Medicare Premium Buy-in Programs: Results of SSA Demonstration Projects

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In response to a Congressional mandate, SSA tested six different techniques to increase enrollment in programs that pay some Medicare expenses, such as premiums, for low-income individuals. This article describes these outreach projects, provides estimates of the eligible population, and discusses what could be expected for future efforts based on the results of the project.

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This paper was presented in a slightly different form at the Annual Research Conference of the Association for Public Policy Analysis and Management in Seattle on November 4, 2000.

Summary

Three programs known collectively as the Medicare buy-in programs are available to pay Medicare Part B premiums and, in some cases, other medical expenses for certain low-income individuals. The Health Care Financing Administration administers those programs, with most functions performed by the states. The Social Security Administration (SSA) plays an indirect role in the buy-in programs: with certain exceptions, people who qualify for Medicare and hence for buy-in are beneficiaries of Social Security retirement or disability programs. SSA is often cited as an agency that might be able to increase enrollment in the buy-in programs through outreach to its beneficiaries and by acting as an intermediary in the enrollment process.

The three buy-in programs have different requirements for eligibility. The Qualified Medicare Beneficiary (QMB) program includes individuals who have Part A Medicare benefits and whose income does not exceed 100 percent of federal poverty guidelines. People in the Specified Low-Income Medicare Beneficiary (SLMB) program are individuals who would otherwise be QMBs but whose income is more than 100 percent but less than 120 percent of poverty guidelines. People in the Qualified Individual (QI) program are those who meet the other criteria but whose income is less than 175 percent of poverty guidelines.

Various reports and studies by government agencies and advocacy organizations conclude that the buy-in programs are not reaching many of the people who are eligible. Low enrollment appears to be a particular issue for the SLMB and QI programs. States have tried various outreach efforts, but the effectiveness of those efforts has not been adequately assessed.

In 1998, Congress mandated that SSA conduct a demonstration project to determine how to increase participation in the buy-in programs. The project tested six different administrative models in which outreach letters were sent to potential beneficiaries asking them to contact SSA and then be screened for eligibility and referred for enrollment. SSA was able to screen about 7.1 percent of letter recipients for buy-in eligibility: 4.2 percent were potentially eligible for the programs based on income and resources, and 3.7 percent enrolled in a buy-in program.

An evaluation of the probability that letter recipients would contact SSA to be screened found that:

- Among the elderly, older individuals were less likely to be screened but more likely to enroll.
- Among the disabled, older individuals were more likely to be screened but less likely to enroll.
- The disabled were less likely to be screened but more likely to enroll.
- Individuals with higher Social Security benefits were more likely to be screened but less likely to enroll.
- Women were more likely to be screened and to enroll.
- Being married did not appear to affect screening but negatively affected enrollment.
- Individuals with a preference for materials in Spanish were much more likely to be screened and enrolled.
- In some of the demonstration sites, enrollment in a Medicare+Choice plan increased the probability of being both screened and enrolled.

SSA conducted a survey of some people who did not respond to the outreach letter. Most of those from whom explanations of the nonresponse were obtained had not responded because they were not eligible on the basis of their income or resources.

If SSA were to reproduce the demonstrations in a nationwide outreach effort, a national mailing would include nearly 20 million individuals. If response rates were similar to those seen in the 1999 demonstrations, outreach would produce over 740,000 new buy-in enrollees. That number might be increased modestly by conducting additional outreach efforts in conjunction with the mailing.

Introduction

Two issues relate to enrollment in most means-tested programs, such as Medicaid or Supplemental Security Income (SSI). First, those programs tend to be under-enrolled; that is, some eligible individuals or families do not enroll and thus do not receive the assistance to which they are entitled. Second, the size of the eligible but nonparticipating population is generally not known.

Medicare buy-in programs, through which low-income individuals who are eligible for Medicare can have various parts of the normal Medicare premium and deductibles paid for by Medicaid, exhibit both of those issues. Proceeding under a Congressional mandate, the Social Security Administration (SSA) is conducting a demonstration project to enroll eligible individuals and has been studying the results of that demonstration.

Legislative History and Provisions of the Buy-in Programs

States have had the option to buy Medicaid recipients into Medicare since the Medicare program began in 1965. In 1986, Congress gave states the option to pay all Medicare cost sharing (premiums, deductibles, and coinsurance) for individuals whose income did not exceed 100 percent of the federal poverty guidelines and who were not otherwise eligible for Medicaid.[1] In 1988, that option, referred to as the Qualified Medicare Beneficiary (QMB) program, became mandatory.

In the 1990s, eligibility for buy-in was extended to individuals with higher income. Beginning in 1993, states were also required to pay the Part B premium only for individuals with income up to 110 percent of federal poverty guidelines (120 percent as of 1995). Those individuals are covered under the Specified Low-Income Medicare Beneficiary (SLMB) program. In 1998, a block grant—referred to as the Qualified Individual (QI) program—was provided to pay the Part B premium for individuals with income up to 135 percent of poverty and a small portion of the premium for those with income up to 175 percent of poverty. Those income limits have entered the vocabulary for policy discussion, particularly when defining proposals for expanding Medicare benefits, such as a prescription drug benefit, and are often used to describe the groups for which benefits will be subsidized.

Qualified Medicare Beneficiaries

QMBs are individuals with Part A Medicare benefits whose income does not exceed 100 percent of federal poverty guidelines ($8,350 annual income for one person in 2000) and whose countable assets do not exceed $4,000 for individuals or $6,000 for couples. The QMB program pays all of beneficiaries' Medicare Part A premiums (if payment is required), Part B premiums, deductibles, and coinsurance for Medicare services. In some states, QMBs also receive related benefits such as coverage for prescription drugs.

Most QMBs are automatically enrolled as a result of their status as Medicaid or SSI beneficiaries in the 32 states (and the District of Columbia) in which SSA determines Medicaid eligibility on behalf of the state (known as Section 1634 states). If the state is not a Section 1634 state or the potential QMB is not a Medicaid or SSI recipient, application with the designated state agency is required.

Specified Low-Income Medicare Beneficiaries

SLMBs are individuals who would otherwise be QMBs but whose income is more than 100 percent but less than 120 percent of federal poverty guidelines. The SLMB program pays beneficiaries' Medicare Part B premiums

in full. Except for some SSI beneficiaries, application with the designated state agency is required.

Qualified Individuals

QIs are persons who meet the other criteria but whose income is less than 175 percent of poverty guidelines. Those with income between 120 percent and 135 percent of poverty guidelines have all of their part B premiums paid for by Medicaid. Payment is partial for QIs whose income is more than 135 percent but less than 175 percent of poverty. Application with the designated state agency is required. The QI program is a block grant with funding from 1998 through 2002 only.

Buy-in Participation

Various reports and studies by the Health Care Financing Administration (HCFA), the General Accounting Office, various advocacy organizations, and other researchers conclude that some poor elderly and disabled persons who are eligible for Medicaid payment of some or all Medicare costs are not enrolled in the buy-in programs to which they are entitled. Table 1 summarizes available estimates of participation in the QMB and SLMB programs.

The estimated percentage of beneficiaries enrolled in a buy-in program is much higher for QMBs than SLMBs. One reason for the disparity may be that many QMBs are automatically enrolled as a result of their participation in Medicaid or SSI. Advocates and other researchers have advanced a number of reasons for the underenrollment, including eligible individuals not knowing about the programs, application forms and procedures that are too complex, and state-administered processes that are inconvenient for applicants.

For example, research conducted by the Barents Group (1999, p. xi) for HCFA 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."

Outreach by HCFA and Advocacy Groups

Individual states have undertaken a variety of outreach efforts for Medicare buy-in programs. About two-thirds of states publicize the programs through brochures or fliers in county welfare offices (Nemore 1999). A handful of states also place posters in public areas or create public service announcements. Two states use particularly innovative methods of outreach: New York includes buy-in information with utility bills, and New Jersey screens for buy-in eligibility among participants in its popular Pharmaceutical Assistance for the Aged and Disabled program.

Although the state efforts cover a wide range of outreach methods, the success of those strategies has not been assessed. The only existing evaluation of buy-in

Table 1.
Estimates of buy-in eligibility and enrollment

Organization	Year of estimate	Eligible (millions)			Enrollment (millions)			Percentage enrolled		
		QMB	SLMB	Both	QMB	SLMB	Both	QMB	SLMB	Both
HCFA/state billing files	2000	*	*	*	*	*	5.4	*	*	*
SSA (Rupp and Sears) [a]	2000	*	*	6.9	*	*	4.5	*	*	65.2
GAO [a]	1999	*	*	5.1	*	*	2.9	*	*	57.0
HCFA/Barents Group	1999	6.5	1.8	8.3	3.6	0.28	3.9	54.7	15.7	*
Families USA [a]	1998	*	*	8.0	*	*	4.1-4.7	*	*	51.5-59.0
Urban Institute	1998	5.7	1.6	7.3	4.5	0.26	4.7	78.0	16.0	*
Urban Institute	1995	5.3	1.9	7.2	3.3	0.19	3.5	62.0	10.0	*
Project Hope	1993	4.7	*	*	1.9	*	*	41.0	*	*
Families USA [a]	1993	4.3	1.0	5.3	2.5	0.005	2.5	58.0	0.5	*

SOURCES: Estimates from the HCFA/state billing files are based on HCFA administrative files. Estimates from the Social Security Administration (Rupp and Sears) are from Kalman Rupp and James Sears, "Eligibility for Medicare Buy-in Programs, Based on a Survey of Income and Program Participation Simulation," *Social Security Bulletin* 63(3):13-25 (2001). All other estimates are from Barents Group, *A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries* (report prepared for the Health Care Financing Administration under Contract No. 500-95-0057/Task Order 2, Washington, D.C., April 7, 1999).

NOTE: QMB = Qualified Medicare Beneficiary program; SLMB = Specified Low-Income Medicare Beneficiary program; HCFA = Health Care Financing Administration; GAO = General Accounting Office; * = not available.

a. Estimates exclude nursing home residents.

outreach was for a 1998 HCFA mailing to new Medicare beneficiaries. HCFA sent letters to 60,847 Texas residents whose Social Security income was below poverty guidelines and who were about to turn 65. The letters included reply cards to mail back for buy-in applications, and 7.3 percent of recipients returned the cards (Booz·Allen & Hamilton 1999).[2] However, only 17 percent of those who requested applications returned them, and about half of those who applied either were already enrolled or were denied enrollment. At the time of the Booz·Allen & Hamilton study, 286 applicants had been approved to receive buy-in, and 127 applications were pending. Although the HCFA mailing may have induced some other individuals to apply for buy-in without returning cards, the apparent outcome is that less than 1 percent of those who received HCFA's letter were enrolled as a result of that outreach.

Role of the Social Security Administration

The Health Care Financing Administration is the federal agency charged with administering the buy-in programs, Medicare, and Medicaid. SSA currently has an indirect role in the buy-in programs because it administers the Social Security retirement, survivors, and disability programs and the Supplemental Security Income program. With certain exceptions, persons who qualify for Medicare and hence for the buy-in programs are beneficiaries of Social Security who are age 65 or older or have received disability benefits for 24 months.

Also, under the authority of section 1634 of the Social Security Act, SSA enters into agreements with states to determine Medicaid eligibility for SSI beneficiaries. SSA currently performs that task for 32 states and the District of Columbia. Many SSI beneficiaries also qualify for Medicare and are enrolled in one of the buy-in programs as a result of their enrollment in Medicaid.

Because of its role in the programs that contain the vast majority of buy-in eligibles, SSA is often identified as an agency that might be able to increase enrollment through outreach to its beneficiaries and by acting as an intermediary in the enrollment process.

SSA Demonstration Projects

In 1998, Congress mandated that SSA conduct a Medicare buy-in demonstration project to determine how to increase participation in the buy-in programs. The project tested six different administrative models that were generally designed to address the three common criticisms of the existing buy-in enrollment systems: lack of knowledge about the programs, complexity of the application procedures, and inconvenience of state-administered procedures.

The outreach effort in the demonstration project included sending letters to all potentially eligible beneficiaries in the demonstration areas. Starting in March 1999, nearly 240,000 letters were sent to potential participants living in selected zip codes who:

- Were receiving no more than $947 of monthly Title II Social Security benefits if single or $1,265 if married (equivalent to 135 percent of the poverty guideline plus the $20 income disregard),[3]

-AND-

- Were not receiving Medicare buy-in,

-AND-

- Were receiving Medicare Part A benefits, *or*
- Were at least age 64 and 11 months or had received at least 24 consecutive months of disability insurance benefits (Alecxih and others 2000a).

The six administrative models were tested to determine their effects in inducing eligible persons to enroll in the buy-in programs. Potential beneficiaries were sent outreach letters inviting them to be screened for eligibility and referred for enrollment. Screening was usually done by SSA personnel, although some models involved state employees and even volunteers under the direction of the American Association of Retired Persons (AARP). Ultimately, the applications and evidence were referred to the designated state agency for the model site for adjudication and enrollment. The details of the models are summarized in Box 1 and more fully described in the appendix.

Results of the Demonstration Project

For the six demonstration models, SSA was able to screen about 7.1 percent of letter recipients for buy-in eligibility: 4.2 percent screened as potentially eligible, and 3.7 percent enrolled in buy-in programs. The rate of new enrollments varied moderately across models and geographic sites. The highest rate of new enrollments (4.5 percent) was achieved when SSA workers assisted beneficiaries in completing buy-in applications and then forwarded the applications to state Medicaid agencies. By comparison, the rate was 2.7 percent at demonstration sites where SSA workers attempted to schedule appointments for potential eligibles with local Medicaid agencies.

In the ongoing demonstration model involving AARP volunteers, the rate of eligibility screening has been only 2.4 percent (compared with 7.1 percent by SSA). That rate may be lower because AARP volunteers attempted to return beneficiaries' calls rather than screen people when they called.

The Lewin Group is evaluating the six demonstration projects under contract to SSA (Alecxih and others

2000a; Alecxih and others 2000b). Ideally, one would like to know the most effective approaches for inducing individuals who are potentially eligible for buy-in to contact SSA and for enrolling those screened as eligible in the program.

The Lewin Group calculated the probability that letter recipients would be screened and the probability that letter recipients and individuals who screened as potentially eligible would enroll. The following findings emerged:

- **Among the elderly, older individuals were less likely to be screened but more likely to enroll.** For all models and almost all sites, age in the elderly population was significantly negatively related to the odds of being screened and significantly positively related to the odds of enrolling. With each increase of a year in age among the elderly, the odds of being screened decreased approximately 1 percent to 2 percent, and the odds of enrolling increased approximately 1 percent to 5 percent.
- **Among the disabled, older individuals were more likely to be screened but less likely to enroll.** For all models and almost all sites, age in the disabled population was significantly positively related to the odds of being screened and significantly negatively related to the odds of being enrolled. With each increase of a year in age among the disabled, the odds of being screened increased approximately 3 percent to 5 percent, and the odds of enrolling decreased approximately 2 percent to 8 percent.
- **Persons with disabilities were less likely to be screened but more likely to enroll.** Being disabled was significantly negatively related to the odds of being screened and significantly positively related to the odds of enrolling. Overall, the odds of being screened for the disabled were 29 percent of the odds of being screened for the elderly. The odds of enrolling were more than nine times higher for the disabled, however, perhaps because they are more likely to enroll in SSI.
- **Those with higher Title II income were more likely to be screened but less likely to enroll.** Title II income was significantly positively related to the odds of being screened overall but was insignificant by model and by site, which partly reflects the small sample sizes. Title II income was significantly negatively related to the odds that letter recipients would enroll, overall and for the screening and co-location models. Title II income was significantly positively related to the odds that persons screened to be potentially eligible would enroll. Beneficiaries with higher Title II income were more likely to take the next step necessary in the enrollment process.
- **Women were more likely to be screened and to enroll.** Being female was significantly positively related to the odds of being screened and enrolling, both overall and by model.
- **Marital status did not appear to affect screening but negatively affected enrollment.** Being married was significantly negatively related to the odds of enrolling, both overall and by model. Overall, the odds of enrolling for married couples were 91 percent of the odds for singles.

Box 1.
Six Administrative Models Used in the Demonstration Project

Screening Model: Outreach letters directed potential applicants to contact Social Security (a special toll-free telephone number or their local office). A Social Security Administration (SSA) worker screened respondents for potential eligibility and set up appointments for them to apply with the local Medicaid agency.

Co-location Model: The same as the screening model, except that the interview with the local Medicaid agency employee took place in the SSA local office rather than the state or county Medicaid office.

Application Model: In this model, the state's application was completed by an SSA employee who also accepted and copied evidence provided by the applicant. The completed application package was forwarded to the state Medicaid agency for further development, if necessary, and adjudication.

Widow(er)s Model: This model provided eligibility screening for recent widow(er)s in recognition that death of a spouse can result in a change in financial circumstances.

Peer Assistance Model: As in the screening model, outreach letters directed potential applicants to a toll-free number. However, instead of immediate screening, respondents were asked to provide their telephone numbers and were contacted and screened at a later time by volunteers from the American Association of Retired Persons.

Decision-Making Model: As in the application model, the state's application is completed by an SSA worker. In this model, the SSA worker also makes an initial eligibility determination.

- **Persons with a preference for materials in Spanish were much more likely to be screened and to enroll.** The odds of being screened for letter recipients with a preference for information in Spanish were 2.7 times those for letter recipients without that preference. Enrollment among those with a preference for Spanish was 2.4 times as high as among letter recipients without that preference.
- **In some of the demonstration sites, enrollment in a Medicare+Choice plan increased the probability of being both screened and enrolled.** Overall, letter recipients who were enrolled in Medicare+Choice plans were 1.3 times more likely to be screened and to enroll. That may be the result of activity on the part of some health maintenance organizations to identify and facilitate enrollment for that population.

Survey of Nonresponders

The Social Security Administration telephoned 879 potentially eligible recipients of outreach letters to determine why they had not responded. Of that group, SSA obtained explanations from 461 individuals.[4] Most of those surveyed (66 percent) did not respond because they were not eligible on the basis of their income or resources. Another 10 percent had contacted SSA, the state Medicaid office, or the welfare office about buy-in. An additional 5 percent were not interested in participating. Table 2 presents a detailed tally of the survey responses.

The overwhelming majority of those surveyed had correctly screened themselves out of the project because their income, resources, or both exceeded the limits for program eligibility. Given the low completion rate for this survey, we cannot conclude that the same is necessarily true for all individuals who did not respond to SSA mailings. However, we do observe the impact that telephone outreach has on screening outcomes. Through an intensive effort to reach 879 individuals by telephone, SSA was able to screen 27 people (3.1 percent) as eligible for buy-in. That share is in addition to the 4.2 percent who screened as eligible in the absence of telephone follow-up.

The initial demonstration mailings appear to have reached the majority of people whom SSA could expect to bring in through combined mail and telephone outreach. SSA continues to experiment with additional modes of publicity including signs, posters, community events, and public service announcements. At the current demonstration sites, those activities do not appear to be having a dramatic effect on the number of individuals who screen as eligible for buy-in.

Table 2.
Results of the survey of persons who did not respond to the letter

Reason	Number of responses	Percentage of sample
Income or resources above limit	305	66.2
No reason given—proceeded to screener [a]	46	10.0
Income or resources above limit	18	3.9
Income and resources below limit	27	5.9
Already responded to outreach [b]	45	9.8
Income or resources above limit	18	3.9
Income and resources below limit	8	1.7
Not interested	22	4.8
Deceased	17	3.4
No Part B coverage	16	3.5
Already receiving buy-in benefits	10	2.0
Total	461	100

a. One person who proceeded to the screener was not actually screened because he no longer lived in a demonstration area.

b. Individuals could have contacted SSA between the time the nonresponder sample was drawn and the survey was administered, because the survey was conducted between September 1999 and January 2000. Ten of those who indicated that they had already responded to the outreach had been screened before the survey call.

Expectations Based on Experience with the Demonstrations

Before the demonstration projects, there was no actual experience by which to estimate how greater SSA involvement in the enrollment process might affect enrollment. Therefore, we used estimates based on surveys of the population of individuals who are eligible but not enrolled. Groups advocating SSA's involvement created the impression that such involvement might boost enrollment of those individuals. However, at this point we can look at what actually happened in the demonstration projects.

In conducting an outreach effort, SSA has available a great deal of useful information. For example, SSA has the Medicare status for persons currently enrolled in Medicare and, for beneficiaries of SSI or Old-Age, Survivors, and Disability Insurance, the amount of their benefit. But SSA does not have information about assets and other income except for those

receiving SSI, most of whom are already receiving buy-in if eligible.

Although the population in the demonstrations does not constitute a valid national sample, it is the best real-world test available. Assuming that the experience is roughly comparable with what would happen in a nationwide effort, one can extrapolate from the results of the demonstrations to a nationwide outreach effort. A national mailing would include nearly 20 million individuals. If response rates were similar to those seen in the completed demonstrations, more than 740,000 persons would enroll. That number might be increased modestly by conducting additional outreach efforts in conjunction with the mailing.

Conclusions

Before the demonstrations, SSA had little information about the size of the population that might respond to its outreach efforts for the buy-in programs. The response to those efforts has been moderate. Targeting outreach efforts based on Title II Social Security income eliminates only about one-third of Social Security beneficiaries from consideration.[5] Many of the targeted individuals have assets or other sources of income that preclude eligibility for buy-in, and many of them screen themselves out rather than respond to outreach.

Even people who initially respond to an outreach effort do not necessarily follow through and receive benefits. HCFA found that only a small fraction of requested applications were returned during the demonstrations in Texas (Booz·Allen & Hamilton 1999). Similarly, SSA is encountering low screening rates when AARP volunteers attempt to return calls rather than immediately screen callers. However, the SSA demonstrations have been able to enroll substantial numbers of individuals in buy-in programs when callers are screened promptly, particularly when SSA or state workers help respondents fill out an application.

Appendix: Descriptions of Models

This appendix describes the six administrative models used in the Social Security Administration's demonstration project.

Screening Model

This model tested the use of the Social Security Administration as a filter for potential buy-in eligibility. In selected communities, letters were sent to Medicare beneficiaries, and brochures and posters directed potential buy-in participants to call a special toll-free number at SSA's Direct Service Unit (DSU) or to visit their local welfare, social services, medical assistance, or Social Security office. An SSA worker, using a PC-based program, screened individuals who called the DSU or visited the local Social Security office. If the beneficiary appeared eligible for the QMB, SLMB, or QI program based on the screening, SSA attempted to set up an appointment for the individual to apply with the local Medicaid agency.

The screening model was tested during 1999 in Carlisle and Lebanon, Pennsylvania. Of the 25,279 letter recipients, 5.8 percent were screened by SSA, and 2.7 percent had enrolled in buy-in programs by the end of 1999.[6]

Co-location Model

This model tested the use of an SSA office, rather than a county Medicaid agency, as the site where screened persons could apply for buy-in. The DSU or local SSA field office first screened beneficiaries. If the beneficiary appeared eligible based on the screening, SSA staff set up an application appointment with a Medicaid agency employee located at the local SSA field office.

The co-location model was tested during 1999 in Muskogee and Oklahoma City, Oklahoma, and in West Chester and Uniontown, Pennsylvania. Of the 77,056 letter recipients, 5.6 percent were screened by SSA, and 2.9 percent had enrolled in buy-in programs by the end of 1999.

Application Model

In this model, applications were completed by SSA employees rather than by Medicaid agency employees. Again, the DSU or SSA field office screened beneficiaries. If the beneficiary appeared eligible based on the screening, SSA set up an application appointment with an SSA employee at the local SSA field office. The SSA worker then completed the state's application form for buy-in, accepted and copied evidence provided at the time of the application, and forwarded the completed application form and evidence to the state Medicaid agency for further development (if necessary) and eligibility determination.

The application model was tested during 1999 in Corpus Christi, Texas; Orlando and Miami, Florida; Lexington, Kentucky; and Evansville, Indiana. Of the 115,559 letter recipients, 8.4 percent were screened by SSA, and 4.5 percent had enrolled in buy-in programs by the end of 1999.

Widow(er)s Model

This model provides screening for buy-in eligibility for individuals who report the death of a spouse to SSA field offices in Massachusetts. When this model began in spring 1999, it did not include any extraordinary out-

reach efforts. However, it has evolved to include active outreach through letters to recent widow(er)s. The model concluded in 2000.

Peer Assistance Model

This model is similar to the screening model, except that Medicare beneficiaries who contact a toll-free number are not immediately screened but are asked to leave their name, telephone number, and times when they are most likely to be at home. A volunteer from the American Association of Retired Persons calls the beneficiaries later and screens them for buy-in eligibility. This model was designed to test an intervention primarily independent of SSA, with the exception of preparing and mailing the letters.

During 1999, the peer assistance model was implemented in Los Angeles, California; St. Louis, Missouri; Omaha, Nebraska; Asheville, North Carolina; and Pittsburgh, Pennsylvania. A total of 217,572 letters were delivered, and 5,278 (2.4 percent) were screened for buy-in eligibility. A variation of the peer assistance model continued through 2000.

Decision-Making Model

This model is a variation of the application model. However, SSA staff not only take the application at the SSA office but also review the application and make an initial eligibility determination. State agencies retain ultimate responsibility for the eligibility determination and adjudication, but SSA helps streamline the process. This model was intended to vest responsibility with the regional offices rather than the central office.

The decision-making model was tested in San Francisco, California; Philadelphia, Pennsylvania; and Dallas and San Antonio, Texas. Letters were sent to more than 200,000 Medicare beneficiaries in those areas. In San Francisco, SSA also launched a large publicity campaign using media and other channels. The model concluded in 2000.

Notes

[1] Income, as used here, means countable income after all applicable exclusions.

[2] A similar mailing to New York residents received a response rate of 13.9 percent, but no information is available about whether the respondents actually applied for buy-in.

[3] Title II income includes Social Security Disability Insurance benefits as well as retired-worker benefits. It does not include Supplemental Security Income.

[4] The survey response rate was 52 percent (461 of 879). The results are not representative of potentially eligible recipients because of selectivity bias from interviewing only half of the sample.

[5] Note that SSA intended to target unenrolled individuals whose Title II Social Security income does not preclude buy-in. It would also be possible to target subsets of that group. For example, HCFA has sent mailings to some new Medicare beneficiaries whose Social Security benefits are below 100 percent of the poverty guidelines (Nemore 1999).

[6] These numbers are based on Alecxih and others (2000b) and do not reflect letters sent to spouses whose combined Social Security Title II income exceeded 135 percent of poverty.

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