kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

February 2006

Medicare-Medicaid Policy Interactions

Medicare and Medicaid are different programs, but it would be a mistake to think of them as occupying two different silos. Since their common enactment in the Social Security Amendments of 1965, Medicare and Medicaid have been linked in numerous ways, in large part because over 7 million elderly and disabled individuals are entitled to benefits under both programs. Policy changes in one program can have dramatic effects on coverage and spending in the other and on access to services by individuals eligible for both programs.

The attached table illustrates the policy interactions between the Medicare and Medicaid programs. The table is designed to provide a quick reference to the most significant linkages between these two programs. The table identifies four areas in which changes in one program potentially affect spending in the other, as well as the beneficiaries covered by both programs: (1) Medicare premiums and cost-sharing; (2) eligibility and enrollment; (3) benefits and coverage; and (4) provider payments. In each of these areas, the table highlights the implications of key policy changes on spending by both the federal and state governments and on dual eligible enrollees.

This introduction briefly summarizes two of the principal policy interactions between Medicare and Medicaid: changes in the Medicare Part B premium and the establishment of the Medicare Part D prescription program.

The Medicare Part B premium

The Medicare Part B premium is a prime example of the policy interaction between Medicare and Medicaid. In order to enroll in Medicare Part B, eligible Medicare beneficiaries must pay a monthly premium ($88.50 in 2006). State Medicaid programs are required to pay the Part B premium on behalf of low-income Medicare beneficiaries who are dually eligible for Medicare and Medicaid, including those covered under the Medicare Savings Programs (MSPs). MSPs provide Medicaid coverage for certain out-of-pocket expenses (e.g., premiums and coinsurance) of eligible low-income Medicare beneficiaries.

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The federal government matches the amount that state Medicaid programs spend on Part B premiums at each state's matching rate (ranging from 50% to 77%, and averages 57%). In 2005, Medicaid spent $8.1 billion on Part B premiums on behalf of dual eligibles; the federal government spent $4.6 billion and the states spent $3.5 billion (CBO, March 2005 Baseline).

Medicare Part B premiums are adjusted each year to ensure that premium revenues pay about 25 percent of the cost of Part B. Between 2005 and 2006, the Medicare Part B premium increased by 13%. As Part B premiums rise, Medicaid spending on behalf of such individuals increases. If the number of dual eligibles in a state and the state's Medicaid matching rate both remain constant, then the state's Medicaid spending for Part B premiums will increase by 13%. In this way, individuals dually eligible for Medicare and Medicaid are protected from the Medicare Part B premium increases by Medicaid.

Because premiums are calculated as a share of Medicare Part B spending, changes in overall Part B expenditures have a direct impact on the Medicaid obligations. If, for example, Part B expenditures rise due to increases in payment to providers or plans, then premiums would increase to cover 25% of the Part B spending. This increase would have the effect of increasing Medicaid payments for Part B premiums on behalf of dual eligibles. About 57 percent of this spending increase would be paid by the federal government, and the rest of the cost would be borne by the states.

Under current law, states have few options to limit Medicaid spending on Medicare Part B premiums – other than to reduce the number of individuals who qualify for Medicaid as dual eligibles. They could terminate Medicaid coverage for certain elderly or disabled individuals that they are not by law required to cover. Under this option, neither the state nor the federal government would be paying the Part B premium for the affected individuals; instead, the premium amounts would be deducted from the individual's monthly Social Security check. If these Medicare beneficiaries were unable to afford to pay the premium themselves and elected to disenroll from Part B, they would lose Part B coverage, and the federal government would no longer pay for Part B services on their behalf. This policy would clearly impact individuals who would lose access to other Medicaid services, and who may have difficulty paying Part B premiums on their own.

Medicare Part D Prescription Drug Coverage

Another prime example of the interaction between the Medicare and Medicaid is the establishment of the Medicare Part D prescription drug benefit. Under Part D, all Medicare beneficiaries will have access to prescription drug coverage from private plans. As of January 1, 2006, Medicare Part D became responsible for prescription drug coverage for 6.2 million dual eligibles who previously had drug coverage through Medicaid. Federal Medicaid matching

funds are no longer available for the costs of prescription drugs used by dual eligibles enrolled in a Medicare Part D plan. States are eligible for federal matching funds for prescription drugs that are categorically excluded from Part D.

State Medicaid programs will no longer be paying the costs of prescription drugs for dual eligibles, and the federal government will no longer be matching those expenditures. In theory, states would no longer have to spend their share of the costs of prescription drugs for this population and could apply these state funds to other purposes. However, federal law requires each state, beginning in February 2006, to make a monthly payment to the Medicare program that is intended to represent 90 percent of the amount that each state would have spent in the previous month on outpatient prescription drugs for dual eligibles in the absence of Part D. The percentage declines gradually each year until it reaches 75 percent in 2015. In FY 2006 States are projected to make over $7 billion in such "clawback" payments to the Medicare program.

Because the current Medicaid drug benefit varies from state to state, and because the Medicare drug coverage available to a dual eligible varies with the Part D plan in which the dual eligible is enrolled, it is not possible to generalize as to whether dual eligibles will be better or worse off as the result of the implementation of Part D. It is clear, however, that the federal government will have primary financial responsibility for the purchase of drug coverage for dual eligibles through Part D plans, but that States will also help finance the costs of Part D through "clawback" payments.

Typically, policy discussions around Medicare and Medicaid occur separately without full consideration of the interactions between the two programs. Clearly, policy changes in either program have the potential to have a significant impact on expenditures in the other, and on the 7 million beneficiaries covered by these two programs. Often, states are fiscally responsible for changes in Medicare, with few resources under current law. More focused attention on the policy interaction between Medicare and Medicaid would be useful in understanding the full ramifications of policy changes being considered or implemented in either program.

This brief was prepared by Health Policy Alternatives, Medicaid Policy, LLC and staff of the Kaiser Family Foundation.

Policy/Change	Potential Impact on Medicaid (federal and state) Spending	Potential Impact on Medicare Spending	Potential Impact on Full-benefit Dual Eligibles	Potential Impact on Medicare Savings Plan Beneficiaries
Policies That Affect Medicare Premiums and Cost-Sharing				
Increases in Medicare Part A or B Premium	**Increases** Medicaid spending for full-benefit dual eligibles, and for QMBs and SLMBs, because states are required to pay the Medicare premium on their behalf and federal government matches this cost at each state's regular matching rate. No impact related to QIs because payments are fully federal and allocations to states are capped.	**Reduces** federal spending on Medicare because it shifts costs to beneficiaries, including those protected by Medicaid.	**Dual eligibles protected** by Medicaid, which pays all increases in premiums on behalf of dual eligibles with federal and state funds.	**Most MSP beneficiaries** protected by Medicaid, which pays all increases in premiums on behalf of QMBs and SLIMBs with federal and state funds. Medicaid pays premium increases for QIs with federal funds up to state allocations; if funds are insufficient, QI-eligible individuals pay premium directly.
Increases in Medicare Part D Premium	**No effect** on Medicaid spending for full-benefit dual eligibles, QMBs, SLMBs, or QIs, because Medicaid does not pay Part D premiums.	**Increases** federal Medicare spending on Low-Income Subsidy (LIS), which pays Part D low-income benchmark premiums for beneficiaries with incomes below 135 percent of Federal Poverty Level (FPL), and partial premium payments for those <150 percent of FPL.	**Dual eligibles protected** by Medicare LIS, which pays increases in Part D low-income benchmark premiums on behalf of beneficiaries with incomes below 135 precent of FPL.	**MSP-eligible beneficiaries protected** by Medicare LIS, which pays increases in Part D low-income benchmark premiums on behalf of beneficiaries with incomes below 135 percent of FPL.

Policy/Change	Potential Impact on Medicaid (federal and state) Spending	Potential Impact on Medicare Spending	Potential Impact on Full-benefit Dual Eligibles	Potential Impact on Medicare Savings Plan Beneficiaries
Increases in Medicare Part A or Part B deductible	**Increases** Medicaid spending for full-benefit dual eligibles and QMBs. In the case of Part A, Medicaid spending increases only if the Medicare payment for hospital care (less the Medicare deductible) is less than what Medicaid would pay for the hospital stay.	**Reduces** federal spending on Medicare because it shifts costs to beneficiaries, including those protected by Medicaid (in which case the increased costs are shared by federal and state governments).	**Dual eligibles not liable** for deductible increases even if the Medicaid program fails to pay full Part A deductible because the Medicare hospital payment (less the Medicare deductible) is less than what Medicaid would pay for the hospital stay.	**QMBs not liable** for deductible increases even if the Medicaid program fails to pay the full Part A deductible. SLIMBs and QIs are fully liable for the Part A and Part B deductibles and any increases in those deductibles.
Increases in Medicare Part D deductible	**No effect** on Medicaid spending for full-benefit dual eligibles, QMBs, SLMBs, or QIs, because Medicaid does not pay Part D deductibles	**Increases** federal Medicare spending on LIS, which reduces Part D deductible to $0 for beneficiaries with incomes below 135 percent of FPL.	**Dual eligibles protected** by Medicare LIS, which reduces Part D deductible to $0 for beneficiaries with incomes below 135 percent of FPL.	**MSP-eligible beneficiaries protected** by Medicare LIS, which reduces Part D deductible to $0 for beneficiaries with incomes below 135 percent of FPL.
Increases in Part A or Part B coinsurance	**Increases** Medicaid spending for full-benefit dual eligibles and QMBs because states are required to pay Medicare coinsurance for these	**Reduces** federal spending on Medicare because it shifts costs to beneficiaries,	**Dual eligibles not liable** for coinsurance increases even if	**QMBs not liable** for coinsurance increases even if the Medicaid program does not pay

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	beneficiaries unless the Medicaid payment rate for a service is less than the amount Medicare pays after the coinsurance is applied.	including those protected by Medicaid (in which case the increased costs are shared by federal and state governments).	the Medicaid program does not pay full coinsurance amount. Access to care may be reduced if providers seek to limit losses on uncollected coinsurance from dual eligibles because the Medicaid payment rate for the service is less than the Medicare payment amount.	full coinsurance amount. Access to care may be reduced if providers seek to limit losses on uncollected coinsurance from QMBs. Medicaid does not pay coinsurance amounts for SLIMBs and QIs under any circumstances. SLIMBs and QIs may experience financial hardship meeting coinsurance liability.
Increases in Part D coinsurance	**No effect** on Medicaid spending for full-benefit dual eligibles, QMBs, SLMBs, or QIs, because Medicaid does not pay Part D premiums.	**Increases** federal Medicare spending on LIS, which eliminates Part D coinsurance for institutionalized dual eligibles and reduces Part D coinsurance to fixed copayments that vary with income for all other dual eligibles.	**Dual eligibles protected** by Medicare LIS to varying degrees. Dual eligibles in institutions are exempt from coinsurance. Dual eligibles with incomes at or below 100 percent of FPL are subject to copayments of $1	**MSP-eligible beneficiaries protected** by Medicare LIS, which reduces Part D coinsurance to fixed copayments of $2 or $5 for beneficiaries with incomes below 135 percent of FPL.

Policy/Change	Potential Impact on Medicaid (federal and state) Spending	Potential Impact on Medicare Spending	Potential Impact on Full-benefit Dual Eligibles	Potential Impact on Medicare Savings Plan Beneficiaries
			or $3. Those with incomes between 100 and 135 percent of FPL are subject to copayments of $2 or $5.	
Changes in Eligibility/Enrollment Policies				
Changes in Medicaid income and/ or asset tests for full-benefit dual eligibles	**Increases** federal and state Medicaid outlays if income or asset thresholds are raised and number of dual eligibles grows. **Decreases** federal and state Medicaid spending if income or asset thresholds are lowered and number of dual eligibles declines.	**Increases** state "clawback" payments to Medicare Part D program if income or asset thresholds are raised and number of dual eligibles grows. **Decreases** state "clawback" payments to Medicare Part D if income or asset thresholds are lowered and number of dual eligibles declines.	Medicare beneficiaries who become ineligible for Medicaid if income or asset thresholds are lowered lose coverage for benefits (e.g., personal care services) not covered by Medicare, and vice versa.	If Medicaid income and assets thresholds are raised, individuals now eligible only for MSP benefits may qualify for full Medicaid benefits.
Changes in Medicaid income and/or assets tests for Medicare Savings Program (MSP) beneficiaries	**Increases** federal and state Medicaid outlays for Medicare premiums and cost-sharing if income or asset thresholds are raised and the number of QMBs or SLIMBs grows. **Decreases** federal and state Medicaid outlays for Medicare premiums and	**No effect** on Medicare spending. **No effect** on amount of state "clawback" payments to Medicare Part D program.		Medicare beneficiaries who become ineligible for QMB status if income or assets thresholds are lowered lose assistance with Medicare Part A and B

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	cost-sharing if income or asset thresholds are lowered and the number of QMBs or SLIMBs declines.			premiums and cost-sharing. Medicare beneficiaries who become ineligible for SLIMB or QI status if income or assets thresholds are lowered lose assistance with Medicare Part B premiums.
Changes in Medicare eligibility for aged beneficiaries	**Increases** federal and state Medicaid outlays if Medicare eligibility is delayed past age 65 because Medicare pays first for services that both programs cover. **Decreases** federal and state Medicaid outlays if Medicare eligibility is accelerated to before age 65.	**Decreases** Medicare spending if eligibility is delayed past age 65 because fewer individuals will qualify. **Increases** Medicare spending eligibility is accelerated to before age 65.	Medicaid beneficiaries have delay in Medicare coverage if Medicare eligibility is delayed past age 65. Medicaid beneficiaries become dual eligibles at a younger age if Medicare eligibility is accelerated to before age 65.	If Medicare eligibility is delayed past age 65, Individuals have no need for MSP protections during the period of delay. If Medicare eligibility is accelerated to before age 65, MSP eligibility will be accelerated as well.
Changes in Medicare eligibility for disabled beneficiaries	**Reduces** federal and state Medicaid outlays if 2-year Medicare waiting period for disabled individuals is reduced/eliminated, because Medicare pays first for services that both programs cover.	**Increases** Medicare spending if 2-year waiting period for the disabled is reduced/eliminated.	Medicaid beneficiaries with disabilities become dual eligibles earlier if 2-year waiting period for the	

Policy/Change	Potential Impact on Medicaid (federal and state) Spending	Potential Impact on Medicare Spending	Potential Impact on Full-benefit Dual Eligibles	Potential Impact on Medicare Savings Plan Beneficiaries
			disabled is reduced/eliminated. Higher Medicare payment rates may improve access to providers.	
Changes in income and/or assets test for Medicare Part D Low-Income Subsidy (LIS)	Changes in eligibility thresholds for the LIS, whether increases or reductions, have **no effect** on federal and state Medicaid spending, because all subsidy costs are borne by Medicare.	**Increases** Medicare spending if income and/or asset thresholds are raised, because more individuals will qualify for subsidies. **Decreases** Medicare spending if income and/or assets thresholds are lowered.	If the 100 percent FPL income threshold for $1 and $3 copayments is raised, more non-institutionalized dual eligibles could qualify for these lower copayments, reducing their financial burden.	If the 100 percent FPL income threshold for $1 and $3 copayments is raised, SLIMBs and QIs could qualify for these lower copayments, reducing their financial burden. MSPs are not eligible for lower copays –only full duals.
Outreach and enrollment by Medicare Part D Low-Income Subsidy (LIS) program	**Increases** federal and state Medicaid spending if more low-income Medicare beneficiaries eligible but not currently participating in Medicaid as a full benefit dual eligible or as a QMB, SLIM, or QI, are identified and enrolled. Also increases federal and state Medicaid administrative costs due to increase in number of applications for benefits to be processed.	Enrollment in the LIS program **increases** Medicare Part D spending because subsidy payments increase.	If outreach and enrollment for LIS increases enrollment in Medicaid, more low-income Medicare beneficiaries will have Medicaid coverage for services not	If outreach and enrollment for LIS increases enrollment in QMB, SLIMB, and QI programs, more low-income Medicare beneficiaries will receive assistance with Medicare Part A and Part B premiums and cost-sharing.

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			covered by Medicare.	
Benefit and Coverage Rules				
Expansion of Medicare Part A or Part B benefits (e.g., addition of diabetes screening tests as a Part B covered service)	**Reduces** federal and state Medicaid outlays to the extent that the new benefit is also covered by state Medicaid programs for dually eligible beneficiaries, because Medicare is primary payer for such services.	**Increases** Medicare spending.	If state Medicaid programs do not already cover the new Medicare service, dual eligibles receive additional coverage. If state Medicaid programs already cover the new Medicare benefit, and if the Medicare payment rate is higher than that under Medicaid, dual eligibles may experience improved access to providers for the service.	MSP beneficiaries receive additional Medicare coverage in the form of the new benefit.
Medicare Part A or Part B coverage policy changes (e.g., limitations or expansions of	**Increases** federal and state Medicaid outlays if Medicare coverage is narrowed for services covered more comprehensively by state Medicaid programs (e.g., Medicare SNF or	**Decreases** Medicare spending if coverage policy changes limit services and **increases** Medicare	If coverage changes limit services that are also covered by Medicaid, dual	If coverage policy changes limit services, MSP beneficiaries experience a reduction in Medicare services.

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covered services)	home health benefits). **Decreases** federal and state Medicaid outlays if Medicare coverage is expanded for services also covered by Medicaid.	spending if coverage policy changes expand services.	eligibles are protected against a loss in coverage by Medicaid.	If coverage policy changes increase services, MSP beneficiaries have additional Medicare coverage.
Establishment of Medicare Part D outpatient drug program	**Reduces** federal Medicaid outlays for outpatient prescription drugs for dual eligibles, because no federal matching payments are available for these costs after December 31, 2006. **Reduces** state Medicaid outlays for the state share of prescription drug costs for dual eligibles, but state savings are substantially reduced by requirements for "clawback" payments to Medicare.	**Increases** Medicare spending. The increase in federal cost is offset by requirements on states to make "clawback" payments to reflect state savings from reduction in Medicaid spending on prescription drugs for dual eligibles.	Creates **risk of discontinuity** during transition period as dual eligibles switch outpatient drug coverage from Medicaid to new Medicare Part D program. The scope of drug **coverage for an individual beneficiary may increase or decrease**, depending on the state Medicaid program and formulary of the Part D plan in which a beneficiary is enrolled.	**Increases** outpatient drug coverage for all MSP-eligible individuals (i.e., with incomes below 135 percent FPL) who choose to enroll in Part D and accept the LIS premium and cost-sharing subsidies.

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Changes in Medicaid benefits (restrictions or expansions in benefits or coverage policy)	**Reduces** federal and state Medicaid spending if Medicaid benefits are eliminated or reduced in scope. **Increases** federal and state Medicaid spending if Medicaid benefits are added or expanded in scope.	**No effect** on Medicare spending if Medicare already covers the service that Medicaid eliminates or reduces. **May reduce** Medicare spending if adding or expanding Medicaid benefit reduces use of Medicare benefits (e.g., personal care services for frail elderly at risk of hospital or SNF care). **May increase** Medicare spending if eliminating or reducing a Medicaid benefit increases use of Medicare services.	**No effect** on dual eligibles if Medicare already covers the service that Medicaid eliminates or reduces (e.g., limiting number of physician visits). **Reduces** coverage for dual eligibles if Medicare does not cover the service that Medicaid eliminates or reduces (e.g., restricting number of personal care attendant hours).	**No effect** on MSP beneficiaries whether or not Medicare already covers the service that Medicaid eliminates or reduces, because MSP beneficiaries do not receive coverage for Medicaid services.
Payments to Providers under Medicaid/Medicare				
Increases in provider payments under Medicare Parts A and B (e.g., increases to the Medicare physician fee schedule)	**Increases** federal and state Medicaid spending for cost-sharing requirements of dual eligibles and QMBs if state Medicaid program pays deductibles and co-insurance for these groups. Increases in Part B payments to providers raise Medicare Part B premiums and thereby **increase**	**Increases** Medicare spending.	**May increase access** of dual eligibles to providers (or prevent access from eroding).	**May increase access** of MSP beneficairies to providers (or prevent access from eroding).

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	Medicaid payments for Medicare Part B premiums on behalf of dual eligibles and MSP beneficiaries.			
Reduction in payments to providers under Medicare Parts A and B (e.g., reductions to the Medicare physician fee schedule)	**Reduces** federal and state Medicaid spending for cost-sharing requirements of dual eligibles and QMBs if state Medicaid program pays deductibles and co-insurance for these groups. Reductions in Part B payments to providers could also reduce the increase in Medicare Part B premiums and thereby **reduce** Medicaid payments for Medicare Part B premiums on behalf of dual eligibles and MSP beneficiaries.	**Reduces** Medicare spending.	**May reduce access** of dual eligibles to providers (or prevent access from eroding).	**May reduce access** of MSP beneficiaries to providers (or prevent access from eroding).
Changes in payments to Medicare Advantageplans under Medicare Part C	Increases in payments to Medicare Advantage plans **would increase** federal and state Medicaid spending because Part B premiums paid by Medicaid would increase due to higher Part B expenditures for these plans. Conversely, decreases in payments to Medicare Advantage plans would **reduce** Medicaid expenditures. Increases to Medicare Advantage plans could also **reduce** federal and state Medicaid spending if higher payments resulted in greater availability of Medicare Advantage plans and more generous benefits,	**Increases** Medicare spending if payments to plans are increased; **reduces** Medicare spending if payments to plans are reduced.	**May increase access** of dual eligibles to MA plans if payment rates to plans are increased and more MA plans enter market or increase their Medicare enrollments.	**May increase access** of MSP beneficiaries to MA plans if payment rates to plans are increased and more MA plans enter market or increase their Medicare enrollments.

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	which in turn resulted in lower enrollment in Medicaid by low-income Medicare beneficiaries who enroll in Medicare Advantage plans instead.			
Changes in payment rates to providers under Medicaid (increases or decreases)	Increases in Medicaid payment rates to providers **increase** federal and state Medicaid spending; decreases in Medicaid payment rates to providers **decrease** federal and state Medicaid spending.	Changes in Medicaid payment rates to providers have **no effect** on Medicare spending	Increases in Medicaid payment rates **may increase access** of dual eligibles to providers; and vice versa.	Increases in Medicaid payment rates may increase amount of coinsurance paid by Medicaid for QMBs, **potentially increasing access** to providers.

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