United States General Accounting Office

GAO

Report to Congressional Requesters

April 1999

LOW-INCOME MEDICARE BENEFICIARIES

Further Outreach and Administrative Simplification Could Increase Enrollment

GAO/HEHS-99-61

GAO

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

Health, Education, and
Human Services Division

B-282061

April 9, 1999

The Honorable Pete Stark
Ranking Minority Member, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Jim McDermott
House of Representatives

Medicare provides health insurance coverage to nearly 39 million Americans who are elderly, disabled, or have end-stage renal disease (ESRD). However, the program's cost-sharing provisions—including premiums, deductibles, and coinsurance—make participation in the program difficult to afford for low-income individuals. In 1995, the annual cost-sharing liability for Medicare-covered services was typically about $760 per beneficiary. This liability represented about 10 percent of income for a single person and about 15 percent of income for couples at the federal poverty level.[1] While many Medicare beneficiaries with low incomes have protection from these costs through Medicaid—the federal-state health financing program for low-income people—those with low incomes who do not qualify for Medicaid face significant cost-sharing obligations.

To assist low-income Medicare beneficiaries with potentially high out-of-pocket costs, the Congress enacted three programs: the Qualified Medicare Beneficiary (QMB) program; the Specified Low-Income Medicare Beneficiary (SLMB) program; and the Qualifying Individuals (QI) program, whereby state Medicaid programs help bear the beneficiary share of costs, which varies depending on the beneficiary's income. However, there has been continuing concern about the level of enrollment in these programs. Therefore, you asked us to

- highlight the demographic and socioeconomic characteristics of (1) Medicare beneficiaries who enroll as a QMB or SLMB and (2) Medicare beneficiaries who qualify for QMB or SLMB but do not enroll,
- examine reasons why eligible beneficiaries are not enrolled, and
- identify strategies to increase enrollment.

[1]This level is based on federal guidelines prepared by the Department of Health and Human Services. The federal poverty level in 1995 was $7,470 and $10,030 for couples.

To perform our work, we conducted a statistical analysis of recent surveys by the Health Care Financing Administration (HCFA), the Census Bureau, and the Federal Reserve Board. We also interviewed officials at HCFA, the Social Security Administration (SSA), Medicaid agencies in seven states, and advocates for low-income elderly. We conducted our work from November 1998 to March 1999 in accordance with generally accepted government auditing standards. (For a detailed description of our scope and methodology, see app. I.)

Results in Brief

Although enrollment in QMB and SLMB has increased since the programs were implemented, many potentially eligible Medicare beneficiaries are not enrolled in these programs. In 1996, about 2.2 million of an estimated 5.1 million potentially eligible Medicare beneficiaries—about 43 percent—were not enrolled in either QMB or SLMB. In general, the characteristics of QMB and SLMB enrollees are similar to individuals who are eligible but do not enroll, placing them among the most vulnerable Medicare beneficiaries. In addition to having low income, these individuals tend to have health conditions affecting their capacity to perform various activities. The groups differ in some respects, however, as beneficiaries who are eligible but not enrolled are more likely to be 80 years of age or older or have no health insurance coverage other than Medicare. Our analysis also indicates that QMB and SLMB enrollment can vary by specific demographic characteristics. For example, enrollment is relatively high among beneficiaries who are disabled, in poor health, are members of minority groups, are separated, or have never married. Conversely, enrollment is lower for beneficiaries who are white, widowed, married, or have Medicare coverage because of age rather than disability.

Advocates for low-income elderly and state officials we interviewed attributed persistently low QMB and SLMB enrollment to limited program awareness among beneficiaries and the programs' administrative complexity. Potentially eligible individuals are perceived to simply be unaware of these programs, their benefits, or their eligibility criteria. Moreover, limited beneficiary awareness is thought to be exacerbated by cultural and language barriers as well as perceptions of social stigma related to enrolling in the Medicaid-administered QMB and SLMB programs. Enrollment can be further hindered by a burdensome and complex application process that can require beneficiaries to interact with more than one government agency. Also, low enrollment in these programs is

thought to result from state cost-sharing obligations that limit states' incentives to notify and enroll eligible individuals.

Recently, HCFA and SSA have initiated efforts aimed at identifying strategies for increasing QMB and SLMB enrollment. HCFA has established a task force that is in the process of identifying targets for increased enrollment and strategies for reaching these goals. SSA selected one state, Massachusetts, and 11 communities in six other states to participate in a demonstration project to examine the effects of various approaches on enrollment. Further, a number of states we contacted have taken steps to simplify their application and enrollment processes, and advocates and state officials who we interviewed suggest that expanded administrative simplification efforts in conjunction with more creative and targeted outreach could increase QMB and SLMB enrollment.

Background

Medicare is the nation's largest health insurance program and provides coverage for a broad array of services. However, many beneficiaries purchase supplemental coverage to offset the program's cost-sharing provisions—that is, premiums, deductibles, and coinsurance.[2] To the extent that beneficiaries can purchase insurance to supplement their Medicare coverage, they limit their potential cost-sharing liability. However, many low-income persons—especially those with poor health—are less able to afford such supplemental coverage.

About 2.5 million persons who qualify for Medicare and are poor also receive assistance from Medicaid, a joint federal-state program that provides health care services for certain vulnerable and needy individuals and families with low incomes and resources.[3] For those who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their state's Medicaid program, which may include prescription drugs and long-term care services—generally not available under Medicare—as well as payment of Medicare part B premiums. Also, Medicare makes payments for

[2]Part A—which covers inpatient care in a hospital or skilled nursing facility, post-institutional home health care, and hospice care—typically has no premiums, but deductibles for an inpatient hospital period were $764 in 1998. Beneficiaries pay no coinsurance for the first 60 days of inpatient care, but they pay 25 percent of the deductible for the 61st through 90th days, and 50 percent of the deductible for hospitalization past the 90th day. For part B—which covers physician services, outpatient hospital services, non-post-institutional home health care, and other health care services—1998 premiums were $43.80 a month, or $526 a year. Also, beneficiaries must pay a coinsurance of 20 percent of allowable expenses.

[3]In 1996, Medicaid provided medical assistance to about 36 million low-income individuals.

Medicare-covered services before the Medicaid program makes any payments.

To assist low-income Medicare beneficiaries with potentially high out-of-pocket costs, the Congress established the QMB, SLMB, and QI programs.

- QMB, implemented in 1986,[4] is a benefit program for Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level. Under QMB, state Medicaid programs are responsible for these individuals' Medicare premiums, deductibles, and coinsurance.
- SLMB, implemented in 1993,[5] requires state Medicaid programs to pay Medicare part B premiums (but not the deductibles or coinsurance) for individuals with incomes above 100 percent but less than 120 percent of the federal poverty level.
- QI, implemented in 1998, requires state Medicaid programs to pay all of the Medicare part B premiums for individuals with incomes at least 120 percent but less than 135 percent of the federal poverty level, and to provide a small rebate of Medicare premiums for beneficiaries with incomes at least 135 percent but less than 175 percent of the federal poverty level. The QI program is funded with $1.5 billion in federal dollars over a 5-year period.[6] Because the funding amount is fixed, eligible individuals receive assistance on a first-come, first-served basis.

These Medicare buy-in programs and full Medicaid have varying eligibility criteria and benefits. (See table 1.)

[4]QMB was enacted as an optional benefit through the Omnibus Budget Reconciliation Act (OBRA) of 1986. The Medicare Catastrophic Coverage Act of 1988 made the QMB benefit mandatory, effective January 1, 1989.

[5]SLMB was enacted under OBRA 1990, effective January 1, 1993.

[6]Because the QI program did not become effective until 1998, we did not examine enrollment in this program.

Table 1: Medicaid Eligibility Criteria and Benefits for Medicare Beneficiaries Under Full Medicaid, QMB, SLMB, and QI

Program	Eligibility criteria	Benefits	Enrollment as of December 1998[a]
Full Medicaid	Low-income Medicare beneficiaries as defined by each state	Medicare part B premiums paid by the state Medicaid program and Medicaid services, including those covered under Medicare	2,450,000
QMB	Medicare beneficiaries whose (1) incomes are at or below 100 percent of the federal poverty level and (2) assets are no greater than twice the limit for Supplemental Security Income (SSI)[b]	Medicare premiums, deductibles, and coinsurance paid by the state Medicaid program[c]	2,420,000
SLMB	Medicare beneficiaries with (1) incomes above 100 percent but less than 120 percent of the federal poverty level and (2) assets no greater than twice the limit for SSI[b]	Medicare part B premiums paid by the state Medicaid program[c]	290,000
QI	Medicare beneficiaries who are otherwise ineligible for Medicaid with (1) incomes at least 120 percent but less than 175 percent of the federal poverty level and (2) assets no greater than twice the limit for SSI[b]	Medicare part B premiums paid for income 120 percent to less than 135 percent of the federal poverty level in 1999; a $2.23 premium contribution for income 135 percent to less than 175 percent of the federal poverty level	16,000

[a]Based on administrative data provided by HCFA.

[b]The asset limits for SSI are $2,000 for individuals and $3,000 for couples.

[c]Individuals may also be eligible for Medicaid services.

Program Enrollment Has Increased, but Some of the Most Vulnerable Eligible Medicare Beneficiaries Are Not Enrolled

Enrollment in QMB has increased steadily since it was implemented.[7] However, nearly half of all Medicare beneficiaries who are eligible for the QMB and SLMB programs are not enrolled. Moreover, these beneficiaries are some of the most vulnerable among the Medicare population.

QMB Enrollment Has Increased

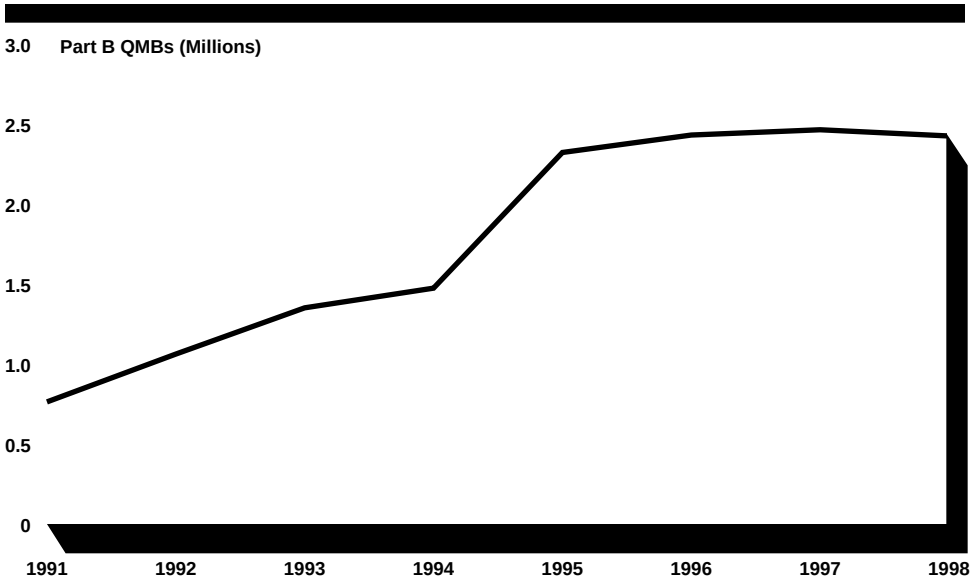
HCFA administrative records based on state-reported enrollment data indicate that enrollment in QMB increased from over 760,000 in 1991 to over 2.4 million in 1998[8] (see fig. 1). Following steady enrollment growth from 1991 to 1994, enrollment has largely stabilized. While enrollment appears to increase sharply between 1994 and 1995, this increase largely represents a change in states' reporting methods, which had undercounted QMB enrollees.[9]

[7]Trend data on SLMB were not available.

[8]Based on part B enrollment data. Most beneficiaries have both part A and part B Medicare coverage.

[9]QMB enrollment was underreported prior to 1995 because some QMBs were counted as full Medicaid recipients. This was changed beginning in 1995, explaining much of the apparent growth in QMB enrollment between 1994 and 1995.

Figure 1: Growth in QMB Part B Enrollment From 1991 to 1998



Note: In 1995, states changed their reporting method, resulting in the apparent sharp increase in reported enrollment.

Many QMB- and SLMB-Eligible Medicare Beneficiaries Are Not Enrolled

While QMB enrollment has increased gradually over time, a relatively low percentage of Medicare beneficiaries who are eligible for the QMB and SLMB programs actually enroll. Based on our analysis of the 1996 Medicare Current Beneficiary Survey (MCBS), an estimated 8.6 million Medicare beneficiaries had income levels low enough to qualify them for these programs. Within this group, about 61 percent had assets within the QMB and SLMB thresholds, based on data from the Survey of Consumer Finance (SCF). Considering both income and assets, we estimate that about 5.1 million Medicare beneficiaries are potentially eligible for the QMB or SLMB program, with MCBS reporting about 2.9 million individuals enrolled in QMB or SLMB. Therefore, about 2.2 million—or 43 percent—of the estimated eligible population are not enrolled. Other analysts have examined enrollment for QMB and enrollment for SLMB separately and found that enrollment is higher in the QMB program but lower in the SLMB program, which serves a population with incomes slightly higher than the QMB population and with more limited benefits.

Demographic Profiles of Enrolled and Nonenrolled Eligibles Are Similar

Based on our analysis of MCBS, the general profile of individuals who are eligible but do not enroll in QMB and SLMB is similar to that of program enrollees.[10] The characteristics of these two groups place them among the most vulnerable Medicare beneficiaries. In addition to having a lower income than noneligible Medicare beneficiaries, QMB and SLMB eligibles and enrollees have fewer years of education and health conditions that limit their capacity to perform various activities. A relatively high percentage of both the QMB and SLMB eligible and enrolled are female, single, living alone, or a member of a minority group.

While the general profiles of enrolled and nonenrolled QMB- and SLMB-eligible individuals are similar, certain characteristics distinguish them. For example, QMB and SLMB enrollees are more likely to be disabled or reside in a facility than those who are eligible but not enrolled. In contrast, individuals who are eligible but not enrolled are more likely to not have health insurance coverage other than Medicare or be 80 years of age or older.

Enrollment Is Highest for Those Who Are Most Vulnerable

Our analysis indicates that enrollment was higher among some of the most vulnerable beneficiaries—those in poor health; receiving Medicare coverage because of a disability or ESRD; with difficulty performing certain life activities; or residing in facilities, such as a nursing home, assisted living facility, or mental health facility. Enrollment was also higher among individuals having 8 or fewer years of education. Conversely, enrollment was lower among beneficiaries who had 13 or more years of education, were in better health, had Medicare coverage due to age, or were living in the community.

QMB and SLMB enrollment was also associated with beneficiaries' race and marital status. For example, Asian- and African-Americans were more likely to be enrolled than whites. Also, beneficiaries who were separated or never married were more likely to be enrolled than those who were widowed or married. (See app. II for more detailed information on the characteristics of QMB and SLMB enrollees, individuals who are eligible but not enrolled, and other Medicare beneficiaries.)

[10]For our analysis, we examined the characteristics of individuals who are eligible for QMB or SLMB based upon income alone.

Low QMB and SLMB Enrollment Attributed to Limited Program Awareness and Administrative Complexity

The state officials and advocates for low-income elderly who we interviewed indicated that low QMB and SLMB enrollment persists because of limited program awareness among beneficiaries and the administrative complexity associated with the programs. Beneficiaries are perceived to have insufficient knowledge of the programs, their benefits, and their eligibility criteria—a problem exacerbated by cultural and language barriers and perceptions of social stigma related to enrolling in Medicaid-administered programs. Furthermore, establishing QMB and SLMB eligibility can be a complex process. For potential beneficiaries, lengthy applications and eligibility verification requirements can discourage them from seeking enrollment. For agencies, the division of financial and programmatic responsibilities between the federal government and states can provide a disincentive to assume full responsibility for maximizing enrollment.

Insufficient and Ineffective Outreach Limits Program Awareness

Although the QMB and SLMB programs have been operable for a number of years, most of those we interviewed reported that many potential recipients do not enroll because they do not know the programs existed. Misperceptions about the programs are also thought to deter some beneficiaries from enrolling. For example, an individual who meets the eligibility criteria might not apply because of a belief that the program is intended only for "poor people." Some potential beneficiaries are thought not to apply because of their apprehensions or misperceptions about their state's Medicaid estate recovery practices. These individuals may fear that, following their death, their state will attempt to recover QMB and SLMB payments made on their behalf through liens on their estate and jeopardize the financial well-being of a surviving spouse or their children. Other potential beneficiaries think the programs are a form of welfare and are unwilling to accept this type of assistance.

Some states we interviewed attributed limited program awareness, in part, to either a general lack of outreach efforts or the lack of effective outreach. They believe, for example, that current outreach efforts are insufficient or ineffective in raising the level of program awareness among beneficiaries with limited English language skills or in allaying concerns regarding the acceptance of public assistance. Our analysis of MCBS data similarly suggests that current outreach efforts may not be reaching all populations. QMB and SLMB enrollment is comparatively high for beneficiaries who are ill or disabled or reside in facilities such as those that provide long-term care. Even without outreach, however, these individuals are more apt to become enrolled because their health

conditions increase their number of encounters with the medical community—some even reside in medical settings—and their caregivers have financial incentives to ensure that they are covered. In contrast, QMB and SLMB enrollment is lower among beneficiaries who are aged, better educated, in better health and with less need for medical care, or living independently in the community—groups for whom outreach efforts are more necessary for increasing program awareness or addressing concerns or misperceptions.

Through our interviews with states, we also found that most discussed previous or ongoing outreach efforts. Only one state reported new outreach initiatives for increasing QMB and SLMB enrollment, and one state reported targeting its outreach to specific groups.

Administrative Complexity Impedes QMB and SLMB Enrollment

Even with improved outreach, boosting enrollment in QMB and SLMB may be undermined by the administrative complexity associated with determining eligibility. The application process is cumbersome and lengthy, and other administrative processes must be coordinated among various federal and state government agencies, given that Medicare is administered by the federal government and Medicaid is administered by the states.

According to the state officials and advocates we interviewed, the process for applying for QMB and SLMB benefits could be a key factor limiting enrollment. In some states, applicants are required to complete the full Medicaid application, which can exceed 10 pages and be difficult to read, given its small print. In addition, applicants may require the assistance of a state caseworker to complete the application. Some states require information that will allow the verification of an applicant's reported resources—a process that can be onerous and time-consuming to both applicants and state workers. Further, some states require applicants to have a face-to-face interview at either a social service or an aging office, instead of accepting applications over the phone, as other states do. Requiring face-to-face interviews likely impedes enrollment for those who are homebound or concerned about perceived welfare stigma.

Other administrative processes—typically those that require coordination among state and federal agencies—can result in eligible individuals' enrollment being delayed. For example, state Medicaid programs may need to coordinate with HCFA and SSA to verify information such as

enrollment in Medicare and income from Social Security, creating the potential for administrative delays and errors.

Some advocates have also suggested that the financing of the QMB and SLMB programs, with state cost-sharing responsibilities, has deterred states from embracing the programs and created a disincentive for states to conduct additional outreach or simplify the application process. A February 1998 National Governors' Association (NGA) position on the financing arrangement supports this belief. NGA stated that it "cannot support Medicare reform strategies, such as increased cost-sharing obligations for the dually eligible, that result in cost shifts to the states."[11] NGA further stated that Medicare, as a federal program, should bear all of its costs, but if it were to continue to make Medicaid responsible for meeting the Medicare cost-sharing obligations of low-income beneficiaries, "Congress should at a minimum clarify that copayments may be reimbursed at Medicaid rather than Medicare rates."[12]

Enhanced Outreach and Simplified Enrollment Could Increase Participation in QMB and SLMB

The federal government has developed various strategies to boost enrollment in QMB and SLMB. A number of these strategies focus on enhancing outreach to increase program awareness and simplifying the enrollment process. For example, as part of its Government Performance and Results Act (GPRA) goals, HCFA has convened a task force to develop an outreach, enrollment, and eligibility simplification strategy for increasing enrollment of those who are dually eligible. SSA is conducting a pilot project intended to increase referral of potential beneficiaries to state Medicaid programs.

The state officials and advocates we interviewed recommended that outreach be improved through strategies such as increasing overall outreach efforts; targeting groups that include large numbers of eligible but nonenrolled individuals; and developing partnerships with key stakeholders, such as seniors' advocates, area agencies on aging, and other community-based organizations. They also recommended strategies for streamlining the application process and providing flexibility in applying eligibility rules to make it easier for eligible individuals to become enrolled in the programs.

[11]National Governors' Association, Policy Positions (Washington, D.C., Feb. 1998).

[12]Since Medicaid reimbursement rates tend to be lower than Medicare rates, such a change would result in cost savings to states. Section 4714 of the Balanced Budget Act of 1997 (P.L. 105-33) clarified that states were not required to provide payments for deductibles, coinsurance, or copayments for the full Medicare cost-sharing amount made under the state plan for services provided to individuals other than Medicare beneficiaries.

HCFA Initiatives to Increase Enrollment

Since the programs were developed, HCFA has made several efforts to increase enrollment in QMB and SLMB. Promotional efforts have included mailing notices to prospective enrollees, distributing pamphlets on the programs, advertising in the media, and developing a section on QMB and SLMB in its Medicare handbook for beneficiaries. HCFA has also issued directives and letters to states providing guidance on program administration and simplification. For example, in October 1998, HCFA wrote state Medicaid program directors suggesting that they develop outreach and enrollment strategies modeled on those used for the new State Children's Health Insurance Program (SCHIP)—a strategy some advocates strongly support.

In response to the Social Security Amendments of 1994, HCFA established a list of newly eligible Medicare beneficiaries that includes demographic information, such as income from Social Security, which states can use to identify individuals potentially eligible for QMB and SLMB benefits.[13] Currently, HCFA is seeking to improve QMB and SLMB enrollment through one of its GPRA goals. To reach this goal, HCFA plans to

- establish targets for increased QMB and SLMB enrollment;
- develop an outreach, enrollment, and eligibility simplification strategy;
- identify best practices in collaboration with states; and
- measure progress toward meeting these goals.

HCFA intends to recommend targets and best practices in summer 1999 and begin measuring progress toward these goals in fiscal year 2000.

SSA Efforts to Increase Enrollment

SSA is an important point of contact for those potentially eligible for QMB and SLMB, not only because it is responsible for enrolling new Medicare beneficiaries but because Social Security is a primary source of income for many low-income beneficiaries. However, a majority of individuals file for Social Security benefits before age 65—when most become eligible for Medicare—and do not have ongoing contact with SSA.[14] SSA's efforts to notify potentially eligible individuals include sending program information in cost-of-living adjustment notices to all Social Security recipients and providing QMB and SLMB information and referral as part of the agency's

[13]Section 154 of the Social Security Amendments of 1994 (P.L. 103-432) directs the Secretary of Health and Human Services to implement a method for obtaining information from newly eligible Medicare beneficiaries that could be used to determine their QMB eligibility and to transmit this information to the state in which the beneficiary resides.

[14]When these individuals become eligible for Medicare, they are automatically enrolled in part A and part B and, therefore, do not have to contact SSA again to enroll in Medicare.

in-person contacts and toll-free telephone service. SSA has also included information about the QMB and SLMB programs in pamphlets available at Social Security offices and distributed to interested individuals.

SSA is currently conducting a demonstration project with selected states to evaluate which strategies are most effective in increasing the number of SSA referrals of potentially eligible beneficiaries to state agencies. The demonstration project will be conducted in Massachusetts and 11 communities in six other states, which were selected based on each participating state's offer to provide access to a concentration of elderly, disabled, and low-income individuals. Under this project, SSA is testing four approaches. In one approach, SSA will use its death report process to identify potential buy-in eligibles and refer them to the state's Medicaid office to file an application for benefits. In the other three approaches, SSA will identify and send mailings to potentially eligible individuals in the selected communities. Respondents will be screened by SSA employees and then referred to complete an application (1) with an SSA employee; (2) with a state Medicaid official located in the SSA office; or (3) with an official at the state Medicaid office, typically at another location. Final eligibility determinations are still performed by the state Medicaid agency, regardless of the approach. The demonstration is scheduled to continue through the end of 1999, and an evaluation of the project and findings on the relative effectiveness of the referral methods is expected to be released in spring 2000.

Increased and More Effective Outreach Could Increase Enrollment

In addition to HCFA's and SSA's recent initiatives to increase QMB and SLMB enrollment, the state officials and advocates we interviewed recommended a number of strategies, some of which have been used, for intensifying and broadening the range and scope of outreach efforts.

- Target outreach to populations with particularly low enrollment: individuals who are widowed, aged 65 or older, white, have 13 years or more of education, or report good health status.
- Target low-income Medicare beneficiaries with health conditions and high use of health care services, who are most likely to benefit from supplemental coverage of Medicare coinsurance and deductibles. For example, Medicare benefits statements, which show Medicare's payments and the beneficiary share of the cost, could include a brief notice suggesting that low-income beneficiaries apply for QMB.
- Use other methods and sources to provide information on QMB and SLMB. For example, states could coordinate with local utility companies to

include QMB and SLMB literature with mailings to subscribers. Delaware's Division of Health and Social Services attempts one-on-one outreach at senior picnics, health fairs, and senior centers. In Arizona, a state coalition enrolled volunteers to conduct door-to-door outreach. In addition, for the SCHIP program, HCFA recommends that states allow application at a wide variety of sites, including public schools and school-based health clinics.

- Enlist physicians and other health care professionals in outreach efforts, such as encouraging them to advise their low-income patients to apply for QMB.
- Coordinate outreach with other programs providing assistance to low-income individuals. For example, elderly pharmacy assistance programs can help identify individuals with ongoing prescription drug needs, who are potentially eligible for QMB and SLMB.
- Establish partnerships with local stakeholders to increase QMB and SLMB enrollment. For example, Tennessee and Arizona partnered with organizations such as religious organizations, advocacy groups, state and local agencies, voluntary health agencies, health professionals and providers, area agencies on aging, and other seniors groups to develop task forces to work on outreach, training, and enrollment.
- Provide outreach information and applications in languages other than English.

While improved outreach could improve enrollment, many of the proposed strategies would likely require the commitment of additional resources by states and HCFA.

Simplifying the Application Process and Eligibility Rules Could Also Increase Enrollment

State officials and advocates also suggested that additional efforts are needed to simplify the application process and eligibility rules. Some approaches that they recommended include the following:

- Use a shorter application form. For example, some states have developed a one- or two-page application for QMB and SLMB.
- Allow beneficiaries to declare the eligibility information they provide as true and accurate. For example, Delaware allows a self-declaration that the applicant meets the asset requirements for enrollment in QMB and SLMB, rather than requiring documentation to verify assets.
- Eliminate the need for applicants to come in person to Medicaid or other state agency offices to apply. Some states have computerized portions of the eligibility determination, which could allow the testing of an electronic application. Intermediaries such as area agencies on aging and community-based organizations could assist in preparing and transmitting

applications electronically to state Medicaid offices. Arizona offers help filling out applications via telephone. New York is encouraging local counties to experiment with allowing those who are potentially eligible to enroll through area agencies on aging staffed with state intake workers. Also, Tennessee performed a 3-month screening of potential beneficiaries at the U.S. Department of Agriculture's commodity distribution centers.[15]

- Relax program eligibility rules. For example, Arizona excludes items such as household goods and personal effects, mineral and timber rights, burial and life insurance from countable resources. Furthermore, most states have no asset requirements for SCHIP applicants.
- Share automated data to improve enrollment.
- Expand the use of retroactive eligibility so beneficiaries can be compensated for medical expenses incurred while their application is pending. QMB and SLMB applications and eligibility determination can take 1 month or longer before enrollment is completed. Potentially eligible individuals who have recently incurred medical expenses covered under QMB, therefore, may be more likely to complete the application process if they expect to be reimbursed for these expenses.

For states that use a uniform application to establish eligibility for multiple programs, developing a simpler application specifically for QMB and SLMB may also have some drawbacks. While a simpler application may help improve QMB and SLMB enrollment, it would make it more difficult to determine whether the applicant is also eligible for other or more comprehensive programs for low-income individuals. For example, some states that maintain longer application forms and require verification of assets use the information to screen the individual for full Medicaid benefits and other programs such as low-income housing or energy assistance. In certain circumstances, a streamlined QMB or SLMB application could hinder a state agency's ability to identify applicants who would also qualify for more comprehensive assistance or benefits.

Concluding Observations

As proposals to restructure and increase the long-term financial strength of the Medicare program are considered in the Congress, increased attention may be focused on the best approaches for providing financial assistance to low-income Medicare beneficiaries. The persistence of relatively low enrollment in the QMB and SLMB programs suggests that enhanced outreach or simplified enrollment processes would be helpful in reaching a larger share of eligible low-income Medicare beneficiaries.

[15]The Food and Nutrition Service, an agency of the U.S. Department of Agriculture, makes food available through various programs, including the Emergency Food Assistance Program, the Commodity Supplemental Food Program, and Nutrition Program for the Elderly.

Effective targeted outreach can also serve as a means to optimize limited outreach resources. Assessment of ongoing efforts—including SSA's demonstration project, SCHIP outreach and enrollment efforts by states, and HCFA's GPRA efforts—could yield new strategies to increase QMB and SLMB enrollment. Successful approaches from these efforts could then be widely disseminated to enhance outreach and enrollment.

Agency Comments

We obtained comments on a draft of our report from HCFA and SSA. HCFA generally agreed with the strategies for increasing enrollment in the QMB and SLMB programs suggested by the advocates and state officials we interviewed. HCFA also indicated its commitment to providing more effective outreach and removing administrative barriers to enrollment and highlighted its current efforts under GPRA to increase QMB and SLMB enrollment.

HCFA also noted that our estimate of the population potentially eligible for the QMB and SLMB programs is lower than their forthcoming estimate. Estimating the number of individuals eligible for means-tested programs is challenging because most available surveys have shortcomings of one kind or another. For this reason, we recognize that different methods can legitimately produce different estimates of this population. Further, as estimates of this population are produced from surveys that are based on statistical samples, these estimates are subject to sampling error so that the actual level of enrollment is likely to be higher or lower than the point estimate. In our opinion, the differences among the various estimates of this population narrow when these sampling errors are taken into account.

HCFA and SSA also noted that other researchers have found significantly higher enrollment among QMB-eligible individuals than SLMB-eligible individuals. In addition, HCFA indicated that combining these groups could mask their differences. We acknowledge in our report that other research has determined that the QMB program reaches a larger portion of eligible individuals than does the SLMB program. We also acknowledge that demographic differences could potentially exist in (1) the enrolled QMB and SLMB populations and (2) the nonenrolled eligible QMB and SLMB populations. However, our study's objective was not to distinguish between these groups, but rather to compare the enrolled and the nonenrolled eligible populations for both programs. Moreover, MCBS income data do not permit differentiating nonenrolled QMB and SLMB eligibles, and given the small number of SLMB enrolled and nonenrolled eligibles included in the MCBS sample, discrete estimates about their

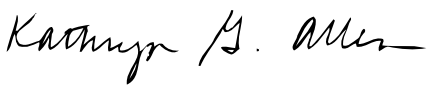
characteristics would not likely be reliable. Nonetheless, this should not be a significant limitation to our study's objective because, based on the eligibility criteria for these programs for the time period we examined, only about $2,000 in income separated an individual eligible for QMB from one eligible for SLMB.

Both HCFA and SSA suggested technical clarifications, which we included where appropriate. HCFA's written comments are provided as appendix III.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this letter until 30 days after its issue date. At that time, we will send copies to other interested congressional committees and members and agency officials. We will also make copies available to others upon request.

Please call me at (202) 512-7114 if you have any questions about the information provided in this report. The information presented in this report was developed by N. Rotimi Adebonojo, Senior Evaluator; Wayne Turowski, Computer Specialist; and Mark Vinkenes, Senior Social Science Analyst, under the direction of John Dicken, Assistant Director.

Sincerely yours,



Kathryn G. Allen
Associate Director, Health Financing
and Public Health Issues

Contents

Abbreviations

CPS	Current Population Survey
ESRD	end-stage renal disease
GPRA	Government Performance and Results Act
HCFA	Health Care Financing Administration
MCBS	Medicare Current Beneficiary Survey
NGA	National Governors' Association
OBRA	Omnibus Budget Reconciliation Act
QI	Qualifying Individuals
QMB	Qualified Medicare Beneficiary
SCF	Survey of Consumer Finances
SCHIP	State Children's Health Insurance Program
SLMB	Specified Low-Income Medicare Beneficiary
SSA	Social Security Administration
SSI	Supplemental Security Income

Scope and Methodology

We conducted an analysis of the 1996 Medicare Current Beneficiary Survey (MCBS) on access to care to estimate the number and characteristics of Medicare beneficiaries who enroll as a QMB or SLMB as well as those who may qualify but do not enroll. Given certain limitations of MCBS, we used the March 1996 Current Population Survey (CPS) and the 1995 Survey of Consumer Finances (SCF) to further refine our estimates. To examine reasons why eligible beneficiaries do not enroll and identify strategies to increase enrollment, we reviewed the available literature and interviewed representatives from HCFA, which administers Medicare and Medicaid; SSA, which is responsible for enrolling eligible individuals in Medicare; national organizations that represent elderly and low-income persons; state health insurance counseling agencies; and Medicaid agencies in Arizona, California, Delaware, Michigan, Nebraska, New York, and Tennessee. We excluded the Qualifying Individuals program from our review due to its recent enactment.

We used MCBS to conduct our analysis because it (1) contains comprehensive information on Medicare beneficiaries, including their demographic characteristics, health status, and health care use, and (2) relies on HCFA administrative records rather than self-reported information for QMB and SLMB enrollment status. This latter factor is important because previous research suggests that QMB enrollees and individuals who are eligible but not enrolled in the program are not always aware of their enrollment status, which could affect the reliability of our estimates. Because MCBS does not contain information on assets and only provides income information in ranges, we also analyzed the 1995 SCF to obtain additional asset information and the 1996 CPS March Supplement to obtain additional income information.

Using MCBS, we categorized Medicare beneficiaries as (1) enrolled in QMB or SLMB, (2) eligible for QMB or SLMB but not enrolled, and (3) ineligible for QMB or SLMB. The first group includes any individual enrolled in QMB or SLMB for at least 1 month. The second group consisted of beneficiaries with income less than or equal to $10,000, no QMB or SLMB enrollment, and less than continuous coverage by full Medicaid. The third group consists of any Medicare beneficiary with income greater than $10,000 and no QMB, SLMB, or Medicaid enrollment.

For purposes of our analysis, we did not distinguish between QMB and SLMB enrollees. Likewise, individuals who were potentially eligible for QMB were not distinguished from those who were eligible for SLMB. This is because the numbers of enrolled and potentially eligible SLMB populations are

relatively small and the resulting sampling errors would have been too great to allow meaningful comparisons. Also, because MCBS measures income within a range rather than as a specific amount, the survey precludes distinguishing individuals who are potentially eligible for QMB from those who are eligible for SLMB.

As shown in table I.1, the maximum income that an individual could have to meet the SLMB income threshold of 120 percent of the federal poverty level was $8,964; for a couple, this income threshold was $12,036. Thus, some individuals we classified as eligible for QMB or SLMB based on the MCBS income range of less than or equal to $10,000 may have exceeded the actual income threshold for individuals. Similarly, some individuals we classified as not eligible for QMB or SLMB may have met the income thresholds for couples.

Table I.1: QMB and SLMB Asset and Income Thresholds, Individuals 65 Years or Older, 1995

	Assets		Income per year	
Category	Individual	Couple	Individual	Couple
QMB	$4,000	$6,000	$7,470	$10,030
SLMB	4,000	6,000	8,964	12,036

To determine the extent to which the discrepancy in MCBS' income data and the actual income requirements of the program influenced our estimates of the eligible but nonenrolled population, we conducted an analysis of income among Medicare beneficiaries using the 1996 CPS. Based on this analysis, using the SLMB income threshold of 120 percent of the federal poverty level instead of $10,000, we estimate 217,000 fewer Medicare beneficiaries could qualify for SLMB based on income. Therefore, our MCBS analysis, based on a $10,000 income threshold, slightly overestimates the number of individuals potentially eligible for QMB or SLMB.

Because MCBS also does not include information on assets available to Medicare beneficiaries, we analyzed the 1995 SCF. As shown in table I.1, in general, individuals qualifying for QMB or SLMB may not have assets exceeding $4,000 in value ($6,000 for a couple). While rules for determining assets for QMB or SLMB eligibility are applied differently by state, we generally used SSI eligibility definitions for the purpose of establishing countable resources for QMB or SLMB eligibility. For example, we excluded from countable assets the value of an individual's home and the first $1,500 in cash surrender value of life insurance policies. Using SCF, we estimate that approximately 39 percent of Medicare beneficiaries with

income of $10,000 or less had countable assets above the QMB and SLMB eligibility thresholds. Thus, we deflated our MCBS estimate of the number of eligible individuals based on income by 39 percent—our estimate, based on SCF, of those who would not meet the QMB and SLMB asset requirements.

Medicare Beneficiary Profiles

Table: II.1: Percentage of QMB and SLMB Enrollees, Eligible but Nonenrolled QMBs and SLMBs, and Beneficiaries Ineligible for QMB or SLMB by Demographic and Other Characteristics

	QMB or SLMB enrolled	QMB or SLMB eligible but nonenrolled	Medicare enrollees ineligible for QMB or SLMB
Age			
Less than 65 years old	32.2%	15.8%	6.9%
65 to 79 years old	41.7	51.9	73.5
80 years old or older	26.1	32.2	19.6
Education			
8 years or less	41.9	35.3	13.9
9 to 12 years	41.3	50.6	49.5
13 or more years	8.1	11.7	36.2
Other demographic characteristics			
Member of a minority group	30.0	18.6	7.5
Hispanic ancestry	13.3	11.5	3.5
Female	65.2	68.1	50.7
Single	81.8	78.7	33.0
Live alone	44.3	48.5	24.5
Live in a facility	20.7	4.6	0.9
Basis for Medicare			
Aged	67.7	84.2	93.1
Disabled	31.9	15.6	6.7
ESRD	0.4	0.3	0.2
Insurance status			
Medicare only	9.3	35.4	16.6
Medicare and private insurance	2.9	45.7	79.2
Health status			
Fair or poor	49.4	34.6	21.2
Limits most or all social life	23.7	20.2	11.3
Physical difficulties			
Seeing	14.1	13.0	6.5
Hearing	9.4	8.9	6.1
Stooping or kneeling	47.6	38.6	24.9
Lifting 10 pounds	37.4	25.9	13.3
Reaching over head	15.4	13.8	6.9
Writing	13.2	9.3	4.8
Walking two blocks	46.1	33.8	19.7

Source: GAO analysis of the 1996 MCBS.

Table II.2: Percentage of Individuals Potentially Eligible for QMB or SLMB Who Are Enrolled, by Demographic Characteristics

Demographic characteristic	Percentage enrolled
Age	
Less than 65 years old	50.6%
65 years old or older	28.9
Education	
8 years or less	37.5
9 to 12 years	29.1
13 or more years	25.9
Race	
American Indian	40.9
Asian/Pacific Islander	67.2
African American	43.6
Caucasian	30.2
Other	38.4
Marital status	
Married	30.2
Widowed	27.6
Divorced	37.4
Separated	43.7
Never married	52.9
Residence	
Community (independent)	29.6
Facility	69.2
Basis for Medicare	
Aged	28.8
Aged With ESRD	74.1
Disabled	50.7
Disabled With ESRD	58.5
ESRD	39.8

Source: GAO analysis of the 1996 MCBS.

Table II.3: Percentage of Individuals Potentially Eligible for QMB or SLMB Who Are Enrolled, by Health Characteristics

Health characteristic	Percentage enrolled
Health status	
Excellent	23.8
Very good	22.2
Good	32.6
Fair	41.1
Poor	43.4
Health limits social life	
No	28.7
Some	41.6
Most	36.4
All	38.2
Have difficulty stooping/kneeling	
No	30.2
Little	27.0
Some	33.3
A lot	33.6
Unable	43.4
Have difficulty lifting 10 pounds	
No	27.6
Little	32.6
Some	35.0
A lot	35.9
Unable	45.8
Have difficulty reaching over head	
No	30.4
Little	38.4
Some	40.9
A lot	32.3
Unable	40.9
Have difficulty writing	
No	30.2
Little	34.6
Some	43.5
A lot	39.2
Unable	49.0
Have difficulty walking two to three blocks	
No	27.2

(continued)

Health characteristic	Percentage enrolled
Little	32.2
Some	33.5
A lot	38.8
Unable	41.5

Source: GAO analysis of the 1996 MCBS.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAR 23 1999

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment"

TO: Kathryn G. Allen, Associate Director
Health Financing and Public Health Issues

We appreciate the opportunity to review your draft report to Congress concerning the enrollment of Medicare beneficiaries in the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs. We agree with the report's recommendations and remain very committed to providing more effective outreach and the removal of administrative barriers to enrollment. Providing affordable health care to this vulnerable group is a high priority for this Administration.

HCFA has initiated efforts to increase QMB and SLMB enrollment. We have already established a workgroup that will identify targets for increased enrollment and strategies for reaching these goals. We look forward to working with the GAO and the Congress as we continue to expand beneficiary enrollment in these programs.

Enclosure

Comments of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report, Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment

General Comments

HCFA shares GAO's concern that more low-income Medicare beneficiaries need to be enrolled as Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs). Providing affordable health care to this vulnerable group remains a high priority for HCFA and the Agency has taken numerous steps to encourage higher enrollment rates.

Under the Government Performance Results Act (GPRA), HCFA established a performance goal to improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private insurance. A workplan which highlights specific HCFA tasks for the fulfillment of this GPRA goal is included as attachment I. In addition, HCFA is developing a Resource Guide to assist Federal agencies, states, and local organizations increase the enrollment rates of dually eligible beneficiaries. In creating this guide, we have initiated a number of activities suggested in this GAO draft report. Specifically, we have:

- Conducted a state survey of outreach and enrollment practices (with 42 responding states);
- Engaged state, local, and beneficiary representatives in discussion interviews;
- Conducted a demographic analysis of enrolled and non-enrolled beneficiaries, and;
- Determined the number of potentially eligible beneficiaries.

While our findings also suggest that further outreach and administrative simplification could increase enrollment, our findings differ from GAO's as to the number of potentially eligible beneficiaries and the demographic composition of the enrolled and non-enrolled population. It appears that this difference may be attributed to the methodology utilized by GAO to conduct its analysis. We believe that HCFA's contractor has utilized a more sophisticated methodology. HCFA's findings are consistent with other organizations that have recently conducted studies in this area, such as American Association of Retired Persons' Public Policy Institute (PPI) and the Henry J. Kaiser Family Foundation. HCFA would be willing to meet with GAO to discuss the discrepancies and technical aspects of this report prior to its publication.

Page 2

Suggested Enhancement to Existing Outreach

The suggested enhancements that GAO recommends are items which have been raised previously through the interviews and surveys HCFA conducted, and the HCFA-sponsored national conference, entitled "Reach Out - A Cooperative Effort by Stakeholders to Enroll Dual Eligibles". During the conference, provider, local, state, and federal stakeholders (including GAO) exchanged ideas and experiences in enrolling dual eligibles. Many of these suggestions have already been pursued by HCFA, such as encouraging states to simplify and shorten their application forms and encouraging them to form partnerships with other local stakeholders. We are also studying these suggestions and others, as part of our effort to create the Outreach, Enrollment, and Eligibility Simplification strategy that is due under the 1999 GPRA Performance Plan (described in attachment II). Our findings will also become part of the Resource Guide that we are developing to enroll this population.

Estimates of Enrollment

GAO estimates that about 5.1 million beneficiaries were eligible for the programs in 1996 (this includes aged, disabled, and institutionalized). This estimate is significantly lower than our findings. Further, we believe that by looking at both the QMBs and the SLMBs in total, the penetration rate of enrollment for QMBs is under-estimated and the enrollment rate of SLMBs is significantly over-estimated. Previous studies consistently showed that the QMB enrollment rate is significantly greater than that of the SLMBs, although there is a slight variation around the actual enrollment rates.

Profiling Section

In our demographic analysis, which will be completed by the end of the month, we have found essentially the same patterns of characteristics among beneficiaries who were QMB/SLMB eligible in 1996 but not enrolled, compared with those who were eligible and enrolled, as GAO found in their analysis. That is, our data support the result that enrollment is higher for those in poorer health, those with disabilities, and those who are single. However, the methodology used by GAO does not distinguish the QMBs from the SLMBs. We consider this a major shortcoming when conducting a demographic analysis of the population. Analyzing these groups in combination masks differences between the groups that we found in our analysis. For example, while we found that education level, race/ethnicity, and Supplemental Security Income recipient status make a difference in QMB participation rates, these factors are not associated positively or negatively with SLMB participation.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested