Medicaid Topics

Impact of Medicare Dual Eligibles

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Issue Summary

The term "dual eligible" refers to the almost 7.5 million low-income older individuals or younger persons with disabilities who are enrolled in both Medicaid and Medicare. About two thirds (5.9 million) of dual eligibles are age 65 and over, while the remaining one-third are disabled younger persons. More than 1.5 million dual eligibles are nursing home residents. Most dual eligibles qualify for full Medicaid benefits. State Medicaid programs are required by federal law to cover the dual eligibles with incomes up to 73% of poverty ($579 per month for an individual in 2005). Twenty-one states and the District of Columbia have gone further in covering these individuals: Most have extended coverage to residents with incomes up to 100% of poverty ($798/month for an individual in 2005). While the dual eligibles account for a relatively small share of total Medicaid enrollment (about 14% of the Medicaid population) they account for more than 40% ($105 billion) of Medicaid expenditures for health care services.

Dual eligibles often face serious health challenges such as diabetes, heart disease, dementia or a severe mental illness. Close to one in four dual eligibles live in nursing homes. These individuals account for most of the costs to Medicaid for dual eligibles (66%). Prescription drugs account for 14%, other acute care services to supplement Medicare account for 15% and payment of Medicare premiums ($938 per beneficiary in 2005) accounts for 5% of spending. Health care costs for dual eligibles on average are double those of other Medicare beneficiaries.
While Medicare covers basic health services, including physician and hospital care, dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as prescription drugs, dental coverage, personal care services, podiatry and non-emergency transportation to medical appointments, hearing and vision and long-term care.

State Medicaid programs will continue to face challenges in financing coverage of dual eligibles. Given their extensive healthcare needs, dual eligibles require and use more services than others in Medicare. Medicaid pays for one out of every two dollars of nursing home payments and is the only major source of long term care financing in the nation. These programs will continue to pay for long-term care and Medicare's Part B premium and cost-sharing for dual eligibles.

As the population continues to age, the fiscal pressure on state budgets will remain. For the six million dual eligibles who receive their prescription drug coverage through Medicaid, the 2003 Medicare Modernization Act (MMA) shifts such coverage to Medicare beginning in 2006. As such, dual eligibles will need to enroll in private Medicare drug plans. In order to help finance the new Medicare drug benefit, States are required to pay the federal government most of the savings that they would realize from no longer having to provide prescription drugs to the dual eligibles in their Medicaid programs.

This payment is called the "claw back" because the federal government is seen as "clawing back" the savings states would have otherwise accrued. States will be required to pay the federal government 90% of the estimated amount they would have paid in drug expenses in 2006 for the dual eligibles. The only way states can reduce their claw back payments is by reducing the number of dual eligibles currently enrolled in Medicaid. Three states, Florida, Mississippi and Missouri, have announced plans to cut off tens of thousands of elderly and disabled people from Medicaid and North Carolina is considering a similar step. These cuts are occurring in states that have previously expanded Medicaid coverage beyond the federally mandated minimum level.

Importance to Family Physicians

Family physicians provide a significant amount of care to the low-income elderly and disabled people who constitute the "dual eligibles". Given the complex health needs of this population, it is important that implementation of the drug law does not compromise access to necessary prescription drugs. As with all Medicare beneficiaries, dual eligibles will be receiving information about the new drug law and must choose a plan. If they do not choose a plan, they will automatically be enrolled in a low or moderate cost plan on a random basis. Once assigned, they may decide to switch plans or drop out of the Medicare drug benefit altogether.

Under the new Medicare prescription drug benefit, most dual eligibles will be required to pay the lowest co-payments, generally $1 per prescription for generics and $3 for brand-name drugs. While this may seem like a small amount, many dual eligibles take seven or more prescriptions a day. In addition, the Medicare drug benefit is not as good as the drug coverage provided under Medicaid. It will not cover some very important drugs that are often covered by Medicaid such as benzodiazepines and prescribed over the counter medications. Furthermore, addressing the health needs of the dual eligibles should be a priority in any Medicaid or Medicare reform plan.

While state Medicaid programs are mandated to cover non-emergency transportation, this is not an allowable service under Medicare. Low income elderly and disabled persons will likely postpone seeing their doctors until their conditions become more urgent and possibly more costly to treat.

Several state Medicaid programs have promoted the development of home and community-based alternatives to institutionalization for the low income elderly and disabled. The people who will be hit the hardest by the loss of Medicaid coverage are those who currently live at home or with their families rather than in long-term care facilities.

Critical components to these alternatives are health care management services, care coordination and education. Such services are an allowable service under Medicaid but not Medicare. Family physicians are well trained to coordinate and direct comprehensive community-care services on behalf of their patients. Acute care services for chronically ill patients are driving much of health care costs. These illnesses can be better managed by applying evidence-based practice guidelines and care management.

Family physicians can demonstrate their willingness to work with State Medicaid authorities to find solutions. State policy makers must be made aware of the harmful consequences of reducing the state's claw back payment by cutting Medicaid coverage for elderly and disabled

persons. Dual eligibles, by definition, are covered by Medicare and Medicaid. Therefore, legislative and regulatory policy barriers that impede care coordination and program management between Medicaid and Medicare must be identified and eliminated, so the most cost-effective, appropriate high quality services can be provided. This would include simplified (i.e., sole source) billing procedures. Family physicians can join with the state in calling for legislative reform to enable more cost-effective delivery systems to be developed.

Some groups, such as the Kaiser Commission on Medicaid and the Uninsured, are recommending that the federal government assume coverage for current state prescription drug expenditures for dual eligibles, as well as acute care services currently covered by Medicaid, but not typically by Medicare. These services include dental care, private duty nursing and transportation. There is considerable variation among states in the extent to which Medicaid covers these services. The National Governors' Association 2003 task force on Medicaid reform agreed unanimously that dual eligibles should be a federal responsibility. While this is probably an attractive option to states from a cost perspective, there is less opportunity for family physicians to influence the redesign of the delivery system toward care coordination and management than if these services remain state administered.

More information on this issue may be found the Kaiser Family Foundation website: www.kff.org

State-by-State Tables

Table 1
States Cutting Eligibility for Medicaid for Elderly and Disabled Individuals

State	Estimated People Losing Coverage in FY2006	Income Range of Those Losing Coverage *(Dollars/year for an individual)*
Florida	77,000	$6,948-$ 8,422
Mississippi	65,000	$6,948-$12,920
Missouri	8,600	$8,135-$ 9,570
North Carolina *(proposed)*	65,000	$6,948-$ 9,570

(1) Steinberg, Marc. Senior Health Policy Analyst, Families USA. Special Report, July 2005.
(2) Holahan, John and Arunabh Ghosh, "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003." Kaiser Commission on Medicaid and the Uninsured, July, 2005.

Table 2

Dual Eligibles as a Percent of Total Medicaid Enrollees, 2003

	All Duals as a % of Medicaid Enrollees	All Duals as a % of Aged & Disabled Medicaid Enrollees
United States	14%	58%
Alabama	21%	59%
Alaska	8%	54%
Arizona	8%	50%
Arkansas	19%	75%
California	10%	58%
Colorado	15%	62%
Connecticut	17%	71%
Delaware	10%	56%
District of Columbia	10%	42%
Florida	15%	57%
Georgia	12%	51%
Hawaii	11%	63%
Idaho	6%	32%
Illinois	10%	51%
Indiana	13%	64%
Iowa	18%	66%
Kansas	15%	57%

Kentucky	18%	53%
Louisiana	14%	51%
Maine	26%	59%
Maryland	11%	52%
Massachusetts	17%	61%
Michigan	13%	54%
Minnesota	16%	66%
Mississippi	19%	60%
Missouri	13%	63%
Montana	14%	56%
Nebraska	13%	69%
Nevada	16%	60%
New Hampshire	16%	72%
New Jersey	17%	60%
New Mexico	8%	53%
New York	15%	55%
North Carolina	18%	65%
North Dakota	21%	75%
Ohio	11%	51%
Oklahoma	14%	65%
Oregon	11%	68%
Pennsylvania	17%	53%
Rhode Island	15%	58%
South Carolina	12%	59%
South Dakota	15%	65%

Tennessee	16%	63%
Texas	16%	67%
Utah	8%	48%
Vermont	17%	73%
Virginia	19%	62%
Washington	10%	53%
West Virginia	14%	45%
Wisconsin	16%	61%
Wyoming	13%	62%

Definitions: Dual Eligibles are individuals entitled to Medicare who are also eligible for some level of Medicaid benefits.
Full dual eligibles qualify for full Medicaid benefits, including long-term care provided in both institutions and in the community as well as prescription drugs. For this group, Medicaid may also pay Medicare premiums and cost sharing.
Partial dual eligibles are not eligible for full Medicaid benefits but may receive assistance with some or all of their Medicare premiums and cost sharing.

Sources: Urban Institute estimates based on data from the Medicaid Statistical Information System (MSIS) prepared for the Kaiser Commission on Medicaid and the Uninsured. For more information, see "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003"; available at http://www.kff.org/medicaid/7346.cfm.

Table 3
Dual Eligibles Spending as a Percent of Total Medicaid, 2003

Rank		Duals Spending as a % of Medicaid
	United States	40%
1	Connecticut	62%
2	North Dakota	60%
3	Wisconsin	56%
4	New Hampshire	53%
5	Massachusetts	52%
6	Minnesota	51%
7	Kansas	50%
8	Arkansas	48%
8	Rhode Island	48%
10	Indiana	46%
10	Iowa	46%
10	Ohio	46%
13	New York	45%
13	Pennsylvania	45%
13	South Dakota	45%
13	Virginia	45%
17	Mississippi	44%
17	Missouri	44%
19	Colorado	43%

19	**North Carolina**	43%
19	**Wyoming**	43%
22	**Nebraska**	42%
22	**New Jersey**	42%
24	**Tennessee**	41%
25	**Oklahoma**	40%
25	**Vermont**	40%
27	**Alabama**	39%
27	**Texas**	39%
29	**California**	38%
29	**Florida**	38%
31	**Kentucky**	36%
31	**Louisiana**	36%
31	**Maine**	36%
31	**Montana**	36%
31	**Oregon**	36%
36	**Delaware**	35%
36	**West Virginia**	35%
38	**Georgia**	31%
38	**Hawaii**	31%
38	**Michigan**	31%
38	**South Carolina**	31%
42	**Maryland**	30%
43	**Nevada**	29%

44	**Illinois**	28%
45	**District of Columbia**	27%
46	**Arizona**	26%
47	**New Mexico**	24%
48	**Utah**	22%
49	**Alaska**	21%
50	**Washington**	20%
51	**Idaho**	19%

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Table 4

Distribution of Medicaid Spending for Dual Eligibles by Service (in Millions), 2003

	Premiums and Medicare Acute	Prescribed Drugs	Other Acute Care	Long-Term Care
United States	16%	14%	4%	66%
Alabama	16%	14%	1%	69%
Alaska	18%	17%	5%	60%
Arizona	22%	13%	7%	58%
Arkansas	29%	15%	4%	53%
California	23%	21%	5%	51%
Colorado	13%	14%	6%	67%
Connecticut	6%	9%	1%	84%
Delaware	14%	10%	3%	73%
District of Columbia	18%	10%	5%	67%
Florida	19%	22%	2%	57%
Georgia	22%	17%	1%	59%
Hawaii	20%	16%	14%	49%
Idaho	19%	17%	8%	55%
Illinois	11%	14%	4%	71%
Indiana	15%	16%	3%	66%
Iowa	11%	13%	3%	73%
Kansas	9%	13%	1%	78%
Kentucky	22%	19%	3%	57%
Louisiana	15%	18%	2%	65%
Maine	14%	16%	14%	56%
Maryland	18%	13%	1%	68%

Massachusetts	12%	12%	8%	69%
Michigan	12%	21%	2%	65%
Minnesota	10%	11%	3%	77%
Mississippi	23%	25%	4%	49%
Missouri	15%	20%	5%	60%
Montana	13%	15%	3%	68%
Nebraska	12%	15%	2%	71%
Nevada	22%	14%	3%	61%
New Hampshire	13%	11%	1%	74%
New Jersey	14%	14%	4%	68%
New Mexico	16%	10%	14%	59%
New York	16%	8%	3%	72%
North Carolina	17%	19%	3%	62%
North Dakota	5%	10%	2%	83%
Ohio	13%	12%	2%	72%
Oklahoma	14%	15%	1%	70%
Oregon	14%	21%	11%	54%
Pennsylvania	11%	15%	4%	70%
Rhode Island	13%	11%	1%	75%
South Carolina	29%	17%	3%	52%
South Dakota	13%	12%	1%	75%
Tennessee	12%	4%	6%	78%
Texas	19%	14%	3%	63%
Utah	12%	22%	8%	59%
Vermont	11%	23%	4%	61%

Virginia	16%	16%	12%	56%
Washington	18%	24%	5%	53%
West Virginia	14%	13%	1%	71%
Wisconsin	9%	13%	6%	73%
Wyoming	10%	12%	1%	78%

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Premiums and Medicare Acute includes premiums and acute care services that Medicare may already cover in whole or part.
Sources: Urban Institute estimates based on data from the Medicaid Statistical Information System (MSIS) and Medicaid Financial Management Reports prepared for the Kaiser Commission on Medicaid and the Uninsured. For more information, see "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003"; available at http://www.kff.org/medicaid/7346.cfm.