligible Beneficiaries?

Federal Efforts

HCFA has undertaken a number of actions to notify potentially eligible Medicare beneficiaries and the general public about the QMB program. However, these efforts have not had an appreciable effect on the QMB enrollment rate. Rather, the rate has gradually and consistently increased since the QMB program began.

In July 1989, HCFA mailed a notice about the QMB program to 14 million Social Security retirement and disability beneficiaries who would meet QMB income eligibility criteria if Social Security was their only income. The notice described the QMB program and identified the income and resource requirements. The notice sent to people living in the 12 states with toll-free Medicaid telephone numbers included the appropriate telephone number. Notices sent to other states advised people to contact their local Medicaid office. (Appendix II shows an example of the notice.)

In January 1992, SSA included information about the QMB program in its notice to all Social Security beneficiaries about the cost-of-living increase in retirement, survivor, and disability payments for 1992. This notice identified the income eligibility level and benefits available and suggested contacting the state or local Medicaid office. (Appendix II shows an example of this notice.)

Besides the two mass mailings, HHS has taken a number of other actions to publicize the QMB program. For example, HCFA prepared a special pamphlet

on the QMB program in 1992 (updated in 1993) and distributed copies to supermarkets and other places visited by the elderly. HCFA also distributed radio and television announcements in 1992 and prepared materials in 1993 that can be used by advocacy groups to help people determine if they might be eligible. SSA also includes QMB data and referrals in its toll-free telephone service and includes information about the program in its various pamphlets. (Appendix III presents a more complete listing of HHS' efforts to publicize the QMB program.)

State Efforts

States also have taken various actions to publicize the availability of the QMB program. Such activities have included press releases printed in local newspapers; public service announcements broadcast on radio and television; toll-free telephone numbers to inform callers about eligibility criteria and enrollment procedures; and brochures, fliers or factsheets, and posters placed in public locations.

Despite these outreach efforts, nearly half of those eligible for the program have not enrolled. To determine the effect that outreach efforts have had on actual QMB enrollment, we compared state outreach activities to the increase in the number of people for whom the states we visited paid part B premiums.

Table 1 presents the results of this analysis and indicates that there was little direct correlation between outreach and increased enrollment. Texas, for example, engaged in extensive outreach but increased enrollment by only 2.8 percent during the first year of the program. Conversely, Michigan used nearly identical outreach activities but increased enrollment by more than 27 percent.

Table 1: State Outreach Activities and Increase in Part B Enrollment

State	Outreach activities	Increase in enrollment (percent)
California	Press releases; toll-free line; and brochures, fliers, or factsheets	4.8
Delaware	Toll-free line; public service announcements; and brochures, fliers, or factsheets	12.5
Georgia	Press releases; toll-free line; and brochures, fliers, or factsheets	2.0
Michigan	Press releases; brochures, fliers, or factsheets; public service announcements; and posters	27.1
Oklahoma	Press releases and public service announcements	21.8
Texas	Press releases; toll-free line; brochures, fliers, or factsheets; and posters	2.8
Washington	Toll-free line	4.1

Table 1 indicates that extensive outreach efforts did not always result in significant increases in enrollment. Outreach efforts are necessary to ensure that eligible individuals are aware of possible benefits. However, as discussed on pages 9 and 10, there are several reasons, other than the extent of outreach, why eligible persons have not enrolled in the QMB program.

The results of an American Public Welfare Association study[6] about the relationship between states' outreach programs and Families USA's estimates of state enrollment are consistent with our observations. The Association's survey of QMB outreach activities in 37 states found that "a positive correlation between the number of outreach activities and enrollment of buy-ins could not be established."

To assess whether HCFA's efforts had an effect on the number of people for whom Medicaid was paying Medicare premiums (referred to as buying-in), we obtained HCFA data on total monthly part B buy-ins from January 1987

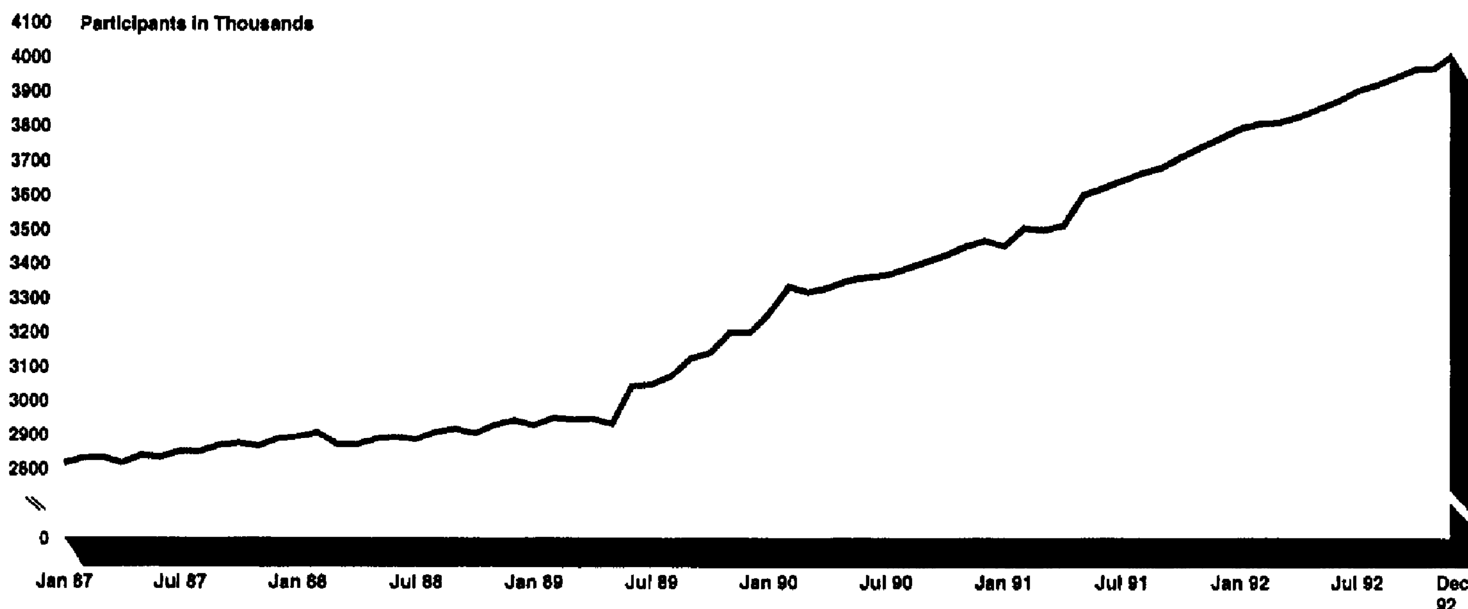
[6] "Issue Brief: State Outreach to Qualified Medicare Beneficiaries," American Public Welfare Association (Washington, D.C., 1991).

to December 1992. These data show the total number of persons for whom Medicaid was paying part B premiums, deductibles, and coinsurance. Monthly participation in part B buy-in began to increase significantly shortly after January 1989 when the QMB program began. This trend in increased enrollment did not change after notifications were mailed in July 1989 or January 1992.

Figure 1 shows the number of persons receiving part B buy-in on a monthly basis from January 1987 through December 1992. Our analysis of these data indicates that between January 1987 and December 1988 part B buy-ins were increasing by about 5,100 people per month. When the QMB program started in January 1989, a different trend emerged with new buy-ins increasing to about 22,400 per month.[7] This trend, established early in 1989, continued through December 1992 with no significant change. We concluded that the mass mailings did not have a dramatic effect on enrollment but the outreach efforts by HCFA and the states resulted in an increase in QMB beneficiaries. Although a substantial number of eligible people have not enrolled, over 1.4 million people have.

[7]Although new monthly enrollment began to increase sharply at the beginning of 1989, HCFA's data show that total buy-ins decreased a statistically significant amount the month the program started and then increased substantially. In analyzing this situation, we found that SSA was unable to locate part B buy-in computer tapes from approximately 30 states in March 1989. HCFA's records show that nearly 44,000 new buy-ins were erroneously excluded from the February enrollment but added in a subsequent month.

Figure 1: Total Part B Buy-Ins (Jan. 1987-Dec. 1992)



Many Reasons Contributed to Low Enrollment

Despite significant information and outreach efforts by federal and state governments as well as by national and local advocacy groups, a significant portion of eligible people have not enrolled in the QMB program. These outreach efforts have contributed to the steady increase in QMBs over the last 3 years, and continued efforts are needed. However, factors other than a lack of information must be contributing to people not enrolling. We discussed what these factors might be with federal, state, and advocacy group officials and identified a number of areas where there was general agreement that problems exist.

Many eligible individuals are reluctant to apply for a Medicaid benefit because of the perceived stigma associated with filing for public assistance or welfare. Although specific information on the extent of this problem is not available, state Medicaid officials and others familiar with the program are generally consistent in their view that it strongly discourages enrollment.

In addition, the QMB application process itself discourages enrollment. Each state we visited requires an applicant to complete a long and

complex Medicaid application—often exceeding 20 pages in length[8]—to determine if the applicant is eligible for any Medicaid benefit. In a recent review of Medicaid enrollment in the District of Columbia,[9] we observed that the length of the District of Columbia's Medicaid application form—10 pages—and the extensive documentation required pose significant barriers to enrolling in Medicaid. We also noted that without substantial assistance or encouragement, many persons who are potentially eligible for Medicaid lack sufficient ability or meaningful incentives to comply with the extensive procedural requirements for enrollment.

Some individuals find that completing the application and gathering and providing all the required supporting documentation is too burdensome for the benefit received. An Alabama Medicaid official, for example, informed HCFA that

> "some potential [QMB] applicants have refused to apply in protest over the limited coverage and a few recipients have requested that their cases be closed because the benefits were not worthy of their time in completing the annual financial review."

Medicaid officials also provided anecdotal information about why eligible people fail to follow through with the application. They said that some people view the requirement to verify resources as an invasion of privacy; some lose interest when they learn that the QMB benefit is not a cash benefit; some decline to return the application because they are unhappy that the program does not cover things such as prescriptions and eyeglasses; and some cannot read or write and have trouble understanding Medicaid's written information.

Another commonly cited reason for people not enrolling as QMBs is the misperception by Medicare beneficiaries that the benefit is not very valuable. In fact, the benefit is quite valuable and on average equals over 10 percent of the annual income of someone living at the poverty level. The lowest possible value is $439, the amount of the part B premium in 1993. For a Medicare beneficiary who has a typical hospitalization and skilled nursing facility stay, being a QMB saves over $2,300 in out-of-pocket expenses over the year. Moreover, Medicare does not have a catastrophic benefit and someone needing extensive health services can incur many thousands of dollars in expenses that would be paid by the QMB program.

[8]Some states have developed a short application form. For example, Tennessee uses a 2-page QMB application that is mailed to applicants. Tennessee officials told us that while the form is generally successful, its use may preclude staff from recognizing that a person ineligible for the QMB program may be eligible for another Medicaid benefit.

[9]District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care (GAO/HRD-93-28, Dec. 29, 1992).

Finally, QMBs who had purchased Medicare supplemental insurance (Medigap policies) would no longer need to do so, thereby saving the cost of those policies, whose average premium was estimated to be $664 in 1991.[10]

Problems With States Paying Part A Premiums

A small percentage of QMBs and regular Medicaid beneficiaries do not qualify for free part A but can be bought into part A if the states pay their part A premiums. We identified problems with part A buy-ins that result in (1) some QMBs having to wait up to 15 months to be enrolled in part A and (2) some regular Medicaid beneficiaries having less hospital coverage under Medicaid than the level provided by part A.

States are authorized to buy-in QMBs at any time during the year, but 17 states require them to enroll in part A during Medicare's annual enrollment period—January through March of each year, with coverage beginning in July. Thus, these QMBs face a minimum delay of 3 months and a possible delay of as much as 15 months before being insured against the costs of hospitalization. If they entered a hospital during this period, they would have to spend sufficient income and resources to qualify for regular Medicaid benefits to obtain coverage. This, in turn, defeats the purpose of the QMB program to protect beneficiaries against impoverishment.

The second part A buy-in problem affects regular Medicaid beneficiaries. Some states have not actively pursued buying-in elderly Medicaid beneficiaries who do not qualify for free part A. Five of these states offer fewer hospital benefits under Medicaid than those that are available under part A and, therefore, beneficiaries in these states are disadvantaged relative to those in the other states.

HCFA has undertaken several efforts to get the states to buy-in all QMBs and elderly Medicaid beneficiaries not eligible for free part A. These efforts have met with limited success. Appendix IV presents details on these two problems.

[10]For Medigap policies purchased after November 5, 1991, section 1882(q)(5)(A) of the Social Security Act requires that insurers, at the request of a QMB, suspend premiums and benefits for up to 24 months and that the Medigap policy be restored if the QMB loses entitlement during that period.

Would Having SSA Determine QMB Eligibility Encourage Enrollment?

Many have proposed authorizing SSA to accept and process QMB applications because they believe that SSA could facilitate QMB enrollment and increase participation. Virtually all Medicaid officials that we interviewed as well as representatives of senior citizen groups, including Families USA, the American Association of Retired Persons (AARP), and the National Senior Citizens Law Center, suggest that this change would increase enrollment, perhaps substantially. Many argue that it would eliminate the perceived negative stigma associated with filing for Medicaid benefits, encourage eligible individuals to apply, and ultimately improve participation in the QMB program.

SSA could make QMB eligibility determinations in the same manner that it currently makes SSI determinations. As part of the SSI application process, SSA identifies an applicant's income level and amount of resources. Although QMB criteria are slightly different from SSI criteria, the information provided by an applicant and SSA's methodology for assessing this information are identical to the SSI application procedure.

SSA has generally resisted suggestions that it accept QMB applications and determine QMB eligibility for several reasons. First, SSA points out that the QMB benefit is a Medicaid benefit requiring the states to determine eligibility. To authorize SSA to make QMB determinations, the Congress would have to amend the Social Security Act.

Second, SSA contends that it could not process QMB applications given its present size and funding level. In 1991, SSA advised the Senate Committee on Finance, Subcommittee on Health for Families and the Uninsured, that costs would amount to about $4.5 million if SSA simply screened individuals who were applying for other benefits to determine if they might qualify for the QMB program and then refer them to Medicaid to complete the QMB application. SSA said that costs would total about $270 million to distribute pamphlets, explain the process, take and develop applications, and provide employees the training necessary to perform these activities. At the time we completed our work in June 1993, SSA had not updated its estimates of the additional funding or staffing needed to process QMB applications on a nationwide basis.

Third, according to a 1992 informal survey by SSA, Medicaid programs in 10 states use income and resource eligibility criteria that are less restrictive than standard SSI criteria. Generally, this means that in making SSI determinations these states disregard certain items of income and resources that the other 40 states include. SSA contends that this lack of

uniformity would complicate determining QMB eligibility. However, these differences in criteria do not affect QMB eligibility but rather only eligibility for regular Medicaid benefits.

Pilot Test Needed Before SSA Enrolls QMBs

Although numerous groups and organizations have urged changes to the QMB enrollment process, including having SSA take and process QMB applications, there is little assurance that SSA would have more success enrolling QMBs than Medicaid has had. We have reported, for example, that SSA had limited success in taking food stamp applications and that a principal reason for this appeared to be a lack of commitment to the effort by SSA management and staff.

The barriers to enrolling QMBs cited by SSA and its problems in taking food stamp applications do not mean that the agency could not successfully enroll QMBs. Nevertheless, several issues need to be addressed before SSA assumes this responsibility. These issues include determining whether QMB enrollment would actually increase if SSA handles eligibility processing, identifying and resolving problems associated with processing applications in states that use less restrictive criteria than SSI, and identifying any additional resources SSA would need to assume responsibility for enrolling QMBs.

Conclusions

The number of people enrolled in the QMB program has steadily increased since the program began, yet a substantial portion of eligibles have not enrolled. This is the case despite the fact that the federal and state governments and private advocacy groups have undertaken numerous efforts to publicize the program.

Many believe that eligible individuals have not enrolled as QMBs because of factors such as the perceived welfare stigma associated with means-tested programs and the complicated process of applying for the QMB benefit. Many also believe that authorizing SSA to make QMB eligibility determinations would help overcome these factors and increase QMB enrollment. While SSA might be able to increase enrollment, we believe that this concept should be tested before it is generally adopted.

Finally, some state part A buy-in practices delay or preclude enrollment of QMBs and regular Medicaid beneficiaries in part A. This in turn can disadvantage some beneficiaries relative to their peers in other states.

Matters for Consideration by the Congress

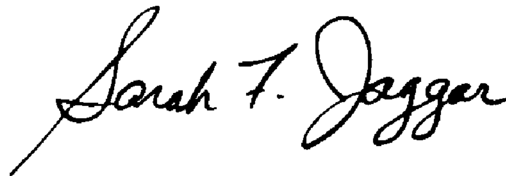
The Congress should consider authorizing a demonstration in selected states to determine the effect on QMB enrollment of having SSA process QMB applications. This demonstration should be designed to determine whether applicants are more likely to apply for QMB benefits at an SSA rather than a Medicaid office and to identify any additional resources SSA would need if the process was adopted nationwide.

To ensure that all eligible Medicaid beneficiaries who are also eligible for Medicare are enrolled in part A of Medicare, the Congress may wish to consider requiring automatic part A buy-in for all QMB and regular Medicaid beneficiaries.

We did not obtain formal comments on a draft of this report from HHS or the states we visited. We did, however, discuss the report's contents with HHS officials and incorporated their comments where appropriate. SSA officials were not opposed to the pilot test we suggested, but would expect resources to be provided for its implementation.

Unless you publicly announce its content earlier, we plan no further distribution of this report until 3 days after its issue date. At that time we will send copies to the Secretary of HHS; the Director, Office of Management and Budget; and interested congressional committees. We will also make copies available to others on request.

If you have any questions about this report, please contact me on (202) 512-7119. Major contributors to the report are listed in appendix V.



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Abbreviations

AARP	American Association of Retired Persons
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
QMB	Qualified Medicare Beneficiary
SSA	Social Security Administration
SSI	Supplemental Security Income

Objectives, Scope, and Methodology

The requestors asked us a series of questions related to the effectiveness of federal and state efforts to identify and enroll people eligible for the Qualified Medicare Beneficiary benefit and administrative alternatives that might improve enrollment. Specifically, we were asked to review (1) the effectiveness of Health Care Financing Administration's 1989 notices; (2) the reasons that eligible seniors do not enroll; (3) the potential benefits of improved coordination between the Social Security Administration, HCFA, and the states to ensure that people are identified and notified; and (4) the options for the Congress to consider to increase participation.

We visited Medicaid offices in seven states. We selected Oklahoma and Washington because Families USA reports suggest that they have been among the most successful in enrolling QMBs. We visited Texas and California because when we started our work they were states that restricted part A enrollment of certain individuals to a general enrollment period. We included Georgia, Michigan, and Delaware as requested by your offices.

In each state, we discussed HCFA's 1989 notices in terms of responses received and effect on enrollment and, where available, obtained data on QMB enrollment levels. We also obtained the views of Medicaid officials on why eligible individuals do not enroll, identified past and current state efforts to identify and enroll QMBs, and discussed actions that the federal government could take to help the states identify and enroll QMBs.

To analyze both state-specific and nationwide QMB enrollment patterns, we obtained enrollment information from HCFA's Bureau of Data Management and Strategy. An official from this office, however, told us that information about QMB enrollment during 1989 was unreliable because at that time the states and HCFA had not implemented a system to accurately reflect QMB enrollment. As an alternative, therefore, we obtained data from this office on total monthly part B buy-in enrollment from January 1987 to December 1992. These data included but did not specifically identify QMB enrollees. These data permitted us to identify trends in total part B buy-in enrollment that would indicate how enrollment patterns changed when key QMB activities occurred, such as in early 1989 when the program began or later in 1989 when HCFA mailed notices about the program to 14 million Medicare beneficiaries.

We also met with officials from HCFA's Medicaid Bureau who developed HCFA's 1989 notices and officials from the Bureau of Program Operations who are responsible for overseeing the QMB program. These officials

provided information on HCFA's past and planned efforts to inform eligible individuals about the program.

We also obtained the views of and reviewed documents provided by HCFA, SSA, and state Medicaid officials about issues related to SSA making QMB eligibility determinations.

We performed our work in accordance with generally accepted government auditing standards, except that we did not review the controls over the states' or HCFA's systems for recording enrollment in the part B buy-in program. We performed our work between November 1991 and June 1993.

Notice and Flier About the QMB Program

Figure II.1: Flier Advising Social Security Recipients of the QMB Program

AN IMPORTANT MESSAGE FROM MEDICARE

YOU MAY QUALIFY FOR A NEW BENEFIT

Dear Medicare Enrollee:

If you can answer yes to the following two questions, you **MAY** qualify for a new benefit which will pay for your Medicare premium.

Will your 1989 income be near or below $444 per month ($589 for a married couple)?*

Important: If you have more income than this amount, you may still be eligible because under the rules some income does not count.

Do you have limited assets such as cash on hand, bank accounts, stocks, etc.? (Your house, if you live in it, does not count.)

If you think you can answer yes to both questions, you **MAY** qualify for the new benefit. This benefit will pay for your monthly Medicare premium, and also covers the Medicare cost sharing amounts (deductibles and coinsurance) for which you are responsible.

NOTE: You may qualify for the benefit even if you are already receiving Medicaid, or if you have previously applied for Medicaid and been denied.

If you think you qualify and you have not already contacted your State, you should contact the local county office of the Arkansas Department of Human Services in the county where you live.

Toll Free Number: 1-800-482-8988

*For future reference, the income eligibility limit for this benefit will rise in future years.

Note: This flier was sent to all Social Security recipients with the January 1992 cost-of-living-allowance increase notice advising recipients of the QMB program.

Figure II.2: HHS Notice of the QMB Benefit

New Payment Amount
Your Social Security benefit increased by 3.7 percent effective with this month's check. The increase is based on the rise in the cost of living.

If You Plan To Work In 1992
Beginning January 1, 1992, you can earn more and still receive all your Social Security benefits.

If you're now 65 or older, or you will reach 65 in 1992, you can earn $10,200 and still get all your benefits. We will deduct $1 in benefits for each $3 you earn over this amount.

If you will be under 65 all year, you can earn up to $7,440 and still get all your benefits. We will deduct $1 in benefits for each $2 you earn over this amount.

Beginning with the month of your 70th birthday, your benefits are not affected by your earnings.

Reporting Your Earnings
In 1991, the earnings limits were $9,720 for people 65 through 69 and $7,080 for people under 65.

If you received benefits in 1991 and you earned more than the annual limit, you must submit an annual report of earnings to Social Security by April 15, 1992, unless you were 70 or older for all of 1991. **There is a substantial penalty for not filing an annual report.** Filing a Federal income tax return does not take the place of filing this report with Social Security.

(over)

Different rules apply to people who work while receiving Social Security disability or Supplemental Security Income (SSI). If you receive Social Security disability or SSI, you must report all work, no matter how little you earn. (Representative payees must report for their beneficiaries.)

If you think you will earn more than the annual limit this year, contact Social Security early in 1992 with your earnings estimate.

Our new toll-free number is:
1-800-772-1213

Medicare
If you are paying for Medicare Part B, the premium was deducted from your check. The basic premium—the amount most people pay—increased to $31.80 a month on January 1, 1992, so your check may not be higher than it was last month.

The 1992 Medicare deductibles are $652 for hospital insurance and $100 for medical insurance (Part B).

If your income is below about $7,000 ($9,000 for a couple), your State may pay your Medicare premium, deductibles, and coinsurance under the "Qualified Medicare Beneficiary" (QMB) program. To find out if you qualify, contact your State or local medical assistance (Medicaid) agency, social service office, or welfare office.

U.S. Department of Health and Human Services
Social Security Administration
SSA Publication No. 05-10364
January 1992

Note: This notice was sent to 14 million Medicare recipients in 1989 informing them of the QMB benefit.

HHS Action to Promote the QMB Program

The Department of Health and Human Services has taken numerous actions to promote awareness of and participation in the Qualified Medicare Beneficiary program. For example, it

- mailed a notice in the summer of 1989 about the QMB program to 14 million Medicare beneficiaries (see app. II);
- included a section on the QMB program in the Medicare Handbook which was sent to more than 33 million Medicare beneficiaries in 1990;
- prepared a camera-ready story about the QMB program, in June 1991, for distribution to major newspapers and senior citizen organizations' information offices;
- distributed copies of Medicare 1991 Highlights, in September 1991, which included information about the QMB benefit, for display in 7,200 supermarkets across the nation;
- sent a letter in October 1991 to the states that require QMBs to enroll in part A during Medicare's general enrollment period asking them to reconsider their decision not to become part A buy-in states and to review their Medicaid rolls to identify individuals who are eligible for premium part A buy-in and to enroll these individuals in the QMB program. At the same time, letters also were sent to 19 part A buy-in states that had enrolled fewer than 65 percent of such individuals asking them to identify these individuals and add them to the state's part A rolls;
- included a flier about the QMB benefit in the January 1992 cost-of-living-allowance increase notice that SSA sent to every Social Security recipient (see app. II);
- provided each member of Congress, in March 1992, with a package of information about the QMB program that was suitable for constituent newsletters;
- provided an information package about QMB benefits, including radio and television announcements, to news media nationwide during the summer of 1992;
- distributed a booklet in January 1993 with state-specific information about QMB benefits to the Health Care Financing Administration's regional offices for redistribution to targeted areas;
- developed a pamphlet describing the QMB benefit and the steps for applying for it and sent it to all state Medicaid agencies in February 1993;
- identified and directly contacted about 250,000 people, in February 1993, who may be entitled to state payment of their part A premium. The letter included a form for the applicant to send directly to the Social Security Administration to enroll in part A and advised the individual to contact a Medicaid office to request a QMB determination.

- worked with advocacy groups to develop and issue a training guide in March 1993 that state Medicaid workers and private organizations can use to increase public awareness of the QMB benefit;
- distributed a worksheet and computer program in September 1993 to advocacy groups, states, and senior centers to facilitate QMB screening; and
- provided grants totaling $20 million (during fiscal years 1993 and 1994) to implement state health insurance assistance, information, and counseling programs to advise seniors on health insurance issues, including the QMB program.

In addition, HHS is continuing outreach efforts with the American Public Welfare Association, senior advocacy groups, and other organizations to target the QMB message and more effectively conduct outreach efforts.

Problems With Part A Buy-Ins

For the small percentage of senior citizens who do not qualify for free part A, we identified two problems that affect their enrollment in part A. First, although states are authorized to buy-in Qualified Medicare Beneficiaries and regular Medicaid beneficiaries at any time during the year, 17 states require beneficiaries to enroll in part A during Medicare's annual enrollment period—January through March of each year. Enrollments during this period become effective in July. Thus, a person found eligible for the QMB program in April of one year will not be covered by part A until July of the next year, a delay of 15 months. The minimum delay is 3 months, from April through June. During the delay period, the QMB would not be insured against hospitalization and in the event of a hospital stay would have to spend sufficient income and resources to qualify for regular Medicaid benefits to obtain coverage. The delay in effect defeats the purpose of the QMB program to protect beneficiaries against impoverishment.

The second part A buy-in problem relates to regular Medicaid beneficiaries. While QMB legislation requires the states to pay the monthly premium for QMBs not eligible for free part A, some states have not actively pursued buying-in individuals who are entitled to hospital coverage under the state's regular Medicaid program but who would also be entitled as QMBs to have the state pay their part A premium. In most states, a QMB is not disadvantaged by this condition because the state's Medicaid hospitalization benefits are equivalent to Medicare's.

Some state Medicaid programs, however, have more restrictive hospital benefits than Medicare.[1] In these states, Medicaid recipients who are eligible for—but not receiving—state buy-in of part A premiums may have access to fewer hospitals and may have more limited hospitalization benefits. Some of these states, particularly those that use the general enrollment period, have bought a low percentage of individuals into part A. In September 1993, the five states that use the general enrollment period and do not buy-in regular Medicaid beneficiaries had enrolled only 12,306 of 39,401 persons, or about 31 percent of those Medicaid beneficiaries who are also eligible for part A buy-in. On the other hand, the eight states with limited Medicaid hospitalization benefits that buy-in QMBs without requiring the general enrollment period had enrolled 71,324 of 78,857 eligible individuals, about 90 percent.

[1]The following states have Medicaid hospitalization benefits more limited than Medicare's: Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, and West Virginia.

The Health Care Financing Administration has made several efforts to encourage the states to identify and enroll all part A buy-in eligible individuals. In October 1991, for example, HCFA sent a letter to each state with a general enrollment period requirement asking them to reconsider their decision not to become part A buy-in states. HCFA also sent letters to 19 part A buy-in states that had enrolled fewer than 65 percent of eligible individuals and asked them to identify these individuals and add them to the part A buy-in rolls.

The states' responses to HCFA's requests were mixed. Generally, the buy-in states indicated that they would undertake further efforts to identify and enroll these individuals. Arizona and New York, however, informed HCFA that they were withdrawing their part A buy-in option and would begin requiring use of the general enrollment period. Both indicated that they were unaware that part A buy-in states were expected to pay part A premium costs for persons who were also regular Medicaid beneficiaries. HCFA advised New York that current QMB legislation requires all states to enroll these individuals regardless of the state's buy-in method.

Most of the 11 states that require the general enrollment period option that responded to HCFA's letter indicated that they would not reconsider their decision and become part A buy-in states.[2] Seven of the 11 indicated that they believed that cost and fiscal considerations prevented them from becoming part A buy-in states and automatically enrolling eligible premium part A individuals.[3] Many also reiterated that such individuals were not disadvantaged because the state's Medicaid hospitalization benefits were equivalent to those provided by Medicare.

In February 1993, frustrated with the unwillingness of several states to enroll Medicaid and QMB beneficiaries in part A, HCFA directly contacted the estimated 250,000 premium part A individuals residing in states using the general enrollment period. HCFA sent each person a letter, telling the individual of his or her possible eligibility for the QMB benefit and included a form for the applicant to send directly to the Social Security Administration to enroll in part A and advised the individual to contact a

[2]Texas, California, and New Jersey responded that they would reconsider their earlier decision. Texas subsequently became a buy-in state. California indicated that it would reconsider its decision when its financial situation improves. Neither California nor New Jersey had informed HCFA of their decision by June 1993, when we completed our work.

[3]If a person does not require hospitalization, the state still pays the part A premiums and for that person would have increased Medicaid costs. Overall, a state should be no worse off, however, because the premium is set at the national actuarial value of the part A benefit.

Medicaid office to request a QMB determination. It is too early to determine the effect that this recent mailing may have on premium part A enrollment.

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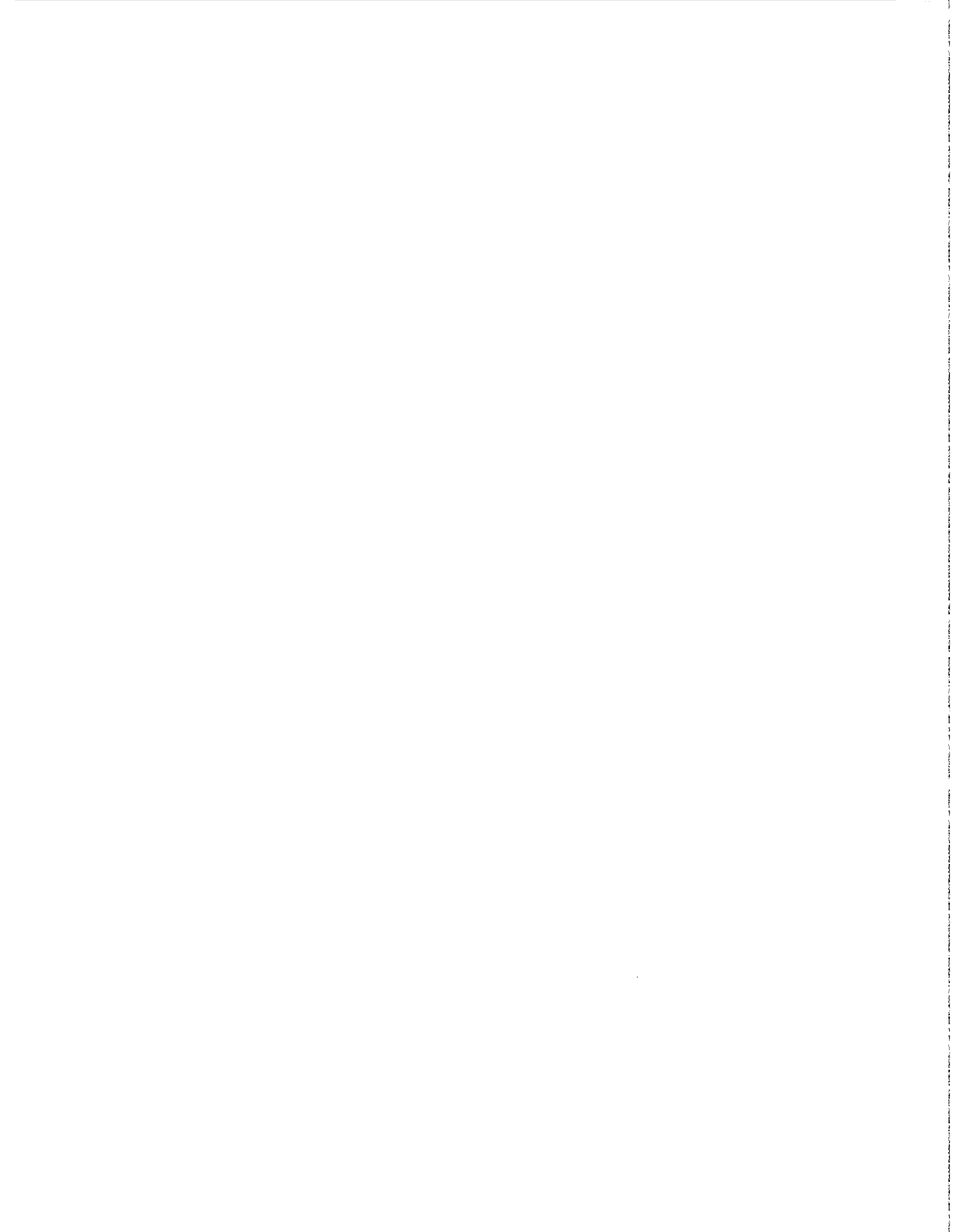

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