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Qualified Medicare Beneficiary Program

Jennifer O'Sullivan
Specialist in Social Legislation
Education and Public Welfare Division

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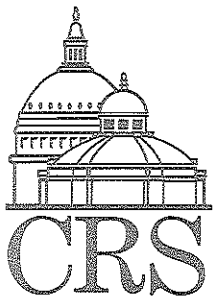

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QUALIFIED MEDICARE BENEFICIARY PROGRAM

SUMMARY

The Medicare program offers protection for aged and certain disabled persons against the costs associated with acute health care services. Medicare beneficiaries are required to pay a portion of the cost of these services themselves in the form of cost-sharing charges. Such charges could pose a potential hardship for some persons, especially those who do not have supplementary protection either through an individually purchased "Medigap" policy or employer-based coverage. In response to this concern, legislation was enacted in 1988 establishing the Qualified Medicare Beneficiary (QMB) program. Under this program, certain low-income Medicare beneficiaries are entitled to have their Medicare cost-sharing charges paid by the Federal-State Medicaid program. More limited Medicaid coverage is offered for two other population groups: (1) persons who meet the QMB criteria except that their income is slightly in excess of the poverty line (the Specified Low-Income Medicare Beneficiary (SLMB) population); and (2) qualified disabled and working individuals (QDWIs).

Persons meeting the qualifications for coverage under one of these categories, but not otherwise eligible for Medicaid, are not entitled to the regular Medicaid benefit package. Instead, they are entitled to have Medicaid make specified payments in their behalf.

When a State pays Medicare cost-sharing charges for its QMB population, it "buys-in" Medicare protection for this group. This buy-in for the QMB population is in addition to the buy-in arrangement that States have traditionally had for some of their Medicaid population. Under the traditional buy-in arrangement States enroll in Medicare Part B persons who are eligible for both Medicare and full Medicaid benefits (the "dually eligible").

The Congress has approved a budget resolution which provides for reductions of $270 billion in Medicare spending and $182 billion in Medicaid spending over the FY1996-2002 period. As part of the budget reconciliation process, the authorizing committees will be identifying specific policies to achieve the savings targets. The specifics of the potential changes are not yet available. In the past, Medicare savings have been achieved primarily through reductions in payments to providers. However, given the magnitude of the potential Medicare savings, it is likely that some beneficiary cost-sharing charges will be increased. Absent any modifications to the QMB program, this would mean increased Federal and State spending under Medicaid for the QMB population.

The interaction of potential Medicare changes with potential Medicaid changes also needs to be considered. It is possible that the Congress may approve significant structural changes in the current Medicaid program, for example turning the program into a block grant or capping Federal Medicaid expenditures. Under either alternative, States are expected to be given additional latitude in designing their programs. The current QMB mandate might be viewed as incompatible with the concept of giving States more flexibility in structuring their programs. Since the specifics of the Medicaid restructuring proposals are not currently available, it is difficult to determine how States would respond to elimination of a QMB requirement. However, in the face of reduced Federal funding, it is possible that some persons could lose protections currently available to them.

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INTRODUCTION

The Medicare program offers protection for aged and certain disabled persons against the costs associated with acute health care services. Medicare beneficiaries are required to pay a portion of the cost of these services themselves in the form of cost-sharing charges. Such charges could pose a potential hardship for some persons, especially those who do not have supplementary protection either through an individually purchased "Medigap" policy or employer-based coverage. In response to this concern, legislation was enacted in 1988 establishing the Qualified Medicare Beneficiary (QMB) program. Under this program, certain low-income Medicare beneficiaries are entitled to have their Medicare cost-sharing charges paid by the Federal-State Medicaid program. More limited Medicaid coverage is offered for two other population groups: (1) persons who meet the QMB criteria except that their income is slightly in excess of the poverty line (the Specified Low-Income Medicare Beneficiary (SLMB) population); and (2) qualified disabled and working individuals (QDWIs).

Persons meeting the qualifications for coverage under one of these categories, but not otherwise eligible for Medicaid, are not entitled to the regular Medicaid benefit package. Instead, they are entitled to have Medicaid make specified payments in their behalf.

QUALIFIED MEDICARE BENEFICIARIES (QMBs)[1]

Definition. State Medicaid programs are required to make Medicare cost-sharing assistance available to QMBs.[2,3] A QMB is an aged or disabled Medicare beneficiary who has: (1) income at or below the Federal poverty line; and (2) resources below 200% of the limit set for the Supplemental Security Income (SSI) program (the cash assistance program for low income aged and disabled persons). Medicaid is required to pay Medicare premiums and cost-sharing charges for these persons. Medicaid coverage is

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[1]The QMB program was authorized under Section 301 of P.L.100-360, the Medicare Catastrophic Coverage Act of 1988 (MCCA), enacted July 1, 1988. While most of the provisions of that legislation were repealed by the Medicare Catastrophic Coverage Repeal Act of 1989 (P.L.101-234), the QMB provision was retained. Section 4501 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L.101-508) accelerated the implementation of the provision.

[2]Specifically, Section 1902(a)(10)(E)(i) of the Social Security Act *requires* State Medicaid programs to make available Medicare cost-sharing assistance (as defined in Section 1905(p)(3) to QMBs described in Section 1905(p)(1)) of the Act.

[3]The requirement is also mandatory in any State providing Medicaid to its residents under a waiver granted under Section 1115 of the Social Security Act, namely Arizona. The requirement is optional in the territories.

limited to payment of these charges unless the beneficiary is otherwise eligible for Medicaid.[4]

Persons meeting the QMB definition must be entitled to Medicare Part A Hospital Insurance coverage. Included is the relatively small group of aged persons who are not automatically entitled to Part A coverage, but who have bought Part A protection by paying a monthly premium. Not included are working disabled persons who have exhausted Medicare Part A entitlement but who have extended their coverage by payment of a monthly premium. (See discussion of qualified disabled and working individuals (QDWIs), below.)

To be eligible as a QMB, an individual must have income at or below 100% of the Federal poverty line for a family of the same size.[5] In 1995, the Federal poverty level is $7,470 for a single and $10,030 for a couple. The Federal poverty level is published annually (usually in mid-February) in the *Federal Register*. By law, cost-of-living increases (COLAs) in social security benefits are disregarded in determining QMB eligibility through the month following the month in which the annual update is published. Thus, in most years COLAs are disregarded through March. For QMBs without social security income, the poverty levels are effective as of the date of publication.

A QMB must also meet specified resources standards, namely resources cannot exceed 200% of that allowed under SSI. For the QMB program, the limits are $4,000 for an individual and $6,000 for a couple. Certain items such as an individual's home and household goods are always excluded from the calculation.

Application for Benefits. QMBs are required to meet general nonfinancial requirements or conditions of eligibility applicable to persons under the regular Medicaid program. This includes filing an application for medical assistance with the State Medicaid office, furnishing a social security number, proving citizenship or satisfactory immigration status, and proving residence.

Eligibility for QMB benefits begins on the first day of the month after the month in which QMB status is first determined. Retroactive eligibility is not permitted for this population group.[6] An eligibility determination is normally effective for 12 months; however, a State may make redeterminations more frequently, but no more frequently than every 6 months. The limitation on redeterminations does not apply in cases where the State becomes aware of an actual change in an individual's situation that could affect his or her eligibility status.

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[4]The QMB program should not be confused with the Medicaid *option* to provided full Medicaid coverage to elderly and disabled persons whose incomes are below 100% of the Federal poverty line.

[5]The determination of income is made in the same manner as is made for SSI. Individuals with income above the threshold are not permitted to spenddown to meet the eligibility criteria.

[6]This prohibition is contained in Section 1905(a) of the Social Security Act.

Many persons meeting QMB criteria are also eligible for regular Medicaid coverage. An applicant may elect to have eligibility determined for all categories for which he or she may be eligible. Eligibility as a QMB constitutes an eligibility status in addition to any other eligibility status the individual may have.

QMB Benefits. Medicaid is required to pay Medicare premiums and cost-sharing charges for QMBs, as follows:

- Medicare Part B monthly premiums ($46.10 in 1995). Medicare Part B pays for physicians services' and other medical services. Almost all persons entitled to Medicare Part A are also enrolled in Medicare Part B.

- Medicare Part A monthly premium paid by the limited number of aged not automatically entitled to Part A protection. The premium is $261 in 1995.[7]

- Coinsurance and deductibles under Medicare Part A and Part B. This includes the Medicare hospital deductible ($716 in 1995), the Part B deductible ($100) and the Part B coinsurance (20% of Medicare's approved payment amount that applies to most Part B services).

- Coinsurance and deductibles that health maintenance organizations (HMOs) and competitive medical plans (CMPs) charge their enrollees. These are in lieu of the Medicare coinsurance and deductibles which would be paid if the individuals were not enrollees of these plans. States, at their option may also pay the HMO and CMP enrollment premiums.

A person entitled to regular Medicaid benefits as well as QMB assistance is entitled to Medicaid payment for Medicare premiums and cost-sharing charges as well as to the full range of Medicaid services otherwise available to them.

Payment of QMB Benefits. States are required to pay Part A and Part B premiums in full for the QMB population. They are also required to pay the requisite deductibles and coinsurance, though the actual amount of required payment has been the subject of some controversy.

State Medicaid programs frequently have lower payment rates for services than those applicable under Medicare. Federal program guidelines permit States to either (i) pay the full Medicare deductible and coinsurance amounts; or (ii) only pay those amounts to the extent that the Medicare provider or supplier has not received the full *Medicaid* rate for the service. For example, assume Medicare's recognized payment amount for a service is $100 and Medicaid's recognized amount is $75. Medicare actually pays $80 (assuming the beneficiary has met the deductible) leaving $20 in coinsurance charges. Under the

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[7]Part A coverage is available at a reduced premium to persons who do not have coverage as social security or railroad retirement beneficiaries but who have at least 30 quarters of social security or railroad retirement coverage. The premium for these persons is $183 in 1995.

guidelines, Medicaid could pay nothing (since the provider had received more than the full Medicaid rate) or any amount up to $20 (the full Medicare coinsurance amount).

If the Medicare service is not covered under the State Medicaid program, the State may either pay the full Medicare deductible and coinsurance amounts or alternatively provide for reasonable payments (subject to approval by DHHS).

As of March 1995, 29 States were reported to be using payment rates below those applicable under Medicare.[8] However, the United States Court of Appeals for four judicial circuits have issued decisions which require States in their jurisdictions to pay the full Medicare cost-sharing expenses for QMBs.[9] As a result, eight of the 29 States are required to change their policies.[10]

Beneficiary Cost-Sharing. A State may require QMBs to pay nominal cost-sharing charges. Medicaid's actual payment plus any Medicaid copayment paid by the QMB is considered payment in full for Medicare coinsurance and deductibles.

A QMB may not be billed for any physicians' charges which exceed Medicare's recognized payment amount (so-called *balance billing charges*). However, a QMB-only individual may be liable for balance billing charges if certain services (e.g., durable medical equipment) are provided by a supplier who has not accepted Medicare assignment for the service (i.e., has not accepted Medicare's recognized payment amount as payment in full). The supplier may not balance bill if the beneficiary is eligible for full Medicaid benefits.

Buy-In. All States have buy-in agreements with the Secretary of the Department of Health and Human Services (DHHS) for their QMB population. Under a buy-in agreement, States enroll their QMB population in Medicare Part B. Some States have also elected to include payment of Part A premiums under their buy-in agreements. Payment of premiums under a buy-in agreement is advantageous to the State, because premiums paid through this method are not subject to delayed enrollment penalties which might otherwise be applicable in the case of delayed enrollment or re-enrollment.

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[8]Alabama, Arizona, California, Colorado, District of Columbia, Florida, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Maryland, Montana, Nevada, New Hampshire, New Jersey, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

[9]The following rulings affect States in the Second, Third, Fourth, and Eleventh Judicial Circuits: (1) *New York City Health and Hospitals Corporation v. Perales*, 954 F.2nd 854 (2nd Cir. 1992); (2) *Pennsylvania Medical Society v. Snider*, et al., 29 F. 3d 886 (3rd Cir. 1994) No. 93-775; (3) *Haynes Ambulance Service, Inc. v. State of Alabama*, et al., 36 F.3d 1074 (11th Cir. 1994); and (4) *Rehabilitation Association of Virginia, Inc. v. Kozlowski and Shalala*, 42 F.3d 1444 (4th Cir. 1994).

[10]Alabama, Florida, Maryland, New Jersey, Pennsylvania, Vermont, Virginia, and West Virginia.

The buy-in agreement for the QMB population is *in addition to the traditional buy-in agreement* that States have for other population groups. Under these traditional buy-in agreements, States enroll in Medicare Part B persons who are eligible for both Medicare and Medicaid. As a minimum, States may limit buy-in coverage to persons receiving cash assistance; alternatively they may add some or all categories of other persons who are eligible for both Medicare and Medicaid. States are given a financial incentive to cover all of their dual eligibles under a buy-in agreement A State may not claim Federal matching payments for any Medicaid expenditure which would have been a Medicare expenditure if the State had covered the beneficiary under a buy-in agreement. States receive Federal matching assistance for payment of the Part B premium in behalf of "categorically needy" persons. (These are generally persons the State is required to cover under its Medicaid program.) States pay the full cost of Part B premiums for other buy-ins (except for QMBs and SLMBs).

Administration of Buy-In. States send to Medicare a tape containing the names of persons (including QMBs) covered under a buy-in agreement. These names are matched with social security records so that deductions for Part B premiums will not be made from beneficiaries' social security checks. Medicare bills State Medicaid plans for the premiums; State Medicaid plans then claim appropriate Federal matching funds. In the case of Medicare cost-sharing charges, State Medicaid programs pay the providers of services and claim appropriate Federal matching funds.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES[11]

Beginning in 1993, States were required to pay Medicare Part B premiums for persons meeting the QMB criteria except for income. The income limit for these specified low-income beneficiaries was 110% of the Federal poverty line in 1993, rising to 120% of the Federal poverty line beginning in 1995. Unlike the rules applicable for QMBs, retroactive eligibility is available for up to 3 calendar months.

Medicaid protection is limited to payment of monthly Part B premiums unless the beneficiary is otherwise eligible for benefits under the program. Medicare Part B premiums are set at $46.10 in 1995.

QUALIFIED DISABLED AND WORKING INDIVIDUALS (QDWIs)[12]

Medicaid is authorized to provide partial protection against Medicare Part A premium charges for another population group known as QDWIs.

Medicare allows certain disabled persons to buy Medicare Part A (Hospital Insurance) protection. These are individuals who were previously entitled to Medicare Part A on the

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[11]This coverage was authorized by Section 4501 of OBRA 90 which added a new Section 1902(a)(10)(E)(iii) to the Social Security Act.

[12]This coverage was authorized under Section 6012 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) which added Section 1902(A)(10)(E)(ii).

basis of a disability, who lost their entitlement based on earnings from work, but who continue to have the disabling condition. Medicaid is required to pay the Medicare Part A premium for such individuals if their incomes are below 200% of the Federal poverty line, their resources are below 200% of the SSI limit, and they are not otherwise eligible for Medicaid. These persons are known as QDWIs.

Income and resources eligibility is determined using the methodologies of the SSI program. States are permitted to impose a premium for individuals with incomes between 150% and 200% of the poverty level. The premium is to be based on a percentage of the Medicare Part A premium according to a sliding scale increasing in reasonable increments as an individual's income increases.

Medicaid benefits for QDWIs are limited to payment of the Medicare Part A premium.

PROGRAM DATA

There is limited data on both the numbers of QMBs and SLMBs as well as expenditures for these population groups.

As of March 1995, Medicare reported that there were 281,024 Medicare Part A beneficiaries for whom QMB payments were being made. As of the same date, States reported a total of 4,662,785 Part B buy-ins[13] of which 2,346,407 were separately identified as QMBs; however this later number is low due to reporting problems. (See table 1.) It should be emphasized that the QMB numbers include many persons who were eligible for the full Medicaid benefit package. No QMB-only number is available. HCFA reports that nationwide, there were 122,293 SLMBs and 14 QDWIs in June 1995; this information is not broken down by State.[14]

DHHS has no data source which separately identifies the amount of expenditures made by the States for Medicare deductible and cost-sharing charges for the QMB population. In part, this reflects the fact that there is considerable overlap between the QMB population and the population eligible for the full range of Medicaid benefits. DHHS does have some data reported by the States on the total amount of payments made for Medicare Part A and Part B premiums. However, the data appear incomplete.

ISSUES

Enrollment. The QMB/SLMB programs were enacted by Congress in response to the concern that Medicare cost-sharing charges could pose a potential financial hardship for low-income persons not eligible for Medicaid. Since the program has been implemented there has been concern that a significant portion of the population eligible for these benefits has not taken advantage of them. A January 1993 survey of the

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[13]This number includes *all* Part B buy-ins. Some Part B buy-ins are not QMBs.

[14]Conversation with HCFA official, July 1995.

implementation of the QMB program by Families USA[15] indicated that many potentially eligible seniors were not receiving program benefits because they were not aware of its existence. The organization stated that QMB benefits were reaching about 58% of the 4.2 million seniors with incomes below poverty. The newly established SLMB program reached less than 1% of an estimated 0.9 million persons who were eligible in the first month.

In response to earlier concerns, DHHS set up mechanisms to increase beneficiary program awareness. Some observers suggested that if Social Security offices, rather than State Medicaid offices, performed the eligibility determination function, more potential eligibles would enroll in the QMB program. However, DHHS noted that while the Social Security Administration could assist in public awareness activities, it did not have the capability of making complete income eligibility determinations.

Section 154 of the Social Security Amendments of 1994 (P.L.103-432) required the Secretary, within 1 year of enactment, to establish and implement a method for (i) obtaining from newly eligible Medicare beneficiaries information that could be used to determine whether they might be QMB-eligible, and (ii) transmitting such information to the States. In response to this directive, a new policy was implemented in April 1995. SSA will transmit, on a monthly basis, to the Health Care Financing Administration (HCFA) a computer tape identifying potential QMB eligibles. The identification of potential QMB eligibles will be based on data from the master beneficiary file for new Medicare beneficiaries. Persons identified as potentially eligible will be those that are entitled to Part A, have a monthly income less than $643, pay their own Part B premium, and are not receiving SSI benefits. HCFA will forward the information to the States; it is expected that the States will use this information to contact potentially eligible persons.

Implications of Potential Changes in Medicare and Medicaid. The Congress has approved a budget resolution which provides for reductions of $270 billion in Medicare spending and $182 billion in Medicaid spending over the FY1996-2002 period. As part of the budget reconciliation process, the authorizing committees will be identifying specific policies to achieve the savings targets. The specifics of the potential changes are not yet available. In the past, Medicare savings have been achieved primarily through reductions in payments to providers. However, given the magnitude of the potential Medicare savings, it is likely that some beneficiary cost-sharing charges will be increased. Absent any modifications to the QMB program, this would mean increased Federal and State spending under Medicaid for the QMB population.

The interaction of potential Medicare changes with potential Medicaid changes also needs to be considered. It is possible that the Congress may approve significant structural changes in the current Medicaid program, for example turning the program into a block grant or capping Federal Medicaid expenditures. Under either alternative, States are expected to be given additional latitude in designing their programs. The current QMB mandate might be viewed as incompatible with the concept of giving States more flexibility in structuring their programs. Since the specifics of the Medicaid restructuring proposals

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[15]Families USA. The Medicare Buy-In: A Promise Unfulfilled. Washington, Mar. 1995.

are not currently available, it is difficult to determine how States would respond to elimination of a QMB requirement. However, in the face of reduced Federal funding, it is possible that some persons could lose protections currently available to them.

TABLE 1. Qualified Medicare Beneficiaries by State, March 1995

State	Part A QMBs	Part B buy-ins[a]	Part B QMBs only
Alabama	3,733	116,294	26,817
Alaska	455	6,046	2
Arizona	276	43,551	29,898
Arkansas	4,402	77,290	2,1053
California	50,347	737,304	449,075
Colorado	553	46,210	13,835
Connecticut	2,511	47,704	39,212
Delaware	457	6,384	1,561
District of Columbia	1,310	14,187	128
Florida	42,472	272,011	198,860
Georgia	8,695	159,300	42,515
Hawaii	4,307	16,567	3,919
Idaho	288	12,754	7,432
Illinois	4,249	136,026	111,791
Indiana	2,202	76,889	47,982
Iowa	1,478	48,080	24,119
Kansas	251	34,121	10,842
Kentucky	3,045	97,677	28,355
Louisiana	5,588	111,769	26,388
Maine	7	29,120	9,857
Maryland	6,395	58,418	52,660
Massachusetts	12,160	125,431	91,975
Michigan	3,503	122,022	0

See footnotes at end of table.

TABLE 1. Qualified Medicare Beneficiaries by State, March 1995

State	Part A QMBs	Part B buy-ins[a]	Part B QMBs only
Minnesota	2,351	51,648	24,672
Mississippi	7,706	107,207	74,093
Missouri	560	71,928	55,149
Montana	480	10,888	8,981
Nebraska	1	16,016	0
Nevada	844	13,936	10,382
New Hampshire	14	5,374	1,476
New Jersey	6,549	122,064	84,483
New Mexico	618	28,703	5,542
New York	99	322,712	157,828
North Carolina	10,907	184,074	24,400
North Dakota	7	5,567	1,242
Ohio	6516	160,414	95,574
Oklahoma	5,143	59,833	56,758
Oregon	18	42,923	24,448
Pennsylvania	14,931	161,237	120,931
Rhode Island	982	15,353	2,520
South Carolina	1936	95,816	71,572
South Dakota	768	12,149	4,562
Tennessee	8,712	147,379	56,569
Texas	38,808	311,594	86,839
Utah	181	13,382	8,926
Vermont	288	12,366	2,983
Virgin Islands	0	217	0
Virginia	2591	102,075	36,445
Washington	3,163	70,651	33,649

See footnotes at end of table.

TABLE 1. Qualified Medicare Beneficiaries by State, March 1995

State	Part A QMBs	Part B buy-ins[a]	Part B QMBs only
West Virginia	3,934	39,642	37,798
Wisconsin	4,003	75,505	18,572
Wyoming	230	5,196	1,737
North Marinas	0	321	0
Guam	0	680	0
Total	281,024	4,662,785	2,346,407

[a]Includes all Part B buy-ins, including QMBs, SLMBs, and persons covered under traditional buy-in agreements. Many Part B buy-ins are not QMBs.

Source: Health Care Financing Administration. June 1995.

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