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Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003

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Almost 7.5 million older Americans and younger persons with disabilities participate in both Medicare and Medicaid. Often referred to as "dual eligibles," these individuals account for only 14 percent of total Medicaid enrollment, but 40 percent of all Medicaid expenditures for medical services are made on their behalf. Dual eligibles have a much higher per capita cost than other Medicaid beneficiaries, making them a focus of attention for both states and the federal government.

Medicaid plays different roles for different types of dual eligibles. Most dual eligibles qualify for full Medicaid benefits. For these individuals, Medicaid pays for the services that are not part of the standard Medicare benefit package. It pays for Medicare premiums, deductibles, and co-payments as well as for services that are not covered by Medicare. Until the Medicare Modernization Act is implemented in January 2006, this includes prescription drugs. The dual eligibles also account for most Medicaid spending for long-term care services. Full dual eligibles account for most of Medicaid's spending on dual eligibles. For partial benefit dual eligibles, Medicaid provides assistance only with Medicare premiums, deductibles, and other coinsurance requirements. Whether they qualify for full or partial benefits, most dual eligibles are very low-income individuals, usually with significant health care needs.

The cost of dual eligibles is a difficult issue for states and the federal government. States often argue that this group, particularly in tough economic times, should be the responsibility of the federal government, and that the responsibility has been shifted inappropriately to states. The National Governors Association (NGA) for several years has argued that dual eligibles should be a federal responsibility.[1] The federal government, in enacting the Medicare Modernization Act, agreed to take over the cost of prescription drugs for dual eligibles, but required the states to make a substantial payment to the federal government to offset most of the federal government's new financial responsibility for this population.

In this paper we use the latest available data to estimate the share of total Medicaid enrollment and spending attributable to dual eligibles in 2003. We provide state-level estimates of Medicaid enrollment and expenditures for dual eligibles. We also provide a breakdown of both enrollment and expenditures for services used by both aged and disabled dual eligibles. We show that a small share of dual eligibles account for a very large share of expenditures on the dual eligibles, and we simulate the state-by-state

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fiscal effects of hypothetical reforms where the federal government takes over some or all of the states' Medicaid expenditures for dual eligibles.

Data Sources & Estimation Methods

Most data used in this analysis come from the Medicaid Statistical Information System (MSIS) maintained by the Centers for Medicare & Medicaid Services (CMS). The MSIS contains demographic, eligibility, and expenditure information for every Medicaid enrollee.[2] Our source data were person-level and aggregated spending into over 30 types of services. We grouped enrollees into four broad categories—adults, children, disabled and elderly—and then further separated disabled and elderly enrollees into dual eligibles and other beneficiaries. For each of these groups, we then aggregated spending into several categories.

The most recent MSIS data available for this analysis were for federal fiscal year (FFY) 2001, but, as has been widely reported, Medicaid enrollment and expenditures increased considerably between 2001 and 2003.[3] To address this issue, we calculated enrollment and spending using the FFY 2001 MSIS data and then projected the results forward to FFY 2003 levels. For enrollment, we based our growth factors on estimates from the Kaiser Commission on Medicaid and the Uninsured of Medicaid enrollment in FFY 2003. For expenditures, we first estimated spending per enrollee in FFY 2001 for each group and category of service. Next, we calculated growth rates of spending per enrollee that were specific to each group and type of service, based on expenditure data from CMS Form 64 (which were available through FFY 2003) and our enrollment projections. This methodology takes into account both the change in spending for particular services and the change in the composition of Medicaid enrollment, providing more accurate group- and service-specific estimates of spending per enrollee for FFY 2003. We then use these spending per enrollee estimates to project expenditures for each enrollment group and category of service in FFY 2003.

As part of a separate analysis we generated two spending distribution tables (by spending category and by service, Tables 6 and 7). These two tables represent recipient (not enrollment) counts and expenditures and were generated from the original person-level MSIS 2001 data. In our other tables, we inflated estimates for expenditure and enrollees using aggregate changes in expenditure and enrollees from the CMS-64 expenditure reports and the Kaiser Commission on Medicaid and the Uninsured estimates of enrollment growth. It is not appropriate to apply these growth trends at the individual level; therefore, Tables 6 and 7 provide only 2001 estimates.

Dual Eligibles in the Existing Medicaid Program

Who Are the Dual Eligibles?

Dual eligibles are individuals who are entitled to Medicare and are eligible for some level of Medicaid benefits. Classes of Medicare participants who are eligible to receive

assistance under Medicaid are listed in Table 1. Note that not all dual eligibles qualify for full Medicaid benefits. Some are eligible only for "Medicare Savings Programs," through which they only receive assistance with some or all of their Medicare premiums, deductibles, and other cost sharing requirements.[4]

Most dual eligibles are very low-income individuals: in 2002, 73 percent of dual eligibles had annual incomes under $10,000, compared to 12 percent of all other Medicare beneficiaries. Many also have significant health care needs: nearly 20 percent of dual eligibles are in nursing facilities, compared to three percent of other Medicare beneficiaries. Over half of dual eligibles are in fair or poor health, twice the rate among others in Medicare. A third of dual eligibles have significant limitations in activities of daily living, compared to 11 percent of other Medicare beneficiaries. The prevalence of chronic conditions is also higher among dual eligibles.[5]

How Many Dual Eligibles are Enrolled in Medicaid?

We estimate that 7.5 million Medicare beneficiaries were enrolled in Medicaid in 2003 (Table 2). This included both those who received full Medicaid benefits as well as those who only received assistance with Medicare premiums and cost sharing. Dual eligibles were a relatively small share of all Medicaid enrollees, accounting for 13.6 percent of all Medicaid enrollees in 2003 (Figure 1). We estimate that 6.2 million out of 7.5 million (83 percent) received full Medicaid benefits. The remaining dual eligibles received help with Medicare's premiums and out-of-pocket costs, but would not have been eligible for non-Medicare covered services such as prescribed drugs and long-term care.

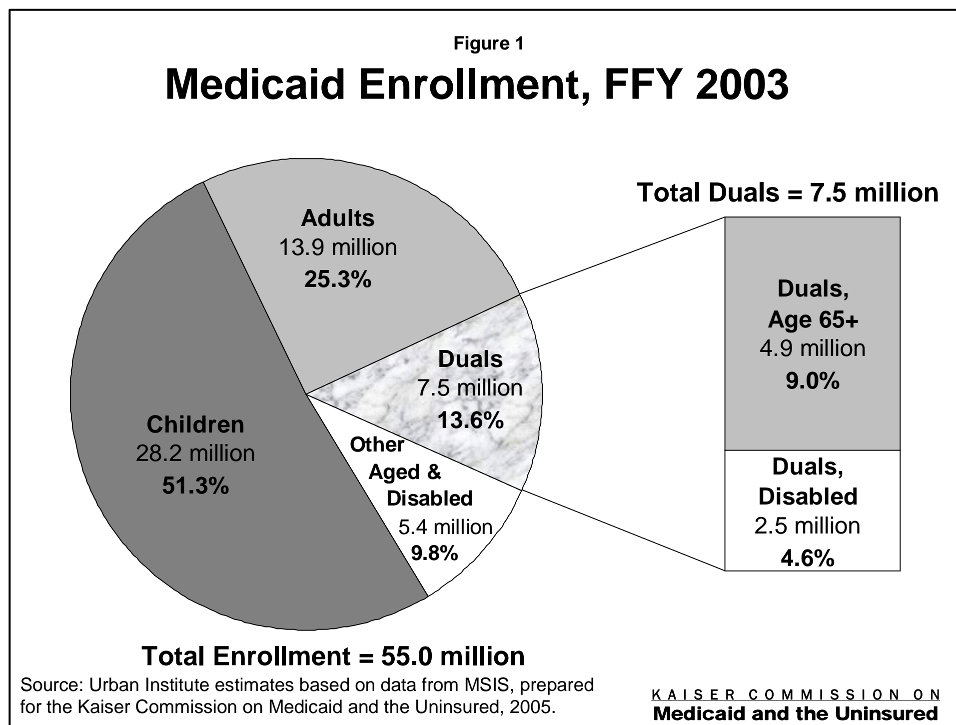


Table 1
Common Medicaid Eligibility Pathways for Medicare Beneficiaries, 2003

	Income Eligibility	Asset Limit	Medicaid Benefits
Individuals Eligible for Full Medicaid Benefits			
SSI Cash Assistance-Related (mandatory)	Generally 74% of the FPL for individuals and 82% of the FPL for couples*[a]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Poverty-Related (optional)	Up to 100% of the FPL*[b]	$2,000 (individual) $3,000 (couple)[b]	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Medically Needy (optional)	Individuals who spend down their incomes to state specific levels. [b,c]	$2,000 (individual) $3,000 (couple)[b]	“Wrap around” Medicaid benefits (may be more limited than those for SSI recipients). Medicaid may also pay Medicare premiums and cost sharing, depending on income.
Special Income Rule for Nursing Home Residents (optional)	Individuals living in institutions with incomes up to 300% of SSI. [d]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Home and Community-Based Service Waivers (optional)	Individuals who would be eligible if they resided in an institution. Several states do not use the special income rule for waivers, so eligibility levels may be lower than 300% of SSI.		Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid may also pay Medicare premiums and cost sharing, depending
Medicare Savings Programs			
Qualified Medicare Beneficiaries (QMB) (mandatory)	Up to 100% of the FPL*[b]	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare premiums (Part B and if needed, Part A) and cost sharing.[e]
Specified Low-Income Medicare Beneficiaries (SLMB) (mandatory)	Between 100% and 120% of the FPL.*[b]	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare Part B premium.
Qualified Working Disabled Individuals (QDWI) (mandatory)	Working, disabled individuals with income up to 200% of the FPL.*	$4,000 (individual) $6,000 (couple)	No Medicaid benefits. Medicaid pays Medicare Part A premium.
Qualifying Individuals [f] (QI) (mandatory)	Between 120% and 135% of the FPL.*	$4,000 (individual) $6,000 (couple)	No Medicaid benefits. Medicaid pays Medicare Part B premium. Federally funded, no state match. Participation may be limited by funding.

Source: Kaiser Commission on Medicaid and the Uninsured.

* In 2003, 100% of the federal poverty level (FPL) was $748 for individuals and $1,010 for couples per month in the 48 contiguous states and the District of Columbia. Higher FPLs apply in Alaska and Hawaii.

a) The maximum federal SSI payment in 2003 was $552 per month for individuals and $849 per month for couples. People with income below these levels qualify for benefits. SSI disregards the first $20 of income from any source, plus the first $65 and half of all remaining earned income, so eligibility levels can be higher. However, few SSI recipients have earned income, so most qualify at or below the income levels shown. Some states using the “209(b) option” use different (often more restrictive) income or asset requirements for Medicaid eligibility for SSI recipients.

b) Section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those that would otherwise apply, enabling states to expand eligibility above these standards.

c) Individuals eligible under the medically needy option have income that are too high to qualify under SSI or Poverty-Related levels. Unless their income falls below their state’s medically needy standards for their family size, these individuals must incur sufficient medical expenses to reduce their income below those standards. Most states use medically needy income limits that are below SSI eligibility levels.

d) In 2003, 300% of SSI was $1,656 per month for an individual. Several states do not use the Special Income Rule, and a few other states use income limits that are below 300% of SSI.

e) States are not required to pay for Medicare cost-sharing if the Medicaid payment rates for a given service are sufficiently lower than the Medicare payment rates.

f) Until September 30, 2002, Medicaid paid a small part of the Medicare Part B premium for additional Qualifying Individuals (QI2s) with incomes between 135% and 175% of the FPL. Congress allowed the authority for the QI2 program to expire on that date.

Table 2

Dual Eligibles and Full Dual Eligibles by State, 2003

State	Dual Eligibles	Duals as a Share of… All Medicaid Enrollees	Duals as a Share of… Aged and Disabled Enrollees	Full Dual Eligibles	Full Duals as a Share of All Dual Eligibles*
United States	7,468,000	14%	58%	6,229,000	83%
Alabama	169,000	21%	59%	125,000	74%
Alaska	9,000	8%	54%	9,000	97%
Arizona	74,000	8%	50%	70,000	95%
Arkansas	124,000	19%	75%	99,000	80%
California	978,000	10%	58%	955,000	98%
Colorado	73,000	15%	62%	61,000	83%
Connecticut	89,000	17%	71%	74,000	84%
Delaware	16,000	10%	56%	9,000	58%
District of Columbia	19,000	10%	42%	15,000	80%
Florida	437,000	15%	57%	380,000	87%
Georgia	184,000	12%	51%	126,000	68%
Hawaii	23,000	11%	63%	21,000	92%
Idaho	13,000	6%	32%	10,000	80%
Illinois	212,000	10%	51%	182,000	86%
Indiana	130,000	13%	64%	104,000	80%
Iowa	69,000	18%	66%	56,000	81%
Kansas	48,000	15%	57%	40,000	84%
Kentucky	156,000	18%	53%	117,000	75%
Louisiana	148,000	14%	51%	108,000	73%
Maine	82,000	26%	59%	66,000	80%
Maryland	94,000	11%	52%	70,000	75%
Massachusetts	224,000	17%	61%	192,000	86%
Michigan	224,000	13%	54%	190,000	85%
Minnesota	123,000	16%	66%	97,000	79%
Mississippi	148,000	19%	60%	144,000	97%
Missouri	158,000	13%	63%	135,000	85%
Montana	16,000	14%	56%	15,000	91%
Nebraska	38,000	13%	69%	35,000	92%
Nevada	30,000	16%	60%	19,000	62%
New Hampshire	20,000	16%	72%	18,000	91%
New Jersey	177,000	17%	60%	145,000	82%
New Mexico	41,000	8%	53%	25,000	62%
New York	624,000	15%	55%	512,000	82%
North Carolina	281,000	18%	65%	238,000	85%
North Dakota	16,000	21%	75%	13,000	79%
Ohio	221,000	11%	51%	176,000	80%
Oklahoma	100,000	14%	65%	81,000	82%
Oregon	79,000	11%	68%	57,000	73%
Pennsylvania	318,000	17%	53%	278,000	87%
Rhode Island	34,000	15%	58%	28,000	83%
South Carolina	124,000	12%	59%	118,000	95%
South Dakota	18,000	15%	65%	14,000	79%
Tennessee	292,000	16%	63%	231,000	79%
Texas	504,000	16%	67%	363,000	72%
Utah	19,000	8%	48%	17,000	88%
Vermont	30,000	17%	73%	27,000	92%
Virginia	153,000	19%	62%	101,000	66%
Washington	118,000	10%	53%	100,000	85%
West Virginia	56,000	14%	45%	40,000	70%
Wisconsin	127,000	16%	61%	116,000	92%
Wyoming	9,000	13%	62%	6,000	72%

Source: Urban Institute estimates based on data from MSIS.

* The percentages of full duals as a share of all duals are based on unrounded estimates of dual eligibles and "full" dual eligibles, and may differ somewhat from calculations that use the rounded estimates shown in this table.

Table 2 shows our estimated numbers of dual eligibles (and full dual eligibles) for all fifty states and the District of Columbia. While dual eligibles account for 13.6 percent of all Medicaid enrollees, they are over 20 percent of all Medicaid enrollees in some states: Alabama, Maine, and North Dakota. Dual eligibles are less than 10 percent of all Medicaid enrollees in Alaska, Arizona, Idaho, New Mexico, and Utah.

About two-thirds of dual eligibles (4.9 million) were individuals age 65 and over and about one-third (2.5 million) were younger persons with disabilities (Figure 1). Not all aged and disabled Medicaid enrollees are dual eligibles, however.[6] Overall, 58 percent of aged and disabled enrollees were dual eligibles (Table 2). However, 91 percent of aged enrollees were dual eligibles with the percentage of duals among all aged enrollees being as high as 98 percent in North Dakota and 97 percent in Iowa, Kentucky, Mississippi, North Carolina, Tennessee, Texas, and Wyoming (Table 3). The number of disabled enrollees who were dual eligibles averages 34 percent, but is as high as 50 percent in Connecticut, New Hampshire, and North Dakota (Table 3).

How Much Does Medicaid Spend on Services for Dual Eligibles?

Although less than 14 percent of Medicaid enrollees were dual eligibles in 2003, they accounted for a much larger share of Medicaid expenditures. We estimate that spending for dual eligibles made up 40.1 percent of all Medicaid expenditures for medical services in FFY 2003 (Figure 2). Most of these expenditures were for dual eligibles who qualify for full benefits. Almost two-thirds of the expenditures on dual eligibles (or $69.4 billion) are for long-term care services (Figure 3).

Another $16.7 billion went for Medicare premiums and deductibles and co-insurance for Medicare acute care services, those for which Medicare and Medicaid both contribute; Medicare is the primary payer and Medicaid picks up the out-of-pocket expenditures. Another $15.2 billion were for prescription drugs. Prescription drug spending for dual eligibles will be absorbed into Medicare in January 2006 as Medicare Part D coverage begins, but states will be required to make a substantial contribution towards this benefit, usually termed “the clawback.” Finally, $4.1 billion is for other acute care services such as dental care, vision and hearing services that are not covered by Medicare.

The states with the highest expenditures on dual eligibles (Table 4) are, not surprisingly, New York ($17.3 billion) and California ($10.4 billion). Florida, Illinois, Massachusetts, North Carolina, Ohio, Pennsylvania, and Texas all have more than $3 billion in spending on dual eligibles.

Table 3

Aged and Disabled Dual Eligibles by State, 2003

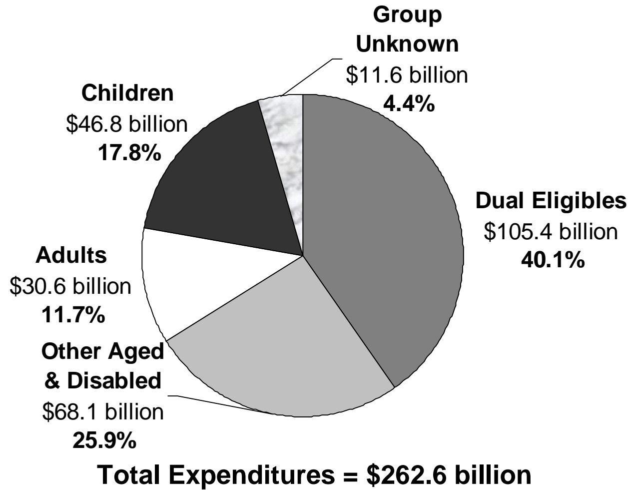
State	Aged Dual Eligibles	Aged Duals as a Share of… All Dual Enrollees	Aged Duals as a Share of… Aged Enrollees	Disabled Dual Eligibles	Disabled Duals as a Share of… All Dual Enrollees	Disabled Duals as a Share of… Disabled Enrollees
United States	4,935,000	66%	91%	2,533,000	34%	34%
Alabama	112,000	67%	95%	57,000	34%	33%
Alaska	5,000	59%	83%	4,000	41%	36%
Arizona	47,000	64%	90%	27,000	36%	28%
Arkansas	67,000	54%	98%	57,000	46%	58%
California	722,000	74%	87%	256,000	26%	30%
Colorado	46,000	63%	92%	27,000	37%	40%
Connecticut	58,000	66%	92%	30,000	34%	50%
Delaware	10,000	61%	90%	6,000	39%	35%
District of Columbia	12,000	66%	82%	6,000	34%	22%
Florida	295,000	68%	87%	142,000	32%	33%
Georgia	119,000	65%	83%	65,000	35%	30%
Hawaii	16,000	69%	75%	7,000	29%	30%
Idaho	6,000	50%	50%	6,000	50%	24%
Illinois	137,000	65%	86%	75,000	35%	29%
Indiana	79,000	61%	95%	51,000	39%	43%
Iowa	42,000	61%	97%	27,000	39%	44%
Kansas	28,000	59%	83%	20,000	41%	39%
Kentucky	95,000	61%	97%	61,000	39%	31%
Louisiana	98,000	66%	92%	50,000	34%	27%
Maine	59,000	72%	89%	23,000	28%	32%
Maryland	61,000	66%	88%	32,000	34%	29%
Massachusetts	136,000	61%	92%	88,000	39%	40%
Michigan	134,000	60%	98%	89,000	40%	33%
Minnesota	84,000	68%	88%	39,000	32%	43%
Mississippi	97,000	65%	97%	51,000	35%	35%
Missouri	98,000	62%	93%	61,000	38%	42%
Montana	10,000	61%	87%	6,000	39%	36%
Nebraska	24,000	62%	95%	15,000	38%	48%
Nevada	20,000	66%	99%	10,000	34%	34%
New Hampshire	13,000	63%	93%	7,000	37%	52%
New Jersey	129,000	73%	84%	49,000	27%	34%
New Mexico	27,000	67%	86%	13,000	33%	29%
New York	448,000	72%	90%	176,000	28%	28%
North Carolina	184,000	65%	97%	97,000	35%	40%
North Dakota	11,000	67%	98%	5,000	33%	51%
Ohio	139,000	63%	89%	82,000	37%	30%
Oklahoma	66,000	68%	96%	34,000	34%	40%
Oregon	46,000	58%	96%	33,000	42%	49%
Pennsylvania	201,000	63%	92%	117,000	37%	30%
Rhode Island	22,000	66%	92%	12,000	34%	34%
South Carolina	78,000	63%	93%	46,000	37%	36%
South Dakota	12,000	68%	96%	6,000	33%	40%
Tennessee	158,000	54%	97%	134,000	46%	45%
Texas	363,000	72%	97%	141,000	28%	37%
Utah	11,000	58%	85%	8,000	42%	30%
Vermont	21,000	70%	94%	9,000	30%	48%
Virginia	98,000	64%	91%	56,000	36%	39%
Washington	71,000	60%	87%	47,000	40%	33%
West Virginia	33,000	59%	95%	23,000	41%	26%
Wisconsin	80,000	63%	96%	47,000	37%	38%
Wyoming	5,000	59%	97%	4,000	41%	41%

Source: Urban Institute estimates based on data from MSIS.

* The percentages of full duals as a share of all duals are based on unrounded estimates of dual eligibles and "full" dual eligibles, and may differ somewhat from calculations that use the rounded estimates shown in this table.

Figure 2

Medicaid Expenditures by Group, Services Only, FFY 2003



Total Expenditures = $262.6 billion

Source: Urban Institute estimates based on data from MSIS and Medicaid Financial Management Reports, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2005.

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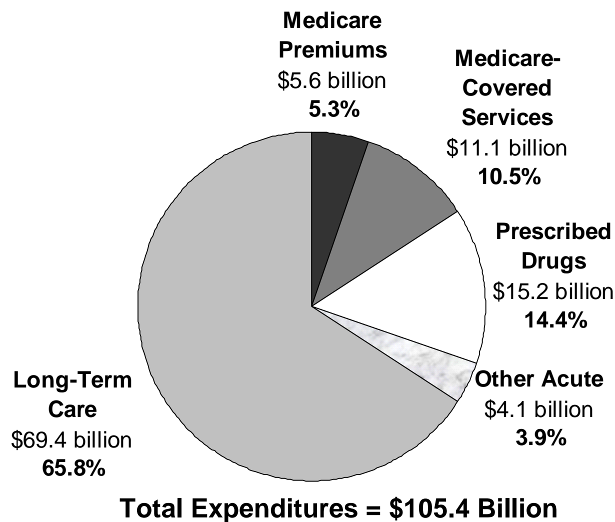
Figure 3

Medicaid Expenditures for Dual Eligibles, FFY 2003



Total Expenditures = $105.4 Billion

Source: Urban Institute estimates based on data from MSIS and Medicaid Financial Management Reports, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2005.

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Spending per dual eligible for the nation averaged $14,114 (Table 4). Several states (Connecticut, Minnesota, New Hampshire, New York, Ohio, and Rhode Island) all spend more than $20,000 per person. Each of these states spends a relatively large amount on long-term care services. In contrast, states with low spending for dual eligibles spend much less on long-term care. The lowest spending for dual eligibles was in Nevada where per capita expenditures were $7,793. Table 4 also shows that more than two-thirds of all spending on dual eligibles goes toward long-term care services in 25 states and in the District of Columbia.

Table 5 and Figure 4 show spending per dual eligible for both the aged and disabled and demonstrate that about two-thirds of spending on dual eligibles is for aged beneficiaries. Spending per aged and disabled dual eligibles is about the same. The states that were mentioned earlier that had spending above $20,000 per dual eligible tend to have spending in that range for both aged and disabled populations. In general these states have high long-term care spending for both populations. Again, there is substantial variation, more than threefold, in spending per dual eligible between the highest and lowest states. For the aged spending ranges from $27,380 in Connecticut to $6,797 in Maine. The disabled spending varies from $33,497 per disabled dual eligible in New York to $5,900 in Michigan.

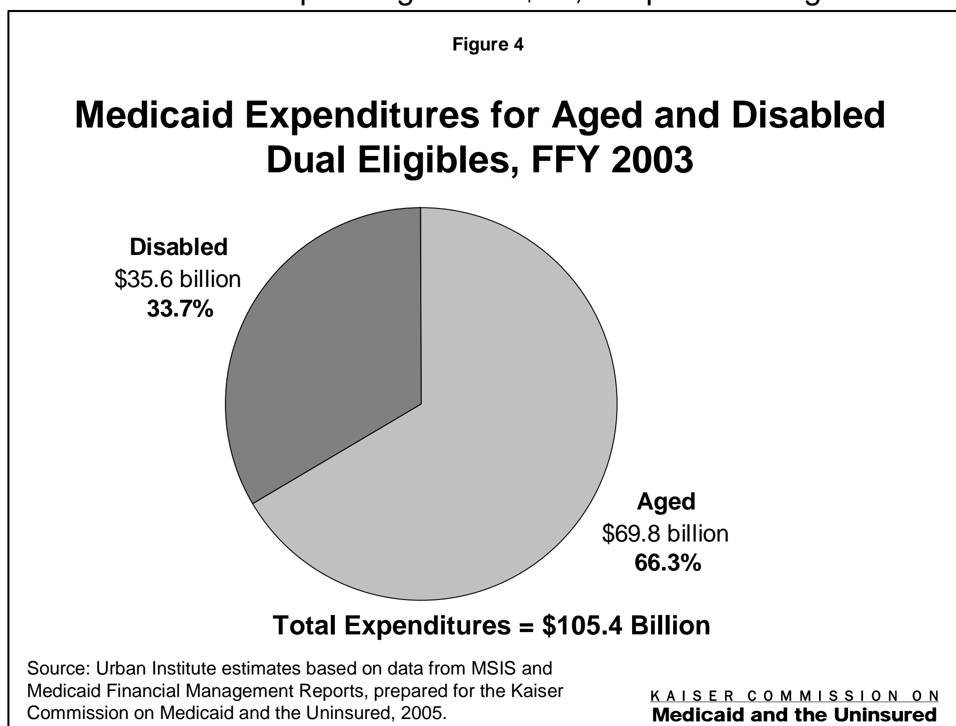


Table 6 and Figure 5 provide detailed data on expenditures by age group and by type of service for 2001. The last column shows that 71.5 percent of Medicaid spending on dual eligibles (excluding Medicare premium payments and cost sharing) goes for spending on long-term care services. Of the $60.7 billion spent on long-term care services, $38.1 billion is spent on nursing home care, almost half of all spending on dual eligibles. Another $15.3 billion or 18.0 percent of spending on dual eligibles went for home and community-based care. Acute care services accounted for the remaining $24.2 billion, or 28.5 percent of all spending. Of this, prescription drug spending accounted for $10.3 billion, or 12.2 percent of expenditures.

Table 4

Medicaid Expenditures for Dual Eligibles by State, 2003

State	Total	Expenditures (in Millions) Premiums & Medicare Acute*	Prescribed Drugs	Other Acute Care	Long-Term Care	Percent Expenditures on Long-Term Care	Dual Eligible Spending as % of Total Medicaid	Spending Per Dual Eligible
United States	$105,405	$16,719	$15,172	$4,106	$69,392	66%	40%	$14,114
Alabama	$1,550	$254	$211	$17	$1,068	69%	39%	$9,170
Alaska	$171	$31	$29	$8	$102	60%	21%	$18,662
Arizona	$939	$208	$119	$70	$541	58%	26%	$12,698
Arkansas	$1,146	$334	$169	$41	$602	53%	48%	$9,253
California	$10,373	$2,387	$2,128	$545	$5,313	51%	38%	$10,603
Colorado	$1,155	$146	$163	$68	$778	67%	43%	$15,731
Connecticut	$2,472	$146	$225	$25	$2,075	84%	62%	$27,920
Delaware	$287	$40	$28	$8	$211	73%	35%	$18,417
District of Columbia	$305	$56	$31	$14	$203	67%	27%	$16,382
Florida	$4,592	$858	$1,002	$97	$2,634	57%	38%	$10,499
Georgia	$1,769	$391	$307	$22	$1,048	59%	31%	$9,631
Hawaii	$252	$51	$41	$35	$125	49%	31%	$11,196
Idaho	$185	$36	$31	$14	$101	55%	19%	$14,712
Illinois	$3,246	$365	$446	$115	$2,319	71%	28%	$15,313
Indiana	$2,103	$315	$341	$62	$1,384	66%	46%	$16,139
Iowa	$1,062	$114	$142	$33	$772	73%	46%	$15,371
Kansas	$935	$82	$121	$7	$726	78%	50%	$19,661
Kentucky	$1,627	$352	$305	$41	$929	57%	36%	$10,437
Louisiana	$1,456	$217	$267	$33	$940	65%	36%	$9,830
Maine	$719	$99	$118	$102	$401	56%	36%	$8,740
Maryland	$1,643	$296	$210	$20	$1,112	68%	30%	$17,527
Massachusetts	$4,071	$479	$480	$320	$2,791	69%	52%	$18,172
Michigan	$2,290	$264	$483	$46	$1,496	65%	31%	$10,230
Minnesota	$2,639	$251	$287	$70	$2,031	77%	51%	$21,398
Mississippi	$1,331	$305	$326	$52	$647	49%	44%	$9,003
Missouri	$2,153	$315	$436	$101	$1,301	60%	44%	$13,601
Montana	$240	$32	$37	$7	$163	68%	36%	$14,650
Nebraska	$639	$75	$97	$13	$453	71%	42%	$16,765
Nevada	$237	$52	$34	$7	$144	61%	29%	$7,793
New Hampshire	$494	$66	$56	$5	$368	74%	53%	$24,490
New Jersey	$2,965	$429	$418	$107	$2,010	68%	42%	$16,739
New Mexico	$508	$84	$53	$71	$300	59%	24%	$12,478
New York	$17,344	$2,789	$1,420	$583	$12,551	72%	45%	$27,809
North Carolina	$3,283	$556	$607	$89	$2,031	62%	43%	$11,670
North Dakota	$306	$16	$30	$6	$255	83%	60%	$19,369
Ohio	$4,876	$657	$574	$113	$3,533	72%	46%	$22,041
Oklahoma	$1,269	$172	$186	$18	$892	70%	40%	$12,741
Oregon	$967	$135	$202	$106	$523	54%	36%	$12,299
Pennsylvania	$4,782	$541	$727	$182	$3,331	70%	45%	$15,025
Rhode Island	$696	$91	$74	$6	$525	75%	48%	$20,584
South Carolina	$1,358	$388	$229	$39	$702	52%	31%	$10,970
South Dakota	$276	$35	$33	$3	$205	75%	45%	$15,306
Tennessee	$2,883	$339	$128	$177	$2,238	78%	41%	$9,879
Texas	$5,265	$1,023	$734	$176	$3,329	63%	39%	$10,447
Utah	$309	$37	$67	$24	$182	59%	22%	$15,927
Vermont	$287	$33	$67	$12	$176	61%	40%	$9,689
Virginia	$1,642	$256	$267	$197	$922	56%	45%	$10,716
Washington	$1,111	$197	$270	$54	$590	53%	20%	$9,402
West Virginia	$759	$108	$100	$11	$539	71%	35%	$13,509
Wisconsin	$2,289	$201	$298	$129	$1,663	73%	56%	$18,096
Wyoming	$146	$14	$17	$1	$114	78%	43%	$16,544

Source: Urban Institute estimates based on data from MSIS and Medicaid Financial Management Reports.

* Includes Medicare premiums and acute care services that Medicare may already cover in whole or part.

Table 5

Medicaid Expenditures for Aged and Disabled Dual Eligibles by State, 2003

	Expenditures (in Millions)					
	Aged			Disabled		
State	Total	Spending Per Aged Dual Eligible	Percent of Dual Eligible Expenditures	Total	Spending Per Disabled Dual Eligible	Percent of Dual Eligible Expenditures
United States	$69,831	$14,150	66%	$35,574	$14,045	34%
Alabama	$1,173	$10,445	76%	$377	$6,647	24%
Alaska	$96	$17,820	56%	$75	$19,873	44%
Arizona	$631	$13,364	67%	$308	$11,522	33%
Arkansas	$656	$9,793	57%	$489	$8,617	43%
California	$6,950	$9,626	67%	$3,423	$13,356	33%
Colorado	$689	$14,855	60%	$467	$17,230	40%
Connecticut	$1,594	$27,380	64%	$878	$28,957	36%
Delaware	$179	$18,684	62%	$108	$17,991	38%
District of Columbia	$215	$17,573	71%	$90	$14,093	29%
Florida	$3,123	$10,571	68%	$1,469	$10,348	32%
Georgia	$1,215	$10,207	69%	$555	$8,571	31%
Hawaii	$173	$10,816	68%	$79	$12,120	32%
Idaho	$87	$13,879	47%	$97	$15,550	53%
Illinois	$2,004	$14,608	62%	$1,243	$16,605	38%
Indiana	$1,318	$16,619	63%	$785	$15,393	37%
Iowa	$648	$15,280	61%	$413	$15,514	39%
Kansas	$546	$19,468	58%	$389	$19,939	42%
Kentucky	$1,153	$12,140	71%	$474	$7,780	29%
Louisiana	$918	$9,340	63%	$538	$10,795	37%
Maine	$400	$6,797	56%	$319	$13,617	44%
Maryland	$1,090	$17,738	66%	$553	$17,126	34%
Massachusetts	$2,443	$17,900	60%	$1,628	$18,596	40%
Michigan	$1,762	$13,111	77%	$528	$5,900	23%
Minnesota	$1,595	$18,968	60%	$1,044	$26,603	40%
Mississippi	$912	$9,440	69%	$419	$8,179	31%
Missouri	$1,375	$14,059	64%	$778	$12,861	36%
Montana	$163	$16,220	68%	$77	$12,160	32%
Nebraska	$391	$16,592	61%	$248	$17,047	39%
Nevada	$169	$8,472	71%	$68	$6,500	29%
New Hampshire	$297	$23,309	60%	$197	$26,509	40%
New Jersey	$2,122	$16,507	72%	$843	$17,352	28%
New Mexico	$314	$11,470	62%	$194	$14,555	38%
New York	$11,457	$25,581	66%	$5,887	$33,487	34%
North Carolina	$2,185	$11,885	67%	$1,098	$11,263	33%
North Dakota	$195	$18,339	64%	$111	$21,483	36%
Ohio	$3,367	$24,263	69%	$1,510	$18,304	31%
Oklahoma	$786	$12,003	62%	$483	$14,159	38%
Oregon	$604	$13,181	62%	$363	$11,068	38%
Pennsylvania	$3,549	$17,646	74%	$1,233	$10,525	26%
Rhode Island	$445	$19,988	64%	$251	$21,733	36%
South Carolina	$846	$10,853	62%	$512	$11,168	38%
South Dakota	$179	$14,916	65%	$96	$16,088	35%
Tennessee	$1,980	$12,552	69%	$904	$6,736	31%
Texas	$3,605	$9,922	68%	$1,660	$11,802	32%
Utah	$157	$13,929	51%	$153	$18,677	49%
Vermont	$179	$8,591	62%	$108	$12,291	38%
Virginia	$1,047	$10,730	64%	$596	$10,690	36%
Washington	$809	$11,371	73%	$302	$6,423	27%
West Virginia	$504	$15,093	66%	$255	$11,189	34%
Wisconsin	$1,454	$18,208	64%	$835	$17,903	36%
Wyoming	$84	$16,142	57%	$63	$17,110	43%

Source: Urban Institute estimates based on data from MSIS and Medicaid Financial Management Reports.

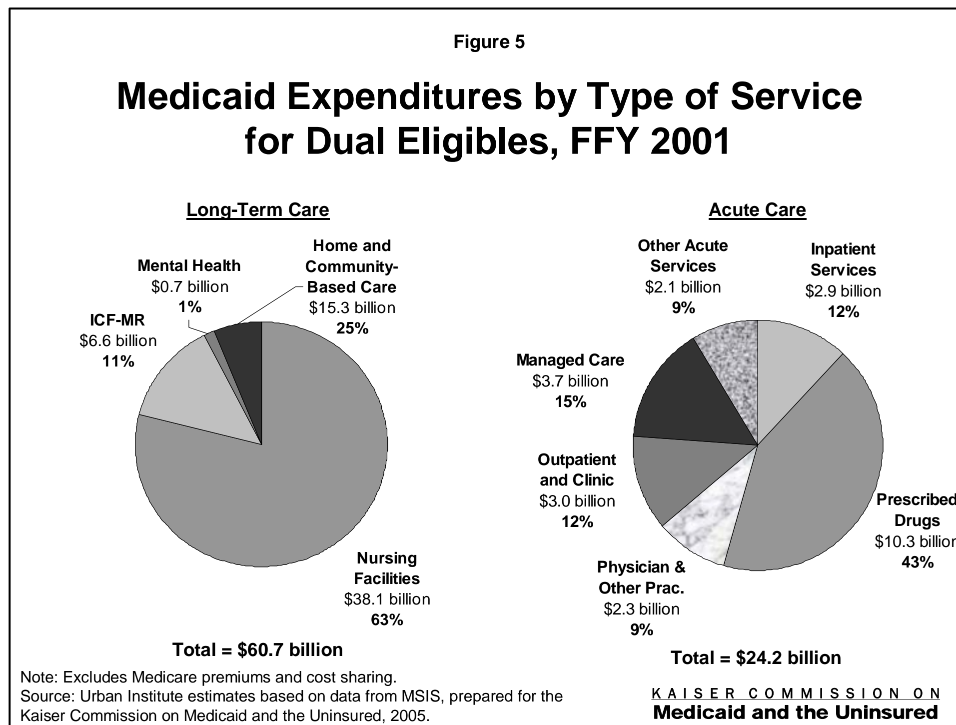
* Includes Medicare premiums and acute care services that Medicare may already cover in whole or part.

Table 6

Medicaid Expenditures by type of Service for Dual Eligibles, 2001
(MSIS 2001, inflated to CMS-64 2001 totals by service)
In millions

Service/Service Group	Less than 65		65 to 75		75 and Above		All	
Long-term Care Services	**$17,392**	**61.5%**	**$8,192**	**60.2%**	**$35,104**	**81.6%**	**$60,687**	**71.5%**
Nursing Facilities	3,567	12.6	5,107	37.5	29,418	68.4	38,092	44.8
ICF-MR	5,784	20.4	518	3.8	300	0.7	6,603	7.8
Mental Health	49	0.2	343	2.5	275	0.6	667	0.8
Home and Personal Care	7,992	28.2	2,223	16.3	5,110	11.9	15,326	18.0
Acute Care Services	**$10,901**	**38.5%**	**$5,422**	**39.8%**	**$7,911**	**18.4%**	**$24,234**	**28.5%**
Inpatient Services	1,022	3.6	754	5.5	1,108	2.6	2,883	3.4
Prescribed Drugs	4,468	15.8	2,309	17.0	3,552	8.3	10,329	12.2
Physician & Other Prac.	1,192	4.2	496	3.6	590	1.4	2,278	2.7
Outpatient and Clinic	1,862	6.6	603	4.4	504	1.2	2,969	3.5
Managed Care	1,434	5.1	826	6.1	1,426	3.3	3,686	4.3
Other Acute Services	923	3.3	433	3.2	731	1.7	2,088	2.5
Unknown	4	0.0	2	0.0	8	0.0	14	0.0
Total Spending	**$28,296**	**100%**	**$13,616**	**100.0%**	**$43,023**	**100.0%**	**$84,936**	**100.0%**

Note: Excludes spending on Medicare premiums and cost sharing.



Spending on disabled duals less than age 65 was $28.3 billion; long-term care services accounted for 61.5 percent of all spending. Of this, over 50 percent was for institutional care in nursing homes and ICFMRs. The remainder, almost half, was spent on home and personal care services. For the dual eligibles between 65 and 75, expenditures are lower ($13.6 billion) and a higher share (39.8 percent) is spent on acute care services. For this group, about 17 percent was spent on prescription drugs, and a similar percentage on home and community-based care. The largest share, 37.5 percent, was spent on nursing home care.

For the dual eligibles 75 and over, spending was $43.0 billion, more than half of all spending on duals. Of this, 81.6 percent was spent on long-term care, with 68.4 percent spent on nursing home care. Another 11.9 percent was for home and community-based care. Acute care services accounted for 18.4 percent of expenditures; of this, almost half was for prescription drugs.

Table 7 examines the expenditure distribution in a somewhat different way.[7] It allows us to examine the distribution of spending among dual eligibles e.g., how many dollars were spent on those who had expenditures of $20,000 or more, $10,000-$20,000 and so forth. The table shows that among all duals, about 20 percent or 1.4 million enrollees had expenditures of more than $20,000 (Figure 6). This group accounted for $64.5 billion or about 76 percent of all expenditures on dual eligibles.

About 19.5 percent of dual eligibles were in an institution for some period during the year. This group accounted for 60.1 percent of all expenditures (Figure 7). Of the institutionalized dual eligibles, 14.4 percent or 1.0 million people had expenditures of more than $20,000. Those in institutions whose expenditures were more than $20,000 accounted for $47.4 billion in Medicaid expenditures, or 55.7 percent of all spending on dual eligibles.

The 80.5 percent of dual eligibles who were never in an institution during 2001 accounted for the remaining $33.9 billion, or 39.9 percent of all expenditures (Figure 7). Those with expenditures of more than $20,000 were about 370,000 enrollees and they accounted for $17.1 billion or 20.2 percent of expenditures on dual eligibles.

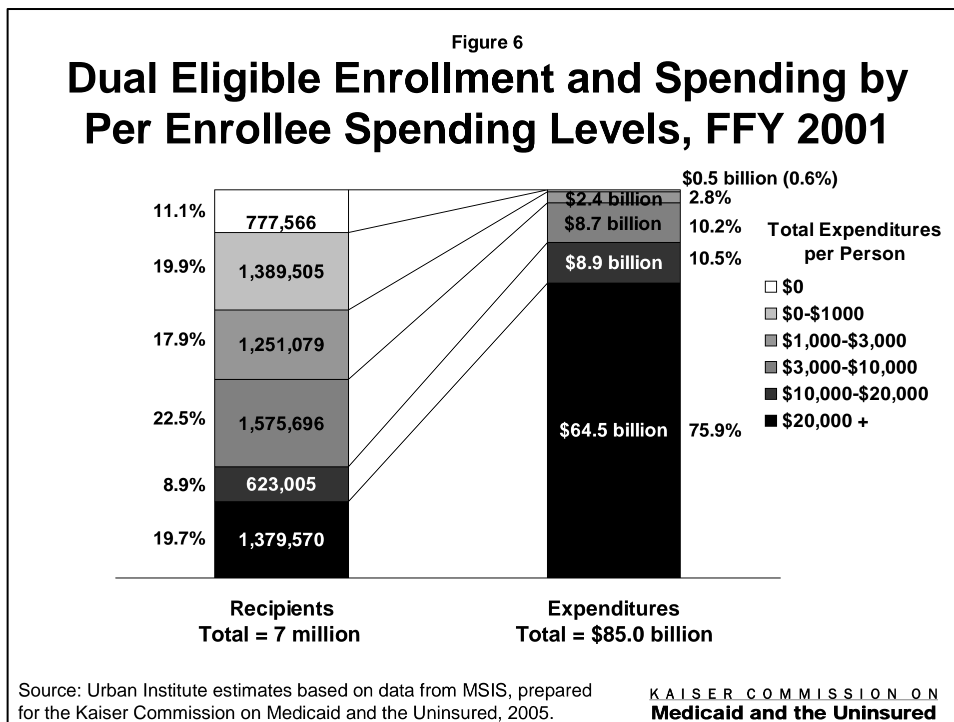
Table 7

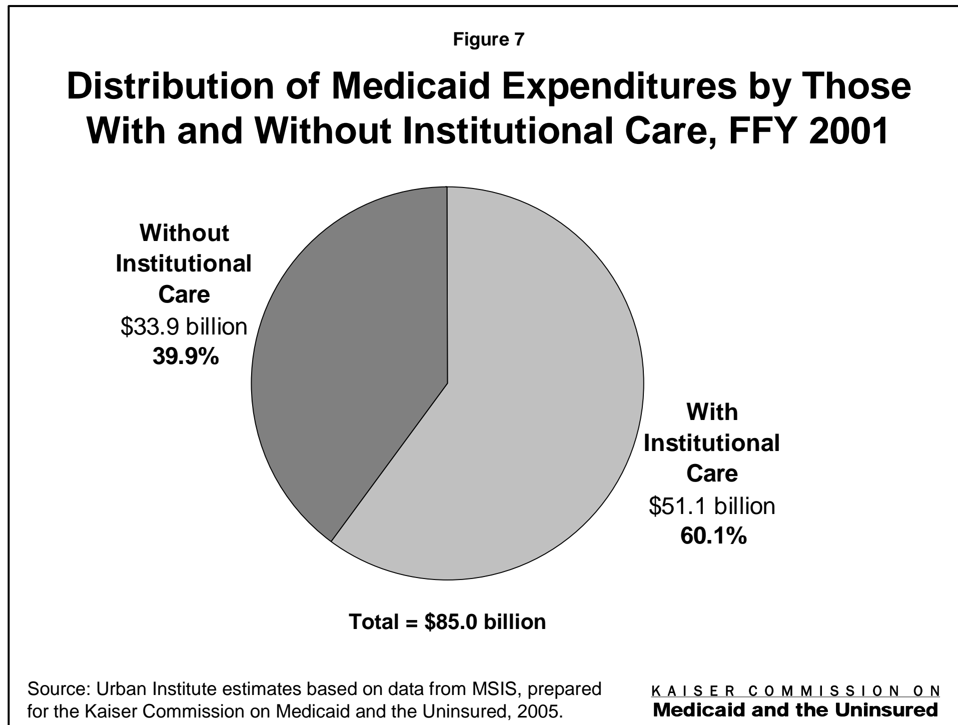
Medicaid Enrollment and Expenditures for Dual Eligibles by Per Enrollee Spending Level, 2001

MSIS 2001

(Inflated to CMS-64 2001 totals by service, does not include Medicare payments, and negative expenditures)

	Total Expenditures per Person	Recipients (in '000s)	% of Dual Enrollees	% of All Enrollees	Expenditures (in '000,000s)	% of Dual Expenditures	% of All Expenditures
	United States	**6,996,421**	**100.0%**	**14.9%**	**$85,024**	**100.0%**	**42.7%**
ALL DUALS	0	777,566	11.1%	1.7%	$0	0.0%	0.0%
	$0-$1000	1,389,505	19.9%	3.0%	$539	0.6%	0.3%
	$1000-$3000	1,251,079	17.9%	2.7%	$2,374	2.8%	1.2%
	$3000-$10000	1,575,696	22.5%	3.4%	$8,677	10.2%	4.4%
	$10000-$20000	623,005	8.9%	1.3%	$8,913	10.5%	4.5%
	$20000+	1,379,570	19.7%	2.9%	$64,521	75.9%	32.4%
	Mean				$12,153		
	United States	**1,361,083**	**19.5%**	**2.9%**	**$51,119**	**60.1%**	**25.7%**
WITH INSTITUTIONAL CARE	0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	8,388	0.1%	0.0%	$4	0.0%	0.0%
	$1000-$3000	25,748	0.4%	0.1%	$54	0.1%	0.0%
	$3000-$10000	129,109	1.8%	0.3%	$848	1.0%	0.4%
	$10000-$20000	188,235	2.7%	0.4%	$2,824	3.3%	1.4%
	$20000+	1,009,603	14.4%	2.2%	$47,388	55.7%	23.8%
	Mean				$37,557		
	United States	**5,635,338**	**80.5%**	**12.0%**	**$33,906**	**39.9%**	**17.0%**
WITHOUT INSTITUTIONAL CARE	0	777,566	11.1%	1.7%	$0	0.0%	0.0%
	$0-$1000	1,381,117	19.7%	2.9%	$534	0.6%	0.3%
	$1000-$3000	1,225,331	17.5%	2.6%	$2,320	2.7%	1.2%
	$3000-$10000	1,446,587	20.7%	3.1%	$7,829	9.2%	3.9%
	$10000-$20000	434,770	6.2%	0.9%	$6,089	7.2%	3.1%
	$20000+	369,967	5.3%	0.8%	$17,133	20.2%	8.6%
	Mean				$6,017		





Simulations of Medicaid Reform Options Involving Dual Eligibles

Background

The National Governors Association and others have suggested that the federal government should take over responsibility for services provided to dual eligibles. Clearly, in the Medicare Modernization Act, the federal government did take over the Medicare prescription drug benefit for dual eligibles, although it required states to make a contribution almost equal to the amount that states are currently spending.

In this section we illustrate the potential fiscal effects of several alternative proposals. We estimate the financial implications of the federal government taking over various pieces of current Medicaid spending on dual eligibles. We estimate the amount that would be shifted from the states to the federal government, the percentage decreases in state spending and the percentage increases in federal spending under each alternative.

We begin with estimates of the effect of the federal government taking over the payment of Medicare premiums. Currently, states make premium payments on behalf of both dual eligibles and Qualified Medicare Beneficiaries (QMBs). In this option the federal government would be responsible for the states' share in addition to what it is currently paying. Next, we look at shifting the full cost of Medicare covered services, i.e. the deductibles and co-insurance that Medicaid now pays would be shifted to the federal government. Third, we examine the fiscal implications of shifting all of the cost of prescription drugs. This is equivalent to eliminating the clawback payment and

having the federal government pick up all expenditures associated with prescription drugs for dual eligibles. The fourth possible shift is to add in the current spending on all acute care services. This is probably quite unlikely given that it would provide added Medicare benefits to a small group of people that are not available to others. The argument for doing so is that this group is so low-income that they face greater financial burdens (relative to income) in paying for these services than do other populations. Finally we examine the implications of shifting all long-term care services.

In conducting this analysis we make no assumptions that the federal government would increase spending on the services that it takes over. This is unlikely to occur; most likely the federal government would set minimum standards that would effectively raise spending for states which were below these; however, the federal government could conceivable lower spending in states above the minimum standards. Since the design of any such federal policy would be complicated and impossible to predict, this is ignored in the analysis that follows.

The results (Table 8) show that absorbing all of the costs of Medicare premiums at the federal level would cost the federal government $2.4 billion and save states a like amount. This reduces state spending for dual eligibles by 5.9 percent, and on all Medicaid enrollees by 2.1 percent (Figure 8). The percentage increases in federal spending are somewhat less because the federal government already pays more than half of the cost.

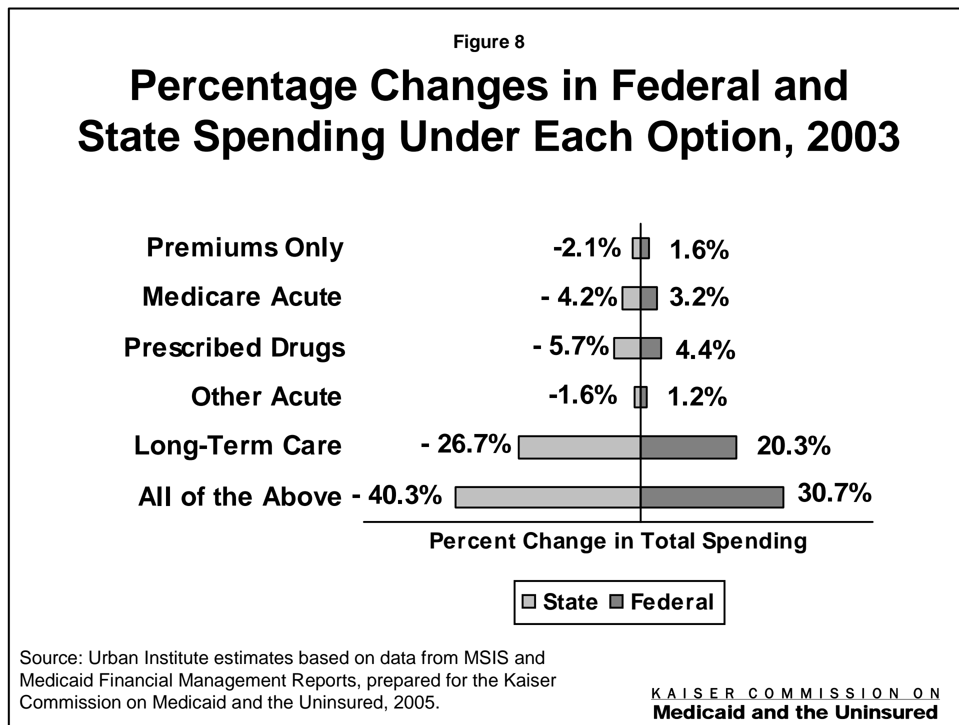
Having Medicare take over deductibles and co-insurance would cause an additional $4.8 billion to be shifted to the federal government. This would be an additional 10.3 percent savings to states for their current spending on dual eligibles and 4.2 percent decrease in spending for all Medicaid enrollees. Fully taking over prescription drugs would cost $6.5 billion and would lower state spending on dual eligibles by 15.2 percent and total state Medicaid spending by 5.7 percent.

Table 8
Fiscal Effects of Hypothetical Medicaid Reform Options in FFY 2003 Dollars

Option	Dollar Amount Shifted to Federal Government (in billions)	Percentage Decrease in State Spending For…		Percentage Increase in Federal Spending For…	
		Dual Eligibles	All Medicaid Enrollees	Dual Eligibles	All Medicaid Enrollees
Medicare premiums	$2.4	(5.9%)	(2.1%)	4.0%	1.6%
Medicare-covered services*	$4.8	(10.3%)	(4.2%)	8.0%	3.2%
Prescribed drugs	$6.5	(15.2%)	(5.7%)	10.9%	4.4%
Other acute care services	$1.8	(4.8%)	(1.6%)	3.0%	1.2%
Long-term care	$30.3	(63.7%)	(26.7%)	50.7%	20.3%
All of the above	$45.7	(100.0%)	(40.3%)	76.6%	30.7%
Aged	$30.3	67.3%	(26.7%)	51.7%	20.3%
Disabled	$15.4	32.7%	(13.6%)	25.1%	10.4%

Source: Urban Institute estimates based on data from MSIS and Medicaid Financial Management Reports.
* Acute care services that Medicare may already cover in whole or part.

By far, the largest effect would be if the federal government were to take over long-term care services. This would shift $30.3 billion to the federal government, reducing state spending by 63.7 percent of the amount it now spends on dual eligibles and 26.7 percent of its spending on all Medicaid enrollees.



Shifting all of the cost of dual eligibles would cost $45.7 billion, reducing state spending on all Medicaid enrollees by 40.3 percent. An alternative way to shift costs of dual eligibles to the federal government would be to have the federal government absorb all of the costs now spent on dual eligibles over the age of 65, leaving current arrangements for the disabled dual eligibles in place. This would shift $30.3 billion to the federal government, saving states 26.7 percent of current spending.

Table 9 provides detailed data on savings to states from having the federal government take over various aspects of current expenditures on dual eligibles. The savings as a percent of state spending vary across states depending on the share of current state expenditures on dual eligibles. For example, states like Connecticut and North Dakota that have a large share of their spending on dual eligibles would save 62 percent of current state Medicaid spending if the federal government took over all expenditures on dual eligibles (Figure 9). In contrast, states like Alaska, Idaho, New Mexico, and Utah would save about 20 percent because dual eligibles are a small share of state expenditures.

Table 10 shows the percentage increase in federal spending in each state from these reforms. Here the change in federal spending would depend on the importance of dual eligibles i.e. a state that spends more money on dual eligibles will have a greater benefit from the federal government absorbing some or all of the cost of dual eligibles. But the increase in federal spending will also depend on the current federal matching rate.

Table 9

Savings to States When the Federal Government Covers Additional Services, 2003

State	Savings to State (in Millions): Premiums & Medicare Acute*	Prescribed Drugs	Long-Term Care	Total**	Savings as a Percentage of State Medicaid Expenditures: Premiums & Medicare Acute*	Prescribed Drugs	Long-Term Care	Total**
United States	$7,187	$6,494	$30,253	$45,738	6%	6%	27%	40%
Alabama	$75	$62	$314	$456	6%	5%	26%	38%
Alaska	$13	$12	$43	$71	4%	3%	12%	20%
Arizona	$68	$39	$177	$307	5%	3%	14%	25%
Arkansas	$86	$43	$155	$295	13%	7%	24%	45%
California	$1,194	$1,064	$2,656	$5,187	9%	8%	20%	39%
Colorado	$73	$82	$389	$578	5%	6%	29%	43%
Connecticut	$73	$113	$1,038	$1,236	4%	6%	52%	62%
Delaware	$20	$14	$106	$144	5%	3%	26%	35%
District of Columbia	$17	$9	$61	$91	5%	3%	18%	27%
Florida	$353	$413	$1,085	$1,891	7%	8%	21%	36%
Georgia	$158	$124	$423	$715	7%	5%	18%	30%
Hawaii	$21	$17	$51	$104	6%	5%	14%	29%
Idaho	$10	$9	$29	$54	4%	3%	10%	19%
Illinois	$183	$223	$1,160	$1,623	3%	4%	20%	28%
Indiana	$120	$129	$526	$800	7%	7%	30%	46%
Iowa	$42	$52	$282	$388	5%	6%	33%	46%
Kansas	$32	$48	$289	$373	4%	6%	39%	50%
Kentucky	$106	$92	$280	$490	8%	7%	21%	36%
Louisiana	$62	$77	$270	$418	5%	6%	23%	35%
Maine	$34	$40	$135	$243	5%	6%	20%	36%
Maryland	$148	$105	$556	$821	5%	4%	20%	30%
Massachusetts	$240	$240	$1,396	$2,035	6%	6%	36%	52%
Michigan	$118	$215	$667	$1,021	4%	7%	21%	32%
Minnesota	$126	$144	$1,016	$1,320	5%	6%	39%	51%
Mississippi	$71	$76	$151	$311	10%	11%	21%	43%
Missouri	$122	$169	$504	$835	6%	9%	26%	43%
Montana	$9	$10	$44	$65	5%	6%	24%	36%
Nebraska	$30	$39	$184	$259	5%	6%	30%	42%
Nevada	$25	$16	$68	$113	6%	4%	17%	28%
New Hampshire	$33	$28	$184	$247	7%	6%	39%	53%
New Jersey	$215	$209	$1,005	$1,483	6%	6%	29%	42%
New Mexico	$21	$14	$76	$129	4%	2%	13%	23%
New York	$1,395	$710	$6,275	$8,672	7%	4%	33%	45%
North Carolina	$208	$227	$760	$1,229	7%	8%	26%	42%
North Dakota	$5	$9	$81	$97	3%	6%	52%	63%
Ohio	$270	$236	$1,454	$2,008	6%	5%	33%	46%
Oklahoma	$51	$55	$263	$374	5%	6%	28%	40%
Oregon	$54	$80	$209	$385	5%	7%	19%	35%
Pennsylvania	$245	$329	$1,509	$2,167	5%	7%	31%	45%
Rhode Island	$41	$33	$234	$311	6%	5%	34%	45%
South Carolina	$117	$69	$212	$410	9%	5%	16%	31%
South Dakota	$12	$11	$71	$96	6%	5%	35%	46%
Tennessee	$120	$45	$793	$1,021	5%	2%	31%	40%
Texas	$409	$294	$1,332	$2,107	8%	5%	25%	39%
Utah	$11	$19	$52	$89	3%	5%	12%	21%
Vermont	$12	$25	$66	$108	5%	9%	25%	40%
Virginia	$127	$132	$456	$812	7%	7%	26%	46%
Washington	$98	$135	$295	$556	4%	5%	11%	21%
West Virginia	$27	$25	$135	$189	5%	5%	25%	35%
Wisconsin	$83	$124	$691	$952	5%	7%	41%	56%
Wyoming	$6	$7	$44	$57	4%	5%	34%	44%

Source: Urban Institute estimates based on data from MSIS and Medicaid Financial Management Reports.

* Includes Medicare premiums and acute care services that Medicare may already cover in whole or part.

** Includes savings from Other Acute Care Services estimated at $1.8 Billion that are not shown in this table.

Figure 9
State Savings as a Percentage of State Medicaid Expenditures for Full Federalization of All Dual Eligible Spending, 2003

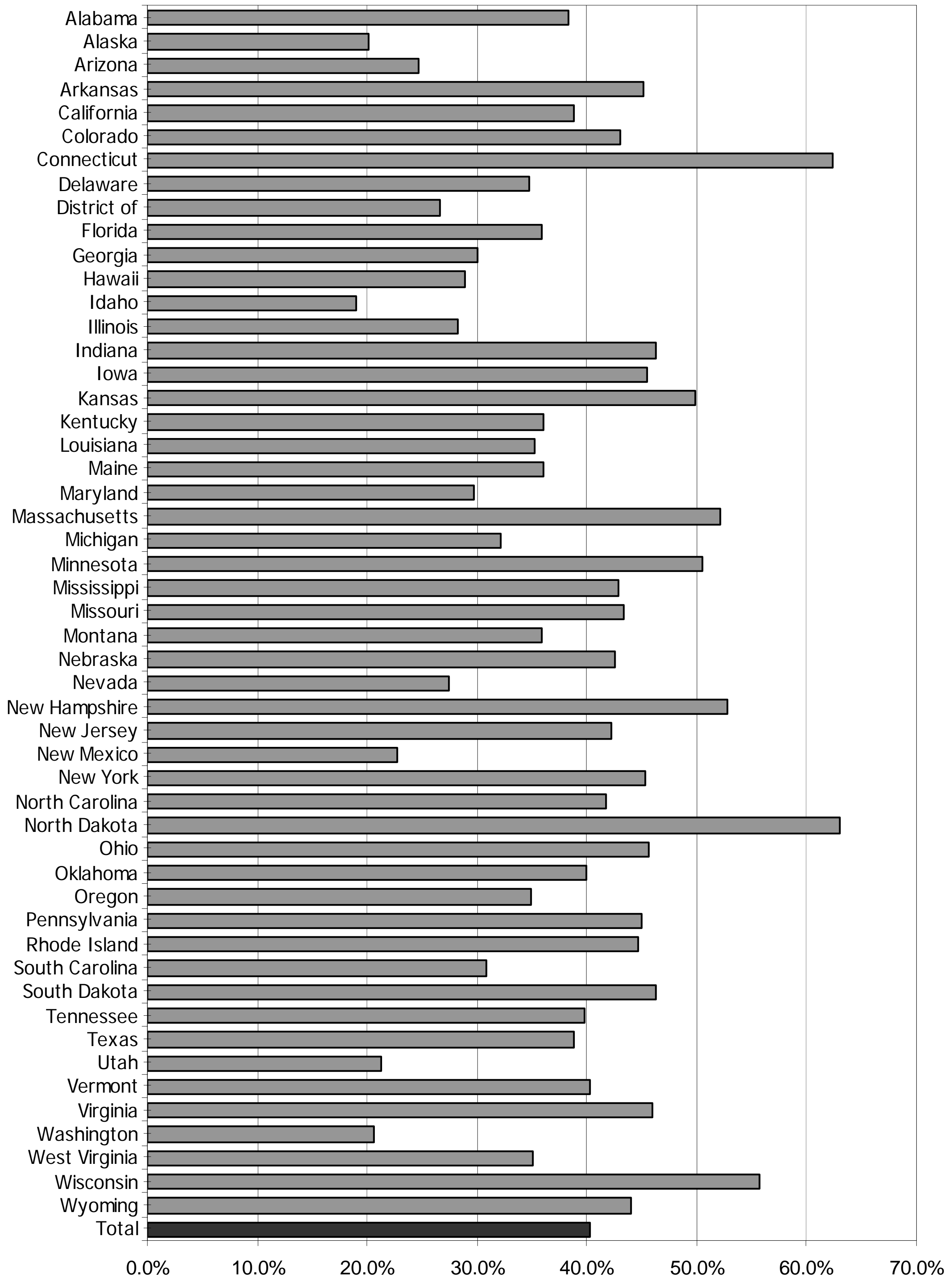


Table 10

Percentage Change in Federal Expenditures Attributable to States if All Expenditures for Duals Are Shifted to the Federal Government, 2003

State	FMAP, FFY 2003	Percentage Change in Federal Spending for… Dual Eligibles Only	All Medicaid Enrollees
California	50.00%	100.0%	37%
Colorado	50.00%	100.0%	43%
Connecticut	50.00%	100.0%	62%
Delaware	50.00%	100.0%	35%
Illinois	50.00%	100.0%	28%
Maryland	50.00%	100.0%	30%
Massachusetts	50.00%	100.0%	52%
Minnesota	50.00%	100.0%	51%
New Hampshire	50.00%	100.0%	53%
New Jersey	50.00%	100.0%	42%
New York	50.00%	100.0%	45%
Washington	50.00%	100.0%	20%
Virginia	50.53%	97.9%	43%
Nevada	52.39%	90.9%	28%
Pennsylvania	54.69%	82.8%	37%
Rhode Island	55.40%	80.5%	40%
Michigan	55.42%	80.4%	25%
Alaska	58.27%	71.6%	15%
Wisconsin	58.43%	71.1%	39%
Hawaii	58.77%	70.2%	22%
Florida	58.83%	70.0%	28%
Ohio	58.83%	70.0%	32%
Nebraska	59.52%	68.0%	29%
Georgia	59.60%	67.8%	21%
Texas	59.99%	66.7%	26%
Kansas	60.15%	66.3%	33%
Oregon	60.16%	66.2%	24%
Missouri	61.23%	63.3%	28%
Wyoming	61.32%	63.1%	27%
Indiana	61.97%	61.4%	28%
Vermont	62.41%	60.2%	24%
North Carolina	62.56%	59.8%	26%
Iowa	63.50%	57.5%	27%
Tennessee	64.59%	54.8%	23%
South Dakota	65.29%	53.2%	24%
Maine	66.22%	51.0%	18%
Arizona	67.25%	48.7%	13%
North Dakota	68.36%	46.3%	27%
South Carolina	69.81%	43.2%	14%
Kentucky	69.89%	43.1%	16%
District of Columbia	70.00%	42.9%	11%
Oklahoma	70.56%	41.7%	17%
Alabama	70.60%	41.6%	16%
Idaho	70.96%	40.9%	8%
Utah	71.24%	40.4%	9%
Louisiana	71.28%	40.3%	15%
Montana	72.96%	37.1%	13%
Arkansas	74.28%	34.6%	17%
New Mexico	74.56%	34.1%	8%
West Virginia	75.04%	33.3%	12%
Mississippi	76.62%	30.5%	13%

States with low federal matching rates e.g., Connecticut, Minnesota, and New York would generate relatively large increases in federal spending, e.g., federal spending on dual eligibles would double if the federal government were to absorb the state share. In contrast, a state like Mississippi that has the highest federal matching rate of all states would see a smaller increase in federal spending. This is because the federal government is already paying about three-quarters of Mississippi's total expenditures. The increase in federal spending on dual eligibles in Mississippi would be only 31percent and only 13 percent of overall federal Medicaid spending in Mississippi.

Conclusion

As shown above, in 2003 there were an estimated 7.5 million dual eligibles. Of these, 6.2 million received full Medicaid benefits and the remainder received assistance with Medicare premiums, deductibles, and co-insurance. About two-thirds of dual eligibles were individuals age 65 and over, with the remainder being younger persons with disabilities.

Spending in 2003 on dual eligibles amounted to $105 billion. This is 40.1 percent of all Medicaid expenditures for medical services in fiscal 2003. About two-thirds of expenditures on dual eligibles were for long-term care services and the remainder was for Medicare premiums, deductibles, and co-insurance, and other acute care services including prescription drugs and inpatient and physician care services.

Only six states spend more than $20,000 per dual enrollee on average. Many states that have high expenditures on a per-person basis spend a relatively large amount on long-term care services. Other states have much lower levels for dual eligibles, primarily because they spend much less on long-term care services.

About 45.0 percent of Medicaid expenditures were for nursing home care, 18.0 percent was for home and community-based care, and another 12.2 percent of all expenditures was for prescription drugs. A small share of dual eligibles account for a very high share of the spending on dual eligibles. We found that 19.7 percent of dual eligibles, most who are receiving institutional care, have expenditures of more than $20,000. This high spending group accounted for $64.5 billion, about three-quarters of all the spending on dual eligibles in 2001.

There has been interest in the National Governors Association and elsewhere to shift some or all of the cost of dual eligibles to the federal government. The arguments for doing so include the proper sorting out of roles between federal and state government e.g., the federal government already has major responsibilities for Medicare. Coverage for prescription drugs and long-term care by this reasoning should also be part of the federal government's responsibility. Another argument is that it will provide fiscal relief to states who are faced with the very difficult problem of financing both acute care for disabled and non-disabled populations, as well as long-term care services. Finally,

shifting more of the cost of dual eligibles to the federal government would assure much greater uniformity and service provision across the nation.

The cost of shifting care for the dual eligibles depends in part on how it is done. Shifting the cost of Medicare premiums, co-insurance, and deductibles would increase federal spending by $2.4 billion. Including Medicare deductibles and co-insurance would add an additional $4.8 billion. Fully taking over prescription drugs, i.e. eliminating the clawback, would cost $6.5 billion. Shifting all long-term care services to the federal government would cost $30.3 billion.

States would save in proportion to what they now spend. If they spend a large share of their Medicaid budgets on dual eligibles, savings will be greater. The increase in federal spending will vary among states in proportion to the amount that is spent on dual eligibles, i.e. states that have more generous coverage, particularly of long-term care services, would generate a greater increase in federal spending. But the amount of new federal spending in any state also depends on the federal matching rate. States with low matching rates e.g., higher income states, would see much greater increases in federal spending than would states with lower per capita income and higher matching rates. The reason for this is simply that the latter states already have a large share of their expenditures on dual eligibles borne by the federal government.

Endnotes

[1] *Dual Eligibles: Making the Case for Federalization.* Washington, DC: National Governors Association. February 2005.

[2] We reviewed the source data to ensure consistency between individuals' demographic and eligibility information, and occasionally made adjustments to correct for likely errors in the source data.

[3] For a closer look at spending and enrollment trends from 2001 and 2003, and the factors influencing these trends, see John Holahan and Arunabh Ghosh, *Understanding the Recent Growth in Medicaid Spending, 2000-2003*, Health Affairs Web Exclusive, 26 January 2005, available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.52v1.

[4] Medicare consists of two types of coverage: Part A, which primarily covers inpatient care; and Part B, which pays for physician services, outpatient care, lab and x-ray services, durable medical equipment and some other services. Both Part A and B require participants to pay premiums, deductibles and coinsurance for services they receive.

[5] Kaiser Commission on Medicaid and the Uninsured analysis of Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey 2002 Access to Care File

[6] For a detailed discussion of Medicaid eligibility pathways for the aged and disabled, see Chapter 1 of Schneider et al., *The Medicaid Resource Book*, The Kaiser Commission on Medicaid and the Uninsured, July 2002, p. 17 et seq., available online at http://www.kff.org/medicaid/2236-index.cfm.

[7] Total expenditures in tables 6 and 7 differ by a small amount on account of negative expenditures, which are included in table 6 but not in table 7.

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