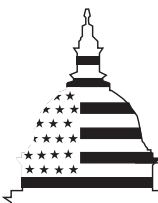


March 2004

MEDICARE SAVINGS PROGRAMS

Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries



G A O

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Highlights of [GAO-04-363](#), a report to congressional committees

Why GAO Did This Study

To assist low-income beneficiaries with their share of premiums and other out-of-pocket costs associated with Medicare, Congress has created four Medicare savings programs. Historic low enrollment in these programs has been attributed to several factors, including lack of awareness about the programs, and cumbersome eligibility determination and enrollment processes through state Medicaid programs. Concerned about this low enrollment, Congress passed legislation as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requiring the Social Security Administration (SSA) to notify low-income Medicare beneficiaries of their potential eligibility for Medicare savings programs. The statute also required GAO to study the impact of SSA's outreach effort. GAO examined what outreach SSA undertook to increase enrollment, how enrollment changed following SSA's 2002 outreach, and how enrollment changed in selected states following SSA's outreach and what additional outreach efforts these states undertook.

GAO reviewed information obtained from SSA and the Centers for Medicare & Medicaid Services (CMS), analyzed enrollment data provided by SSA and CMS, and interviewed officials in and obtained data from six selected states (Alabama, California, Louisiana, New York, Pennsylvania, and Washington).

www.gao.gov/cgi-bin/getrpt?GAO-04-363.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

MEDICARE SAVINGS PROGRAMS

Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries

What GAO Found

In response to a statutory requirement, SSA is carrying out an annual outreach effort to help increase enrollment in Medicare savings programs. This outreach effort consists of mailing letters to potentially eligible low-income beneficiaries nationwide as well as sharing data with states to assist with their supplemental outreach efforts. In 2002, SSA sent 16.4 million letters to low-income Medicare beneficiaries whose incomes from Social Security and certain other federal sources met the income eligibility criteria for Medicare savings programs. The 2002 letters provided eligibility criteria for programs in the beneficiary's home state and urged beneficiaries interested in enrolling to call a state telephone number provided. In addition to sending these letters, SSA provided states with a data file containing information on the beneficiaries to whom it sent letters. In 2003, SSA sent another 4.3 million letters to potentially eligible beneficiaries, and indicated that it intends to repeat the outreach mailing annually to newly eligible beneficiaries and a portion of prior letter recipients.

Following SSA's outreach efforts in 2002, GAO estimated that more than 74,000 additional eligible beneficiaries enrolled in Medicare savings programs, 0.5 percent of all 2002 letter recipients, than would have likely enrolled without the letter. CMS enrollment data also showed that growth in Medicare savings programs enrollment for the year following SSA's mailing was nearly double that for each of the 3 prior years. Of the 74,000 additional enrollees, certain states and demographic groups had somewhat larger increases in enrollment than other groups. The highest additional enrollment increase was in Alabama, where 2.9 percent of letter recipients enrolled, followed by Delaware at 2.0 percent. Beneficiaries less than 65 years old, persons with disabilities, racial and ethnic minorities, and residents in southern states also had higher enrollment rates than other groups.

The percentage of letter recipients newly enrolling in Medicare savings programs following SSA's 2002 mailing ranged from 0.3 to 2.9 percent among the six states GAO reviewed. The varying effects on enrollment by state could be attributable to several factors, including the share of eligible beneficiaries enrolled in Medicare savings programs prior to the outreach, each state's ability to handle increased call and application volume, and a state's income and asset limits. Four states GAO reviewed reported increases in the numbers of calls received or applications mailed or received following the SSA mailing and then decreases after the mailing period ended. Each of the states GAO reviewed reported that the state or other stakeholders conducted additional outreach during SSA's 2002 outreach.

SSA generally agreed with GAO's findings. CMS stated that it did not have specific comments on the report.

Contents

Letter		1
	Results In Brief	3
	Background	5
	SSA Is Conducting an Annual Outreach Effort Targeted to Low- Income Medicare Beneficiaries	12
	Medicare Savings Program Enrollment Increased by More than 74,000 Beneficiaries Following the 2002 SSA Mailing	16
	Enrollment Increases Varied among Selected States We Reviewed, with Several Reporting Increased Calls and Applications Concurrent with SSA Mailing	20
	Agency and State Comments	25
Appendix I	Methodology	28
Appendix II	SSA 2002 Outreach Letter	32
Appendix III	Medicare Savings Program Enrollment following 2002 SSA Mailing by State	34
Appendix IV	Medicare Savings Program Enrollment following 2002 SSA Mailing by Demographic Group	36
Appendix V	Comments from the Social Security Administration	38
Related GAO Products		40
Tables		
	Table 1: Medicare Coverage and Beneficiary Cost Sharing for 2003	6
	Table 2: Medicaid and Medicare Savings Programs' Eligibility Criteria and Benefits for Low-Income Medicare Beneficiaries, 2003	9

Table 3: Enrollment in Medicare Savings Programs by Sample Cohort, December 2002	18
Table 4: Medicare Savings Program Enrollment, May 1999 to May 2003	19
Table 5: Increase in Enrollment following SSA's Outreach to Targeted Population in Six Selected States, December 2002	20
Table 6: Average Monthly Calls and Applications Related to Medicare Savings Programs for Four States prior to, during, and/or after SSA's Mailing Outreach, January 2002 to April 2003	23

Figures

Figure 1: Medicare Savings Programs Enrollment in Two Sample Cohorts of SSA Letter Recipients, June 2002 through December 2002	17
Figure 2: Sample 2002 SSA Letter	33
Figure 3: Estimated Percentage Change in Medicare Savings Program Enrollment Following 2002 SSA Mailing by State, December 2002	35
Figure 4: Estimated Percentage Change in Medicare Savings Program Enrollment Following 2002 SSA Mailing by Demographic Group, December 2002	37

Abbreviations

BIPA	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare & Medicaid Services
FPL	federal poverty level
MBR	Master Beneficiary Record
QDWI	Qualified Disabled and Working Individuals
QI	Qualifying Individuals
QMB	Qualified Medicare Beneficiaries
SLMB	Specified Low-Income Medicare Beneficiaries
SSA	Social Security Administration
SSI	Supplemental Security Income

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Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

March 26, 2004

Congressional Committees

Medicare provides health insurance coverage for a broad array of services, including hospital, physician, home health, and other services, to more than 40 million Americans who are elderly, disabled, or have end-stage renal disease. Medicare beneficiaries pay a portion of the program's costs through cost-sharing provisions—including premiums, deductibles, and coinsurance—that can be difficult to afford for low-income beneficiaries. To assist low-income beneficiaries, Congress has created several Medicare savings programs that help pay for some or all of Medicare's cost-sharing provisions. There are four Medicare savings programs, each with differing income eligibility requirements and levels of benefits—the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled and Working Individual (QDWI) programs. To enroll, eligible beneficiaries must have incomes and assets within the specific program's federal ceilings and enroll through their state Medicaid program, the joint federal state program that covers health care services for certain individuals with low incomes and resources. States may have less restrictive income and asset requirements that eligible beneficiaries meet to qualify. As of September 2003, about 6.2 million beneficiaries were enrolled in Medicare savings programs.

We reported in 1999 that 43 percent of beneficiaries eligible for the QMB and SLMB programs were not enrolled.¹ More recent studies also have reported low enrollment rates.² Low program enrollment has been attributed to several factors, including a lack of awareness about the programs, ineffective outreach, a cumbersome eligibility determination

¹U.S. General Accounting Office, *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment*, [GAO/HEHS-99-61](#), (Washington, D.C.: Apr. 9, 1999).

²See, for example, Kim Glaun, National Senior Citizens Law Center, *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings*, prepared for The Kaiser Commission on Medicaid and the Uninsured, December 2002; and Susan G. Haber et al, RTI International, *Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs*, prepared for the Centers for Medicare & Medicaid Services, October 1, 2003.

and enrollment process that varies among state Medicaid programs, and perceived stigma among some potentially eligible beneficiaries about enrolling in a program for low-income people.

Concerned about low enrollment in Medicare savings programs, Congress passed legislation in 2000 requiring the Social Security Administration (SSA) to conduct outreach to low-income Medicare beneficiaries to notify them of their potential eligibility for Medicare savings programs.³ SSA began notifying beneficiaries in response to the statutory requirement in 2002. The statute also required us to study the impact of SSA's outreach.⁴ As agreed with the committees of jurisdiction, this report addresses the following questions:

- What outreach has SSA undertaken to increase enrollment in Medicare savings programs in response to the statutory requirement?
- How did enrollment in the Medicare savings programs change following SSA's 2002 outreach to potential beneficiaries?
- How did enrollment in these programs change in selected states following SSA's outreach, and what outreach efforts did these selected states also undertake?

To examine SSA's response to the statutory requirement for outreach to eligible low-income Medicare beneficiaries, we obtained relevant documents and interviewed officials from SSA and the Centers for Medicare & Medicaid Services (CMS), the federal agency responsible for administering the Medicare savings programs. To determine how enrollment in Medicare savings programs changed following SSA's outreach, we analyzed records from SSA's Master Beneficiary Record (MBR)—a database that contains the administrative records of Social Security beneficiaries, including payments for Medicare premiums—and we report the additional enrollment following the 2002 SSA outreach that was beyond what would have likely occurred in the absence of SSA's outreach. We estimated the additional enrollment increase following the SSA mailing to all letter recipients.⁵ We analyzed these enrollment changes

³Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554, App. F, § 911(a), 114 Stat. 2763, 2763A-583 (adding section 1144 to the Social Security Act; codified at 42 U.S.C. § 1320b-14 (2000)).

⁴BIPA § 911(b), 114 Stat. 2763A-584.

⁵Throughout this report, we refer to all beneficiaries who were included in SSA's mailing as "recipients" because past SSA efforts found that only 1.5 percent of letters were returned as undeliverable.

at the national level as well as separately for all states⁶ and several demographic groups, such as beneficiaries less than 65 years of age or in certain minority groups. Any difference in increased enrollment among state or demographic groups that we report was statistically significant at a 95 percent confidence level. We also obtained CMS's national enrollment data for the Medicare savings programs and compared enrollment trends before and after the SSA outreach. Whereas the SSA MBR data we analyzed are specific to those beneficiaries who were sent SSA's mailing, the CMS data also included existing beneficiaries and are not limited to the beneficiaries who were sent SSA's mailing. To assess how SSA's outreach affected enrollment in selected states and what outreach efforts these states undertook, we interviewed officials and collected data from six states—Alabama, California, Louisiana, New York, Pennsylvania, and Washington. We selected these states based on several factors, including their different levels of change in overall Medicare savings programs enrollment from 2002 to 2003, geographic diversity, relatively large populations of Medicare savings programs enrollees, and availability of data on their program enrollment. It was beyond the scope of our work to examine the effectiveness of any outreach performed by states or CMS separately from SSA's outreach. In conducting our analyses, we obtained information from SSA and CMS on reliability checks they made on the data and any data limitations provided to us, and concluded that their data were sufficiently reliable for our analysis. Appendix I provides more detailed information on our methodology. We performed our work from February 2003 through March 2004 in accordance with generally accepted government auditing standards.

Results In Brief

In response to a statutory requirement in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), SSA is carrying out an annual outreach effort to help increase enrollment in Medicare savings programs. This outreach effort consists of mailing letters to all low-income Medicare beneficiaries nationwide who were not enrolled in Medicare savings programs at the time the letters were sent as well as sharing data with states to assist with any state outreach efforts. From May through November 2002, SSA sent 16.4 million letters to low-income Medicare beneficiaries whose incomes from Social Security and certain other federal sources met the income eligibility criteria for Medicare savings programs. Because SSA does not have complete

⁶Throughout this report, we include the District of Columbia in our discussion of states.

information on beneficiaries' income and assets, however, many of these beneficiaries could have had other income or assets that would exceed the program's eligibility criteria, thus reducing the number of eligible beneficiaries. The 2002 letters provided eligibility criteria for the Medicare savings program in the beneficiary's home state and urged beneficiaries interested in enrolling to call a state telephone number provided. In addition to sending these letters, SSA provided states with a data file containing information on the beneficiaries to whom it sent letters. From June through October 2003, SSA sent 4.3 million letters to potentially eligible beneficiaries, including beneficiaries newly eligible for Medicare savings programs as well as a portion of those who had been sent the 2002 letter but who had not enrolled. SSA indicated that it intends to annually repeat the outreach mailing to potentially eligible beneficiaries.

Following SSA's outreach efforts in 2002, we estimated that more than 74,000 additional eligible beneficiaries enrolled in Medicare savings programs than would have likely enrolled without the letter. This represents about 0.5 percent of all letter recipients. Further, CMS data showed that overall enrollment growth in Medicare savings programs nationwide for the year following SSA's mailing was nearly double each of the 3 prior years. Thirty-five states had a statistically significant additional increase in enrollment nationwide following the SSA mailing, with the largest increases in Alabama (2.9 percent) and Delaware (2.0 percent). Beneficiaries less than 65 years old, persons with disabilities, racial and ethnic minorities, and residents in southern states had higher additional enrollment rates than other groups.

Additional enrollment in Medicare savings programs varied significantly among the six states we reviewed, ranging from 0.3 percent in California, Washington, and New York to a high of 2.9 percent in Alabama. The varying effects on enrollment by state could be attributable to several factors, including the share of eligible beneficiaries already enrolled in Medicare savings programs prior to the outreach, a state's ability to handle increased call and application volume, and a state's income and asset limits. Four states we reviewed reported significant increases in the numbers of calls received by their hot lines related to Medicare savings programs and applications mailed or received during the SSA mailing and then decreases after the SSA mailing period ended. Each of the states we reviewed reported that the state or other stakeholders, such as community organizations that advocate for low-income elderly or private health plans that participated in Medicare, supplemented SSA efforts with additional outreach that may have also contributed to increased interest and enrollment in Medicare savings programs.

In commenting on a draft of this report, SSA generally agreed with our findings and noted that improvements in state enrollment processes could further increase enrollment. CMS stated that it did not have specific comments on the report. Louisiana noted that, in comparison to its experience in 2002, it observed little increase in calls following the 2003 SSA mailing. New York noted that it had a larger increase in Medicare savings program enrollment overall than we showed in the draft report. However, we report the increase in enrollment specifically attributable to the 2002 SSA outreach mailing, not the net increase in enrollment, which could also be due to factors besides the SSA mailing.

Background

Medicare covers about 40 million elderly (over 65 years old) and disabled beneficiaries. Individuals who are eligible for Medicare automatically receive Hospital Insurance, known as part A, which helps pay for inpatient hospital, skilled nursing facility, hospice, and certain home health services. A beneficiary generally pays no premium for this coverage unless the beneficiary or spouse has worked fewer than 40 quarters in his or her lifetime, but the beneficiary is liable for required deductibles, coinsurance, and copayment amounts. Medicare-eligible beneficiaries may elect to purchase Supplementary Medical Insurance, known as part B, which helps pay for certain physician, outpatient hospital, laboratory, and other services. Beneficiaries must pay a premium for part B coverage, which was \$58.70 per month in 2003.⁷ Beneficiaries are also responsible for part B deductibles, coinsurance, and copayments. Table 1 summarizes the benefits covered and cost-sharing requirements for Medicare part A and part B.

⁷The premium amount is adjusted each year so that expected Medicare premium revenues equal 25 percent of expected Medicare part B spending. 42 U.S.C. § 1395r(a) (2000).

Table 1: Medicare Coverage and Beneficiary Cost Sharing for 2003

Part A – Hospital insurance	Beneficiary pays
Part A premium	No premium if beneficiary or spouse worked at least 40 quarters in lifetime Premium if beneficiary or spouse worked fewer than 40 quarters in lifetime
Inpatient hospital	\$840 deductible per benefit period ^a \$210 copayment per day for days 61-90 \$420 copayment per day for days 91-150 ^b All costs beyond 150 days
Skilled nursing facility ^c	Nothing for first 20 days Up to \$105 copayment or less per day for days 21-100 All costs beyond 100 days in the benefit period
Home health ^d	No cost sharing 20 percent coinsurance for durable medical equipment
Hospice	Up to \$5 copayment for outpatient drugs 5 percent coinsurance for inpatient respite care
Blood	Cost of first 3 pints
Part B – Medical insurance^e	
Part B premium	\$58.70 per month
Physician and medical	\$100 deductible each year 20 percent coinsurance for most services 50 percent coinsurance for outpatient mental health services
Clinical laboratory	No cost sharing
Home health ^d	No cost sharing 20 percent coinsurance for durable medical equipment
Outpatient hospital	Coinsurance may vary by service and may exceed 50 percent
Blood	Cost of first 3 pints 20 percent coinsurance for additional pints

Source: CMS.

^aNo deductible is charged for second and subsequent hospital admissions if they occur within 60 days of the beneficiary's most recent covered inpatient stay.

^bAfter the first 90 days of inpatient care, Medicare will help pay for an additional 60 days of inpatient care (days 91–150). Each beneficiary is entitled to a lifetime reserve of 60 days of inpatient coverage. Each reserve day may be used only once in a beneficiary's lifetime.

^cTo qualify, a Medicare beneficiary must require daily skilled nursing or rehabilitative therapy services, generally within 30 days of a hospital stay of at least 3 days in length, and must be admitted to the nursing home for a condition related to the hospitalization.

^dTo qualify for services, beneficiaries must be confined to their homes; have a plan of care signed by a physician; and need intermittent skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample), physical therapy, speech-language pathology services, or have a continuing need for occupational therapy services.

⁸No cost sharing is required for certain preventive services, including specific screening tests for colon, cervical, and prostate cancer, and flu and pneumonia vaccines.

Many low-income Medicare beneficiaries who cannot afford to pay Medicare's cost-sharing requirements receive assistance from Medicaid. For Medicare beneficiaries qualifying for full Medicaid benefits, state Medicaid programs pay for Medicare's part A (if applicable) and part B cost-sharing requirements up to the Medicaid payment rate as well as for services that are not generally covered by Medicare, such as prescription drugs.⁸ To qualify for full Medicaid benefits, beneficiaries must meet their state's eligibility criteria, which include income and asset requirements that vary by state.⁹ In most states, beneficiaries that qualify for Supplemental Security Income (SSI) automatically qualify for full Medicaid benefits.¹⁰ Other beneficiaries may qualify through one of several optional eligibility categories targeted to low-income beneficiaries, individuals with high medical costs, or those receiving care at home or in the community who otherwise would have been institutionalized.

To assist low-income Medicare beneficiaries with their premium and cost-sharing obligations, Congress established several Medicare savings programs—the QMB, SLMB, QI, and QDWI programs. Under these programs, state Medicaid programs pay enrolled beneficiaries' Medicare premiums. As a result, for QMB, SLMB and QI beneficiaries, Medicare part B premiums would not be deducted from their monthly SSA checks. The QMB program also pays Medicare deductibles and other cost-sharing requirements, thereby saving beneficiaries from having to make such payments. Beneficiaries eligible for Medicare savings programs can apply

⁸Within broad federal guidelines, states have considerable flexibility in how they administer their Medicaid programs. States administer covered services under a state Medicaid plan that CMS approves. State Medicaid programs must cover certain mandatory services, such as physician services and nursing facility care. While Medicare covers some or all of up to 100 days of skilled nursing facility care following a hospitalization, Medicaid covers extended nursing facility care. State Medicaid programs may also cover certain CMS approved optional Medicaid services, such as prescription drugs. The federal government shares the cost of state Medicaid expenditures according to a statutory formula, whereby the federal share ranged from 50 to 77 percent of state Medicaid expenditures in fiscal year 2003.

⁹Section 1902(r)(2) of the Medicaid statute provides states flexibility to use less restrictive or liberalized methodologies than are typically used for Medicaid in counting applicants' income and resources to expand eligibility for the Medicare savings program.

¹⁰SSI provides cash assistance to aged, blind, and disabled individuals who have limited income and resources. In 2003, the resource limit was \$2,000 for individuals and \$3,000 for couples. SSI resource limits typically exclude the beneficiary's automobile and house.

for and be determined to be eligible through their state Medicaid programs. Thirty-three states have agreements with SSA whereby SSA makes eligibility determinations for a state if beneficiaries are deemed eligible by SSA to receive SSI benefits.¹¹ In the other 18 states, even if an individual is eligible to receive SSI benefits, an individual must file an application with the state or local Medicaid agency to be eligible. Beneficiaries qualifying for Medicare savings programs receive different levels of assistance depending on their income. See table 2 for eligibility criteria and benefits for each program.

¹¹These agreements are made under authority contained in 42 U.S.C. § 1383c(a) (2000).

Table 2: Medicaid and Medicare Savings Programs' Eligibility Criteria and Benefits for Low-Income Medicare Beneficiaries, 2003

Program	Income eligibility criteria^{a,b}	Benefits
Medicaid	Low-income Medicare beneficiaries, as defined by each state, whose incomes are up to 100 percent of the federal poverty level	Optional benefits vary by state, but typically include Medicare part B premiums and Medicaid services, including those not covered under Medicare
Medicare savings programs		
Qualified Medicare Beneficiary (QMB)	Medicare beneficiaries whose incomes are at 100 percent or less of the federal poverty level	Medicare part A ^c (if applicable) and B premiums, deductibles, and coinsurance paid by state Medicaid program
Specified Low-Income Medicare Beneficiary (SLMB)	Medicare beneficiaries whose incomes are above 100 percent but less than 120 percent of the federal poverty level	Medicare part B premiums paid by state Medicaid program
Qualifying Individuals (QI) ^d	Medicare beneficiaries whose incomes are at 120 percent but less than 135 percent of the federal poverty level	Medicare part B premiums paid by state Medicaid program
Qualified Disabled and Working Individuals (QDWI) ^e	Disabled and working Medicare beneficiaries whose incomes do not exceed 200 percent of the federal poverty level	Medicare part A premiums paid by state Medicaid program

Source: CMS.

^aIn 2003, the federal poverty level (FPL) per month was \$748 for individuals and \$1,010 for couples in the 48 contiguous states and the District of Columbia. Higher amounts were specified for Alaska and Hawaii.

^bStates also have asset limits for individuals to qualify for Medicaid or Medicare savings programs. These vary by state, but most often for Medicaid, eligible beneficiaries must have assets no greater than the limit for SSI, which is \$2,000 for individuals and \$3,000 for married couples. SSI resource limits typically exclude the beneficiary's automobile and house. For Medicare savings programs, eligible beneficiaries typically must have assets no greater than twice the limit for SSI.

^cMedicare part A premiums are covered under the QMB program for beneficiaries who worked fewer than 40 quarters.

^dUntil December 2002, the QI program, a federal block grant to the states, consisted of two parts—QI-1 and QI-2. The QI-1 program (covering beneficiaries with incomes at least 120 percent but less than 135 percent of FPL) and the QI-2 program (covering beneficiaries with incomes at least 135 percent but less than 175 percent of FPL) were originally authorized through December 2002. The QI-2 program ended as originally provided, but the QI-1 program was reauthorized through September 2004.

⁶These individuals are required to pay part A premiums because they are no longer entitled to free Medicare part A benefits having successfully returned to work and exhausted the free Medicare part A benefits available to them following the end of their disability benefits.

In 1998, Congress passed legislation specifically providing funding for SSA to evaluate ways to promote Medicare savings programs.¹² In response, SSA conducted demonstration projects to explore the effects of using various approaches to increase participation in Medicare savings programs. In one of these demonstrations conducted in 1999 and 2000, SSA tested six models designed to increase awareness and reduce barriers to enrollment. The models were implemented at 20 sites in 10 states, as well as the entire state of Massachusetts. The models differed in the extent to which SSA was involved in outreach efforts beyond mailing the letters. For example, in the “application model,” SSA staff screened beneficiaries if they appeared to be eligible, completed applications, collected supporting documents, and forwarded the completed application form and supporting evidence to the state Medicaid agency for an eligibility determination. In the “peer assistance model,” Medicare beneficiaries contacted an AARP toll-free number and were screened for program eligibility by an AARP volunteer.¹³ Across all six models, SSA sent more than 700,000 letters informing low-income Medicare beneficiaries that they may be eligible for benefits under the Medicare savings programs. The enrollment rate for each model varied—ranging from an additional 7 enrollees per 1,000 letters to 26 enrollees per 1,000 letters—with the application model recording the highest enrollment rate and peer assistance recording the lowest.¹⁴

In 2000, Congress amended the Social Security Act, through BIPA, requiring the Commissioner of Social Security to notify eligible Medicare beneficiaries about assistance available from state Medicaid programs to help pay Medicare premiums and cost sharing. BIPA also required SSA to furnish each state Medicaid program with the names and addresses of individuals residing in the state that SSA determines may be eligible for

¹²Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, Pub. L. No. 105-277, 112 Stat. 2681, 2681-383 (1998).

¹³AARP, formerly known as the American Association for Retired People, is an association representing individuals over the age of 50.

¹⁴For further information on the six models and the demonstration project results, see Lisa Maria B. Alexih et al, *Results from the SSA Buy-In Demonstration: Final Report*, prepared by The Lewin Group SSA, October 4, 2001.

the Medicare savings programs. SSA is required to update such information at least annually.¹⁵

In addition to SSA's outreach efforts, CMS and individual states have engaged in efforts to increase enrollment in Medicare savings programs. Since fiscal year 2002, CMS has included increasing awareness of the Medicare savings programs as one of its Government Performance and Results Act (GPRA) goals.¹⁶ Specifically, CMS's goal in fiscal year 2002 was to develop a baseline to measure awareness of Medicare savings programs and to set future targets for increasing awareness. CMS estimated that 11 percent of beneficiaries were aware of Medicare savings programs in 2002 and the goal was to increase this to 13 percent for fiscal year 2003. As part of its efforts to increase awareness, CMS has coordinated with states, SSA, and other organizations regarding various outreach efforts; provided information about Medicare savings programs in various CMS publications; and developed a variety of educational materials for targeted populations, including minorities. CMS efforts in increasing enrollment in earlier years included setting state-specific enrollment targets and measuring progress toward these enrollment targets; developing and disseminating training and outreach materials to the states, and sponsoring national and regional training workshops for a variety of stakeholders, including other federal and state agencies, health care providers, and community organizations; designing a model application for Medicare savings programs that states can consider adopting; and providing grant funding to state Medicaid agencies, state health insurance assistance programs, and national advocacy groups to test and promote innovative approaches to outreach.

In 2001, CMS also contracted for a survey of states to identify activities undertaken to increase program enrollment and streamline administration of these programs. Some of the most common state efforts included allowing application by mail (49 states), eliminating in-person interviews (46 states), developing a shorter application form (43 states), and conducting outreach presentations at health fairs (34 states). Other state efforts identified by the survey included

¹⁵42 U.S.C. § 1320b-14(b) (2000).

¹⁶See CMS, *FY 2004 GPRA Annual Performance Plan* (Washington, D.C., 2003).

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- increasing awareness of the programs through outreach efforts such as direct mailings and other printed material, and public service announcements on radio, television, and in newspapers;
 - providing training for employees and education for beneficiaries;
 - developing partnerships with other entities, such as State Health Insurance Assistance programs and local agencies on aging, to enhance outreach efforts and promote issues and solutions involving the Medicare savings programs;
 - eliminating potential barriers to enrollment such as streamlining the enrollment and renewal process and easing financial eligibility rules;
 - supplementing program benefits with other benefits, such as prescription drug discount programs; and
 - providing information targeting underserved populations, including minorities.

SSA Is Conducting an Annual Outreach Effort Targeted to Low-Income Medicare Beneficiaries

In response to BIPA, SSA is conducting an annual outreach effort to help increase enrollment in Medicare savings programs. This outreach consists of a nationwide mailing campaign and data sharing with the states. SSA selected low-income Medicare beneficiaries to be sent an outreach letter if their incomes were below the income eligibility ceilings for the Medicare savings programs. From May through November 2002, SSA sent a total of 16.4 million outreach letters to persons potentially eligible for QMB, SLMB, and QI. Additionally, in late 2002, SSA sent about 53,000 letters to those potentially eligible for benefits under the QDWI program. Starting in 2003, SSA has targeted annual outreach letters to individuals newly eligible for Medicare as well as a subset of those who were sent outreach letters in 2002 but are still not enrolled. From June through October 2003, SSA sent outreach letters to 4.3 million of these beneficiaries. SSA intends to continue its outreach mailing annually to potentially eligible beneficiaries, including recipients who did not enroll after receiving earlier letters, as well as those whose income has declined, making them eligible for the program. In addition to sending outreach letters, in 2002 and 2003 SSA provided states with a data file that listed residents who were potentially eligible for benefits under the Medicare savings programs. SSA plans to continue sharing these data once a year with states. The data provided by SSA could be used by the states to coordinate their outreach with SSA's or supplement SSA's outreach efforts.

For the 2002 mailing, SSA sent letters three times each week from May through November. Each time letters were mailed, SSA sent them to approximately 207,000 Medicare beneficiaries randomly selected from the 16.4 million beneficiaries who were identified as potentially eligible for

QMB, SLMB, and QI.¹⁷ Letters were targeted to beneficiaries whose incomes from Social Security and certain other federal sources were less than 135 percent of the federal poverty level (FPL).¹⁸ Specifically, those selected to be sent the outreach letters were intended to meet the following three criteria:

- individuals and couples entitled to Medicare, or within 2 months of Medicare entitlement eligibility;
- individuals who were not currently receiving Medicare savings program benefits under a state Medicaid program or not already entitled to full Medicaid based on SSI participation; and
- individuals and couples whose combined Social Security income and Department of Veterans Affairs and federal civil service pensions fell below the program's income eligibility ceiling.

The letters provided information in English or Spanish about the Medicare savings programs, including state-specific asset guidelines and a state contact number.¹⁹ (See app. II for a sample 2002 outreach letter.) At the end of November 2002, SSA sent a separate mailing to about 53,000 disabled working adults who were potentially eligible for benefits under the QDWI program.²⁰

Medicare beneficiaries who had sources of income other than Social Security—such as income from employment and public and private pensions—and whose incomes were above the programs' eligibility thresholds were selected nonetheless to be sent the SSA outreach letter because SSA's data systems do not collect information on these income

¹⁷SSA officials stated that the mailings were based on the last two digits of the recipients' Social Security numbers, which are random and not based on any geographic, age, or other demographic characteristic. For each mailing, SSA's mail vendor selected approximately 207,000 letters based on this sequence, and then sorted the letters by zip code before mailing them out.

¹⁸SSA elected to send this mailing only to individuals potentially eligible for the QMB, SLMB, and QI-1 programs. SSA did not have current income data needed to select potentially eligible QDWI individuals. The FPL for an individual in the 48 contiguous states was \$8,860 in 2002. For a couple, the FPL was \$11,940. The FPL is higher in Alaska and Hawaii.

¹⁹Letters were sent in either English or Spanish based on the language preference provided to SSA in the past.

²⁰The QDWI letters were timed by SSA to arrive near the general enrollment period for Medicare part A, which runs from January 1 through March 31 each year.

sources. In addition, SSA's records do not contain information about beneficiaries' private assets, making it impossible for SSA to identify whether letter recipients had assets within their states' Medicare savings programs' eligibility limits—typically \$4,000 for an individual and \$6,000 for couples.

In 2002, the Medicare Rights Center, a national health advocacy group for older adults and people with disabilities, sought a federal court order requiring SSA to resend 1.4 million letters to potentially eligible beneficiaries in Connecticut and New York to correct erroneous information on the asset limit for the QI program. The New York and Connecticut letters had incorrectly informed potential beneficiaries that only individuals with assets of less than \$4,000 were eligible for the QI program, even though Connecticut and New York abolished the asset requirement for QI eligibility in 2001 and 2002, respectively. SSA agreed to resend the letters and the parties settled the case before trial.

In addition to sending letters to potentially eligible low-income Medicare beneficiaries, in 2002 SSA provided all but six states with an electronic data file containing the names of all beneficiaries to whom it had sent letters in that state.²¹ The data file contained information that could assist states with outreach efforts, such as the name, address, Social Security number, date of birth, spouse's name, and the basis for Medicare entitlement of each letter recipient. SSA is required to provide updated data to the states each year.²²

For the June through October 2003 mailing, SSA sent a second round of letters to about 4.3 million potentially eligible low-income Medicare beneficiaries nationwide whom its records indicated might have met the QMB, SLMB, and QI income eligibility criteria and were not currently enrolled in Medicare savings programs. This mailing included beneficiaries who were newly eligible since the 2002 mailing, current Medicare beneficiaries who newly met the income criteria,²³ and about one-fifth of the beneficiaries notified in 2002 who still met the mailing criteria but

²¹SSA's security protocol requires states to provide certain information in order for SSA to send the data files. Six states did not provide this information and therefore SSA did not send the data file to them.

²²42 U.S.C. § 1320b-14(b)(1)(B) (2000).

²³For example, individuals who did not previously receive an outreach letter may subsequently meet the income criteria due to reduced income from the death of a spouse.

were not enrolled in a Medicare savings program.²⁴ At the time we conducted our work, enrollment data for beneficiaries who were sent the letter in 2003 were not available.

In contrast to the 2002 letter that provided state-specific eligibility criteria and a state-specific telephone number, the 2003 letter did not contain customized state information, but provided more general national information. The letter suggested that beneficiaries who may be eligible check the government list in their local telephone books for their local Medicaid contact or call the general 1-800-Medicare number that refers callers to state help lines, such as state or local medical assistance offices, social services, or welfare offices. SSA gave several reasons for not including state-specific information in the 2003 letter. One official indicated that there was additional cost to SSA to develop state-specific letters and therefore the agency did not tailor the letters for each state. CMS officials reported that a few states did not want to provide state-level contact numbers because eligibility and other Medicare savings program administrative matters were actually conducted at the county levels. Furthermore, in some cases, the telephone numbers states initially provided were changed shortly before the 2002 mailings were begun, creating additional need for SSA to coordinate with states in finalizing the letters. However, some state officials we interviewed expressed concern about the lack of state-specific information for the 2003 mailing. Their concern was that, given that most states had established mechanisms for responding to these inquiries for the larger 2002 mailing, not including state-specific criteria or contact information on the letter could make the letter less effective since it could be more difficult for beneficiaries to obtain direct assistance or applications for eligibility determinations.

²⁴Thus, over a period of 5 years, SSA will resend letters to all 2002 letter recipients who still meet the mailing criteria but have not enrolled in Medicare savings programs.

Medicare Savings Program Enrollment Increased by More than 74,000 Beneficiaries Following the 2002 SSA Mailing

We estimate that SSA's mailing from May through November 2002 to 16.4 million potentially eligible beneficiaries contributed to more than 74,000 additional beneficiaries enrolling in Medicare savings programs. Further, in the year following SSA's mailing, nationwide enrollment in Medicare savings programs increased 2.4 to 2.9 percentage points over that in the 3 previous years. Certain demographic groups also had larger additional increases in enrollment following the 2002 SSA mailing. For example, beneficiaries less than 65 years old, persons with disabilities,²⁵ racial and ethnic minorities, and residents in southern states experienced larger additional increases in enrollment.

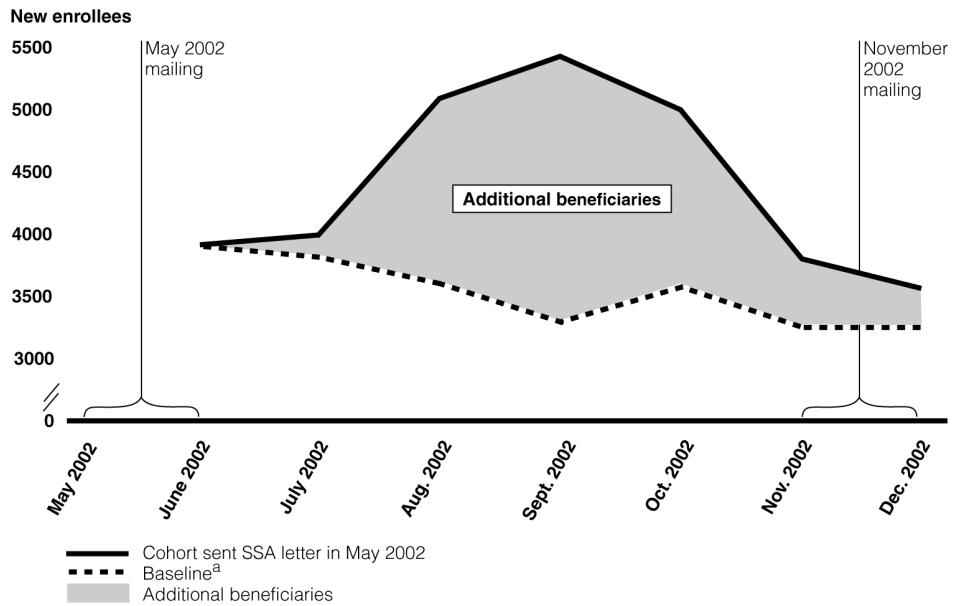
More than 74,000 Additional Beneficiaries Enrolled in Medicare Savings Programs Following SSA's 2002 Mailing

On the basis of our analysis of SSA's Master Beneficiary Record (MBR), we estimate that, of the 16.4 million SSA letter recipients in 2002, an additional 74,000 beneficiaries (0.5 percent of letter recipients) enrolled in Medicare savings programs than would have likely enrolled without the mailing. To estimate this increased enrollment, we examined two cohorts of letter recipients—a cohort of 1.3 million beneficiaries who were sent the letters during the first six mailings in May 2002 and a baseline cohort of 1.3 million beneficiaries who were sent the letters during the last six mailings through November 2002. Because SSA sent the mailing to beneficiaries in a random order nationwide from May through November 2002, the only difference between the cohorts is the time at which the letters were sent to them. As a result, other factors that could influence enrollment patterns, such as demographic differences or other outreach efforts by CMS and the states, should affect the May and November cohorts similarly. We used the November 2002 cohort as a baseline to examine how the May 2002 cohort's enrollment in Medicare savings programs was affected following SSA's mailing.

As shown in figure 1, by August 2002—3 months after the initial letters were sent in May 2002—the Medicare savings program enrollment for the May cohort began to increase faster than that of the November cohort, which was yet to have the SSA letter sent to them. While the cohorts were sent the SSA letters in May or November 2002, SSA officials reported that it typically takes about 3 months before enrollment is reported in the MBR.

²⁵Persons with disabilities are persons of any age who are unable to do any kind of substantial gainful activity because of a physical or mental impairment (or a combination of impairments) that has lasted or is expected to last for a continuous period of at least 12 months, or that is expected to result in death. 42 U.S.C. § 416(i)(1)(A) (2000).

Figure 1: Medicare Savings Programs Enrollment in Two Sample Cohorts of SSA Letter Recipients, June 2002 through December 2002



Source: GAO analysis of SSA MBR data.

^aThe baseline is the cohort that was sent the letter in November 2002.

As of December 2002, more than 5,800 additional beneficiaries in the cohort of 1.3 million beneficiaries who were sent the letter in May had enrolled in Medicare savings programs compared with the November cohort, whose enrollment was not yet affected by the mailing.²⁶ (See table 3.) This additional enrollment in the May cohort represents 0.5 percent of the letter recipients. Projecting the experience of the May cohort to the universe of the 16.4 million letter recipients results in an estimate of over 74,000 additional beneficiaries enrolling in Medicare savings programs as a result of the 2002 SSA mailing.

²⁶After December 2002, additional enrollment among the baseline group began increasing faster than the May cohort, indicating that the maximum cumulative effect of the 2002 SSA mailing for the May cohort relative to the baseline occurred as of December 2002.

Table 3: Enrollment in Medicare Savings Programs by Sample Cohort, December 2002

	Cohort that the SSA letter was sent to in May 2002	Baseline cohort^a	Difference
Number of letter recipients in sample cohort who enrolled	30,291	24,473	5,818
Percent of letter recipients who enrolled	2.4	1.9	0.5
Estimated total number of recipients who enrolled	386,243	311,786	74,457

Source: GAO analysis of SSA MBR data.

Note: Each cohort included 1.3 million letter recipients.

^aThe baseline represents the cohort that was sent the letter in November 2002 because the effect of the letter was not yet evident during the period we analyzed.

Nationwide, CMS data showed that Medicare savings programs experienced an overall net increase in enrollment of 5.9 percent (341,069 individuals) from May 2002—the start of SSA’s mailing—to May 2003.²⁷ This 5.9 percent increase was nearly double the 3.0 to 3.5 percent increases in the 3 previous years before SSA’s nationwide mailings. (See table 4.) These data suggest that SSA’s mailing helped to increase enrollment at a greater annual rate than in earlier years.

²⁷The CMS data showing about a 341,000 increase in Medicare savings program enrollment from May 2002 to May 2003 represents the net change in enrollment including both increases (due to new enrollees) as well as decreases (due to former program enrollees who died or otherwise were no longer enrolled). Our analysis of the SSA MBR data, estimating an increase in enrollment following the SSA mailing of about 386,000 beneficiaries, reflects only new enrollees because the SSA letter went only to those beneficiaries not enrolled in Medicare savings programs at the time.

Table 4: Medicare Savings Program Enrollment, May 1999 to May 2003

Month/year	Enrollment	Annual change in enrollment	Annual percentage increase
May 1999	5,242,378	—	—
May 2000	5,398,468	156,090	3.0
May 2001	5,570,231	171,763	3.2
May 2002	5,763,553	193,322	3.5
May 2003	6,104,622	341,069	5.9

Source: GAO analysis of CMS third-party master file.

Certain States and Demographic Groups Had Higher Enrollment Rates Following SSA's Outreach

Across the United States, letter recipients residing in the southern states had a 0.6 percent additional increase in enrollment following SSA's mailing. This was more than residents in the Northeast, Midwest, and West, where the additional increase in enrollment was 0.4 percent. Thirty-five states had an additional increase in enrollment following the SSA mailing compared to the increase that would likely have occurred without the letter. Of the thirty-five states, the largest additional increase in enrollment following the SSA mailing occurred in Alabama, (2.9 percent), followed by Delaware (2.0 percent), and Mississippi (1.3 percent). While data from 13 other states showed an increase in enrollment following the SSA mailing, these increases were not statistically significant. Another three states showed a decrease in enrollment following the SSA mailing, but these changes also were not statistically significant. Appendix III provides the additional percentage change in enrollment following the 2002 SSA mailing for each state.

Certain demographic groups also had higher additional increases in enrollment rates than the additional increase among all letter recipients. In comparison to the 0.5 percent additional increase in enrollment among all letter recipients, beneficiaries less than 65 years old and beneficiaries of any age who qualified for Medicare as a result of a disability each had a 0.8 percent additional increase in enrollment following SSA's outreach.²⁸ Also, minority beneficiaries, which based on SSA's data categories include blacks or individuals of African origin, Asians and Pacific Islanders, and North American Indians or Eskimos, had a 0.7 percent additional increase

²⁸We calculated age as of May 10, 2002, the first date of the SSA mailing, using the beneficiary's date of birth.

in enrollment. Appendix IV provides data for all demographic groups that we examined.

Enrollment Increases Varied among Selected States We Reviewed, with Several Reporting Increased Calls and Applications Concurrent with SSA Mailing

The percentage of additional letter recipients newly enrolling in Medicare savings programs following SSA's mailings varied significantly among the six states we reviewed. Among these six states, enrollment increases ranged from 0.3 to 2.9 percent. Further, several states we reviewed reported that calls to their telephone hot lines and applications mailed or received increased sharply during the period of the SSA outreach. In addition, some states supplemented SSA efforts with outreach efforts of their own, while other states were aware of or assisted outreach efforts by private or community groups.

SSA Outreach Efforts Had Varying Effects on Enrollment in Selected States

Among the states we reviewed, SSA's outreach had varying effects on the percentage of letter recipients enrolling. Alabama, with 2.9 percent additional letter recipients enrolled compared to the percentage that likely would have enrolled without the SSA letter, had the largest additional increase in enrollment following the SSA mailing. This contrasts with the national average of 0.5 percent. For the states we reviewed, SSA's outreach had the least impact on Medicare savings program enrollment in California, Washington, and New York with a 0.3 percent increase in additional enrollment. (See table 5.)

Table 5: Increase in Enrollment following SSA's Outreach to Targeted Population in Six Selected States, December 2002

State	Percentage of additional letter recipients enrolling following SSA mailing
Alabama	2.9
Louisiana	0.9
Pennsylvania	0.4
California	0.3
Washington	0.3
New York	0.3
All States	0.5

Source: GAO analysis of SSA's Master Beneficiary Record.

The varying effects on enrollment by state can be attributed to several factors, including, the share of eligible beneficiaries already enrolled in Medicare savings programs prior to the outreach, a state's ability to handle increased phone calls and applications, and a state's income and asset limits. For example, a smaller share of low-income elderly beneficiaries in Alabama was enrolled in QMB as of the year prior to the SSA mailing than the national average. Specifically, the number of QMB enrollees in Alabama in 2001 was about half the number of Alabama seniors reported by the Census Bureau to have incomes below the limit for the QMB program. In contrast, about three-quarters of the seniors nationwide who reported income below the QMB limit were enrolled. As a result, a larger number of letter recipients in Alabama may have been able to meet the QMB and other Medicare savings program eligibility criteria whereas other states may have already enrolled a larger share of these beneficiaries. Further, each of the states we reviewed established or used an existing state-specific telephone number that was listed in the SSA letter to receive calls. After the SSA mailing started, however, California's phone number was discontinued and calls were redirected to CMS's nationwide 1-800-Medicare number. California's lower enrollment could also result from its eligibility requirements for SSI. For example, in a prior demonstration, SSA's mailing in 1999 and 2000 resulted in lower enrollment in California than in other demonstration sites, in part because the state offered a generous state supplement to SSI. Therefore, there were potentially not as many people eligible for the Medicare savings programs.²⁹ In addition, other state differences, such as different state asset eligibility requirements and application requirements as well as state efforts to support the SSA outreach, may have contributed to different effects among states.

States Reported Increased Interest in Medicare Savings Programs Concurrent with SSA and States' Outreach Efforts

States we reviewed often reported that calls to their hot lines and applications for Medicare savings programs increased significantly during the period of the 2002 SSA mailing. Four states provided data on the monthly trends in the number of calls either related to Medicare and Medicaid in general or the Medicare savings program specifically that showed increases concurrent with the 2002 SSA mailing. Three states were also able to provide data on changes in the number of applications sent to interested beneficiaries or received from beneficiaries. (See table 6.) While

²⁹See Lisa Maria B. Alecxih et al, *Results from the SSA Buy-In Demonstration: Final Report*.

officials in several states indicated that not all of the increases noted could be attributed directly to the SSA mailing, the data provided by the states suggest that beneficiaries' interest in Medicare savings programs increased during the mailing period. For example, Alabama experienced a 19 percent increase in monthly calls to its state hot line related to any Medicare and Medicaid issue after the SSA mailings began; this was followed by a 25 percent decrease after the mailings ended. Alabama also experienced a 158 percent surge in applications received per month during the SSA mailing and then a decrease of 57 percent afterwards. State officials reported that Washington tracked calls and applications specific to the SSA mailing, and these data showed 85 percent decreases in both monthly call volume and applications mailed out to beneficiaries after the mailings ended; Washington also reported a 72 percent monthly decrease in applications received after the 2002 mailings ended.

Table 6: Average Monthly Calls and Applications Related to Medicare Savings Programs for Four States prior to, during, and/or after SSA's Mailing Outreach, January 2002 to April 2003

State	Average monthly calls	Average monthly applications
Alabama	<p>Average monthly calls for any Medicaid or Medicare issue (including Medicare savings programs):</p> <ul style="list-style-type: none"> • Prior to: 25,133 • During: 30,010 (19 percent increase) • After: 22,485 (25 percent decrease) 	<p>Average monthly applications received related to Medicare (including Medicare savings programs):</p> <ul style="list-style-type: none"> • Prior to: 1,474 • During: 3,802 (158 percent increase) • After: 1,618 (57 percent decrease)
Louisiana	<p>Average monthly calls for Medicare savings programs:</p> <ul style="list-style-type: none"> • Prior to: 301 • During: 1,849 (515 percent increase) • After: 516 (72 percent decrease) 	<p>Average monthly applications mailed for Medicare savings programs:^a</p> <ul style="list-style-type: none"> • Prior to: 53 • During: 1,571 (2,865 percent increase) • After: 226 (86 percent decrease) <p>Average monthly applications received for Medicare savings programs:</p> <ul style="list-style-type: none"> • Prior to: 2,131^b • During: 2,940 (38 percent increase) • After: 3,634 (24 percent increase)
Pennsylvania	<p>Average monthly calls for Medicare savings programs:</p> <ul style="list-style-type: none"> • Prior to: 1,095 • During: 4,418 (303 percent increase) • After: 2,039 (54 percent decrease) 	Not available ^c
Washington	<p>Average monthly calls for Medicare savings programs specific to the SSA mailing:</p> <ul style="list-style-type: none"> • Prior to: not available • During: 1,180 • After: 175 (85 percent decrease) 	<p>Average monthly applications mailed to beneficiaries in response to the SSA mailing:</p> <ul style="list-style-type: none"> • Prior to: not available • During: 1,127 • After: 168 (85 percent decrease)

State	Average monthly calls	Average monthly applications
Washington (continued)		Average monthly applications received in response to the SSA mailing: <ul style="list-style-type: none"> • Prior to: not available • During: 436^d • After: 121 (72 percent decrease)

Source: GAO analysis of data from selected states.

Note: Unless otherwise noted, the period prior to the SSA mailing included January through April 2002; the period during the mailing was May through November 2002; and the period after the mailing was December 2002 through April 2003.

^aLouisiana provided data on the number of applications that were sent to beneficiaries from the state's Medicaid office. These averages do not include applications mailed by other agencies or organizations across the state, which may explain why more applications were received than mailed during the same period.

^bWe did not include January 2002 applications in the monthly average because of a large surge in applications during that month, which was probably attributable to the state's QI program temporarily closing and reopening for enrollment.

^cPennsylvania reported that about 0.5 percent of individuals sent the SSA mailing filed applications, and 73 percent of filed applications were approved, but the officials could not provide monthly data.

^dData on applications received were not available for May and June 2002 and are not included in the average.

Concurrent with SSA's mailing, each of the states we reviewed reported that the state or other stakeholders conducted additional outreach. For example, the Louisiana Department of Health and Hospitals and the Pennsylvania Health Law Project, a coalition advocating for low-income individuals and the disabled, each received 3-year grants from the Robert Wood Johnson Foundation in 2002 to conduct outreach to low-income Medicare beneficiaries in these states. A state official also reported that in 2002 the New York Department of Health developed and distributed 100,000 copies of a brochure called "How To Protect Your Health and Money," which included information about the Medicare savings programs, and conducted a "Senior Day" at 16 sites in New York City and several other districts as well as presentations at local fairs. Other states reported coordinating with community or state organizations as well as private health plans participating in Medicare, such as health maintenance organizations participating in the Medicare + Choice program.³⁰ Some private health plans conducted outreach to increase Medicare savings program enrollment since CMS pays these plans a higher rate for these

³⁰California officials also reported that Medicare health maintenance organizations in California provided outreach through private contractors approved by CMS.

enrollees. Several state officials also said that their states work with other groups, such as the local departments of aging or senior services and local businesses and community organizations, to assist with outreach efforts to potentially eligible beneficiaries. None of the states we reviewed reported having assessed the effectiveness of their outreach efforts.

Of the six states we reviewed, only Louisiana and Pennsylvania officials reported that they used the data file listing names and addresses of potentially eligible beneficiaries provided by SSA in 2002 to assist with state outreach or enrollment efforts. For example, after receiving the SSA data file, seven parishes in Louisiana used it to obtain a list of potentially eligible beneficiaries and sent an application with a letter and return envelope to these beneficiaries. In 2003, about 20,450 applications were mailed to potential beneficiaries. Pennsylvania officials used the file to cross-check against the state's own data system to assess the number of applications authorized, rejected, or denied as a result of the SSA mailing.

Agency and State Comments

We provided a draft of this report to SSA, CMS, and state Medicaid agencies in Alabama, California, Louisiana, New York, Pennsylvania, and Washington. In written comments, SSA generally concurred with our findings and provided technical comments that we incorporated as appropriate. SSA also noted that improvements in state enrollment processes could further increase enrollment. SSA's comments are reprinted in appendix V. In a written response, CMS stated it did not have any specific comments on the report. However, CMS provided technical comments that we incorporated as appropriate.

While we did not examine the effects of SSA's 2003 mailing, Louisiana Medicaid officials indicated that, in comparison to the 2002 SSA mailing, there was little increase in call volume following SSA's 2003 mailing, and that they believe that this was because a state-specific telephone number was not included in the 2003 outreach letter. New York Medicaid officials stated that they found an increase in Medicare savings program enrollment of over 6 percent from December 2002 to December 2003. However, in addition to being a different timeframe from what we examined, we do not believe that all of this increase can be attributed to the SSA mailing. Based on our analysis of SSA's MBR data, we report a 0.3 percent increase in enrollment in New York specifically attributable to the 2002 SSA outreach mailing. We found the net increase in enrollment from May 2002 to May 2003 (following SSA's 2002 mailing) to be 5.9 percent nationwide, similar to the net increase in enrollment that New York reported from December 2002 to December 2003. Louisiana and Pennsylvania Medicaid officials

also provided technical comments that we incorporated as appropriate. Alabama, California, and Washington Medicaid officials reviewed the draft and stated that the report accurately reflected information relevant to their respective states.

We are sending copies of this report to the Commissioner of SSA, the Administrator of CMS, and other interested parties. We will also provide copies to others on request. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

Please call me at (202) 512-7118 or John Dicken at (202) 512-7043 if you have any additional questions. N. Rotimi Adebajo and Rashmi Agarwal were major contributors to this report.



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Director, Health Care—Medicaid
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List of Committees

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Committee on Ways and Means
House of Representatives

Appendix I: Methodology

To determine what outreach the Social Security Administration (SSA) conducted in response to the statutory requirement, we obtained and reviewed copies of SSA documents, including sample 2002 and 2003 outreach letters and data on the number of letters sent to eligible Medicare beneficiaries in each state, as well as reports prepared by the Centers for Medicare & Medicaid Services (CMS) related to the Medicare savings program. In addition, we interviewed officials from the SSA and CMS.

To determine how enrollment changed following SSA's outreach, we analyzed records from SSA's Master Beneficiary Record (MBR)¹—a database that contains the administrative records of Social Security beneficiaries, including payments for Medicare premiums—and CMS's national enrollment data for the Medicare savings programs. The MBR data contain demographic information as well as information on the monthly deductions made from beneficiaries' Social Security checks to cover Medicare part B premiums.² We obtained MBR data on beneficiaries who were sent the outreach letters in the first six mailings in May and the last six mailings through November 2002,³ representing 2.6 million of the 16.4 million Social Security beneficiaries who were sent letters from SSA. To determine which letter recipients enrolled in the Medicare savings programs following SSA's 2002 mailing, we identified letter recipients who met the following criteria:

- those whose date of eligibility for Medicare savings programs began January 2002 or afterwards;
- those for whom a third-party payer, specifically a state, made payments on their behalf to cover Medicare part B premiums;⁴ and

¹The MBR contains records for Social Security beneficiaries who were entitled to receive benefits under the Old-Age, Survivors and Disability Insurance program. SSA provided us with certain records from the MBR that included demographic information as well as Medicare benefit payments.

²For Medicare beneficiaries who elect to participate in Medicare part B, SSA typically withholds an amount equal to their Medicare part B premium from their monthly Social Security checks.

³Mailing dates for the May cohort include those from May 10 through May 22, 2002, and for the November cohort include mailing dates from October 28 through November 8, 2002.

⁴MBR data show third-party payments from three sources—a state, a private payer, or federal civil service.

- those who no longer had the premium deduction made from their Social Security checks to cover Medicare part B premiums at any point from June 2002 through December 2002.⁵

In order to estimate the impact of the SSA outreach mailing on additional enrollment in Medicare savings programs, we analyzed monthly enrollment from June 2002 to December 2002 for two cohorts of letter recipients to identify letter recipients who enrolled in Medicare savings programs following the initiation of the SSA mailing in May 2002.⁶ Because the mailings were sent to beneficiaries in a random order, the only notable difference between the recipients in the two cohorts would be the timing of when the SSA letters were sent to them. SSA officials noted that it typically takes about 3 months until enrollment is reported on the MBR. Therefore, since the mailings began in May 2002, the first effects of the mailing would not have been apparent until after June 2002. We analyzed the MBR data provided by SSA to determine specifically what month and year a letter recipient enrolled in Medicare savings programs. Using the enrollment by the November cohort as a baseline because these individuals met the same selection criteria as those in the May cohort, we estimated the net effect of the SSA mailing by comparing the difference in cumulative monthly enrollment between the May and November cohorts in December 2002—this difference represented the additional enrollment we attributed to the SSA mailing.⁷ We made the comparison in December 2002 because after this date the enrollment of the baseline group began increasing at a rate faster than the May cohort, indicating that this was the point when the largest cumulative difference in enrollment between the two cohorts occurred before the effects of the mailing started becoming evident for the November cohort. Using the same methodology, we calculated the effect of the SSA outreach letter for certain demographic

⁵When a Medicare beneficiary enrolls in a Medicare savings program, the Medicare part B premium is no longer deducted from the beneficiary's Social Security check but is instead paid by the state.

⁶Our data for both cohorts did not include beneficiaries potentially eligible for QI-2 or the 53,000 beneficiaries who were sent a November 2002 SSA mailing about potential eligibility for the separate QDWI program.

⁷Our analysis may not include potential beneficiaries in the May cohort who significantly delayed presenting a Medicare savings program application to state Medicaid offices for eligibility screening or those whose applications were in the eligibility determination process after December 2002. In addition, some letter recipients in the November cohort may have enrolled prior to receiving the letter because they learned about the programs from others, such as neighbors or relatives, who already received the mailing.

groups and for beneficiaries in each state. We also obtained and analyzed data contained in CMS's third party master file for the period May 1999 to May 2003 that tracks national Medicare savings programs enrollment.⁸ Using these data, we examined how national Medicare savings enrollment trends compared before and after the 2002 SSA mailing.

To determine how additional enrollment in the programs changed in selected states following SSA's outreach and what outreach efforts these states undertook, we interviewed Medicaid officials in six states—Alabama, California, Louisiana, New York, Pennsylvania, and Washington. We selected these states based on several factors, including states with different levels of change in overall Medicare savings programs enrollment from 2002 to 2003, geographic diversity, relatively large populations of Medicare savings programs enrollees, and availability of data on program enrollment. We also reviewed CMS's third party master file to identify how many beneficiaries in each state were enrolled in Medicare savings programs, and analyzed records from SSA's MBR to estimate the additional enrollment in each state following the SSA mailing. In addition, we obtained information from each state to the extent available on its involvement with the SSA mailing, the state's specific eligibility criteria for its Medicare savings program, outreach efforts conducted by the state to low-income Medicare beneficiaries, and state data on call and application volume before, during, and after the SSA outreach.

We obtained information from SSA and CMS on their data reliability checks and any known limitations on the data they provided us. SSA and CMS perform quality controls, such as data system edits, on the MBR and the third party beneficiary master file, respectively. We concluded that their data were sufficiently reliable for our analysis. A few MBR variables have certain limitations. For example, some Medicare beneficiaries receive their Social Security payments electronically, and therefore may not keep the record of their mailing address current. For our analysis we only used the beneficiary's state of residence, which is less likely to change as SSA reported that, even if a beneficiary's address changes, the beneficiary often


⁸The third-party master file contains records for Medicare beneficiaries for whom a third party, such as a state welfare agency or a private group payer, pays their Medicare part A or B premiums. SSA's field offices, state welfare agencies, private groups, and the Office of Personnel Management collect the information and send it to CMS for monthly updates. CMS uses these data to track enrollment and bill states and other groups accordingly.

stays within the same state of residence. Finally, since it is optional for beneficiaries to identify their race, a number of Social Security recipients do not. However, sufficient numbers of individuals reported their race to allow us to analyze these data and also report missing or unknown values.


Appendix II: SSA 2002 Outreach Letter

SSA mailed 16.4 million letters in 2002 to potentially eligible Medicare beneficiaries notifying them about state Medicare savings programs. These letters were customized to include state-specific information, including a state contact number. These letters were sent in English or Spanish, depending on the beneficiary's preference. Figure 2 provides a sample of the outreach letter sent to a beneficiary in Texas between May and November 2002.

Figure 2: Sample 2002 SSA Letter



SOCIAL SECURITY



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The Social Security Administration and the Centers for Medicare & Medicaid Services are working together to let you know about special State programs that can help you pay your Medicare Part B (Medical Insurance) premium and other medical costs. Many people save more than \$600 a year because of these programs. To get help from these programs, you must have Medicare Part A. You will also need to figure out if the money you have coming in and the value of the things you own is less than a certain amount.

First

- If you are single, and the money that comes in each month is less than \$1,017, or
- If you are married, and you and your spouse live together, and the combined amount of money that comes in each month is less than \$1,364,

(If you are working you may be able to get help even if you have more income.)

And The money you have saved and the value of the things you own is \$4,000 or less if you are single or \$6,000 or less for both you and your spouse if you live together (do **not** count the value of your home or one car),

Then ➤ Call the Texas Department of Human Services at 1-888-834-7406.

There is **no** cost for this help. Call right away, even if you just have a question. And even if you have too much money coming in now, the limits change every April, so you may be able to get help later on. Look for information about these programs in the *Medicare and You* handbook you receive each fall.

Please do not delay. These special programs can help you save more than **\$600** a year!

/s/

Jo Anne B. Barnhart
Commissioner
Social Security Administration

/s/

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048 for help with your Medicare questions.

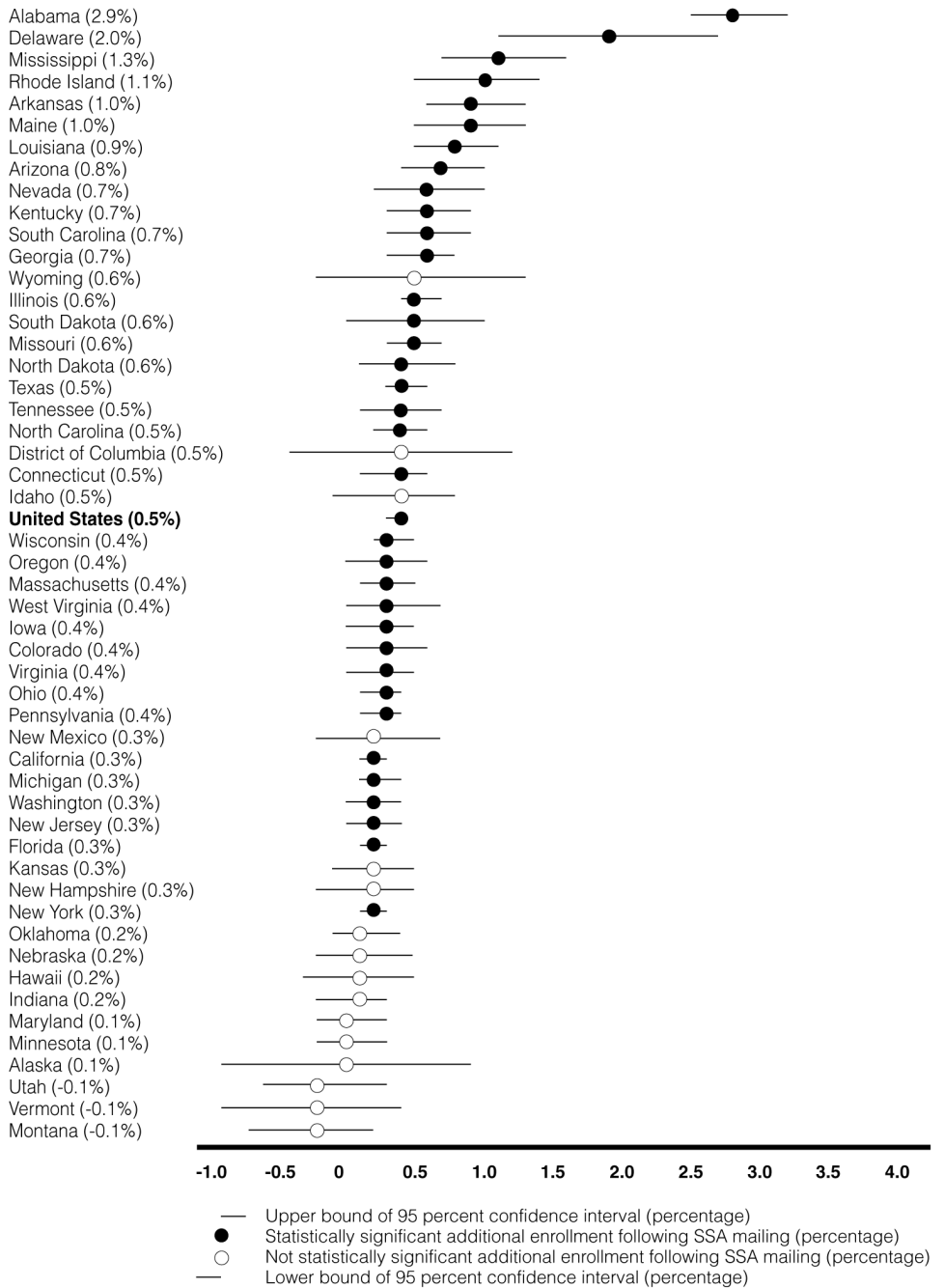
Source: SSA.

Appendix III: Medicare Savings Program Enrollment following 2002 SSA Mailing by State

Figure 3 shows enrollment by state of the estimated 74,000 additional beneficiaries who enrolled in Medicare savings programs following the 2002 SSA mailing. Because these estimates are based on two cohorts of about 1.3 million beneficiaries each that represent a sample of the entire population of 16.4 million beneficiaries, we calculated 95 percent confidence intervals to reflect the potential for statistical error in projecting these estimates from the sample cohorts to the entire population. The small sample size in states with smaller populations results in larger confidence intervals for the estimates for these states. The highest additional increase in enrollment was in Alabama, in which an estimated 2.9 percent (with a 95 percent confidence interval of 2.6 percent to 3.3 percent) of beneficiaries who were sent the SSA letter enrolled than if the mailing had not occurred. In three states (Montana, Utah, and Vermont) our analysis showed no additional or slightly negative enrollment following the SSA mailing, and because the confidence intervals for these and 13 other states overlap the numeric value zero, the data do not show a statistically significant change in additional enrollment in the Medicare savings programs following the 2002 SSA mailing for these states. The other 35 states showed a statistically significant increase in additional enrollment in the Medicare savings programs following the 2002 SSA mailing.

Appendix III: Medicare Savings Program Enrollment following 2002 SSA Mailing by State

Figure 3: Estimated Percentage Change in Medicare Savings Program Enrollment Following 2002 SSA Mailing by State, December 2002



Source: GAO analysis of SSA MBR data.

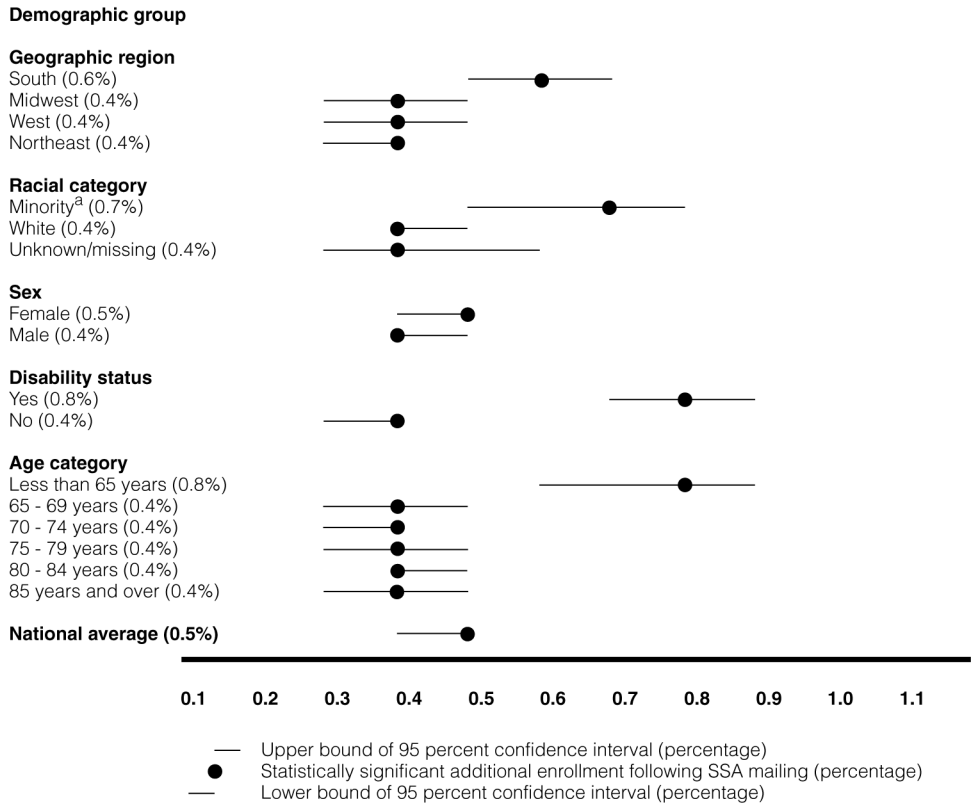
Appendix IV: Medicare Savings Program Enrollment following 2002 SSA Mailing by Demographic Group

On the basis of our analysis of SSA's MBR, we estimate that enrollment in Medicare savings programs was about 74,000 higher for Medicare beneficiaries following the 2002 SSA mailing than it would have been without the mailing. This represents about 0.5 percent of the 16.4 million letters sent nationwide. However, this additional enrollment following the SSA mailing varied among demographic groups.

Figure 4 shows the additional enrollment in Medicare savings programs following the 2002 SSA mailing by geographic region and demographic groups, including racial categories, sex, disability status, and age categories. Because these estimates are based on two cohorts of about 1.3 million beneficiaries each that represent a sample of the entire population of 16.4 million beneficiaries, we calculated 95 percent confidence intervals to reflect the potential for statistical error in projecting these estimates from the sample cohorts to the entire population. Additional enrollment following the 2002 SSA mailing was statistically significantly higher among beneficiaries in southern states compared to other geographic regions, minorities compared to white beneficiaries, beneficiaries with disabilities compared to beneficiaries without disabilities, and beneficiaries who were younger than 65 years compared to those who were 65 years or older.

Appendix IV: Medicare Savings Program Enrollment following 2002 SSA Mailing by Demographic Group

Figure 4: Estimated Percentage Change in Medicare Savings Program Enrollment Following 2002 SSA Mailing by Demographic Group, December 2002



Source: GAO analysis of SSA MBR data.

Note: Some estimates do not show an upper or lower bound because the 95 percent confidence interval was the same as the point estimate due to rounding.

^aBased on SSA's data categories, "minority" includes blacks or individuals of African origin, Asians and Pacific Islanders, and North American Indians or Eskimos.

Appendix V: Comments from the Social Security Administration



SOCIAL SECURITY

The Commissioner
February 20, 2004

Ms. Kathryn G. Allen
Director, Health Care--Medicaid
and Private Health Insurance Issues
U.S. General Accounting Office
Room 5C27
441 G Street, NW
Washington, D.C. 20548

Dear Ms. Allen:

Thank you for the opportunity to review and comment on the draft report "Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries" (GAO-04-363). Our comments on the report are enclosed.

If you have any questions, please have your staff contact Candace Skurnik, Director, Audit Management and Liaison Staff, at (410) 965-4636.

Sincerely,

A handwritten signature in black ink that reads "Jo Anne B. Barnhart".

Jo Anne B. Barnhart

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

COMMENTS ON THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT "MEDICARE SAVINGS PROGRAMS: RESULTS OF SOCIAL SECURITY ADMINISTRATION'S 2002 OUTREACH TO LOW-INCOME BENEFICIARIES" (GAO-04-363)

Thank you for the opportunity to review and comment on the draft report. We agree with GAO's findings that the Social Security Administration's (SSA) mailings of 16.4 million letters in 2002 to potentially eligible beneficiaries contributed to the increased enrollment in the Medicare Savings Programs. We are pleased to see that more than 74,000 additional eligible beneficiaries enrolled in Medicare savings programs as a result of the outreach mailings carried out by SSA in 2002. We anticipate a continued increase in participation by low-income beneficiaries as the outreach efforts by SSA and State agencies generate increased awareness among eligible individuals. Indeed, SSA intends to repeat these outreach mailings on an annual basis.

Although outreach is an important component of this program, we believe that improvements in the State enrollment process could further increase enrollments. States may wish to consider publishing their eligibility requirements on a central website. They could also share information with each other on methods for streamlining the enrollment process or increasing enrollments.

Related GAO Products

Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging. [GAO/HEHS-00-94](#). Washington, D.C.: August 18, 2000.

Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment. [GAO/HEHS-99-61](#). Washington, D.C.: April 9, 1999.

Medicare and Medicaid: Meeting Needs of Dual Eligibles Raises Difficult Cost and Care Issues. [GAO/T-HEHS-97-119](#). Washington, D.C.: April 29, 1997.

Medicare and Medicaid: Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program. [GAO/HEHS-94-52](#). Washington, D.C.: January 20, 1994.

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