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FINAL

A PROFILE OF QMB-ELIGIBLE AND SLMB-ELIGIBLE MEDICARE BENEFICIARIES

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TABLE OF CONTENTS

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EXECUTIVE SUMMARY

Introduction

Despite having Medicare coverage, many low-income elderly and persons with disabilities have difficulty paying for all of their health care costs. These costs consist of Medicare coinsurance and deductibles, payments for services not covered by Medicare, and Medicare's monthly Part B (and sometimes Part A) premium. Several State Medicaid programs are available to pay for some or much of these costs for Medicare beneficiaries with low incomes and very limited assets, including the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, and the Qualifying Individuals (QI) programs.[1] Individuals eligible for both Medicare and Medicaid coverage through these and other available programs are collectively known as "dual eligibles."

Medicaid assistance programs can substantially reduce the financial burdens for Medicare beneficiaries, but a significant number of eligible beneficiaries are not enrolled. The Health Care Financing Administration (HCFA) has undertaken a number of efforts in the past to increase enrollment (Neumann, et al., 1995; U.S. General Accounting Office, 1994), and is continuing to conduct direct outreach and enrollment activities and to work with States and other local partners to develop and improve education and outreach activities related to the dual-eligible population.

Purpose of Report

A key step to improving outreach to Medicare beneficiaries who are potentially eligible for Medicaid assistance but are not enrolled is understanding who these beneficiaries are and what characteristics set them apart from beneficiaries who are enrolled. Profiling the characteristics of the enrolled and non-enrolled dual-eligible populations can be used to:

- Identify barriers to Medicaid program enrollment for non-enrolled beneficiaries;
- Develop appropriate messages to motivate individuals to find out more about Medicaid programs and to enroll in these programs; and
- Design targeted communication strategies to more effectively reach distinct segments of the potential dual-eligible population, and to improve outreach, education, and enrollment activities related to this population.

In the analysis for this report, estimates are made for the total number of Medicare beneficiaries living in community settings in 1996[2] who were potentially eligible for either the QMB or the SLMB program.[3] The estimated total number of potentially-eligible beneficiaries for each

[1] The QMB program pays the Medicare Part B premium (and sometimes the Medicare Part A premium) and Medicare coinsurance and deductibles, the SLMB program pays the Medicare Part B premium, and the QI programs pay either all of some of the Medicare Part B premium. Other Medicaid assistance includes the Qualified Disabled and Working Individuals (QDWI) program that pays the Medicare Part A premium, and full State Medicaid benefits that are provided by Medicaid providers, which are either combined with QMB or SLMB benefits or are independent of these programs ("Medicaid only").

[2] The analysis excludes beneficiaries who lived in short- or long-term care facilities in 1996.

[3] QMBs and SLMBs include beneficiaries who were only eligible for the particular program and those who were eligible for the program plus their State's full Medicaid benefits.

program is then split into two groups: (1) community-based beneficiaries who were enrolled in the QMB or SLMB program for at least one month in 1996, and (2) community-based beneficiaries who did not participate in the QMB or SLMB program throughout all of 1996. The analysis then examines, on a national level, the characteristics of community-based beneficiaries who were eligible and participated in the QMB or SLMB programs in 1996 versus those who were eligible for these programs but did not participate.

Key Findings

General Findings

- Almost one-fourth (24.1 percent) of the disabled and elderly non-institutionalized Medicare population is estimated to be eligible for either QMB or SLMB Medicaid assistance or were enrolled in a Medicare buy-in program in 1996 (QMB, SLMB, QI, QDWI, or Medicaid full benefits program).
- Similar to other recent estimates of the dual-eligible population, however, approximately 52.7 percent of beneficiaries eligible for the QMB or SLMB programs did not participate in these programs in 1996.4 Approximately 45.3 percent of Medicare beneficiaries estimated to be eligible for the QMB program were not enrolled in 1996, and 84.3 percent of those estimated to be eligible for the SLMB program were not enrolled.
- Outside of economic measures, being female, disabled, low educated, part of a non-White racial or ethnic group, single, or living in a rural area or a region outside of the Midwest was associated with a higher likelihood of being eligible for the QMB and SLMB programs in 1996. Beneficiaries with lower health status and lower measures of access to care were also more likely to be eligible for these programs.
- Beneficiary characteristics with the greatest range in eligibility estimates (outside of economic measures) are: Age (72 percent of beneficiaries 18 to 44 years old were estimated to be eligible vs. 18 percent of those 65 to 69 years old); education (66 percent of beneficiaries with only a 5th grade education or less were eligible vs. 5 percent of those with education beyond high school); race/ethnicity (60 percent of Hispanic beneficiaries were eligible vs. 17 percent of non-Hispanic White beneficiaries); and living arrangement (56 percent of beneficiaries who lived with relatives other than their children were eligible vs. 12 percent of beneficiaries who lived with their spouse).

QMB Profile

- A comparison of QMB-eligible beneficiaries who did not participate in the program with those who did participate in 1996 reveals the following statistically significant differences between the two groups.[5] Compared with participating QMB eligibles, non-participating QMB eligibles:
  - Had somewhat higher representation in the oldest age category (80 years or older);

[4] Figures are for Medicare beneficiaries who are disabled or elderly and who lived in community settings in 1996.
[5] These differences were all statistically significant at the 5 percent (or less) level of confidence in a Chi-square test of independence.

- ◊ Were over-represented in the White, non-Hispanic subgroup;
- ◊ Were substantially more likely to be married;
- ◊ Were slightly more likely to be living in urban rather than rural areas;
- ◊ Were over-represented in the Northeast and Midwest U.S. Census regions;
- ◊ Had slightly higher education levels;
- ◊ Were overwhelmingly less likely to be Social Security Income (SSI) or welfare program income recipients;
- ◊ Had higher home ownership rates;
- ◊ Reported being in much better health and were much less likely to have had an outpatient hospital visit in 1996;
- ◊ Were substantially more likely to have privately-purchased supplemental insurance; and
- ◊ Were more likely to be enrolled in a Medicare Health Maintenance Organization (HMO).

- ♦ Eligible beneficiaries with the lowest estimated QMB participation rates: *had private supplemental insurance* (15 percent); *were enrolled in a Medicare HMO* (22 percent); *did not receive SSI* (30 percent); *owned their home* (35 percent); and/or *were married* (39 percent).
- ♦ Other beneficiary characteristics for which less than one-half of the estimated eligible group were enrolled in the QMB program include beneficiaries who: *were 80 years old or older* (44 percent); *had graduated from high school* (47 percent); *lived with their spouse* (41 percent); *reported excellent* (46 percent) or *very good health* (44 percent); *had no outpatient visits* (43 percent); *did not have a usual place of care* (47 percent); and/or *did not receive welfare* (46 percent).
- ♦ Eligible beneficiaries with the highest estimated QMB participation rates: were *disabled and younger than 44 years old* (less than 18 years old – 100 percent; 18 to 44 years old – 76 percent); had *SSI income* (89 percent) or *welfare income* (84 percent); identified themselves as being of *"other" racial or ethnic descent* (71 percent)[6]; *rented their home* (68 percent); and/or were in *worse health* than other beneficiaries (self-reported poor health– 67 percent; limitations in two Activities of Daily Living (ADLs) – 68 percent).
- ♦ Outside of income and asset measures, the five beneficiary characteristics associated with the greatest range in estimated QMB participation rates are: *private insurance holdings* (66 percent for beneficiaries without private supplemental insurance vs. 15 percent for those with private insurance), *managed care enrollment* (57 percent for beneficiaries not enrolled in a Medicare HMO vs. 22 percent of those enrolled in an HMO), *age* (76 percent for beneficiaries 18 to 44 years old vs. 44 percent for those 80 years old or older), *self-reported health status* (67 percent for beneficiaries reporting poor health vs. 44 percent for those

[6] Other races and ethnicities include beneficiaries who do not identify themselves as African American, Hispanic, or White non-Hispanic.

reporting very good health), and *race/ethnicity* (71 percent for beneficiaries reporting "other" races/ethnicities[7] vs. 50 percent of non-Hispanic White beneficiaries).

- The following beneficiary characteristics had no statistically significant affect on whether or not Medicare beneficiaries participated in the QMB program:
  - Gender;
  - Presence of ADL limitations;
  - Inpatient hospital stays, SNF admissions, home health visits; and
  - Receipt of a flu shot; or
  - Having a usual place of care.

SLMB Profile

- A comparison of SLMB-eligible beneficiaries who did not participate in the program with those who did participate in 1996 reveals the following statistically significant differences between the two groups.8 Compared with participating SLMB eligibles, non-participating SLMB eligibles:
  - Had somewhat higher representation in the oldest age category (80 years or older);
  - Were substantially more likely to be married;
  - Were less likely to be welfare program income recipients;
  - Had higher home ownership rates;
  - Reported being in much better health and were much less likely to have had an inpatient hospital stay, outpatient hospital visit, or home health visit;
  - Were less likely to have had a flu shot or to have a usual place for care; and
  - Were substantially more likely to have privately-purchased supplemental insurance.
- Eligible beneficiaries with the lowest estimated SLMB participation rates: reported *excellent health* (5 percent) or *very good health* (8 percent); *had private supplemental insura*nce (5 percent); *had no usual place of care* (8 percent); *owned their home* (10 percent); and/or identified themselves as being of *Hispanic* descent (10 percent).
- Eligible beneficiaries with the highest estimated SLMB participation rates: reported *receiving SSI income* (44 percent) or *welfare income* (58 percent); *used health services* (had a hospital stay – 24 percent; had a SNF stay – 25 percent; had a home health visit – 25 percent); were *disabled and 18 to 44 years old* (29 percent); did *not have private supplemental insurance* (23 percent); and/or *rented their home* (22 percent).
- Outside of income and asset measures, the five beneficiary characteristics associated with the greatest range in estimated SLMB participation rates are: *education* (19 percent for beneficiaries with a 5th grade education or less vs. 0 percent for those with more than a high school education); *age* (29 percent for beneficiaries 18 to 44 years old vs. 10 percent for

[7] Other races/ethnicities include beneficiaries who do not identify themselves as African American, Hispanic, or White non-Hispanic.

[8] These differences were all statistically significant at the 5 percent (or less) level of confidence in a Chi-square test of independence.

those 75 years old or older), *private insurance holdings* (23 percent for beneficiaries without private supplemental insurance vs. 5 percent for those with private insurance); *self-reported health status* (19 percent for beneficiaries reporting poor health vs. 5 percent for those reporting excellent health), and *home health visits* (25 percent for beneficiaries reporting a home health visit vs. 12 percent of those reporting no home health visits).

- The following beneficiary characteristics had no statistically significant affect on whether or not Medicare beneficiaries participated in the SLMB program:
  - Gender;
  - Race/ethnicity;
  - Urban/rural status;
  - Education level;
  - SSI recipient;
  - Presence of ADL limitations;
  - SNF admissions; and
  - Medicare HMO enrollment.

Comparison of QMB and SLMB Profiling Results

- Several beneficiary characteristics associated with greater program non-participation are common to both the QMB and the SLMB programs. These include beneficiaries who were:
  - 80 years old or older;
  - Married;
  - Not welfare income recipients;
  - Homeowners;
  - In better health and less likely to have an outpatient visit; and
  - Private supplemental insurance policyholders.
- The following beneficiary characteristics associated with greater QMB program non-participation had no statistically significant effect on SLMB participation vs. non-participation. This could be due to the much lower SLMB participation rates for all categories of beneficiaries so that differences among subgroups are not statistically detectable.
  - Race/ethnicity;
  - Urban/rural status;
  - U.S. Census region;
  - Education level;
  - SSI participation; and
  - Medicare HMO enrollment.
- The following beneficiary characteristics associated with greater SLMB program non-participation had no statistically significant effect on QMB participation vs. non-participation:
  - Inpatient stay or home health visit;
  - Receipt of a flu shot; or

◊ Having a usual place for care.

Implications for Outreach to Potential QMB- and SLMB-Eligible Populations

♦ The profiling results for the QMB- and SLMB-eligible populations indicate there are two general categories of beneficiaries who have relatively low participation rates compared to their counterparts.

1. The first category consists of beneficiaries who are often considered to be the most financially vulnerable and "hard-to-reach." This category includes very elderly beneficiaries, Hispanic-Latino beneficiaries, and beneficiaries who appear to have less contact with the health care system (i.e., beneficiaries who did not receive a flu shot in 1996 and those who reported they did not have a usual source of care).

   ◊ Very elderly beneficiaries had lower participation rates in both the SLMB and QMB programs compared with their younger counterparts. These beneficiaries tend to be female, live alone or with their children, have very low income levels, are in poor health, and may be relatively isolated from the rest of the community. Communication sources and modes that are most preferred by this subgroup (e.g., audio and video-enhanced communication, easy-to-read materials, and the use of senior centers to distribute information) are possible ways to increase participation. Our current inventory research on outreach to dual eligibles indicates that beneficiaries who have someone to help them collect the required application documents, fill out forms, and manage the in-office segment of the application process are the most likely to successfully enroll in dual eligible programs. This type of help is very resource intensive, but extremely effective and well received by beneficiaries. In cases where face-to-face help is not available, a working phone number connected to a well-informed source is also very helpful.

   ◊ Hispanic-Latino beneficiaries had one of the lowest participation rates for SLMBs and lower participation in the QMB program compared with African American beneficiaries and beneficiaries of other races/ethnicities. Our communications research indicates that this group of beneficiaries may have poor literacy skills in both English and Spanish and need written materials to be at most a 4th grade reading level and properly translated into Spanish. Other communication modes (e.g., toll-free telephone lines) should also be available in both English and Spanish. This population tends to rely on families, friends, and community networks for much of their information about the Medicare program (Matthies, 1999). Use of Spanish language radio and print media can also broaden the reach of the message about dual eligibility.

   ◊ Beneficiaries who do not have as much contact with the health care system may be relatively healthy beneficiaries who do not feel they need Medicaid assistance, or they may be relatively isolated beneficiaries who have difficulty getting to their health provider or paying for health care. Either way, these beneficiaries are probably not receiving QMB and SLMB program information through their providers and require other outreach approaches. Current dual-eligible outreach research under this contract indicates that an effective way that organizations reach dual eligibles is by linking their outreach activities with other programs that serve low-income seniors.

Many groups make dual eligible program information a supplemental or complementary component of a more established or larger education/outreach activity, such as for Medicare+Choice campaigns, food stamps, or general health education.

2. The second general category of beneficiaries with comparatively low QMB and SLMB participation rates consists of beneficiaries who may not traditionally be considered hard-to-reach but still may be difficult to communicate with. This category comprises Medicare beneficiaries who are relatively better off (although, by definition, they still have low incomes and assets and need assistance in paying their health care bills). It includes beneficiaries who identify themselves as White non-Hispanic, are married, have relatively high formal education levels, are homeowners, are in relatively good health, do not receive SSI or welfare income, and have private supplemental insurance.

   ◊ To tailor messages and communication channels to more effectively reach these beneficiaries, it will be important for HCFA to better understand how the above characteristics overlap and which characteristics are the most important for designing communications. For example, the most important factor may be that they can afford private supplemental insurance and do not feel they want or need to go through the sometimes difficult process of enrolling in a Medicaid assistance program. Additionally, beneficiaries eligible for QMB benefits may not want to give up their private supplemental policy since QMB-only benefits do not cover prescription drugs. It may not be possible to persuade many of these beneficiaries to enroll in the QMB or SLMB programs. However, it may be that the overriding characteristic for this group is their good health and low health care costs, and they do not see the benefits of applying for the programs. These individuals would likely be quite passive in seeking information about dual eligibility. Our communications research for HCFA has found that getting a message to passive information seekers is difficult and potentially expensive. The outreach needs to be aggressive and multi-faced, using a variety of communications approaches.

   ◊ There are at least three reasons why the second category of beneficiaries may have low QMB and SLMB participation rates, each calling for a different approach to outreach design.

      a. Beneficiaries may be unaware of the QMB and SLMB programs. Our market research found that many beneficiaries had never heard of the QMB, SLMB, or QI programs, and that even some social service workers and community groups who provide services to the elderly are not aware of the programs (Edder, 1999). Outreach strategies need to include communication sources, channels, and modes that are more often used by these beneficiaries. They may not hear about the programs through channels that less financially well-off or less healthy beneficiaries might use, such as through the SSI or welfare program offices or through hospitals, public health clinics, or other providers that tend to be more aware of programs available to low-income seniors.

         ◊ The analysis indicates that this group of Medicare beneficiaries are somewhat more mainstream than those with higher QMB and SLMB participation, yet still have relatively low incomes.

- The outreach message should emphasize how the programs can help with their Medicare bills.
- Sources or partners for reaching this population might include:
  - Senior centers;
  - HMOs (because this group has higher Medicare HMO enrollment);
  - AARP or other senior-oriented organizations.
- Since this a quite diverse group, further research is probably needed to help identify the best sources and modes of communication.

b. Beneficiaries may be aware of the programs but are confused about eligibility requirements and think their incomes or assets are too high. They may also not know where or how to apply. Our market research on dual-eligible beneficiaries found that queries regarding the QMB, SLMB, and QI programs center on eligibility requirements. Specifically, beneficiaries do not understand the concepts of "federal poverty level" and "resources" (Edder, 1999).

   ◊ For example, there is a common misconception that an individual's home is counted as a resource, although this is not the case. This is one possible explanation for the very low participation rates of homeowners in both the QMB and SLMB programs. Successful outreach and enrollment depends on people having the correct information about eligibility, written in a way they can easily understand.

   ◊ Beneficiaries who have heard about the QMB, SLMB, or QI programs may need assistance and more information on the application process and where to apply.

c. Some beneficiaries may not feel that the benefits of the program outweigh the time and effort costs of enrolling. Outreach strategies can attack this problem through several different routes.

   ◊ Outreach messages should stress the benefits of the buy-in programs in a way that specifically address the needs and preferences of this group.

   - Messages that attract people are those that focus on how the programs can help provide access to prescription drug coverage (for full Medicaid dual eligibles), or can help "put money back in your pocket" so the beneficiary can afford to pay for their prescription drug costs or pay for more comprehensive coverage through a Medigap policy (for non-full Medicaid QMBs, SLMBs, and QIs).

   ◊ Many beneficiaries in this group, such as those who are in relatively better health, may not feel it is worth the time and effort to apply for Medicaid assistance. To induce such beneficiaries to enroll, the time and effort of enrolling must be reduced. Outreach and enrollment strategies should focus on making the application process as easy as possible and messages should

emphasize the simplicity of applying for benefits (if the process has been streamlined).

- It is interesting that the beneficiary characteristics associated with greater SLMB non-participation but that do not appear to significantly affect QMB participation are all connected to contact with the health care system. Beneficiaries will less contact had lower SLMB participation compared with those with more contact. Outreach campaigns that mimic those of the Centers for Disease Control and Prevention's public health campaigns (e.g., for increasing child immunization rates) might be effective for reaching people who are relatively healthy.
- QMB and SLMB participation is clearly connected to SSI and welfare program participation, although less so for the SLMB program.
  - Increasing the number of States who "auto-accrete" their SSI enrollees into Medicare buy-in programs may increase enrollment.
  - A survey of State outreach programs for dual-eligibles conducted under this HCFA contract found that States believe they must be sensitive to the "welfare stigma" sometimes associated with Medicare buy-in programs (Shaner, 1999). An effective message identified by Rosenbach and Lamphere (1999) is that the QMB and SLMB programs provide a benefit that people have earned by working hard and is not a government "handout."

INTRODUCTION

Despite having Medicare coverage, many low-income elderly and persons with disabilities still have difficulty paying for all of their health care costs. These costs include the share of expenses not paid for by the Medicare program (i.e., coinsurance and deductibles), the costs of non-Medicare covered benefits, and the monthly premium that allows beneficiaries to receive Part B (and sometimes Part A) Medicare benefits. Several State Medicaid programs are available that pay these Medicare costs, or provide full Medicaid benefits, for certain elderly and disabled persons who have low incomes and very limited assets, all of whom, collectively, are known as "dual-eligibles."

Medicaid assistance programs can substantially reduce the financial burdens for Medicare beneficiaries, but significant numbers of eligible beneficiaries are not enrolled. The Health Care Financing Administration (HCFA) has undertaken a number of efforts in the past to increase enrollment (Neumann, et al., 1995; U.S. General Accounting Office, 1994), and is continuing to conduct direct outreach and enrollment activities and to work with States and other local partners to develop and improve education and outreach activities related to the dual-eligible population.

PURPOSE OF REPORT

A key step to improving outreach to Medicare beneficiaries who are potentially eligible for Medicaid assistance but are not enrolled is an understanding of who these beneficiaries are and what characteristics set them apart from Medicare beneficiaries who are enrolled. Profiling the characteristics of the enrolled and non-enrolled dual-eligible populations can be used to:

- Identify barriers to Medicaid program enrollment for non-enrolled beneficiaries;
- Develop appropriate messages to motivate individuals to find out more about Medicaid programs and to enroll in these programs; and
- Design targeted communication strategies to more effectively reach distinct segments of the potential dual-eligible population, and to improve outreach, education, and enrollment activities related to this population.

Numerous reports have indicated that the Medicaid protections are not reaching all or even a sizable fraction of those who are eligible and could benefit from coverage. The main focus of this report, however, is not on estimating the non-participating dual-eligible population and does not represent the methodology or figures for HCFA's official estimates. Rather, the primary purpose of this report is to examine the characteristics of beneficiaries who were eligible and participated in Medicare buy-in programs in 1996 versus those who were eligible but did not participate in these programs.

In this analysis, estimates are made for the total number of Medicare beneficiaries living in community settings in 1996[9] who are potentially eligible for either the QMB program or the

[9] The analysis excludes beneficiaries living in short- or long-term care facilities in 1996.

SLMB program.[10] The estimated total number of potentially-eligible beneficiaries for each program are then split into two groups: (1) community-based beneficiaries who were enrolled in the QMB and SLMB programs for at least one month in 1996, and (2) community-based beneficiaries who did not participate in the QMB or SLMB programs throughout all of 1996. The analysis then examines, on a national level, the characteristics of community-based beneficiaries who were eligible and participated in the QMB or SLMB programs in 1996 versus those who were eligible for these programs but did not participate.

BACKGROUND

Historically, certain low-income beneficiaries have been eligible for both Medicare and Medicare. Prior to 1989, Medicare beneficiaries were eligible for Medicaid often because they qualified for Supplemental Security Income (SSI)[11] – the cash assistance program for aged, blind, or disabled people with low incomes – or because they were considered to be medically needy.[12] These Medicare beneficiaries were eligible for full Medicaid benefits, including services covered by the individual's State Medicaid program but not covered by Medicare, such as vision care, dental benefits, or prescription drugs. States also had the option to pay their Medicare premiums and deductibles (i.e., States could "buy-in" to the Medicare program). In 1988, however, the Congress passed the Qualified Medicare Beneficiary (QMB) program under the Medicare Catastrophic Coverage Act,[13] which required State Medicaid programs to pay the Part B (and Part A if necessary) Medicare premiums, deductibles, and coinsurance amounts for Medicare beneficiaries with incomes at or below the poverty level and assets not exceeding twice the limits set for SSI. Since 1995, States have also been required under the Specified Low-Income Medicare Beneficiary (SLMB) program to pay the Part B premium, but not deductibles or coinsurance, for Medicare beneficiaries with incomes above 100 percent, but less than 120 percent of poverty and assets not exceeding twice the SSI limits.

The Balanced Budget Act of 1997 (BBA) introduced further provisions for low-income Medicare beneficiaries. As of January 1, 1998, Medicare beneficiaries with incomes above 120 percent but less than 135 percent of poverty and assets not exceeding twice the SSI limits (Qualifying Individuals-1 or QI-1s), and who are otherwise not eligible for Medicaid coverage, are eligible through a State capped program to apply for payment of their Part B premiums from their State's Medicaid program. Qualifying Individuals-2 (QI-2s), who have incomes above 135 percent, but less than 175 percent of poverty and assets not exceeding twice the SSI limits and who are not otherwise eligible for Medicaid coverage are eligible through a State capped program for partial payment of their Medicare Part B premium ($1.07 per month in 1998).

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[10] QMBs and SLMBs include beneficiaries who were only eligible for the particular program and those who were eligible for the program plus their State's full Medicaid benefits.

[11] To qualify for SSI, an individual must be 65 or older, blind or disabled, have qualifying income, and have no more than $2,000 in assets (if single) and $3,000 in assets (if married). Asset amounts exclude the value of the person's or couple's home and certain other items.

[12] The medically need group comprises the aged and disabled, many of whom are in nursing homes, who are ineligible for SSI but whose health bills are so high that their net incomes put them near or below the poverty level (Moon, Brennan, and Sigal, 1998).

[13] The Act was largely repealed in 1989 but the QMB program was retained.

Within the QMB and SLMB categories of dual eligibility, individuals may be eligible only for the specific Medicare cost-sharing benefits or they may be eligible for both the Medicare cost-sharing benefits and their State's full Medicaid benefits. Appendix A describes the various categories of individuals who are known as dual eligibles.

KEY FINDINGS

General Findings

- Almost one-fourth (24.1 percent) of the disabled and elderly non-institutionalized Medicare population is estimated to be either eligible for QMB or SLMB Medicaid assistance or were enrolled in a Medicare buy-in program in 1996 (QMB, SLMB, QI, QDWI, or Medicaid only).
- Similar to other recent estimates of the dual-eligible population, however, approximately 52.7 percent of beneficiaries eligible for the QMB or SLMB programs did not participate in these programs in 1996.[14] Approximately 45.3 percent of Medicare beneficiaries estimated to be eligible for the QMB program were not enrolled in 1996, and 84.3 percent of those estimated to be eligible for the SLMB program were not enrolled.
- Outside of economic measures, *being female, disabled, low educated, part of a non-White racial or ethnic group, single,* or *living in a rural area* or *a region outside of the Midwest* was associated with a higher likelihood of being eligible for the QMB and SLMB programs in 1996. Beneficiaries with *lower health status* and *lower measures of access to care* were also more likely to be eligible for these programs.
- Beneficiary characteristics with the greatest range in eligibility estimates (outside of economic measures) are: *Age* (72 percent of beneficiaries 18 to 44 years old were estimated to be eligible vs. 18 percent of those 65 to 69 years old); *education* (66 percent of beneficiaries with only a 5th grade education or less were eligible vs. 5 percent of those with education beyond high school); *race/ethnicity* (60 percent of Hispanic beneficiaries were eligible vs. 17 percent of non-Hispanic White beneficiaries); and *living arrangement* (56 percent of beneficiaries who lived with relatives other than their children were eligible vs. 12 percent of beneficiaries who lived with their spouse).

QMB Profile

- A comparison of QMB-eligible beneficiaries who did not participate in the program with those who did participate in 1996 reveals the following statistically significant differences between the two groups.[15] Compared with participating QMB eligibles, non-participating QMB eligibles:
  - ◊ Had somewhat higher representation in the oldest age category (80 years or older);

[14] Figures are for Medicare beneficiaries who are disabled or elderly and who lived in the community in 1996.
[15] These differences were all statistically significant at the 5 percent (or less) level of confidence in a Chi-square test of independence.

- ◊ Were over-represented in the White, non-Hispanic subgroup;
- ◊ Were substantially more likely to be married;
- ◊ Were slightly more likely to be living in urban rather than rural areas;
- ◊ Were over-represented in the Northeast and Midwest U.S. Census regions;
- ◊ Had slightly higher education levels;
- ◊ Were overwhelmingly less likely to be Social Security Income (SSI) or welfare program income recipients;
- ◊ Had higher home ownership rates;
- ◊ Reported being in much better health and were much less likely to have had an outpatient hospital visit in 1996;
- ◊ Were substantially more likely to have privately-purchased supplemental insurance; and
- ◊ Had higher enrollment rates in Medicare Health Maintenance Organizations (HMOs).

- ♦ Eligible beneficiaries with the lowest estimated QMB participation rates: *had private supplemental insurance* (15 percent); *were enrolled in a Medicare (HMO)* (22 percent); *did not receive SSI* (30 percent); *owned their home* (35 percent); and/or *were married* (39 percent).
- ♦ Other beneficiary characteristics for which less than one-half of the estimated eligible group were enrolled in the QMB program include beneficiaries who: *were 80 years old or older* (44 percent); *had graduated from high school* (47 percent); *lived with their spouse* (41 percent); *reported excellent* (46 percent) or *very good health* (44 percent); *had no outpatient visits* (43 percent); *did not have a usual place of care* (47 percent); and/or *did not receive welfare* (46 percent).
- ♦ Eligible beneficiaries with the highest estimated QMB participation rates: were *disabled and younger than 44 years old* (less than 18 years – 100 percent; 18 to 44 years – 76 percent); had *SSI income* (89 percent) or *welfare income* (84 percent); identified themselves as "other" *race/ethnicity* (71 percent)[16]; *rented their home* (68 percent); and/or were in *worse health* than other beneficiaries (self-reported poor health status – 67 percent; limitations in two Activities of Daily Living (ADLs) – 68 percent).
- ♦ Outside of income and asset measures, the five beneficiary characteristics associated with the greatest range in estimated QMB participation rates are: *private insurance holdings* (66 percent for beneficiaries without private supplemental insurance vs. 15 percent for those with private insurance), *managed care enrollment* (57 percent for beneficiaries not enrolled in a Medicare HMO vs. 22 percent of those enrolled in an HMO), *age* (76 percent for beneficiaries 18 to 44 years old vs. 44 percent for those 80 years old or older), *self-reported health status* (67 percent for beneficiaries reporting poor health vs. 44 percent for those

[16] Other races/ethnicities include beneficiaries who do not identify themselves as African American, Hispanic, or White, non-Hispanic.

reporting very good health), and *race/ethnicity* (71 percent for beneficiaries reporting "other" races/ethnicities[17] vs. 50 percent of non-Hispanic White beneficiaries).

- The following beneficiary characteristics had no statistically significant affect on whether or not Medicare beneficiaries participated in the QMB program:
  - Gender;
  - Presence of ADL limitations;
  - Inpatient hospital stays, SNF admissions, home health visits; and
  - Receipt of a flu shot or having a usual place of care.

SLMB Profile

- A comparison of SLMB-eligible beneficiaries who did not participate in the program with those who did participate in 1996 reveals the following statistically significant differences between the two groups.[18] Compared with participating SLMB eligibles, non-participating SLMB eligibles:
  - Had somewhat higher representation in the oldest age category (80 years or older);
  - Were substantially more likely to be married;
  - Were less likely to be welfare program income recipients;
  - Had higher home ownership rates;
  - Reported being in much better health and were much less likely to have had an inpatient hospital stay, outpatient hospital visit, or home health visit in 1996;
  - Were less likely to have had a flu shot or usual place of care in 1996; and
  - Were substantially more likely to have privately-purchased supplemental insurance.
- Eligible beneficiaries with the lowest estimated SLMB participation rates: reported *excellent health* (5 percent) or *very good health* (8 percent); *had private supplemental insura*nce (5 percent); *had no usual place of care* (8 percent); *owned their home* (10 percent); and/or identified themselves as being of *Hispanic* descent (10 percent).
- Eligible beneficiaries with the highest estimated SLMB participation rates: reported *SSI income* (44 percent) or *welfare income* (58 percent); *used health services* (had a hospital stay – 24 percent; had a SNF stay – 25 percent; had a home health visit – 25 percent); were *disabled and 18 to 44 years old* (29 percent); did *not have private supplemental insurance* (23 percent); and/or *rented their home* (22 percent).
- Outside of income and asset measures, the five beneficiary characteristics associated with the greatest range in estimated SLMB participation rates are: *education* (19 percent for beneficiaries with a 5th grade education or less vs. 0 percent for those with more than a high school education); *age* (29 percent for beneficiaries 18 to 44 years old vs. 10 percent for those 75 years old or older), *private insurance holdings* (23 percent for beneficiaries without

[17] Other races/ethnicities include beneficiaries who do not identify themselves as African American, Hispanic, or White, non-Hispanic.

[18] These differences were all statistically significant at the 5 percent (or less) level of confidence in a Chi-square test of independence.

private supplemental insurance vs. 5 percent for those with private insurance); *self-reported health status* (19 percent for beneficiaries reporting poor health vs. 5 percent for those reporting excellent health), and *home health visits* (25 percent for beneficiaries reporting a home health visit vs. 12 percent of those reporting no home health visits).

- The following beneficiary characteristics had no statistically significant affect on whether or not Medicare beneficiaries participated in the SLMB program:
  - Gender;
  - Race/ethnicity;
  - Urban/rural status;
  - Education level;
  - SSI recipient;
  - Presence of ADL limitations;
  - SNF admissions; and
  - Medicare HMO enrollment.

Comparison of QMB and SLMB Profiling Results

- Several beneficiary characteristics associated with greater program non-participation are common to both the QMB and the SLMB programs. These include beneficiaries who were:
  - 80 years old or older;
  - Married;
  - Not welfare recipients;
  - Homeowners;
  - In better health and less likely to have an outpatient visit; and
  - Private supplemental insurance policyholders.
- The following beneficiary characteristics associated with greater QMB program non-participation had no statistically significant effect on SLMB participation vs. non-participation. This could be due to the much lower SLMB participation rates for all beneficiaries so that differences among subgroups of beneficiaries is not statistically detectable.
  - Race/ethnicity;
  - Urban or rural status;
  - U.S. Census region;
  - Education level;
  - SSI participation; and
  - Medicare HMO enrollment.
- The following beneficiary characteristics associated with greater SLMB program non-participation had no statistically significant effect on QMB participation vs. non-participation:
  - Inpatient stay or home health visit;
  - Receipt of a flu shot; or
  - Having a usual place for care.

ESTIMATE OF POTENTIAL QMB- AND SLMB-ELIGIBLES[19]

Estimate of Beneficiaries Potentially Eligible for the QMB and SLMB Programs

The primary data source used in this study is the Medicare Current Beneficiary Survey (MCBS). The 1997 Income and Asset Supplement to the MCBS was used to estimate Medicare beneficiaries who were potentially eligible for a Medicare buy-in program in 1996, by buy-in eligibility (Part A, Part B, QMB, SLMB). Estimates of potentially-eligible individuals were then separated into those who were enrolled in the Medicare buy-in program and those who were not enrolled in the buy-in program in 1996, using HCFA's Medicare buy-in files. Profiling variables were selected from the 1996 MCBS Access to Care files. This study focuses on beneficiaries who were living in community settings at the time of the MCBS surveys, representing approximately 35.3 million disabled and aged community-based beneficiaries.[20]

Of the 35.3 million Medicare beneficiaries, 8.51 million beneficiaries, or one-fourth (24.1 percent), were estimated to be eligible and/or were enrolled in Medicare buy-in programs in 1996.[21] Beneficiaries enrolled in the buy-in programs in 1996 accounted for 11.4 percent of the community-based Medicare beneficiary population. Similar to other recent estimates of the dual-eligible population (see Table 1 in Appendix C), over one-half (52.7 percent) of the potentially dual-eligible population did not participate in their State's Medicare buy-in program in 1996.[22] Approximately 45.3 percent of Medicare beneficiaries eligible for the QMB program were not enrolled in 1996, and 84.3 percent of those eligible for the SLMB program did not participate.

Comparison of Actuarial Research Corporation and Barents Group Estimates

The Actuarial Research Corporation (ARC), under contract to HCFA, recently developed estimates of the number of Medicare beneficiaries potentially eligible for Medicaid payment of their Part B premiums who were not enrolled in Medicare buy-in programs as of July 1996 (Actuarial Research Corporation, 1999). In the aggregate, ARC estimated that a total of approximately 9.12 million Medicare beneficiaries were potentially eligible for buy-in, of whom 54 percent, or roughly 5 million, were actually bought in as of July 1996. This report, produced by Barents Group under contract to HCFA, also develops an estimate of the potential dual eligible population for 1996. Barents estimates that approximately 8.51 million Medicare beneficiaries were eligible for and/or enrolled in a Medicare Part B buy-in program during 1996, of whom about 47.4 percent, or 4 million, were actually bought in at least one month during 1996.

While ARC and Barents present two different estimates of the size of the potential dual eligible population, it is important to note that the estimates apply to different groups of Medicare beneficiaries, were arrived at through different methodologies, employed different datasets, and,

[19] The MCBS data do not support State-level estimates of the dual eligible population. Therefore, estimates and profiling were done on a national basis.
[20] See Appendix B for a more detailed methodology for the estimates of potential dual eligibles.
[21] Some Medicare beneficiaries reported as enrolled in a Medicare buy-in program in 1996 were not estimated to be eligible for these programs. See Appendix B for possible explanations for this result.
[22] These figures are for Medicare beneficiaries who are disabled or elderly and who lived in the community in 1996.

most importantly, were derived for different purposes. The primary purpose of the ARC contract was to develop for HCFA the most accurate estimate possible with existing data of the aggregate number of Medicare beneficiaries who are eligible for Medicaid assistance but who are not enrolled in Medicaid programs. ARC also developed comparable estimates for each State and the District of Columbia. HCFA intends to use these estimates as a starting point for setting national and State baseline enrollment figures and enrollment targets for dual eligibles. These targets will help HCFA and States assess the effectiveness of outreach and education campaigns aimed at enrolling more potential dual eligibles.

ARC's estimates – for use in determining aggregate enrollment baselines and enrollment targets – do not require identifying on an individual basis which beneficiaries are or are not enrolled in buy-in programs and their characteristics. ARC's estimates do, however, require the use of the most accurate income and asset data to estimate beneficiaries who are potentially eligible for buy-in status, which is why they employed the Current Population Survey (CPS) income data and the Survey of Income and Program Participation (SIPP) asset data. The percentage of estimated potential eligibles enrolled in Medicare buy-in programs in 1996 was arrived at through an aggregate accounting of Medicare beneficiaries bought in to Medicaid as of July 1996. Because HCFA wanted an estimate of the total dual eligible population, this involved estimating the number of institutionalized Medicare beneficiaries potentially eligible for buy-in status[23] and the number of individuals eligible for buy-in as full Medicaid recipients as well as QMBs and SLMBs.

In contrast to ARC's work, the primary purpose of Barents' study is to compare the characteristics of beneficiaries who are eligible for Medicare buy-in but are not bought in, with characteristics of beneficiaries who are eligible and actually enrolled in a Medicare buy-in program. Rather than setting baselines figures for assessing the effectiveness of outreach and education campaigns, Barents' results will help HCFA and States better understand who the unenrolled, but potentially eligible, population is in order to better design and target these outreach and education campaigns. Comparing the profiles of two populations requires an individual, rather than aggregate, accounting of who is and is not enrolled in a Medicare buy-in program, what type of program they are enrolled in, and individual characteristics of these beneficiaries. Barents, therefore, relied on the Medicare Current Beneficiary Survey (MCBS) income and asset data to estimate potential dual eligibles because this data can be linked on a person-level basis to MCBS Medicare buy-in data and to other segments of the MCBS that contain beneficiary attributes (e.g., age, race/ethnicity, marital status, health status, and insurance holdings). MCBS income and asset data are not available for the Medicare institutionalized population,[24]so they are not included in Barents' estimates or profiling activity. Full Medicaid benefits dual eligibles are not identified on the MCBS and are included in the profiling activity to the extent they are also eligible for QMB or SLMB buy-in status.

[23] ARC estimated the institutional population that is potentially eligible based on data from the 1995 Medicare Current Beneficiary Survey (MCBS).

[24] Income data is imputed for institutionalized beneficiaries on an annual basis, but was not yet available for 1996. No asset data is available, either actual or imputed, for institutionalized beneficiaries.

PROFILING RESULTS[25]

Based on data availability, prior research on "hard-to-reach" populations, and a previous examination of the characteristics of participating and non-participating QMB-eligibles in 1992 (Neumann, et al., 1995), a number of variables were selected from the MCBS to profile the eligible participating and non-participating QMB and SLMB populations.[26] Comparisons of characteristics of Medicare beneficiaries who were eligible for these buy-in programs in 1996 but did not participate with characteristics of beneficiaries who were eligible and did participate produce the following results:

Demographic Characteristics

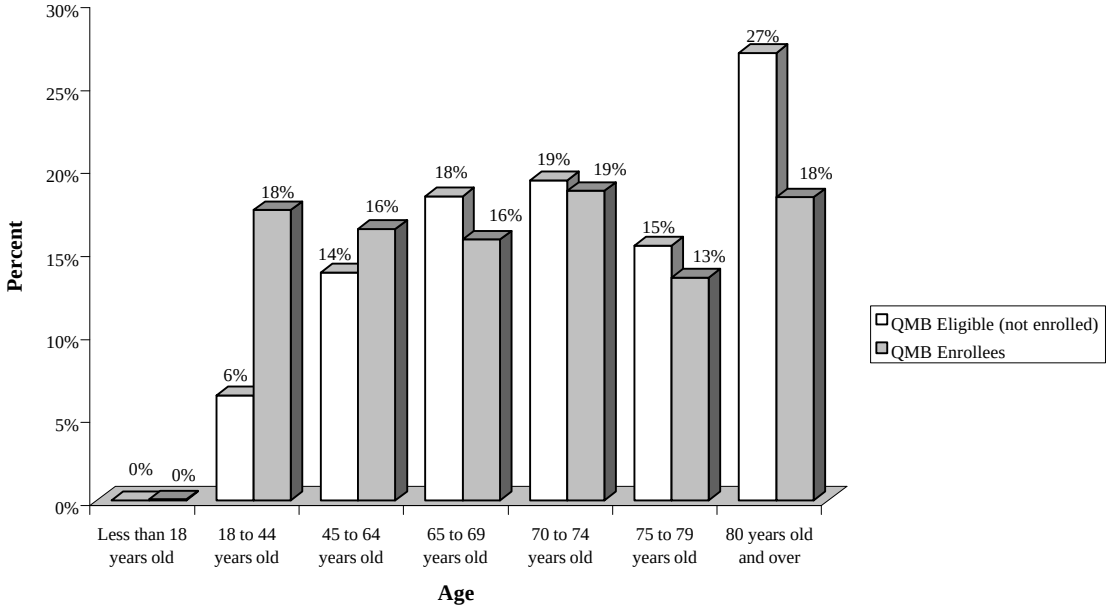
***Age*:** A much higher proportion of disabled Medicare beneficiaries (those age 64 or younger) were estimated to be eligible for the QMB or SLMB programs than elderly Medicare beneficiaries (see Table 2 in Appendix C). Almost three-fourths of Medicare beneficiaries between the ages of 18 and 44 and almost one-half of those 45 to 64 years old were estimated to be eligible, in contrast to an estimated one-fifth of beneficiaries in the 65 to 79 year old categories and one-fourth of beneficiaries' 80 years old or older (Table 2).

Although a lower fraction of elderly beneficiaries may be eligible for QMB or SLMB buy-in, their participation rate was lower than disabled beneficiaries, most likely because a higher percentage of disabled beneficiaries have contact with the SSI program and automatic enrollment in the QMB or SLMB programs. In a bivariate comparison of QMB-eligibles who were not enrolled in the QMB program and QMB enrollees, non-participating beneficiaries were found to be somewhat older than those who participated. For example, 27 percent of non-participants were 80 years old or older compared with 18 percent of participants in that age group (Figure 1a). This is reflected most markedly in the lower QMB participation rates of the oldest age cohort shown in Table 3 in Appendix C, with only 44 percent of eligible beneficiaries 80 years old or older enrolled in 1996. Older beneficiaries may be more isolated from community organizations and be less likely to hear about the QMB or SLMB programs, have a more difficult time getting to a welfare office to sign up for Medicaid programs due to greater health problems, and may be less likely to have a spouse or someone else who can help with this process.

[25] Statistical significance for Figures 1a through 21b is based on a Chi-square test of independence between QMB or SLMB enrollment and the variable of interest. Only those with a confidence level of 5 percent or less were considered to be statistically dependent.

[26] In a multivariate comparison of potential QMB enrollees with current QMB enrollees, Neuman, et al., (1995) found that the following characteristics were associated with greater participation in the program: being female, low income, low education, racial/ethnic minority membership, non-home ownership, region (with the South having the highest participation rate), poorer self-reported health, and greater ADL limitations.

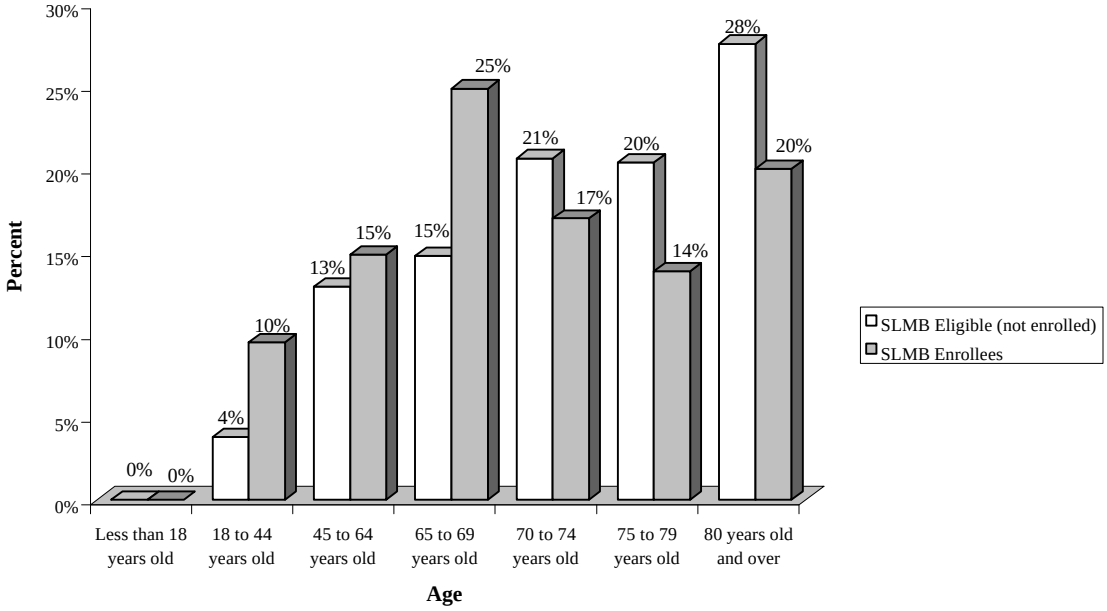
Figure 1a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Age - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

A bivariate comparison of SLMB-eligibles who were not enrolled in the SLMB program and SLMB enrollees similarly indicates that enrollment was statistically dependent on age (Figure 1b). As with QMB eligibles, SLMB non-participants tended to be older than SLMB participants. Again, this is reflected in the lower SLMB participation rates of the two oldest age cohorts shown in Table 3, with less than10 percent participation for those ages 75 or older compared with almost 30 percent for beneficiaries 18 to 44 years old.

Figure 1b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Age - 1996*

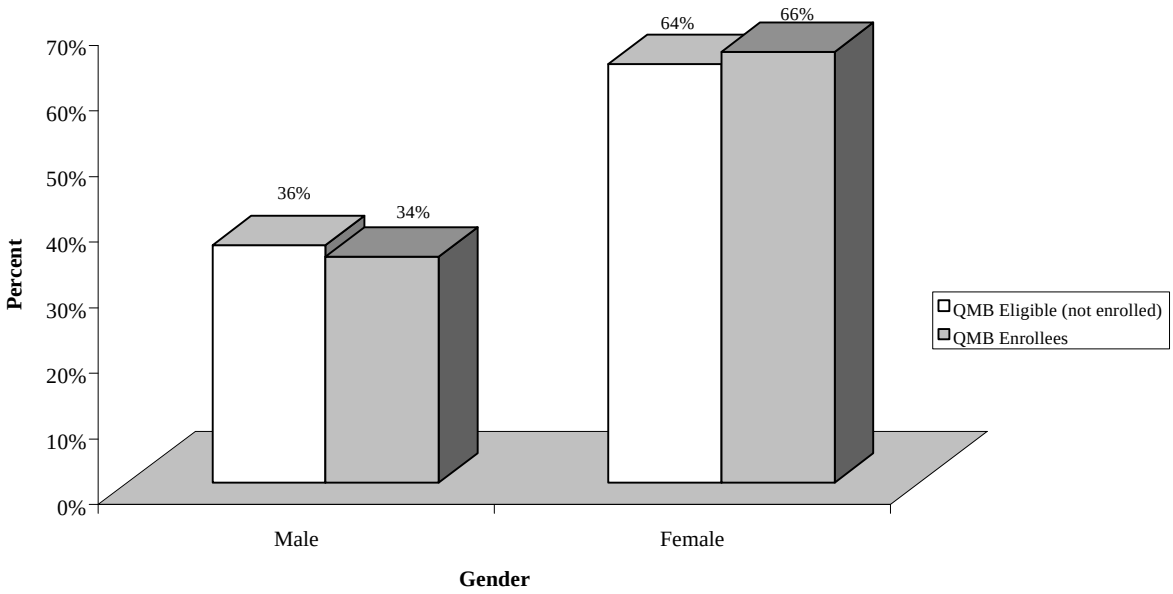


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at the 3 percent level.

Gender: A higher fraction of female Medicare beneficiaries are potentially eligible for the QMB or SLMB programs than male beneficiaries (Table 2). About 20 percent of all male beneficiaries and 28 percent of all female beneficiaries are estimated to be eligible for this assistance.

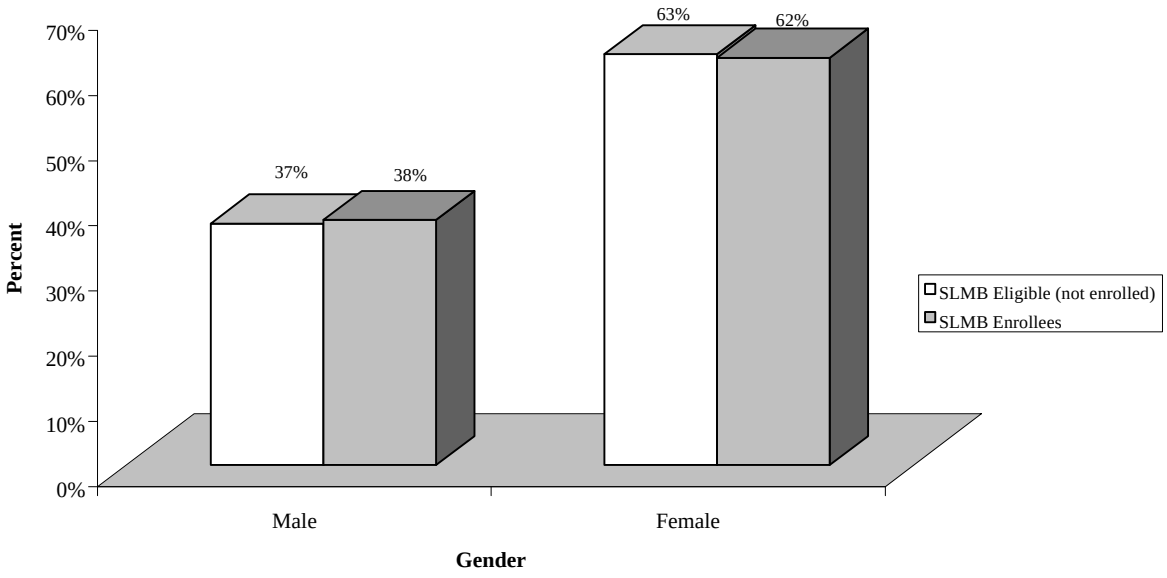
Although gender was associated with eligibility rates, it was not associated with whether or not beneficiaries participated in either the QMB or SLMB programs (Figures 2a and 2b). There were virtually no differences in participation rates by gender, with about one-half of eligible females and eligible males participating in the QMB program and about 14 percent of both groups participating in the SLMB program (Table 3).

Figure 2a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Gender - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

Figure 2b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Gender - 1996*

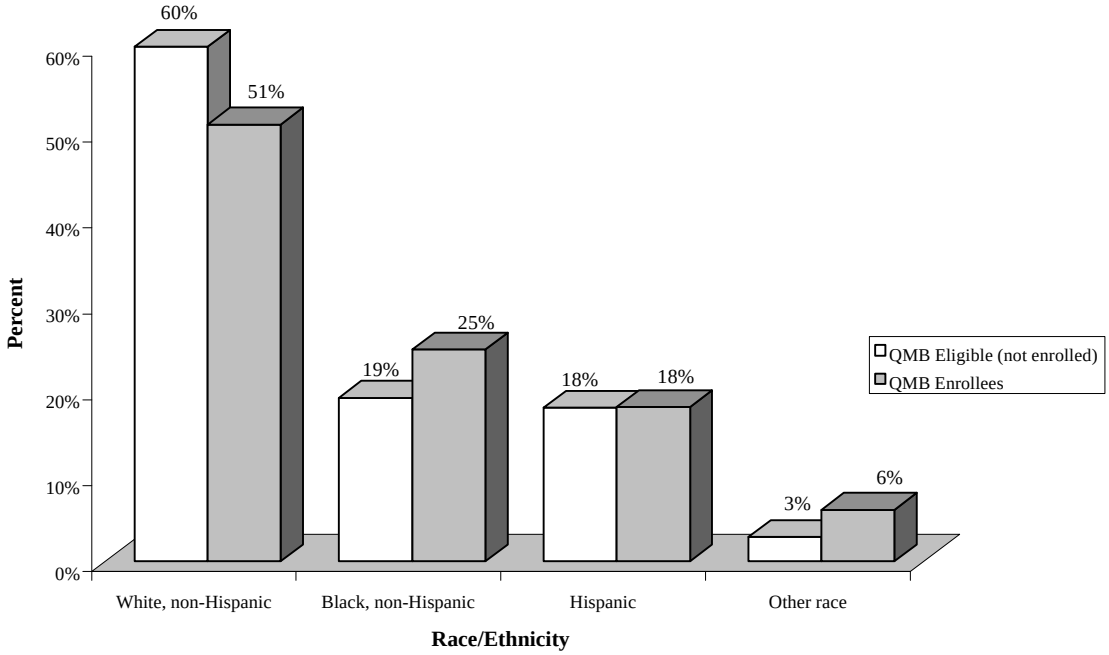


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

Race/ethnicity: A much larger proportion of beneficiaries identifying themselves as part of a racial and ethnic group other than White non-Hispanic are estimated to be potentially eligible for the QMB and SLMB programs compared with non-Hispanic White beneficiaries (Table 2). Compared with 17 percent of non-Hispanic White Medicare beneficiaries who are potentially eligible, about one-half of African American, Hispanic, and beneficiaries of other races/ethnicities are estimated to be eligible in 1996.

QMB participation rates are also associated with race/ethnicity, with non-Hispanic White beneficiaries and Hispanic beneficiaries having comparatively lower participation. African American beneficiaries and those of other races/ethnicities accounted for a higher percentage of QMB enrollees than non-enrollees. In particular, African Americans made up one-fourth of the enrolled QMB population but only one-fifth of QMB non-enrollees (Figure 3a). This trend can be seen in the higher participation rate of African Americans at 60 percent, although beneficiaries of other races/ethnicities also had relatively high QMB participation at 71 percent (Table 3). White non-Hispanic beneficiaries and Hispanics, in contrast, each had an approximately 50 percent participation rate. It appears that African American beneficiaries are being reached more effectively through the messages and outreach campaigns conducted by HCFA, States, and other national and local organizations.

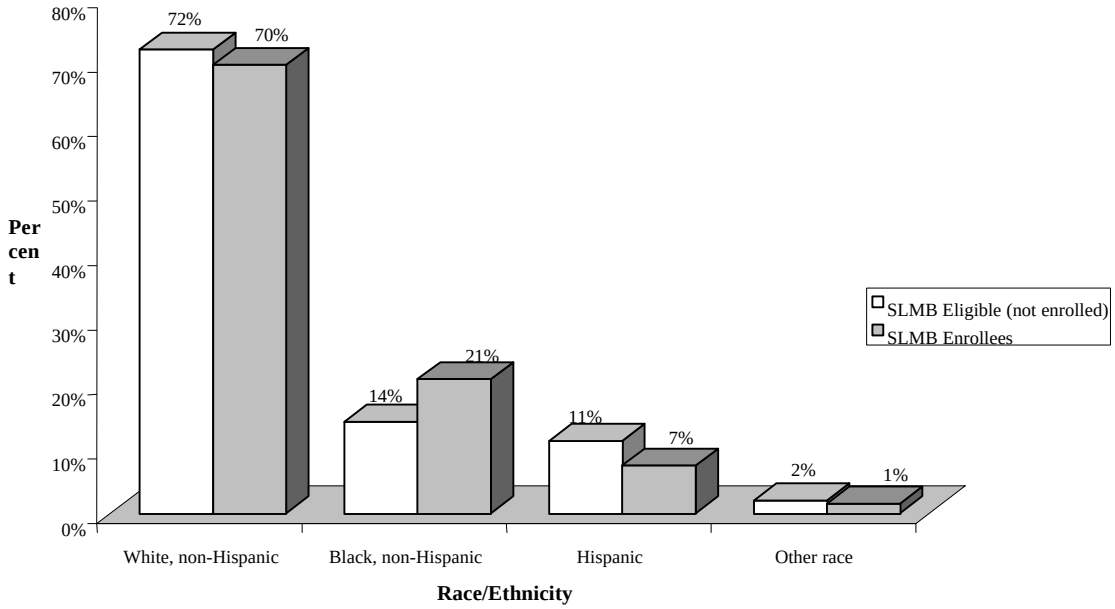
Figure 3a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Race/Ethnicity - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

In contrast to the QMB-eligible population, the racial/ethnic makeup of the SLMB-eligible population did not differ to any statistically significant extent between those enrolled and not enrolled in the program (Figure 3b), although African American beneficiaries again had a higher enrollment rate than White non-Hispanics, Hispanics, or beneficiaries of other races/ethnicities (Table 3).[27]

Figure 3b: Comparison of Non-Enrolled SLMB Eligible Enrollees, by Race/Ethnicity -



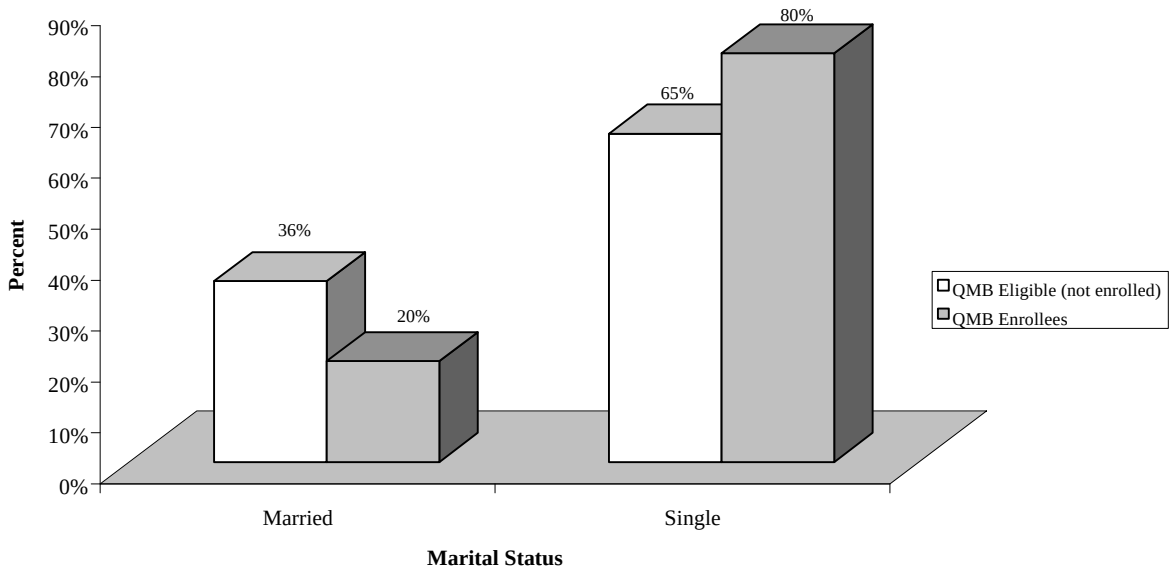
Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

Marital status: Medicare beneficiaries who are not married had higher eligibility rates than married beneficiaries (Table 2). About 39 percent of single beneficiaries were estimated to be eligible for QMB or SLMB buy-in in 1996, compared with 13 percent of married beneficiaries.

Single beneficiaries also had higher buy-in participation rates in both programs than married beneficiaries. Single beneficiaries accounted for a much larger proportion of both the QMB and SLMB eligible populations who were enrolled in these programs (Figures 4a and 4b). Table 3 indicates that about 3 out of 5 eligible single beneficiaries were QMB participants compared with only 2 out of 5 eligible married beneficiaries. Single beneficiaries may have lower incomes on average than married beneficiaries, thus having more contact with the SSI program and other welfare programs and more awareness of and referrals to the QMB and SLMB programs.

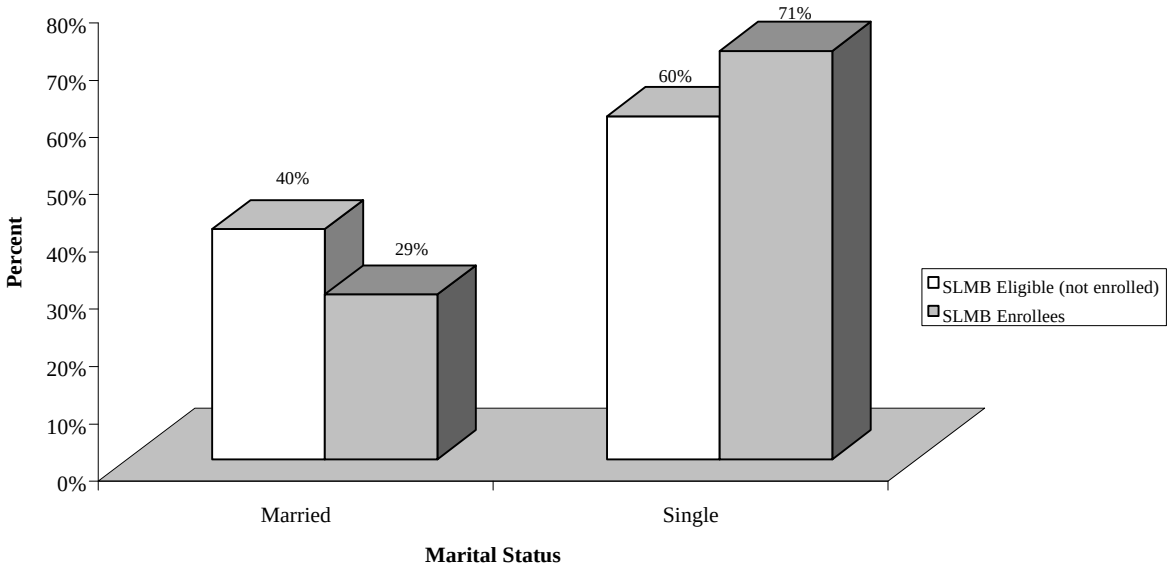
[27] The SLMB-eligible (unweighted) sample of 734 beneficiaries in the MCBS may be too small to statistically detect differences among some subgroups of beneficiaries, especially when the sample for the subgroup becomes very small.

Figure 4a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Marital Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 4b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Marital Status - 1996*

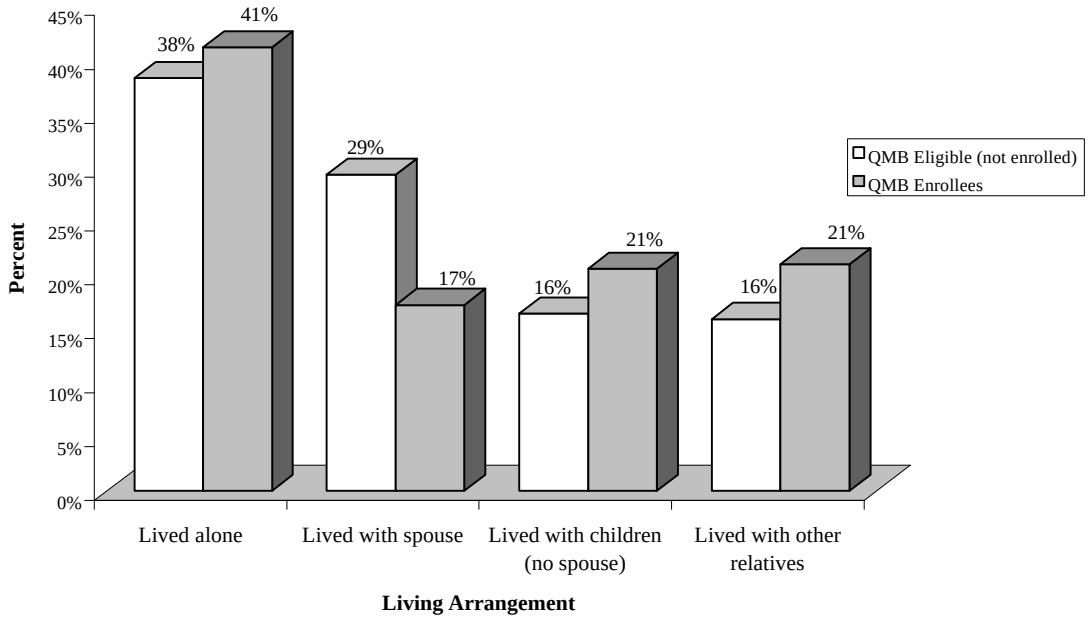


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at the 3 percent level.

Household living arrangement: A substantially higher proportion of Medicare beneficiaries who live with their children or other relatives are estimated to be potentially eligible for QMB or SLMB buy-in compared to those who live alone or with their spouse (Table 2). However, beneficiaries who live alone are still twice as likely to be eligible for QMB or SLMB assistance as those who live with their spouse.

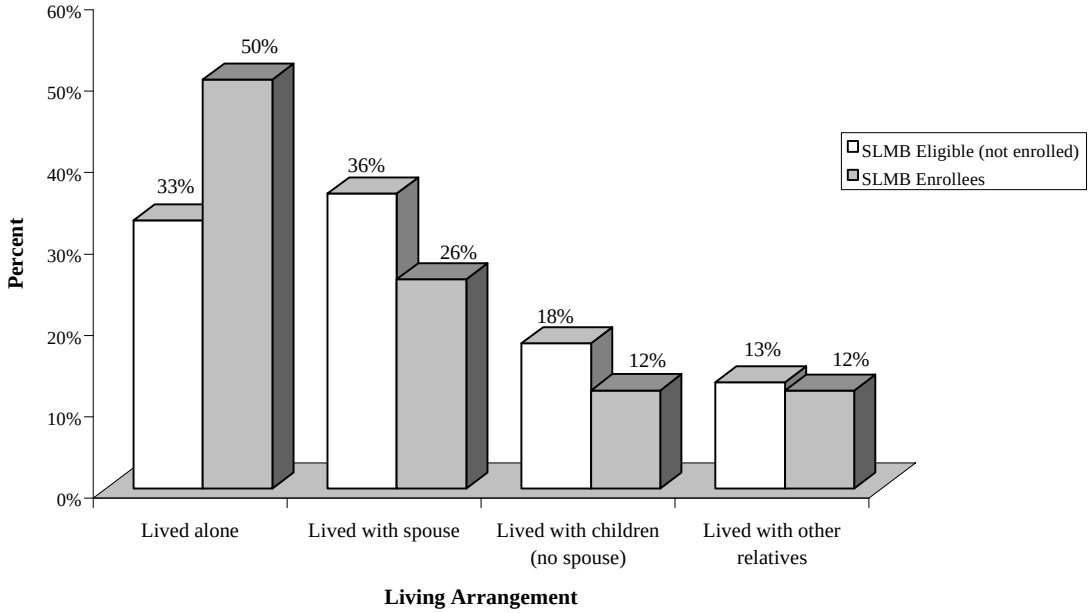
The effect of not living with a spouse also affects QMB and SLMB buy-in participation. The percentages of beneficiaries who lived alone, lived with their children, or lived with other relatives was higher for QMB and SLMB enrollment than for non-enrollment (Figures 5a and 5b). The opposite is true for beneficiaries who lived with their spouse. Table 3 indicates that beneficiaries who lived with their spouse had the lowest QMB participation rate of these four subgroups. SLMB eligibles who lived with their spouse also had relatively low participation, but those who lived with their children had even slightly lower enrollment. Married beneficiaries living with their spouse are likely to have higher joint incomes, less contact with SSI or welfare programs, and less awareness that they are potentially eligible for Medicaid assistance with their Medicare costs.

Figure 5a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Living Arrangement - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 5b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Living Arrangement - 1996*

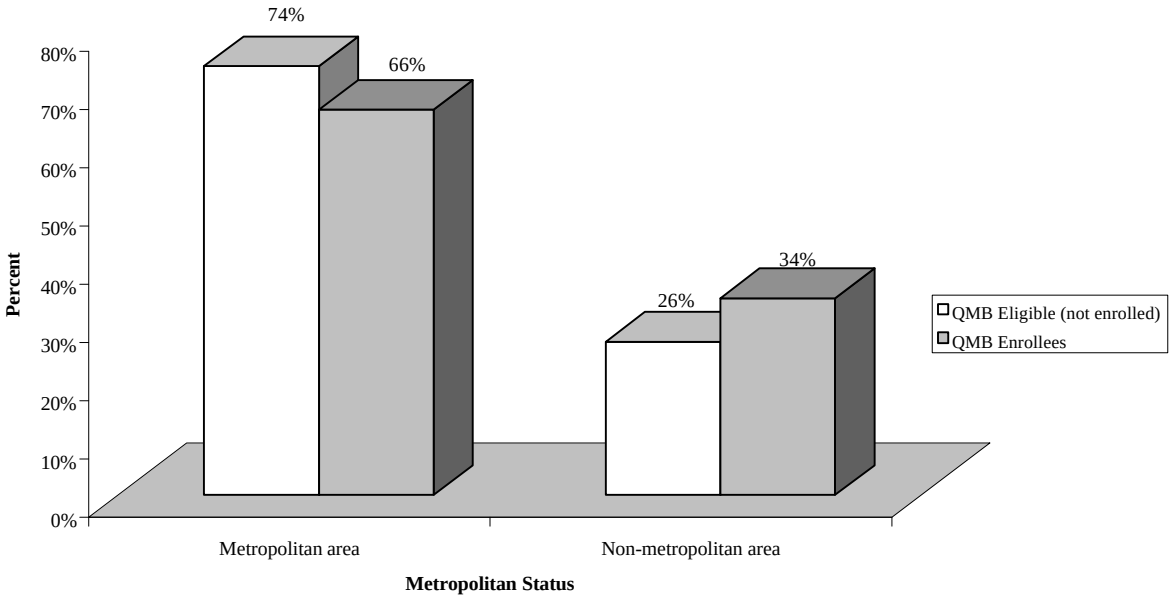


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Urban/rural: A slightly higher proportion of Medicare beneficiaries who lived in rural areas are estimated to be eligible for QMB or SLMB buy-in compared with those who lived in urban areas (27 percent versus 23 percent, respectively) (Table 2).

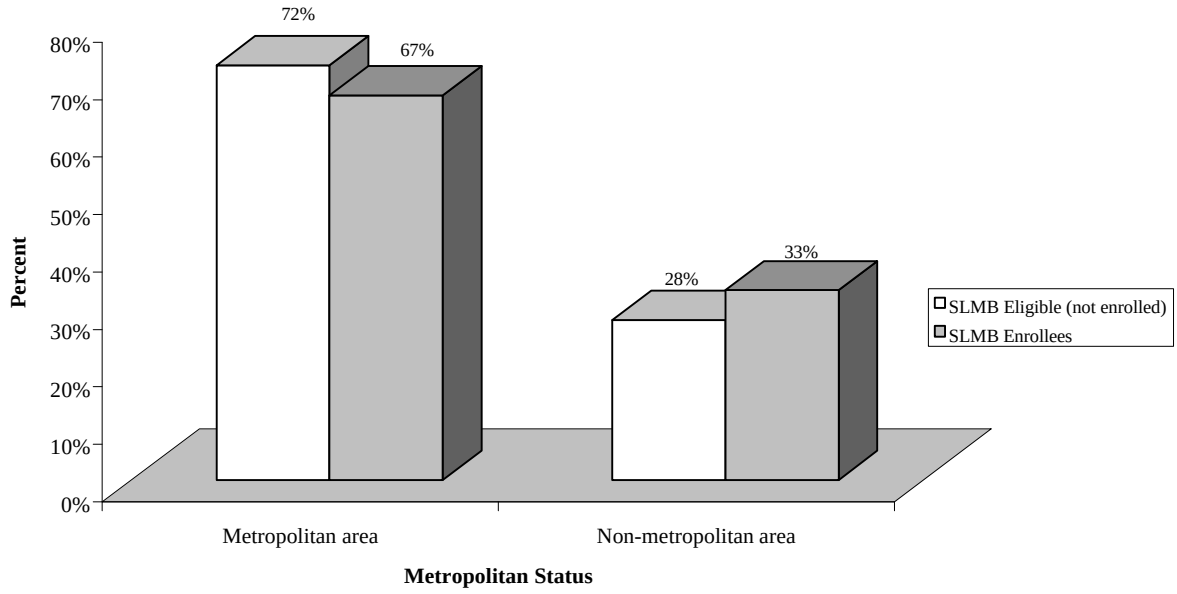
Similar to lower eligibility rates of beneficiaries who lived in urban areas, they also had a somewhat lower participation rate in the QMB program (Table 3). Beneficiaries eligible for the QMB program but not participating were slightly more likely to live in urban areas compared with QMB participants (Figure 6a). However, this difference is not statistically detected for the SLMB-eligible population (Figure 6b).

Figure 6a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Metropolitan Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

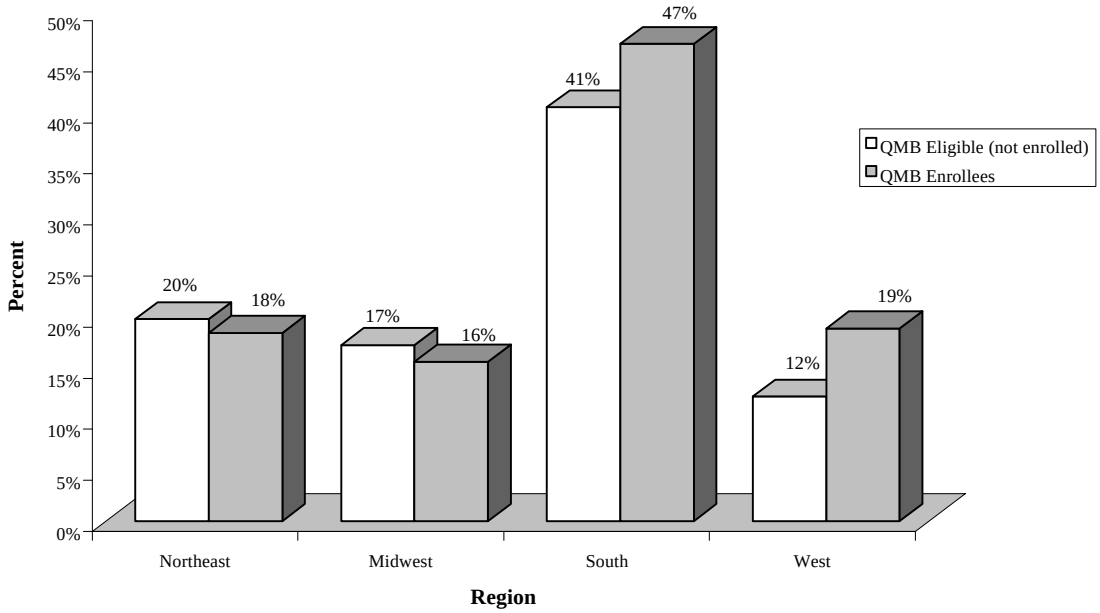
Figure 6b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Metropolitan Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

Region: The highest proportion of beneficiaries eligible for the QMB or SLMB programs is estimated to be Medicare beneficiaries living in the South at 29 percent (Table 2). The Midwest is estimated to have the lowest percentage of beneficiaries who are eligible for QMB or SLMB buy-in (17 percent).

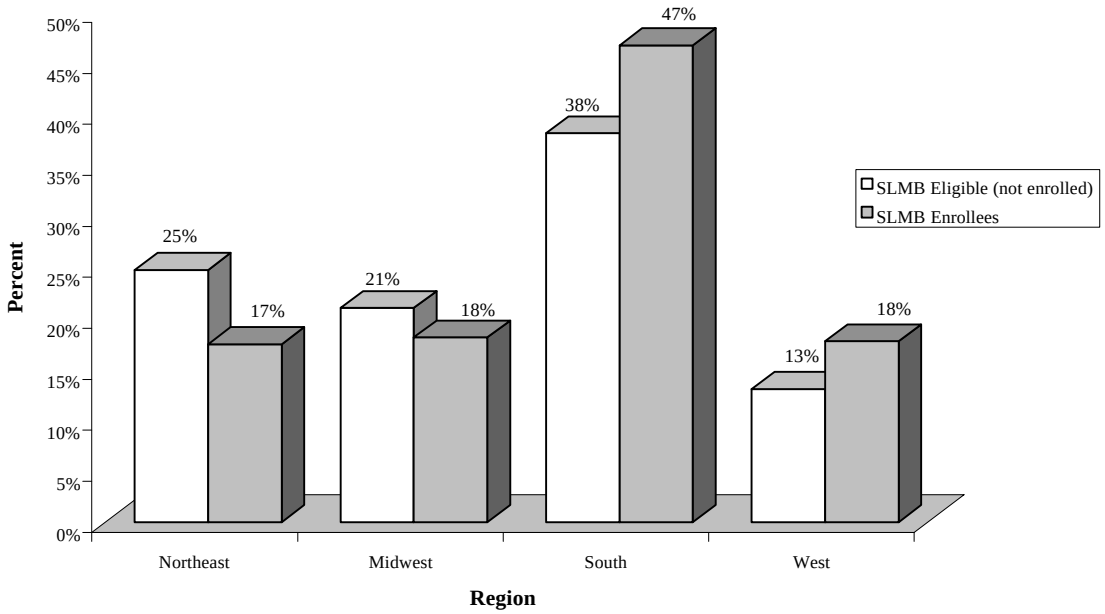
Figure 7a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Region - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

There was also some variation in enrollment versus non-enrollment for QMB eligibles among the four U.S. Census regions, as shown in Figure 7a. QMB participation rates were higher in the South and West regions and lower in the Northeast and Midwest regions (Table 3). There was a bit more variation in SLMB participation rates among the regions, but the same pattern of participation held as for QMBs (Figure 7b).

Figure 7b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Region - 1996*

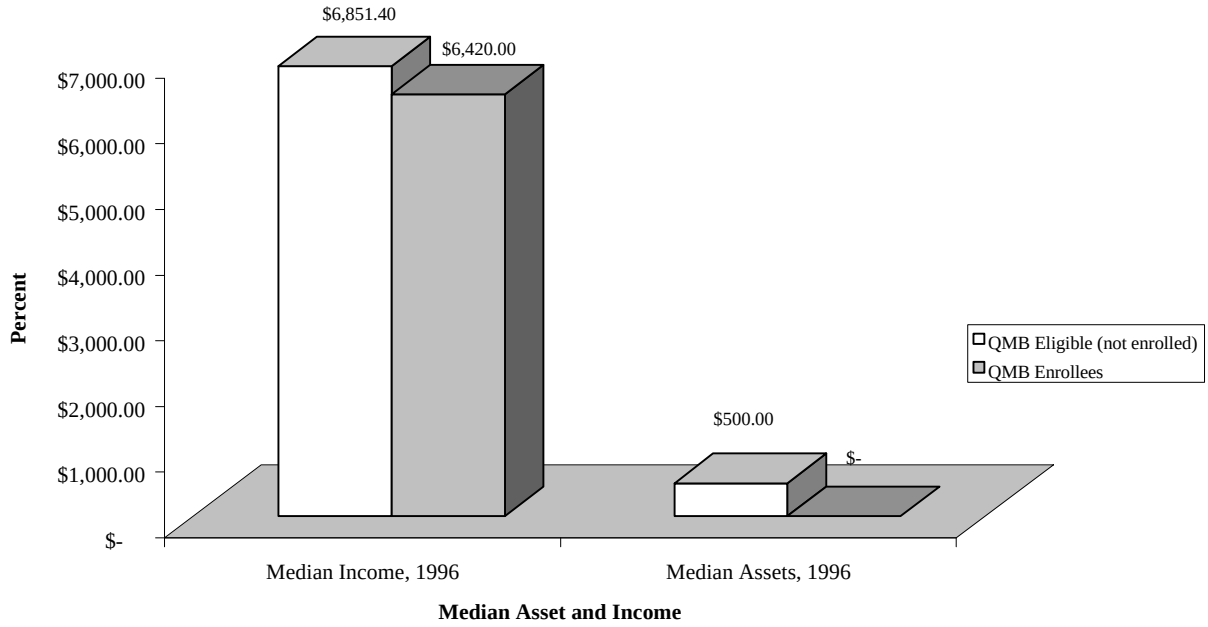


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at the 4 percent level.

Socioeconomic Characteristics

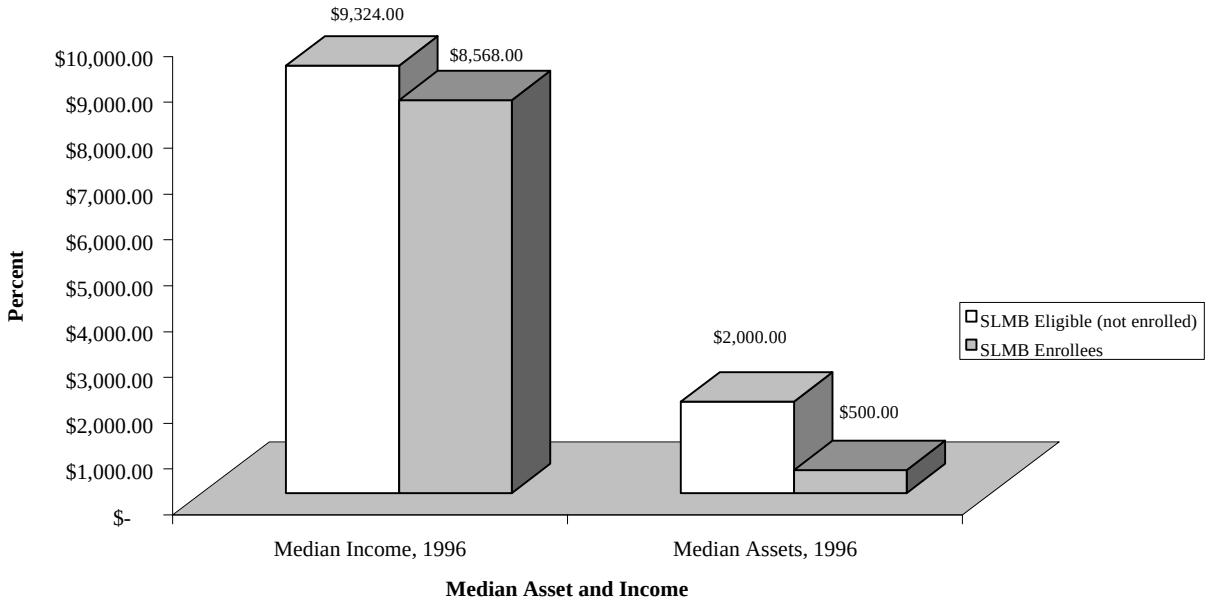
Although by definition, beneficiaries who are potentially eligible for Medicare buy-in have lower incomes and assets than those who are not eligible, Figures 8a and 8b indicate that beneficiaries who were eligible for Medicaid assistance but did not enroll in the QMB or SLMB programs in 1996 had higher median income and asset amounts than those who did enroll. This suggests that individuals who need the programs the most have higher buy-in rates, but it also suggests that outreach needs to be more heavily targeted at individuals who have somewhat higher incomes but who could still greatly benefit from Medicaid assistance.

Figure 8a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Median Asset and Income - 1996



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.

Figure 8b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Median Asset and Income - 1996

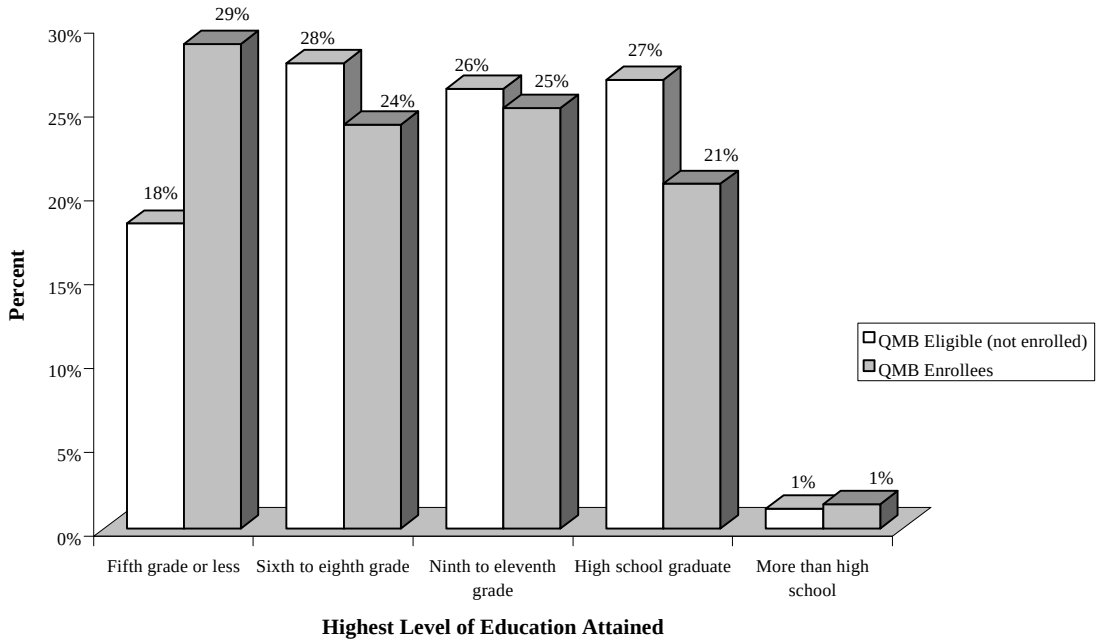


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.

Education: Medicare beneficiaries at the lowest end of the education spectrum are estimated to have much higher rates of eligibility for the QMB and SLMB programs (Table 2). About 66 percent of those with only a 5th grade education or less were potentially eligible in 1996, compared with only 5 percent of those with at least a high school education.

Education also had a statistically significant affect on QMB participation, with those with the least years of education having the highest participation. Those who were QMB-eligible but not enrolled were somewhat more highly educated than QMB participants (Figure 9a). Table 3 displays a slight trend toward decreasing participation rates with increasing education, although this is not true at education levels beyond high school. Because education is highly correlated with income, beneficiaries with lower education may have more contact with the SSI, Medicaid, and other welfare programs and be more likely to hear about and be automatically enrolled in the QMB program.

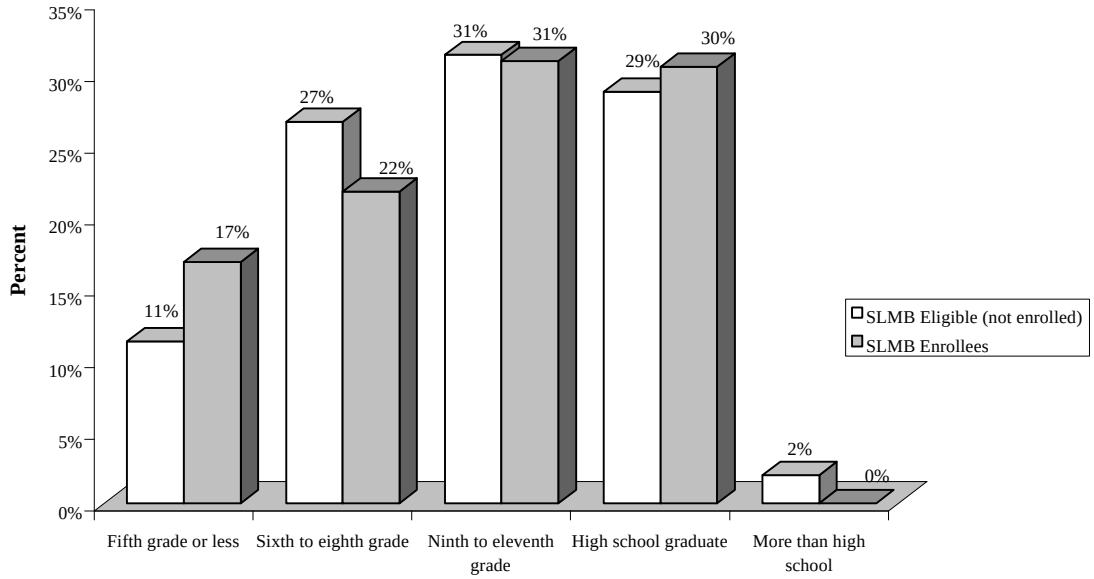
Figure 9a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Education Level - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

In contrast to QMB enrollment, SLMB enrollment was not statistically dependent on education level (Figure 9b and Table 3). It may be that, because SLMB eligibility is based on higher income levels than QMB eligibility, beneficiaries eligible for SLMB in general have less contact with SSI, Medicaid, and other welfare programs than QMB-eligibles. Education and income levels may not play as much of a role in SLMB participation as it does in QMB participation.

Figure 9b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Education Level - 1996*



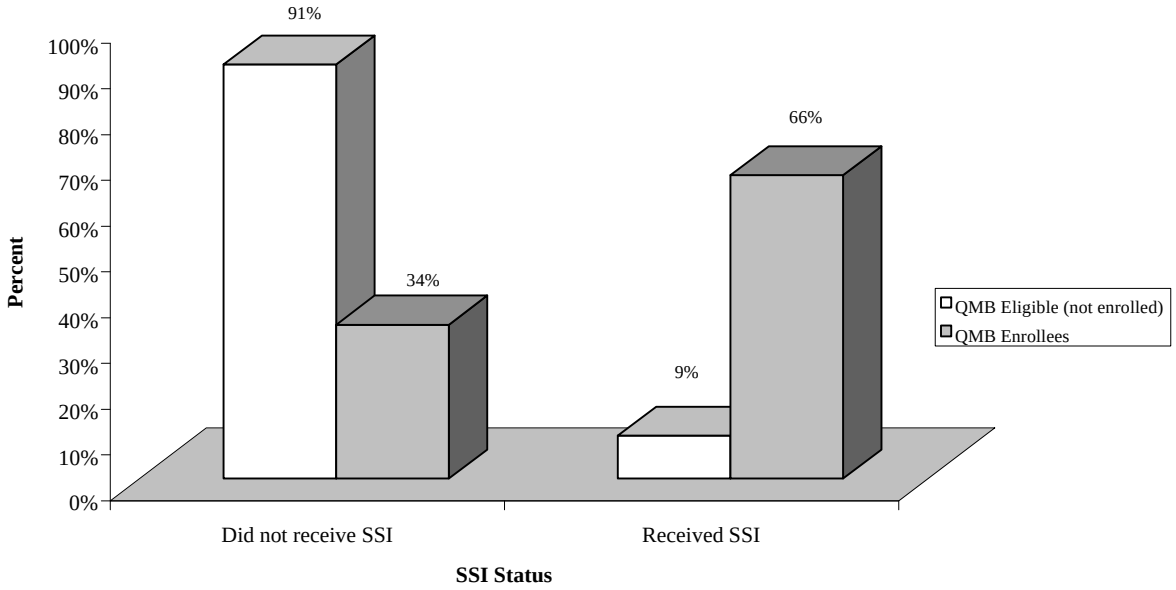
Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

SSI and welfare program participation: As expected, the rate of estimated eligibility for QMB and SLMB buy-in is substantially higher among those who are SSI recipients or have other welfare program income (about 90 percent) compared with other beneficiaries (about 20 percent) (Table 2).

Also as might be expected, there is a substantial difference in the proportion of beneficiaries with SSI and welfare program income between non-participating QMB-eligibles and participating QMBs (Figures 10a and 11a). Nine out of 10 non-participants did not receive SSI income or income from other welfare programs in 1996 but were still estimated to be eligible for the QMB program. Only about 3 out of 10 QMB participants, however, did not report SSI income and 7 out of 10 did not have other welfare income in 1996. Table 3 shows the much higher participation rates of SSI and welfare income recipients in both the QMB and SLMB programs. Almost 90 percent of those who received SSI payments participated in QMB, compared with only 30 percent of non-SSI recipients.

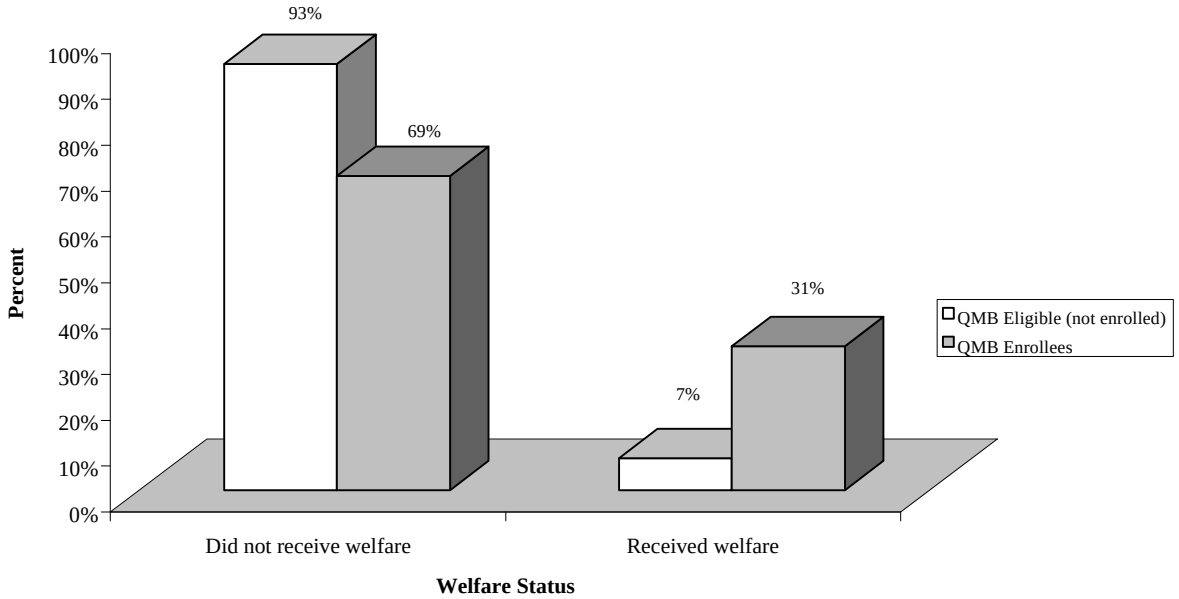
As discussed above, these figures indicate that individuals in the most economic distress are being reached relatively successfully through processes in place to enroll welfare or SSI recipients into the buy-in programs, but those who do not go through these systems require outreach through other channels.

Figure 10a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Supplemental Security Income (SSI) Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

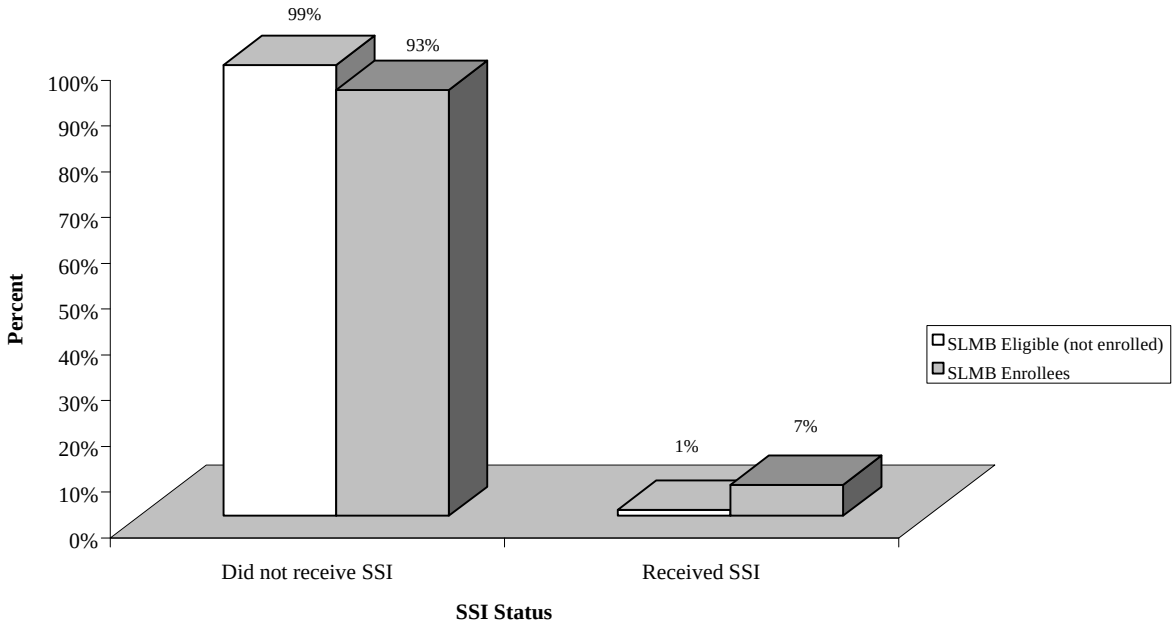
Figure 11a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Welfare Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

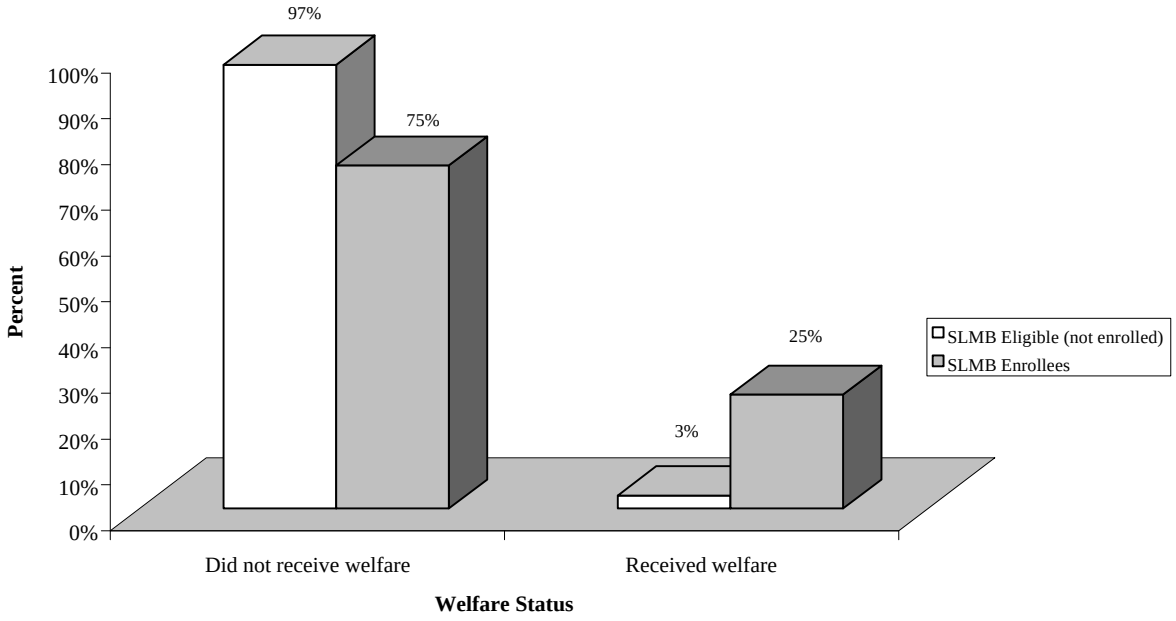
The difference in SSI eligibility is not statistically apparent for the SLMB-eligible population probably because so few of the SLMB-eligible population are SSI eligible (Figure 10b). However, a much higher proportion of SLMB participants had welfare program income in 1996 compared to non-participants (Figure 11b). Almost 60 percent of eligible beneficiaries with welfare income participated in the SLMB program in 1966 compared with only 11 percent of those with no welfare income (Table 3).

Figure 10b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Supplemental Security Income (SSI) Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 1 percent level.

Figure 11b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Welfare Status - 1996*

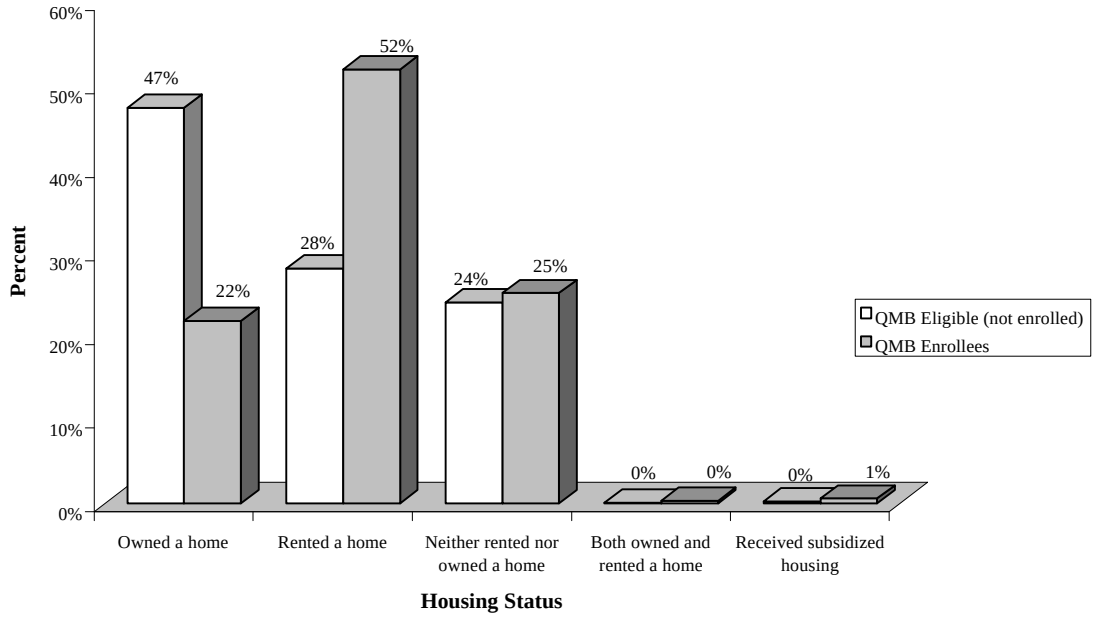


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Home ownership: Medicare beneficiaries who rent rather than own their homes have higher estimated eligibility rates for the QMB and SLMB programs than those who own their home, most likely due to differences in income and asset levels between these two groups (Table 2).

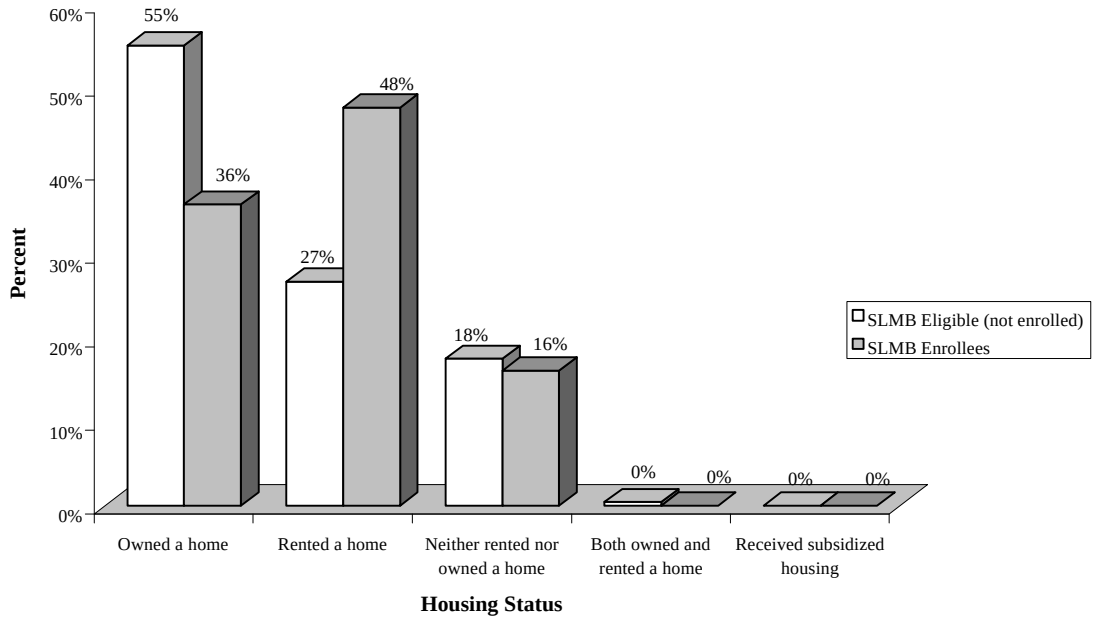
Beneficiaries who rent also had higher buy-in participation rates than those who own their homes. The differences in economic well-being between QMB and SLMB participants and those who did not participate is evidenced by differences in home ownership among these populations (Figures 12a and 12b). A substantially higher proportion of both QMB and SLMB non-participants owned their home rather than rented compared to the QMB and SLMB enrolled populations. This is reflected in Table 3, where 68 percent of QMB-eligibles who rented participated in the program compared with only 35 percent of those who owned their home; 10 percent of SLMB eligibles who owned homes participated compared with 22 percent who rented.

Figure 12a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Housing Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 12b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Housing Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

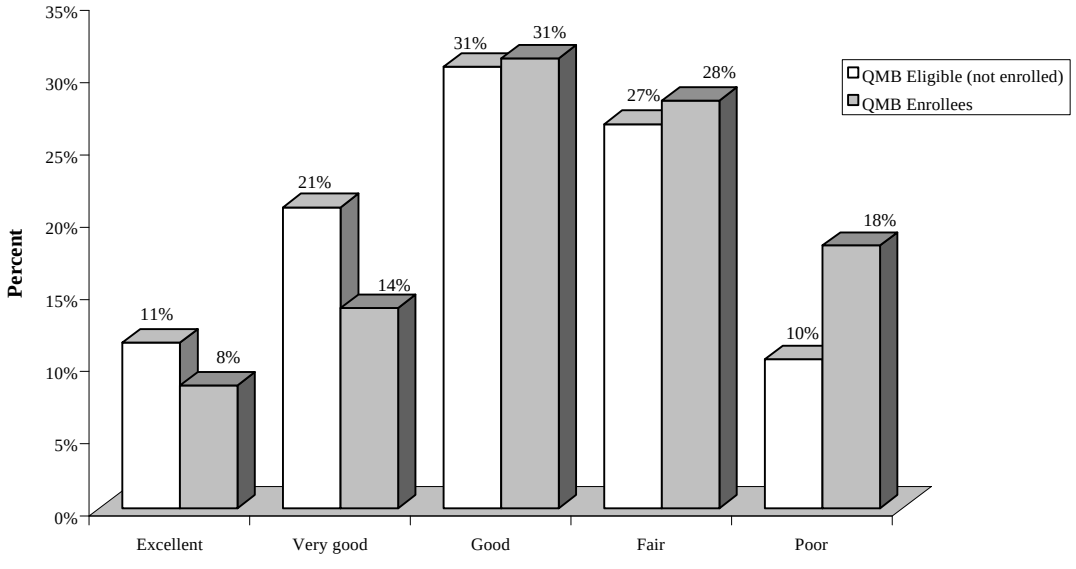
Health Status

Self-reported health: The estimated proportion of Medicare beneficiaries in excellent or very good health who are eligible for QMB or SLMB buy-in is markedly lower than those who reported good, fair, or poor health (Table 2). About 42 percent of beneficiaries who reported poor health were estimated to be buy-in eligible compared with only 14 percent of those who reported excellent health.

Participation in both the QMB and SLMB buy-in programs is also affected by general health status, with higher participation rates for those in worse health. For example, less than one-half of QMB-eligibles who reported excellent health participated in the program compared with two-thirds of those who reported poor health. QMB- and SLMB-eligible beneficiaries but not enrolled reported being in better health than those participating in these programs (Figures 13a and 13b). Differences in the SLMB eligible population were even more pronounced than for QMB-eligibles, with 34 percent of SLMB non-participants reporting excellent or very good health compared with only 16 percent of SLMB participants.

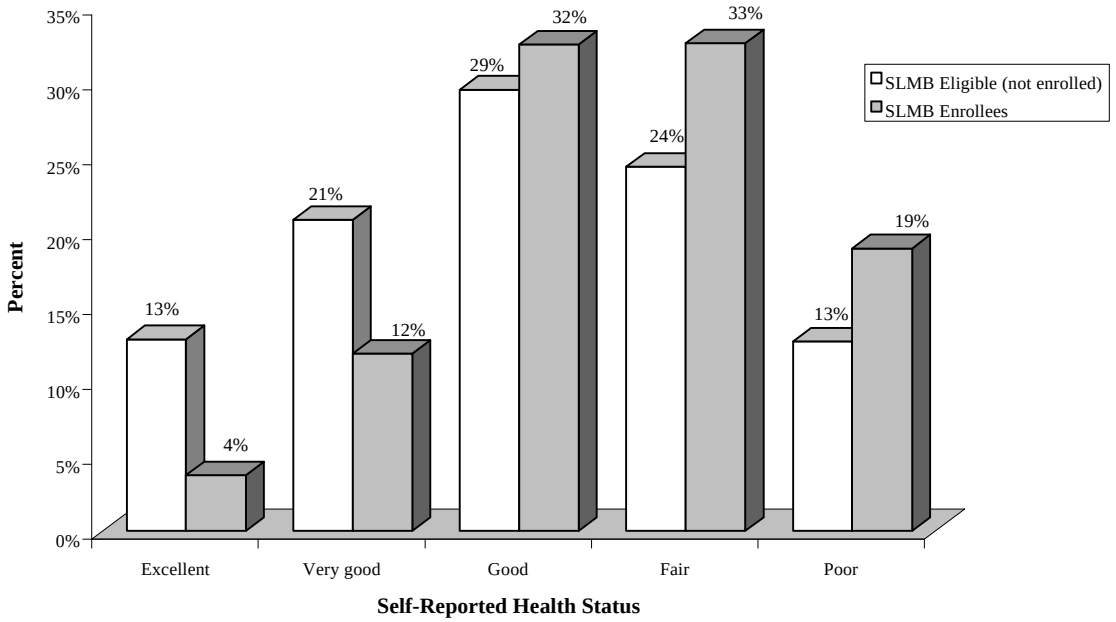
There are at least two possible explanations for greater QMB and SLMB participation by beneficiaries in poor health: those in worse health are likely to have greater contact with the health care system and to be made aware of these programs, and those with greater health care use are likely to have higher costs and need more assistance with paying their health care bills. These beneficiaries either are more likely to actively seek out such assistance and learn about these programs, or value the benefits of these programs more highly than healthier beneficiaries and are, therefore, more likely to take the time to enroll.

Figure 13a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Self-Reported Health Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 13b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Self-Reported Health Status - 1996*

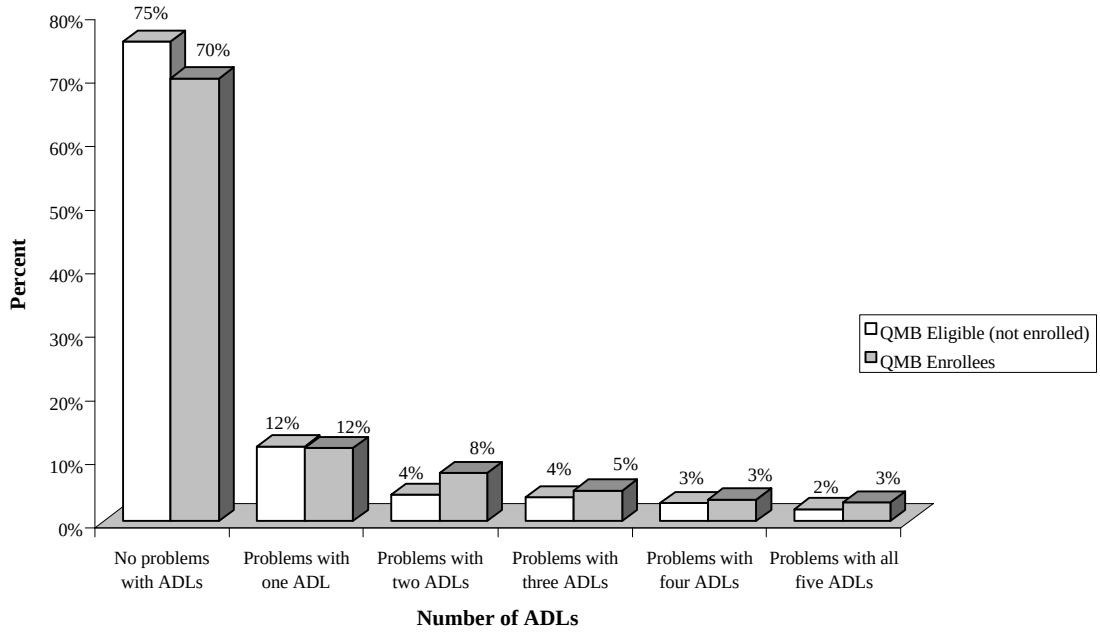


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at the 5.7 percent level.

Number of ADL Limitations: As with self-reported general health, Medicare beneficiaries with one or more Activities of Daily Living (ADL) limitations were more likely to be estimated to be eligible for QMB or SLMB buy-in than those with no ADL limitations (Table 2). Those with 5 or more ADL limitations were most likely to be eligible for these programs.

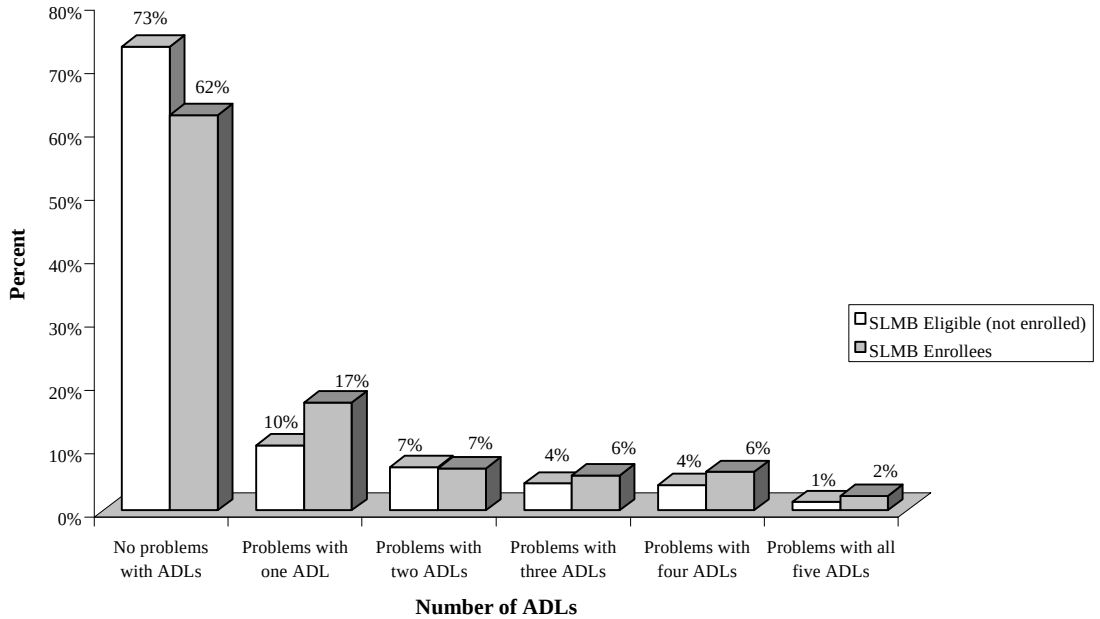
Although QMB participation was statistically dependent on difficulties with ADLs, differences in the number of ADL limitations present for QMB participants versus non-participants were only modest (Figure 14a). The difference in these two groups for SLMB participation was more pronounced, but the results were not statistically significant at the 5 percent level (Figure 14b). Table 3 indicates that QMB-eligibles with ADL limitations were only slightly more likely to participate in the program compared with those who had no ADL limitations.

Figure 14a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Those Reporting Problems with Activities of Daily Living (ADLs) - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 14b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Those Reporting Problems with Activities of Daily Living (ADLs) - 1996*



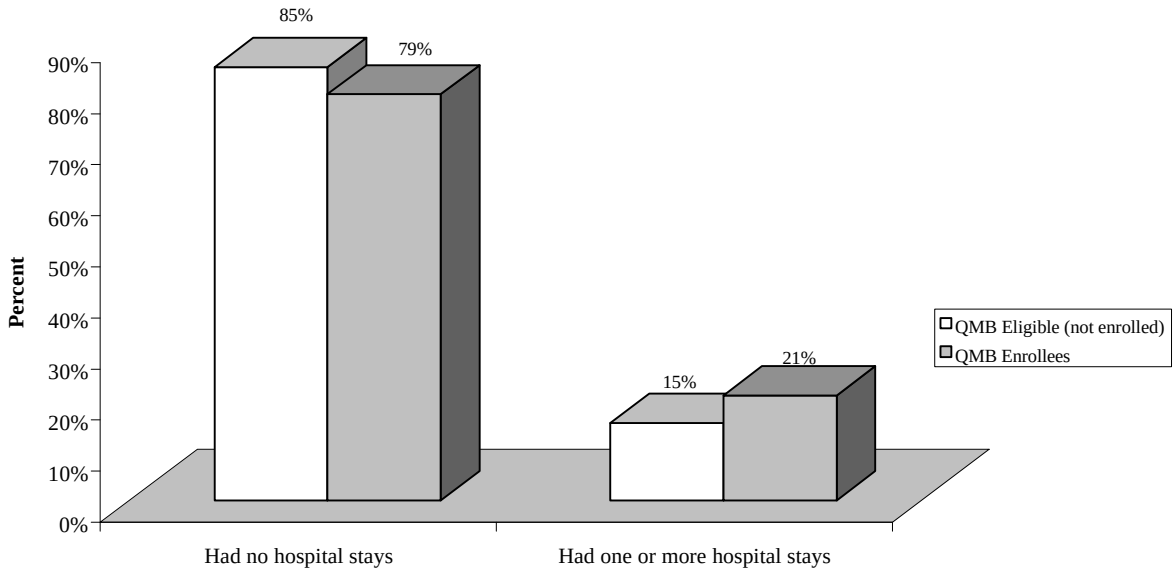
Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

Health Care Use

Use of health services: In contrast to the results on self-reported health status, there are only minor differences in the estimates of beneficiaries eligible for the QMB or SLMB program who did and did not have an inpatient hospital stay, SNF admission, outpatient hospital visit, or home health visit in 1996. Those who did use these services were somewhat more likely to be estimated as eligible for these programs (Table 2).

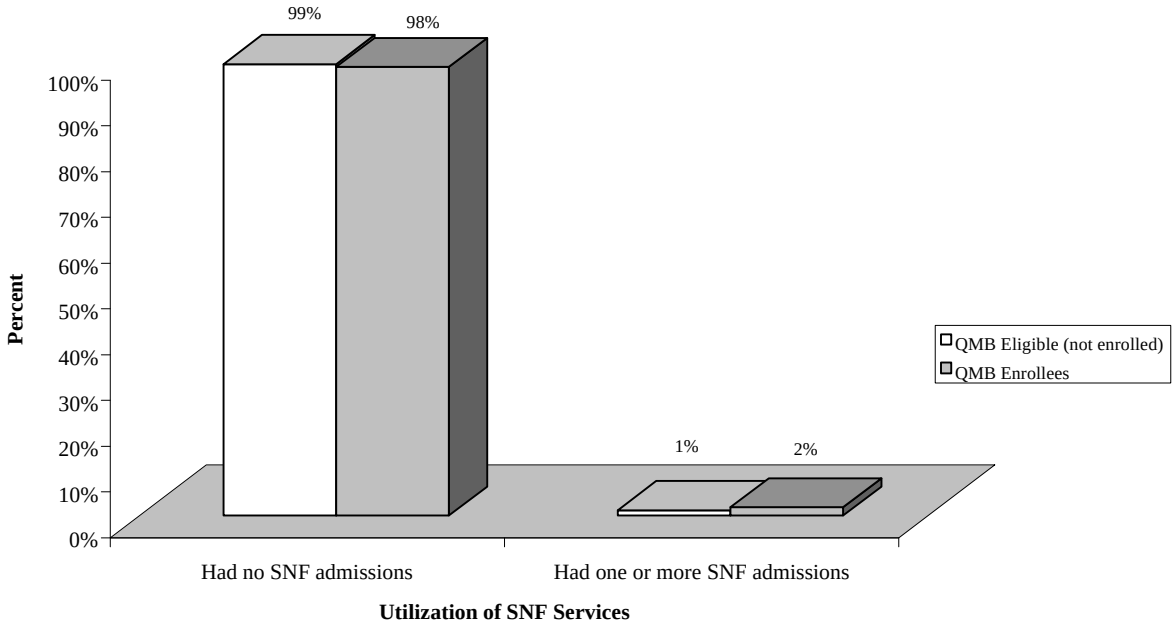
Similarly, there were only slight differences between the percentage of QMB participants and non-participants who had an inpatient hospital stay, an SNF admission, or a home health visit in 1996. Beneficiaries not enrolled in the program had only slightly less of these types of health care utilization (Figures 15a, 16a, and 18a). However, the comparatively better health status of non-participants is highlighted by the higher proportion of these beneficiaries with an outpatient visit in 1996 (Figure 17a). Less than one-half of QMB non-participants reported a hospital outpatient visit in 1996 compared with almost two-thirds of QMB participants. About 62 percent of QMB-eligibles who had at least one outpatient visit in 1996 participated in the program compared with only 43 percent of those with no outpatient visits (Table 3).

Figure 15a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Utilization of Inpatient Hospital Services - 1996*



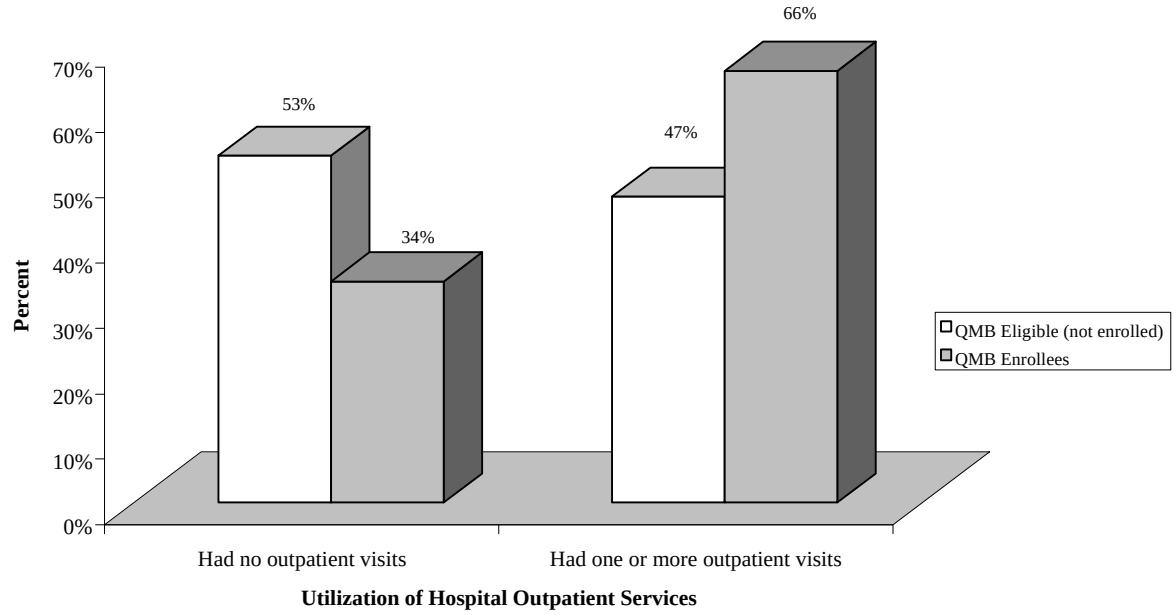
Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 16a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Utilization of Skilled Nursing Facility (SNF) Services - 1996*



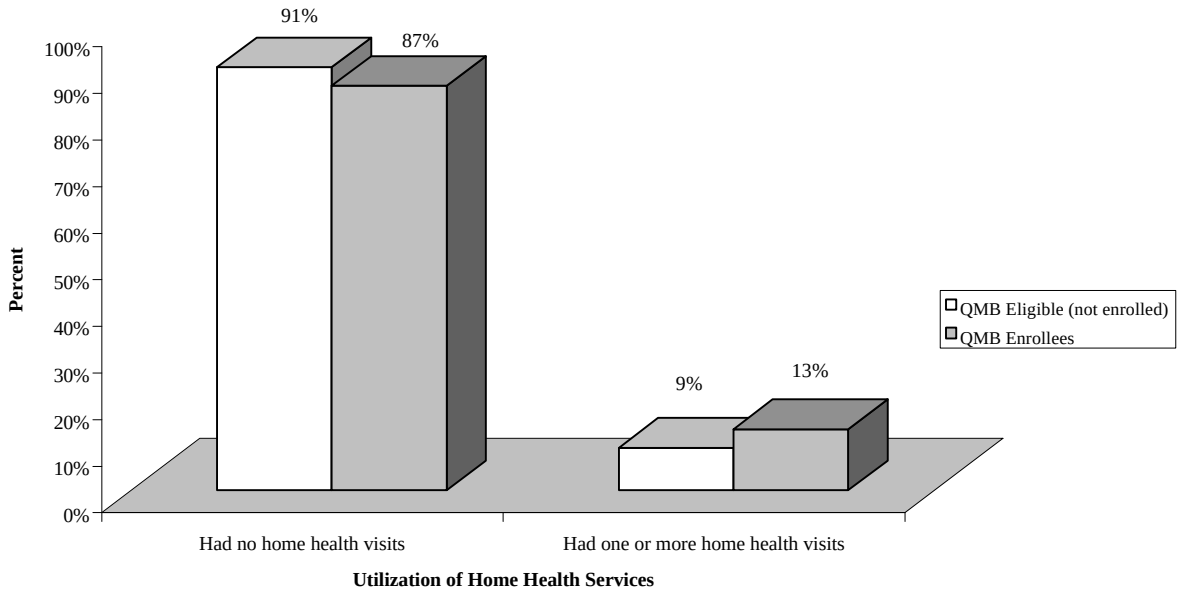
Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

Figure 17a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Utilization of Hospital Outpatient Services - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

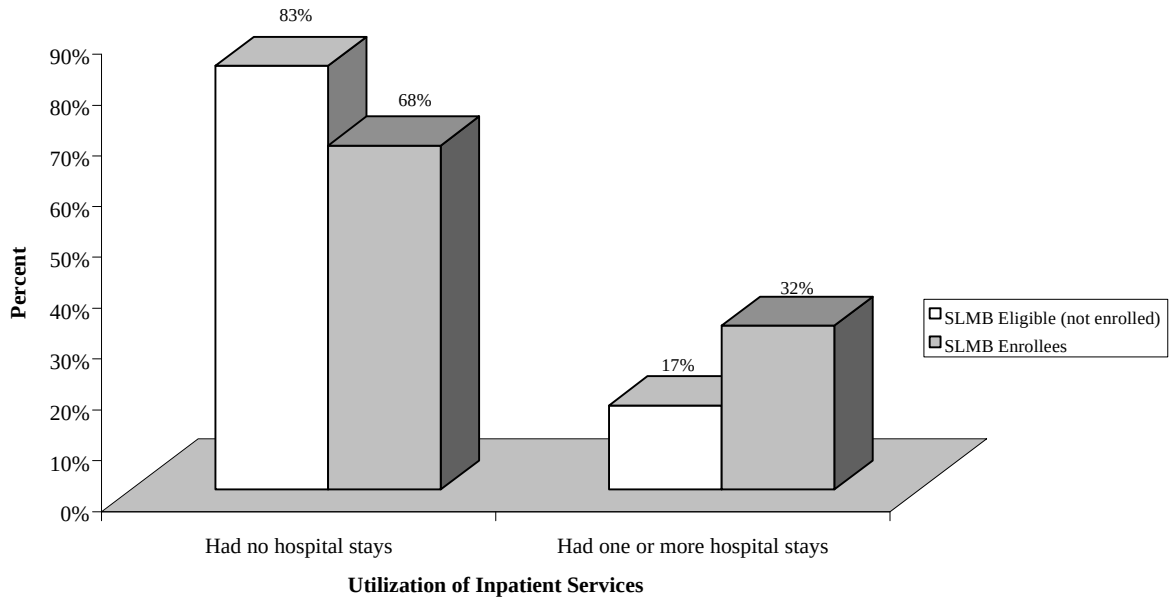
Figure 18a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Utilization of Home Health Services - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

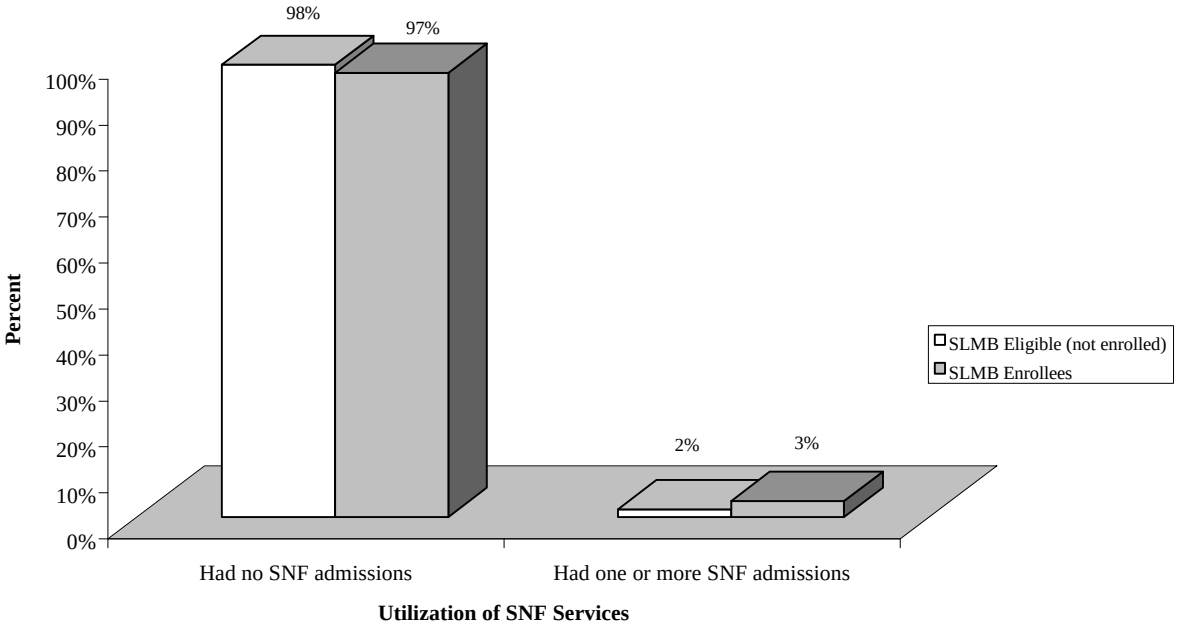
This group's much lower use of health services compared with SLMB participants (Figures 15b, 16b, 17b, and 18b) also evidences the substantially better health status of eligible SLMBs who did not participate in the program in 1996. Those not participating in the SLMB program were much less likely to have had an inpatient hospital stay, a hospital outpatient visit, or a home health visit in 1996 (Table 3). It may be that people who have more contact with the health care system are more likely to hear about and enroll in the QMB and SLMB programs.

Figure 15b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Utilization of Inpatient Hospital Services - 1996*



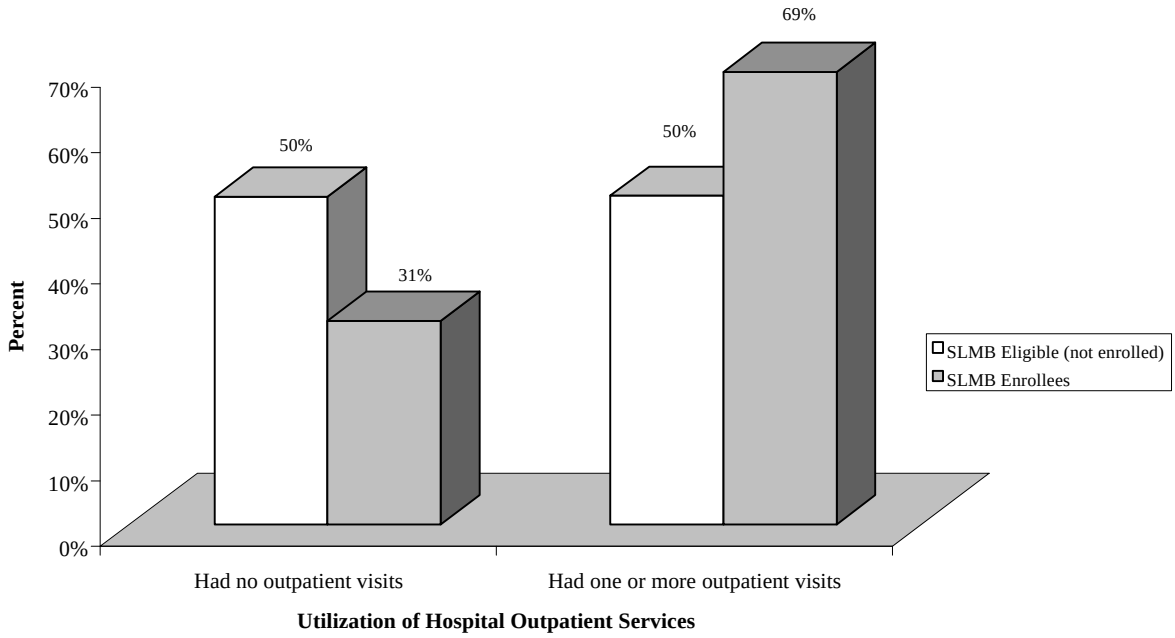
Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 16b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Utilization of Skilled Nursing Facility (SNF) Services - 1996*



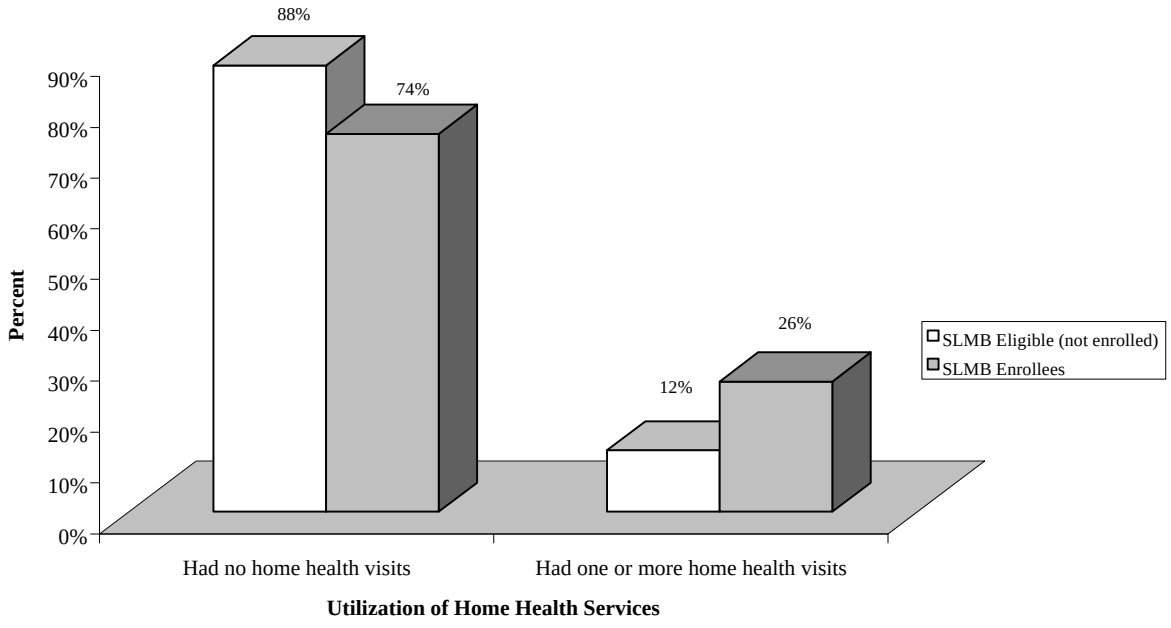
Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

Figure 17b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Utilization of Hospital Outpatient Services - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 18b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Utilization of Home Health Services - 1996*

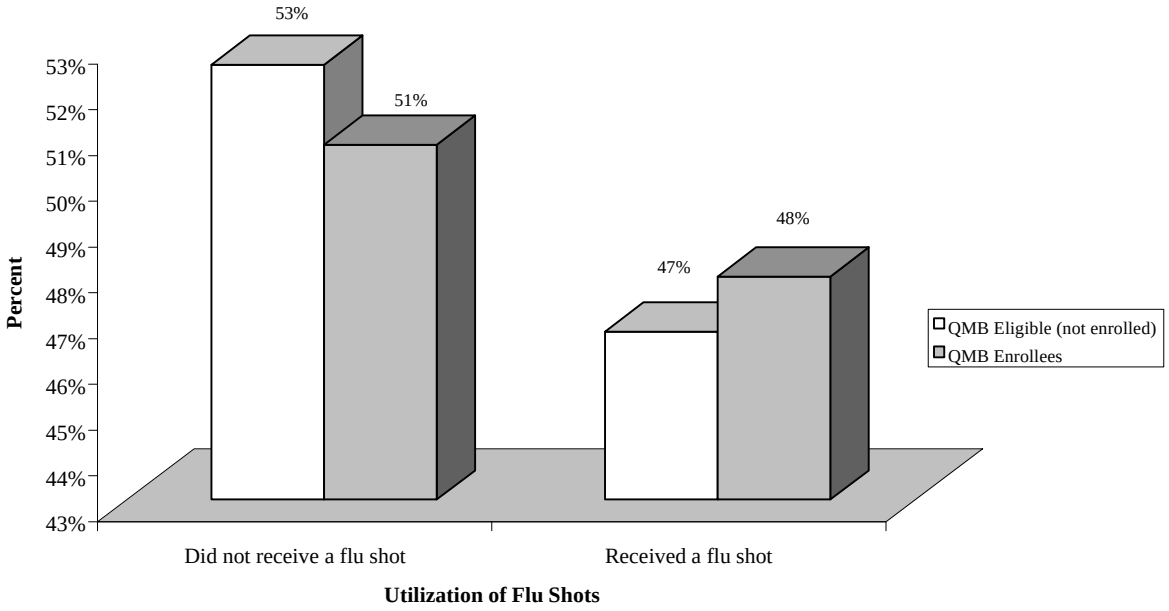


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at the 1 percent level.

Flu shot/Usual place of care: Access to health care, as measured by having received a flu vaccination and having a usual place for care, was correlated with estimates of eligibility for QMB or SLMB buy-in. A higher percentage of Medicare beneficiaries who did not receive a flu shot or did not have a usual place for care in 1996 were estimated to be eligible for the QMB and SLMB programs (Table 2).

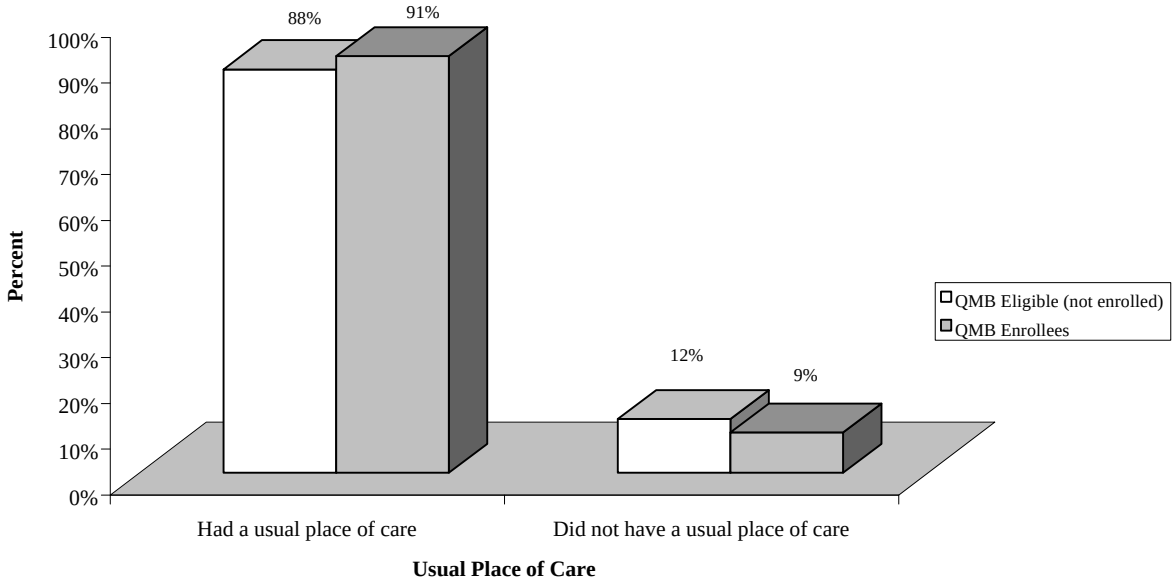
These access to health care measures, however, did not vary much between the group of QMB non-participants and QMB participants. QMB participants were only slightly more likely to have a usual place of care and to have received a flu shot than non-participants (Figures 19a and 20a and Table 3).

Figure 19a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Those Receiving a Flu Shot - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

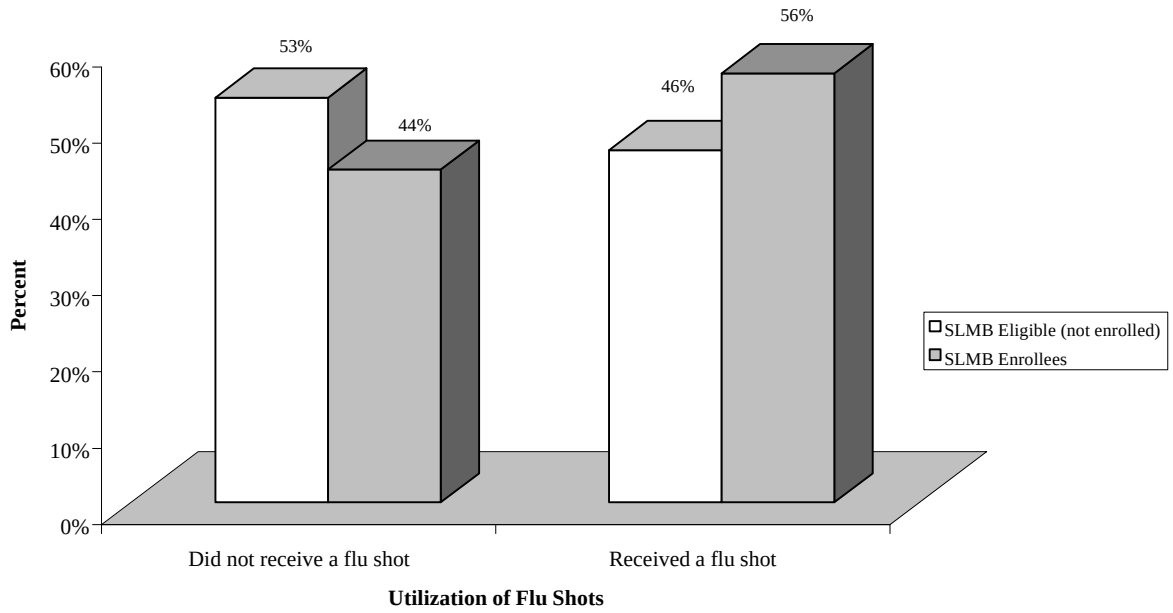
Figure 20a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Usual Place of Care - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at the 4 percent level.

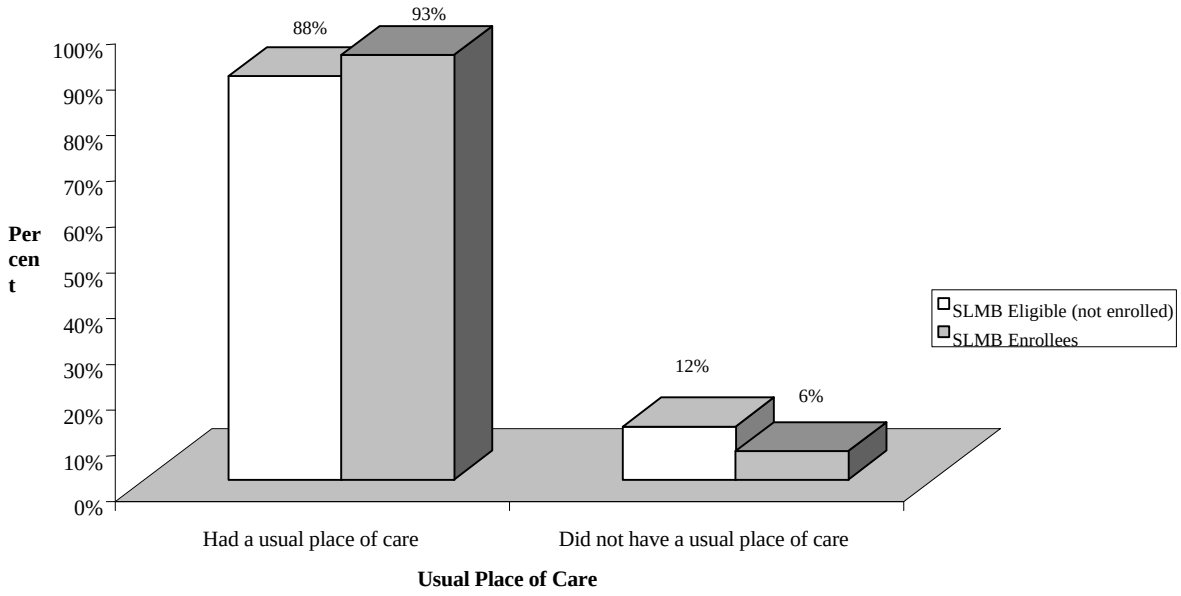
There were slight differences in these access measures for the SLMB-eligible population, with non-participants less likely to have received a flu shot or to have a usual place of care (Figures 19b and 20b). This is reflected in the somewhat higher SLMB participation rates for eligible beneficiaries who had a flu shot or usual place of care in 1996 (Table 3). As noted above, more contact with the health care system may be correlated with being more informed about the availability of Medicaid programs that can help pay for health care costs.

Figure 19b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Those Receiving a Flu Shot - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at the 5 percent level.

Figure 20b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and Enrollees, by Usual Place of Care - 1996*



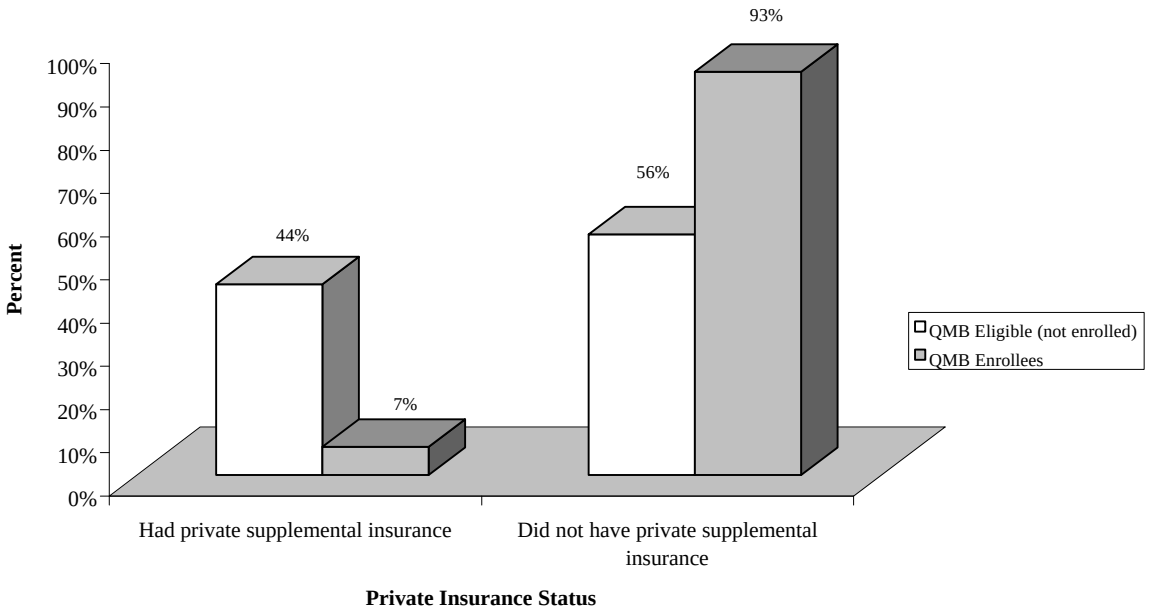
Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at the 5 percent level.

Health Insurance

Private insurance: Not surprisingly, about 55 percent of Medicare beneficiaries who had no private supplemental health insurance plan were estimated to be potentially eligible for QMB or SLMB buy-in compared with only 10 percent of beneficiaries who had a private plan in 1996 (Table 2).

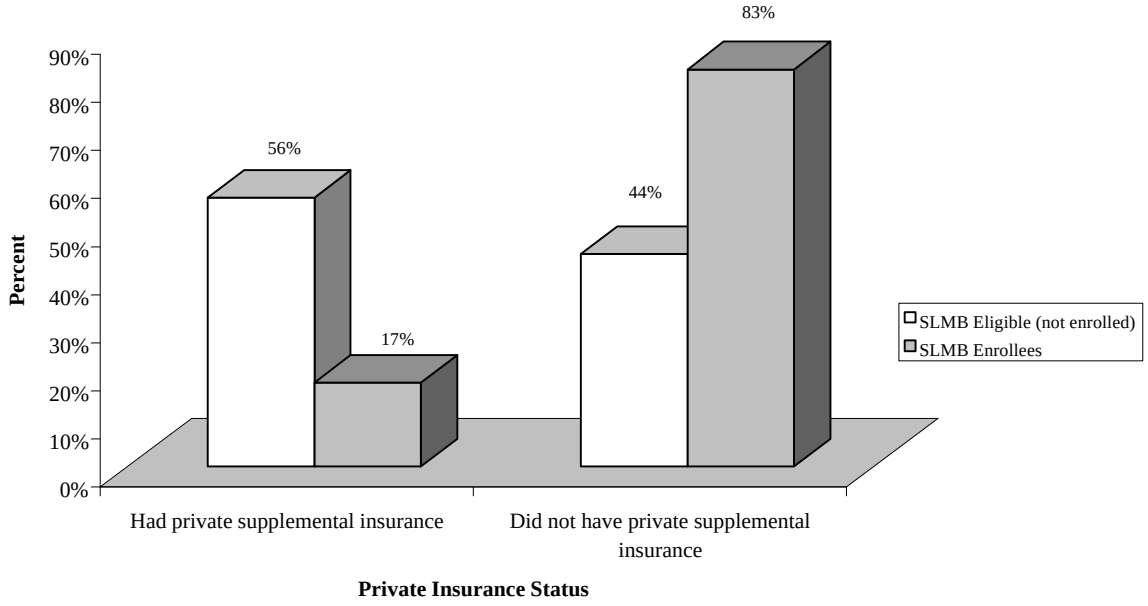
Also as might be expected, a substantially higher fraction of QMB and SLMB participants did not have private supplemental insurance in 1996 compared with QMB and SLMB non-participants (Figures 21a and 21b). This is reflected in the very large differences in participation rates between the two groups (Table 3). On the one hand, beneficiaries participating in the buy-in programs have much less need to purchase private supplemental insurance, an, on the other hand, those without private supplemental insurance may have more need to enroll in the Medicare buy-in programs.

Figure 21a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Private Insurance Status - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 21b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Private Insurance Status - 1996*

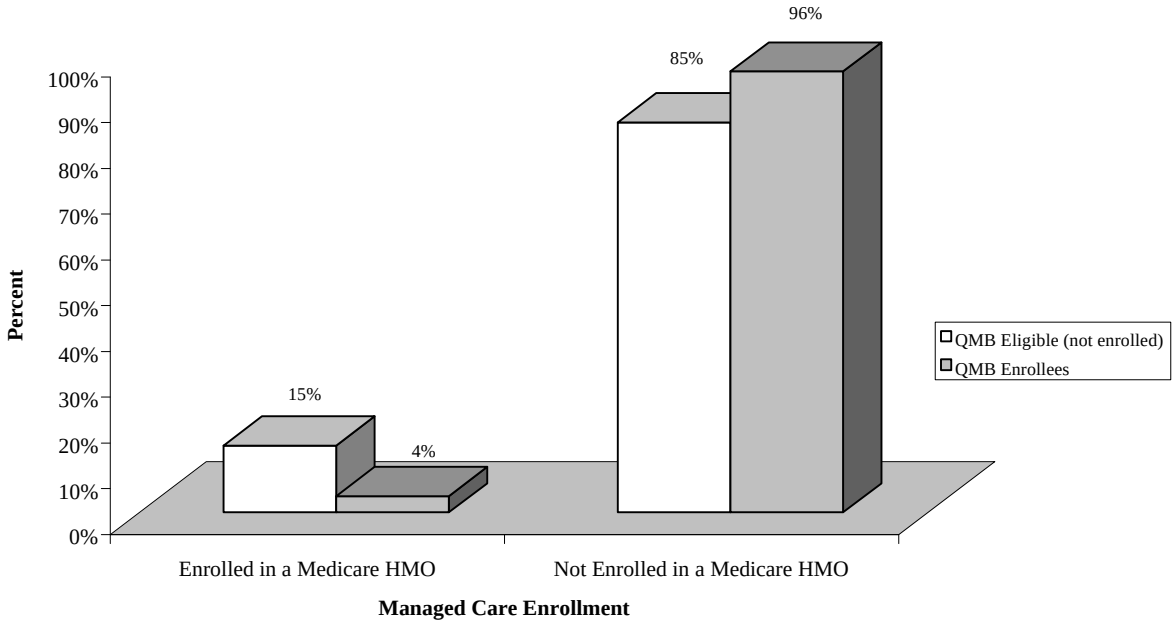


Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

HMO enrollment: Beneficiaries who were not enrolled in a Medicare HMO in 1996 had greater estimated eligibility rates for the QMB and SLMB programs. One-fourth of Medicare beneficiaries who were not enrolled in a Medicare HMO were estimated to be eligible for QMB or SLMB buy-in compared to less than one-fifth of Medicare HMO-enrolled beneficiaries (Table 2).

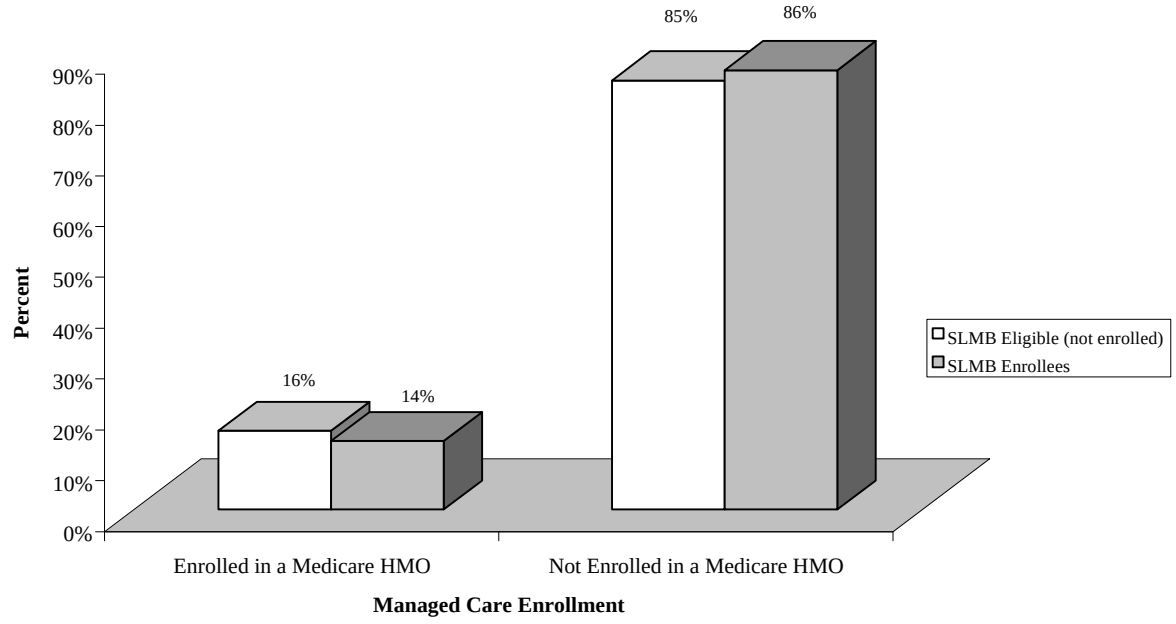
Beneficiaries who were not enrolled in a Medicare HMO in 1996 also had higher participation in these programs, especially in the QMB program. A somewhat higher percentage of QMB non-participants were enrolled in HMOs in 1996 (15 percent of non-participants versus 4 percent of participants), but there was virtually no difference in HMO enrollment among the SLMB-eligible population (Figures 22a and 22b). Of QMB-eligibles enrolled in a Medicare HMO, less than one-fourth participated in the QMB program compared with over one-half of QMB-eligibles not enrolled in a Medicare HMO (Table 3). It may be that HMO enrollment, with its often lower copayments and broader benefits coverage, reduces incentives for eligible beneficiaries to enroll in Medicare buy-in programs.

Figure 22a: Comparison of Non-Enrolled QMB Eligible Beneficiaries and QMB Enrollees, by Managed Care Enrollment - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Statistically significant at less than the 1 percent level.

Figure 22b: Comparison of Non-Enrolled SLMB Eligible Beneficiaries and SLMB Enrollees, by Managed Care Enrollment - 1996*



Source: Barents Group LLC analysis of Medicare Current Beneficiary Survey data.
Note: Percentages may not sum to 100 percent due to missing responses.
*Not statistically significant at less the 5 percent level.

IMPLICATIONS FOR OUTREACH TO POTENTIAL QMB- AND SLMB-ELIGIBLE POPULATIONS

- The profiling results for the QMB- and SLMB-eligible populations indicate there are two general categories of beneficiaries who have relatively low participation rates compared to their counterparts.

  1. The first category consists of beneficiaries who are often considered to be the most financially vulnerable and "hard-to-reach." This category includes very elderly beneficiaries, Hispanic-Latino beneficiaries, and beneficiaries who appear to have less contact with the health care system (i.e., beneficiaries who did not receive a flu shot in 1996 and those who reported they did not have a usual source of care).

     - Very elderly beneficiaries had lower participation rates in both the SLMB and QMB programs compared with their younger counterparts. These beneficiaries tend to be female, live alone or with their children, have very low income levels, are in poor health, and may be relatively isolated from the rest of the community. Communication sources and modes that are most preferred by this subgroup (e.g., audio and video-enhanced communication, easy-to-read materials, and the use of senior centers to distribute information) are possible ways to increase participation. Our current inventory research on outreach to dual eligibles indicates that beneficiaries who have someone to help them collect the required application documents, fill out forms, and manage the in-office segment of the application process are the most likely to successfully enroll in dual eligible programs. This type of help is very resource intensive, but extremely effective and well-received by beneficiaries. In cases where face-to-face help is not available, a working phone number connected to a well-informed source is also very helpful.

     - Hispanic-Latino beneficiaries had one of the lowest participation rates for SLMBs and lower participation in the QMB program compared with African American beneficiaries and beneficiaries of other races/ethnicities. Our communications research indicates that this group of beneficiaries may have poor literacy skills in both English and Spanish and need written materials to be at most a 4th grade reading level and properly translated into Spanish. Other communication modes (e.g., toll-free telephone lines) should also be available in both English and Spanish. This population tends to rely on families, friends, and community networks for much of their information about the Medicare program (Matthies, 1999). Use of Spanish language radio and print media can also broaden the reach of the message about dual eligibility.

     - Beneficiaries who do not have as much contact with the health care system may be relatively healthy beneficiaries who do not feel they need Medicaid assistance, or they may be relatively isolated beneficiaries who have difficulty getting to their health provider or paying for health care. Either way, these beneficiaries are probably not receiving QMB and SLMB program information through their providers and require other outreach approaches. Current dual-eligible outreach research under this contract indicates that an effective way that organizations reach dual eligibles is by linking their outreach activities with other programs that serve low-income seniors.

Many groups make dual eligible program information a supplemental or complementary component of a more established or larger education/outreach activity, such as for Medicare+Choice campaigns, food stamps, or general health education.

2. The second general category of beneficiaries with comparatively low QMB and SLMB participation rates consists of beneficiaries who may not traditionally be considered hard-to-reach but still may be difficult to communicate with. This category comprises Medicare beneficiaries who are relatively better off (although, by definition, they still have low incomes and assets and need assistance in paying their health care bills). It includes beneficiaries who identify themselves as White non-Hispanic, are married, have relatively high formal education levels, are homeowners, are in relatively good health, do not receive SSI or welfare income, and have private supplemental insurance.

   ◊ To tailor messages and communication channels to more effectively reach these beneficiaries, it will be important for HCFA to better understand how the above characteristics overlap and which characteristics are the most important for designing communications. For example, the most important factor may be that they can afford private supplemental insurance and do not feel they want or need to go through the sometimes difficult process of enrolling in a Medicaid assistance program. Additionally, beneficiaries eligible for QMB benefits may not want to give up their private supplemental policy since QMB-only benefits do not cover prescription drugs. It may not be possible to persuade many of these beneficiaries to enroll in the QMB or SLMB programs. However, it may be that the overriding characteristic for this group is their good health and low health care costs, and they do not see the benefits of applying for the programs. These individuals would likely be quite passive in seeking information about dual eligibility. Our communications research for HCFA has found that getting a message to passive information seekers is difficult and potentially expensive. The outreach needs to be aggressive and multi-faced, using a variety of communications approaches.

   ◊ There are at least three reasons why the second category of beneficiaries may have low QMB and SLMB participation rates, each calling for a different approach to outreach design.

      a. Beneficiaries may be unaware of the QMB and SLMB programs. Our market research found that many beneficiaries had never heard of the QMB, SLMB, or QI programs, and that even some social service workers and community groups who provide services to the elderly are not aware of the programs (Edder, 1999). Outreach strategies need to include communication sources, channels, and modes that are more often used by these beneficiaries. They may not hear about the programs through channels that less financially well-off or less healthy beneficiaries might use, such as through the SSI or welfare program offices or through hospitals, public health clinics, or other providers that tend to be more aware of programs available to low-income seniors.

         ◊ The analysis indicates that this group of Medicare beneficiaries are somewhat more mainstream than those with higher QMB and SLMB participation, yet still have relatively low incomes.

- The outreach message should emphasize how the programs can help with their Medicare bills.
- Sources or partners for reaching this population might include:
  - Senior centers;
  - HMOs (because this group has higher Medicare HMO enrollment);
  - AARP or other senior-oriented organizations.
- Since this a quite diverse group, further research is probably needed to help identify the best sources and modes of communication.

b. Beneficiaries may be aware of the programs but are confused about eligibility requirements and think their incomes or assets are too high. They may also not know where or how to apply. Our market research on dual-eligible beneficiaries found that queries regarding the QMB, SLMB, and QI programs center on eligibility requirements. Specifically, beneficiaries do not understand the concepts of "federal poverty level" and "resources" (Edder, 1999).

   ◊ For example, there is a common misconception that an individual's home is counted as a resource, although this is not the case. This is one possible explanation for the very low participation rates of homeowners in both the QMB and SLMB programs. Successful outreach and enrollment depends on people having the correct information about eligibility, written in a way they can easily understand.

   ◊ Beneficiaries who have heard about the QMB, SLMB, or QI programs may need assistance and more information on the application process and where to apply.

c. Some beneficiaries may not feel that the benefits of the program outweigh the time and effort costs of enrolling.

   ◊ Outreach messages should stress the benefits of the buy-in programs in a way that specifically address the needs and preferences of this group.

   - Messages that attract people are those that focus on how the programs can help provide access to prescription drug coverage (for full Medicaid dual eligibles), or can help "put money back in your pocket" so the beneficiary can afford to pay for their prescription drug costs or pay for more comprehensive coverage through a Medigap policy (for non-full Medicaid QMBs, SLMBs, and QIs).

   ◊ Many beneficiaries in this group, such as those who are in relatively better health, may not feel it is worth the time and effort to apply for Medicaid assistance. To induce such beneficiaries to enroll, the time and effort of enrolling must be reduced. Outreach and enrollment strategies should focus on making the application process as easy as possible and messages should emphasize the simplicity of applying for benefits (if the process has been streamlined).

- It is interesting that the beneficiary characteristics associated with greater SLMB non-participation but that do not appear to significantly affect QMB participation are all connected to contact with the health care system. Beneficiaries will less contact had lower SLMB participation compared with those with more contact. Outreach campaigns that mimic those of the Centers for Disease Control and Prevention's public health campaigns (e.g., for increasing child immunization rates) might be effective for reaching people who are relatively healthy.
- QMB and SLMB participation is clearly connected to SSI and welfare program participation, although less so for the SLMB program.
  - Increasing the number of States who "auto-accrete" their SSI enrollees into Medicare buy-in programs may increase enrollment.
  - A survey of State outreach programs for dual-eligibles conducted under this HCFA contract found that States believe they must be sensitive to the "welfare stigma" sometimes associated with Medicare buy-in programs (Shaner, 1999). An effective message identified by Rosenbach and Lamphere (1999) is that the QMB and SLMB programs provide a benefit that people have earned by working hard and is not a government "handout."

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APPENDIX A. DEFINITIONS OF DUAL ELIGIBLE PROGRAMS

Qualified Medicare Beneficiaries (QMBs): Individuals entitled to Part A of Medicare, with income at or below 100 percent of the Federal Poverty Level (FPL),[28] and resources not exceeding twice the limit for SSI eligibility.[29] QMBs may have Medicaid eligibility limited to payment of Medicare Part A (if necessary) and Part B premiums and Medicare cost-sharing for Medicare services provided by Medicare providers (**QMB-Only**) or QMBs may be eligible for that assistance plus full Medicaid benefits (**QMB-Plus**). Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

Specified Low-Income Medicare Beneficiaries (SLMBs): Individuals entitled to Part A of Medicare, with income above 100 percent, but less than 120 percent of FPL, and resources not exceeding twice the limit for SSI eligibility. SLMBs may have Medicaid eligibility limited to payment of Medicare Part B premiums (**SLMB-Only**) or SLMBs may be eligible for that assistance plus full Medicaid benefits (**SLMB-Plus**). FFP equals FMAP.

Qualifying Individuals (QI-1s): Effective January 1, 1998 to December 31, 2002. Individuals entitled to Part A of Medicare, with income above 120 percent, but less than 135 percent of FPL, resources not exceeding twice the limit for SSI eligibility, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. FFP equals FMAP at 100 percent, but is annually capped. Entitlement of individuals is limited by the availability of the capped allocation.

Qualifying Individuals (QI-2s): Effective January 1, 1998 to December 31, 2002. Individuals entitled to Part A of Medicare, with income above 135 percent, but less than 175 percent of FPL, resources not exceeding twice the limit for SSI eligibility, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of Medicare Part B premiums. Payment of Part B premiums is limited to that portion of the Part B premium increase directly attributable to the transfer of home health visits to the Part B program ($1.07 in 1998). FFP equals FMAP at 100 percent, but is annually capped. Entitlement of individuals is limited by the availability of the capped allocation.

Medicaid-Only Dual Eligibles: These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

[28] The FPL in 1996 for an individual was $7,740 and $10,360 for two people.

[29] Asset limits for QMBs, SLMBs, and QIs equaled $4,000 for single people and $6,000 for married couples in 1996.

Qualified Disabled and Working Individuals (QDWIs): These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200 percent of FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. FFP equals FMAP.

APPENDIX B. METHODOLOGY

The primary data source used in this study of the dual-eligible population is the Medicare Current Beneficiary Survey (MCBS). The 1996 MCBS Access to Care files provided the majority of variables to describe beneficiary characteristics (e.g., age, gender, health status, and education level). The Access to Care files also include HCFA's Enrollment Data Base (EDB) and Medicare buy-in files, which were used to identify Medicare Part A and Part B coverage, Medicare buy-in status, and health insurance holdings (private insurance and HMO enrollment) of Medicare beneficiaries in the MCBS sample. The 1997 Income and Asset Supplement to the MCBS (which collects data on 1996 income and assets) was used to estimate the number of Medicare beneficiaries who were potentially eligible for Medicare buy-in in 1996, by buy-in eligibility (Part A, Part B, QMB, SLMB). Estimates of potentially-eligible individuals were separated into beneficiaries enrolled in the Medicare buy-in program and those who were not enrolled in the buy-in program, for each program.

The MCBS data were used to estimate the potentially dual-eligible population – even though the income and asset amounts may be under-reported on the survey – because profiling requires *individual* beneficiary identification of Medicare buy-in eligibility, by buy-in category. Most estimates of this population are based on the Current Population Survey (CPS) data and/or Survey of Income Program Participation (SIPP) data. Estimates of aggregate potential eligibles are derived (either at the national or State level) by buy-in category. This population is then separated into the percentage who are participating and those who not participating in the program based on HCFA data on the aggregate number of Medicare buy-ins (either at the national or State level) by buy-in category. This type of estimation does not rely on individual identification of beneficiaries, who are enrolled or potentially eligible in each category, as did the profiling task.

Because the Income and Asset supplement is only administered to Medicare beneficiaries who live in the community (i.e., it is not fielded for those who are residing in short- or long-term health care facilities at the time of the interview), the study focuses on community-based beneficiaries who were living in households at the time of the interview. Merging the 1996 MCBS Access to Care and 1997 MCBS Income and Assets files provided a sample of 13,231 respondents, who represent approximately 31.2 million disabled and aged community-based beneficiaries. These beneficiaries constitute about 90 percent of Medicare beneficiaries who lived in the community in 1996. The estimates for potential dual-eligibles presented in this report were adjusted to reflect the total 35.3 million Medicare beneficiaries who lived in community settings in 1996.

The sample of 13,231 respondents were "weighted up" to represent the 31.2 million community-based beneficiaries through the use of cross-sectional weights – one for each of the respondents in the data set – contained in the 1996 MCBS Access to Care files. These weights reflect the overall selection probability of each sample person, including adjustment for survey nonresponse and post-stratification to control totals based on accretion status, age, sex, race, region, and metropolitan area status. The weights inflate the sample to 90 percent of the ever-enrolled Medicare population in 1996.

The MCBS Medicare buy-in variable separates beneficiaries into the following buy-in categories:

- No buy-in
- State Part A
- State Part B
- State Part A and B
- State Part A and B QMB
- State Part B QMB
- State Part B SLMB

State Part A, Part B, and Part A and B beneficiaries were combined into one category (A/B buy-in), while State Part A and B QMB and State Part B QMB were combined into one category (QMB buy-in). There is no way to determine from the file whether QMB or SLMB beneficiaries have full Medicaid coverage (QMB Plus or SLMB Plus) or QMB or SLMB coverage only, so these separate categories were not constructed. QI-1s are not currently separated from the Part B buy-ins, so this category of dual-eligible could not be separately constructed. Additionally, the Medicare buy-in file, extracted from the Third Party Premium Billing File, may undercount the extent of QMB and SLMB participation in some States because Medicare beneficiaries who qualify for QMB coverage plus full Medicaid benefits usually are not included in the QMB counts but, rather, are included in the total buy-in category (Part A and/or Part B) on the HCFA file (Rosenbach and Lamphere, 1999). To account for this, beneficiaries classified as Part A and/or Part B buy-ins who were estimated to be eligible for the QMB program were reclassified as QMBs in this study, and those estimated to be eligible for the SLMB program were reclassified as SLMBs.

Medicare buy-in codes in the MCBS are presented on a monthly basis. However, MCBS income and asset data is collected on an annual basis. Therefore, for the purposes of this study, Medicare beneficiaries were considered to be QMBs in 1996 if they were enrolled in the QMB program at least one month in 1996 and had not been enrolled in the SLMB program (2 QMBs were reclassified as SLMBs), or SLMBs if they were enrolled in the SLMB program at least one month in 1996. If the beneficiary was a Part A or Part B buy-in at least one month during the year, but was not classified as a QMB or SLMB, the beneficiary was classified as an A/B buy-in. Only beneficiaries who were not enrolled in any of the buy-in programs for all of 1996 were classified as non-dual eligibles. This seemed an appropriate set of rules for translating monthly buy-in status into annual buy-in status since the focus of the project for which the profiling was done is on improving Medicare beneficiary awareness and enrollment in these programs. Even beneficiaries who were only enrolled for one month were aware of the program and had made the effort (or the effort was made on their behalf) to enroll them. A month-by-month accounting of beneficiary enrollment would likely lower estimates of eligible beneficiary enrollment rates.

The 1996 MCBS Asset and Income file identifies whether or not a Medicare beneficiary received income from certain sources (e.g., SSI or employment) and whether or not the beneficiary held assets such as an automobile, home, or life insurance. However, assets and income are reported in the aggregate, which did not fully allow for the level of detail needed to identify potentially eligible beneficiaries because of income disregards (described below). The 1992 MCBS Asset and Income file, which did collect data for individual income and asset items, was used,

therefore, to impute individual income and asset item responses in the 1996 Asset and Income records for some of the income and asset disregards. This was accomplished by determining averages for income and asset item responses in the 1991 data stratified by categories of total income and applying these averages to the same income categories in the 1996 file.

The 1991 income responses were then inflated to their 1996 levels. Income variables were inflated by the cost of living adjustment (COLA) for OASDI for each year as reported by the Social Security Administration (SSA) and assets were grown by the consumer price index (CPI) for each year. SSI payments individuals and couples for 1996 were actual figures obtained from SSA.

The MCBS data *may* overstate QMB and SLMB eligibles due to potential *under-reporting* of income and assets compared to other survey data, such as the CPS income data. Adjustment factors were developed using a Medicare-specific subset of the March 1997 Current Population Survey to benchmark the MCBS asset and income data. The factors developed were based on the following matrix of variables assessed to be the most important for determining income levels: age, marital status, gender, highest level of education attained, and health status. CPS mean family income was divided by MCBS mean income (which measures the respondent's income if single or the respondent and spouse's income if married) for each cell of the matrix to develop adjustment factors. These factors were then applied to the 1996 MCBS income data. However, estimates of potential eligibles based on the benchmarked MCBS income data were substantially lower than similar estimates reported in other studies. This method also produced unacceptably high estimates of non-eligible beneficiaries who were actually enrolled in Medicare buy-in programs in 1996. Further exploration of benchmarking factors need to be conducted. However, the estimates in this study based on non-benchmarked MCBS data seem very reasonable in light of other estimates of this population and in light of the number of those beneficiaries actually enrolled as dual-eligibles in 1996.

In order to estimate the population of Medicare beneficiaries that qualify for, but are not enrolled in the QMB and SLMB programs, program criteria were applied to beneficiary income and assets. Specifically, reported total income and asset amounts were adjusted to account for income and assets that are allowed to be disregarded when calculating eligibility. To determine whether a Medicare beneficiary was eligible for either the QMB or SLMB programs, we first disregarded $240 from all beneficiaries' total annual income in 1996 ($20 a month). For those beneficiaries who received Supplemental Security Income (SSI) in 1996, an additional $5,640 for single beneficiaries and $8,460 for married beneficiaries was deducted from total annual income in 1996 ($470 a month and $705 a month, respectively). For beneficiaries with earned income, $780 was first subtracted their total annual income ($65 a month). One-half of the remaining earned income was then deducted from their total income. In summary, a beneficiary's reported income was adjusted by the following formula:

$TI_{96adj}=TI_{96}-SSI_{96}-(0.5 * (EI_{96}-\$780)$

Where TI_{96adj} = adjusted 1996 income
TI_{96} = Total reported 1996 income
SSI_{96} = Total 1996 SSI payments for beneficiaries who received SSI income in 1996
EI96 = Total 1996 earned income for beneficiaries who had earned income in 1996

Adjustments were made to total assets in 1996 to take into account ownership of automobiles and life insurance policies. A $4,500 deduction was made to asset totals for beneficiaries owning an automobile in 1996. For beneficiaries with life insurance, the value of the life insurance was deducted from their total assets in 1996. In summary, a beneficiary's reported total asset value was adjusted by the following formula:

$TA_{adj96} = TA_{96}-AD_{96}-LID_{96}$

Where TA_{adj96} = Adjusted 1996 assets
TA_{96} = Total 1996 assets
AD_{96} = Automobile disregard ($4,500) for beneficiaries who reported owning an automobile in 1996
LID_{96} = Insurance Disregard (total value of life insurance policy) for beneficiaries who reported owning a life insurance policy that builds up cash equity

To determine whether beneficiaries were eligible for the QMB program, the following rules were applied:

- Adjusted assets must be less than or equal to twice the SSI limits in 1996, equal to $4,000 for single beneficiaries and $6,000 for married beneficiaries; and
- Adjusted income must be less than or equal to $7,740 for single beneficiaries and $10,360 for married beneficiaries, which equals 100 percent of the Federal Poverty Level (FPL) in 1996.

To determine whether beneficiaries were eligible for the SLMB program, the same asset rules apply as in the QMB determination, but adjusted income for single and married beneficiaries increases to $9,288 and $12,432 respectively (120 percent of the FPL). In addition, beneficiaries must be entitled to Medicare Part A to be eligible for the SLMB program.

Estimates of potential dual eligibles, by buy-in category, were separated into eligible but not enrolled and eligible and enrolled by applying the four Medicare buy-in enrollment codes to each individual (i.e., not enrolled, A/B buy-in enrolled, QMB buy-in enrolled, SLMB buy-in enrolled).

Based on the methodology used to estimate dually-eligible beneficiaries, some beneficiaries who were enrolled in Medicare buy-in programs in 1996 do not appear eligible for those programs. About 10 percent of beneficiaries identified in the MCBS with State Part A and/or Part B buy-in were estimated to be non-eligible for either the QMB or SLMB programs. These may be "medically needy" dual eligibles who were bought in or QI-1s, both of which are included in the Part A and Part B buy-in categories in the MCBS and are not identified separately (Discussions

with HCFA, January 1999). Of the QMB-enrollees, 6.6 percent were estimated to be non-eligible, as were 18.6 percent of SLMB-enrollees. These could be beneficiaries in States that have set higher income or asset limits for QMB or SLMB eligibility (e.g., Florida). These could also be individuals whose monthly income qualified them for these programs during some part of 1996, but whose annual income (collected by the MCBS) appears to be too high for qualification. In addition, it could be that the buy-in files or the methodology for estimating potential dual eligibles have inaccuracies that cause some enrollees to appear ineligible. Because comparable non-participating eligibles could not be estimated, the profiling results in this study compare beneficiaries estimated to be eligible but not participating only to beneficiaries estimated to be eligible and who are participating.

WesVarPC – a statistical package designed by Westat to use replication methods for producing variance estimates – was used to conduct the bivariate statistical analyses for this report. The MCBS employs a stratified, unequal-probability, multistage sample design. When data are collected as part of a complex sample survey such as the MCBS, there is often no easy way to produce approximately unbiased and design-consistent estimates of variance analytically. The variance of survey statistics, including means and proportions, estimated through standard statistical packages such as SAS assume that the data were collected from a simple random sample and are not appropriate for the MCBS. They could produce overestimates or, more likely, underestimates of the true sampling error. WesVarPC was specifically designed by Westat to estimate the appropriate standard errors for surveys that use the MCBS sampling strategy. WesVarPC also allows for the calculation of two modified chi-square statistics for the bivariate analyses that incorporate an estimated MCBS "design effect" (*A User's Guide to WesVarPC*, 1997*)*.

APPENDIX C. TABLES

Table 1

Table 1.
Selected Estimates of Medicare/Medicaid Dual-Eligible Participation

Study Author	Year of Estimate	Primary Data Sources	Total QMB/SLMB Estimate	QMB Estimate	SLMB Estimate	Medicare Beneficiary Population
Urban Institute (1998)	1998	CPS	7.3 million are eligible for QMB/SLMB; 2.59 million QMB/SLMB eligibles not enrolled (35.5%)	1.25 million of 5.7 million eligible are not enrolled (22%)	1.34 of 1.6 million eligible are not enrolled (84%)	Elderly and Disabled; Institutionalized
HCFA (Barents Group) (1999)	1996	MCBS	8.51 million are eligible for QMB/SLMB/ Part B buy-in; 4.48 million QMB/SLMB eligibles not enrolled (52.7%)	2.96 million of 6.54 million eligible are not enrolled (45.3%)	1.52 million of 1.80 million eligible are not enrolled (84.3%)	Elderly and Disabled; Noninstitutional-ized
Families USA (1998)	1996	CPS/SIPP	8.04 million are eligible for QMB/SLMB; 3.3–3.9 million QMB/SLMB eligibles not enrolled (41.5%–47.9%)	1.9-2.4 million eligible are not enrolled	1.4 million eligible are not enrolled	Elderly and Disabled; Noninstitutional-ized
HCFA (Actuarial Research Corp.) (1999)	1996	CPS/SIPP	9.12 million are eligible for QMB/SLMB or SSI/Medically Needy; 4.21 not enrolled (46.1%)			Elderly and Disabled; Institutionalized
Urban Institute (1996)	1995	CPS	7.2 million are eligible for QMB/SLMB; 3.71 million QMB/SLMB eligibles not enrolled (51.5%)	2 million of 5.3 million eligible are not enrolled (37%)	1.71 of 1.9 million eligible are not enrolled (90%)	Elderly and Disabled; Institutionalized

Table 1. Selected Estimates of Medicare/Medicaid Dual-Eligible Participation						
Study Author	**Year of Estimate**	**Primary Data Sources**	**Total QMB/SLMB Estimate**	**QMB Estimate**	**SLMB Estimate**	**Medicare Beneficiary Population**
Project HOPE (1995)	1993	MCBS		2.8 million of 4.7 million eligible are not enrolled (59%)		Elderly only; Noninstitutional-ized
Families USA (1993)	1993		5.3 million are eligible for QMB/SLMB; 2.8 million QMB/SLM eligibles not enrolled (52.8%)	1.8 million of 4.3 million eligible are not enrolled (42%)	995,000 of 1 million eligible are not enrolled (99.5%)	Elderly only; Noninstitutional-ized

Table 2

Table 2 Eligibility and Enrollment Rates in the QMB and SLMB Programs, by Medicare Beneficiary Characteristics - 1996				
Beneficiary Characteristic	**Percent Eligible**	**Percent Enrolled**	**Percent Not Enrolled**	**Percent of Eligible Who Are Enrolled**
Age				
Less than 18 years old	100.0%	100.0%	0.0%	100.0%
18 to 44 years old	72.4%	53.6%	18.8%	74.0%
45 to 64 years old	48.4%	25.2%	23.2%	52.0%
65 to 69 years old	17.6%	8.2%	9.4%	46.8%
70 to 74 years old	18.1%	8.2%	9.9%	45.4%
75 to 79 years old	18.8%	7.7%	11.0%	41.2%
80 years old and over	26.5%	9.9%	16.6%	37.5%
Gender				
Male	19.5%	9.0%	10.6%	46.0%
Female	27.7%	13.3%	14.4%	48.1%
Educational Attainment				
Fifth grade or less	65.5%	39.8%	25.7%	60.7%
Sixth to eighth grade	42.5%	18.4%	24.1%	43.2%
Ninth to eleventh grade	21.3%	9.8%	11.5%	45.9%
High school graduate	14.7%	6.2%	8.6%	41.8%
More than high school	5.3%	2.4%	2.9%	46.0%
Race/Ethnicity				
White, non-Hispanic	17.2%	11.1%	6.1%	64.3%
Black, non-Hispanic	56.7%	31.3%	25.4%	55.2%
Hispanic	59.7%	29.5%	30.2%	49.4%
Other race	45.6%	30.8%	14.8%	67.5%
Marital Status				
Married	12.7%	4.4%	8.3%	34.4%
Single	38.9%	20.6%	18.4%	52.8%
Living Arrangement				
Lived alone	31.5%	15.9%	15.6%	50.4%
Lived with spouse	11.6%	4.1%	7.5%	35.4%
Lived with children (no spouse)	48.8%	24.9%	23.9%	51.0%
Lived with other relatives	55.7%	30.3%	25.3%	54.5%

Table 2 Eligibility and Enrollment Rates in the QMB and SLMB Programs, by Medicare Beneficiary Characteristics - 1996				
Beneficiary Characteristic	**Percent Eligible**	**Percent Enrolled**	**Percent Not Enrolled**	**Percent of Eligible Who Are Enrolled**
Metropolitan Status				
Metropolitan area	22.9%	11.3%	11.6%	49.3%
Non-metropolitan area	27.4%	14.5%	12.9%	52.9%
Residence				
Northeast	23.3%	9.8%	13.5%	42.2%
Midwest	17.1%	7.4%	9.7%	43.2%
South	29.3%	15.1%	14.3%	51.4%
West	20.5%	12.1%	8.4%	58.9%
Self-Reported Health Status				
Excellent	13.9%	5.3%	8.6%	38.2%
Very good	15.7%	5.8%	9.9%	37.0%
Good	24.7%	12.0%	12.7%	48.5%
Fair	38.1%	18.8%	19.3%	49.4%
Poor	41.7%	24.9%	16.8%	59.7%
Problems with ADLs				
No problems with ADLs	21.4%	9.7%	11.7%	45.2%
Problems with one ADL	32.2%	15.9%	16.4%	49.2%
Problems with two ADLs	38.6%	22.1%	16.6%	57.1%
Problems with three ADLs	38.4%	20.7%	17.7%	53.9%
Problems with four ADLs	35.5%	17.8%	17.6%	50.3%
Problems with all five ADLs	48.8%	30.1%	18.7%	61.6%
Hospital Stays				
Had no hospital stays	23.2%	10.6%	12.6%	45.6%
Had one or more hospital stays	29.2%	16.1%	13.1%	55.1%
SNF Admissions				
Had no SNF admissions	24.1%	11.4%	12.7%	47.2%
Had one or more SNF admissions	25.2%	14.1%	11.0%	56.2%
Outpatient Visits				
Had no outpatient visits	22.2%	8.3%	13.9%	37.3%
Had one or more outpatient visits	25.9%	14.3%	11.6%	55.1%
Home Health Visits				
Had no home health visits	23.1%	10.7%	12.4%	46.3%
Had one or more home health visits	36.2%	19.9%	16.3%	54.9%

Table 2 Eligibility and Enrollment Rates in the QMB and SLMB Programs, by Medicare Beneficiary Characteristics - 1996				
Beneficiary Characteristic	**Percent Eligible**	**Percent Enrolled**	**Percent Not Enrolled**	**Percent of Eligible Who Are Enrolled**
Flu Shot				
Did not receive a flu shot	32.8%	15.3%	17.6%	46.5%
Received a flu shot	18.5%	8.9%	9.6%	48.0%
Usual Place of Care				
Did not have a usual place of care	34.6%	13.5%	21.1%	39.1%
Had a usual place of care	23.3%	11.3%	12.1%	48.3%
SSI Enrollment				
Did not receive SSI	18.0%	5.1%	12.9%	28.3%
Received SSI	92.3%	82.0%	10.3%	88.8%
Welfare Enrollment				
Did not receive welfare	20.9%	8.4%	12.6%	40.0%
Received welfare	90.7%	75.1%	15.6%	82.8%
Private Insurance Status				
Had private supplemental insurance	10.3%	1.4%	8.9%	13.4%
Did not have private supplemental insurance	54.8%	33.6%	21.1%	61.4%
Managed Care Enrollment				
Enrolled in a Medicare HMO	17.7%	3.9%	13.8%	21.9%
Not Enrolled in a Medicare HMO	25.1%	12.6%	12.5%	50.2%
Home Ownership				
Owned a home	12.8%	4.0%	8.9%	30.8%
Rented a home	49.9%	31.1%	18.8%	62.3%
Neither rented nor owned a home	57.5%	28.2%	29.3%	49.0%
Both owned and rented a home	22.1%	11.9%	10.2%	53.9%
Received subsidized housing	89.2%	69.5%	19.7%	77.9%

Table 3

Table 3 Participation Rates in the QMB and SLMB Programs, by Medicare Beneficiary Characteristics – 1996		
	QMB	**SLMB**
Age		
Less than 18 years old	100.0%	0.0%
18 to 44 years old	76.2%	28.8%
45 to 64 years old	58.0%	15.6%
65 to 69 years old	49.9%	21.4%
70 to 74 years old	52.8%	11.7%
75 to 79 years old	50.3%	9.8%
80 years old and over	44.0%	10.5%
Gender		
Male	52.4%	14.0%
Female	54.4%	13.8%
Educational Attainment		
Fifth grade or less	64.8%	19.4%
Sixth to eighth grade	50.1%	11.6%
Ninth to eleventh grade	52.6%	13.7%
High school graduate	47.1%	14.6%
More than high school	58.7%	0.0%
Race/Ethnicity		
White, non-Hispanic	49.6%	13.5%
Black, non-Hispanic	60.0%	19.1%
Hispanic	53.8%	9.6%
Other race	71.2%	10.7%
Marital Status		
Married	39.2%	10.3%
Single	59.0%	16.1%
Living Arrangement		
Lived alone	55.4%	19.7%
Lived with spouse	40.5%	10.3%
Lived with children (no spouse)	59.2%	9.8%
Lived with other relatives	60.4%	12.9%
Metropolitan Status		
Metropolitan area	51.0%	13.0%
Non-metropolitan area	59.8%	16.0%
Residence		
Northeast	51.9%	10.2%
Midwest	51.2%	12.2%
South	57.2%	16.5%
West	64.2%	17.9%

Table 3 Participation Rates in the QMB and SLMB Programs, by Medicare Beneficiary Characteristics – 1996		
	QMB	**SLMB**
Self-Reported Health Status		
Excellent	46.2%	4.5%
Very good	43.5%	8.4%
Good	54.1%	15.1%
Fair	55.1%	17.7%
Poor	67.1%	19.4%
Problems with ADLs		
No problems with ADLs	51.7%	12.1%
Problems with one ADL	53.1%	21.1%
Problems with two ADLs	67.7%	13.5%
Problems with three ADLs	59.5%	17.2%
Problems with four ADLs	58.0%	19.7%
Problems with all five ADLs	64.4%	21.6%
Hospital Stays		
Had no hospital stays	52.0%	11.6%
Had one or more hospital stays	61.0%	23.8%
SNF Admissions		
Had no SNF admissions	53.5%	13.7%
Had one or more SNF admissions	63.6%	24.7%
Outpatient Visits		
Had no outpatient visits	42.5%	9.1%
Had one or more outpatient visits	62.0%	18.2%
Home Health Visits		
Had no home health visits	52.5%	12.0%
Had one or more home health visits	62.4%	25.4%
Flu Shot		
Did not receive a flu shot	52.8%	11.7%
Received a flu shot	54.3%	16.4%
Usual Place of Care		
Did not have a usual place of care	46.5%	8.0%
Had a usual place of care	54.5%	14.5%
SSI Enrollment		
Did not receive SSI	30.1%	13.2%
Received SSI	89.1%	44.0%
Welfare Enrollment		
Did not receive welfare	46.1%	11.1%
Received welfare	83.9%	57.8%
Private Insurance Status		
Had private supplemental insurance	14.7%	4.8%
Did not have private supplemental insurance	66.0%	23.1%
Managed Care Enrollment		
Enrolled in a Medicare HMO	22.0%	12.3%
Not Enrolled in a Medicare HMO	56.7%	14.2%

Table 3 Participation Rates in the QMB and SLMB Programs, by Medicare Beneficiary Characteristics – 1996		
	QMB	**SLMB**
Home Ownership		
Owned a home	34.8%	9.6%
Rented a home	68.1%	22.3%
Neither rented nor owned a home	54.8%	12.9%
Both owned and rented a home	80.5%	0.0%
Received subsidized housing	73.1%	0.0%