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# Rethinking Medicaid's Financing Role for Medicare Enrollees

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Medicaid currently fills in the gaps in Medicare's benefit package for 8.8 million enrollees with limited income and resources (dual eligibles). This financing role has important implications for state budgets, and consolidating aspects of this financing at one level of government could create new opportunities for better care management and coordination for dual eligibles. As federal policymakers in the new administration and Congress develop proposals for fiscal stimulus and health reform, it is instructive to consider changes to Medicaid's current financing role for low-income Medicare enrollees.

In 2006, the federal government took steps to expand its role for low-income Medicare beneficiaries through the implementation of the new Part D drug benefit and low-income subsidy programs. The following options represent further restructuring of the federal-state financing relationship for duals that could help advance national efforts to control health spending growth for some of our nation's highest need and most costly individuals:

- **Full federal financing of the payment of Medicare premiums**. Federal assumption of the state's share of Medicare premiums paid by Medicaid would reduce state Medicaid spending by an estimated **$3.7 billion** in 2005 dollars (Table 1).
- **Federal assumption of the full-cost of Medicare-covered services,** i.e., the deductibles and co-insurance that Medicaid now pays. This would decrease state Medicaid spending by **$7.6 billion** in 2005 dollars.
- **Federal assumption of the full cost of Medicaid acute care services that are not currently covered by Medicare** (e.g. transportation, dental, and vision services). This would lower state spending by **$2.1 billion** in 2005 dollars.
- **Full federal financing for all Medicaid long-term care services provided to dual eligibles**. This would result in an estimated **$33.5 billion** in savings to the states.

Table 1

**Summary of Estimated State Savings from Federal Assumption of Selected Services and Benefits for Dual Eligibles, FFY 2005**

| Option | Reduction in State Medicaid Spending (in billions of 2005 $) |
|---|---|
| Medicare premiums | 3.7 |
| Medicare-covered services* | 7.6 |
| Other acute care services** | 2.1 |
| Long-term care | 33.5 |
| All of the above | 46.8 |

Source: Urban Institute and KCMU estimates based on data from MSIS and CMS Form 64.

* Acute care services that Medicare may already cover in whole or part.

** Entire table excludes prescription drug spending for duals.

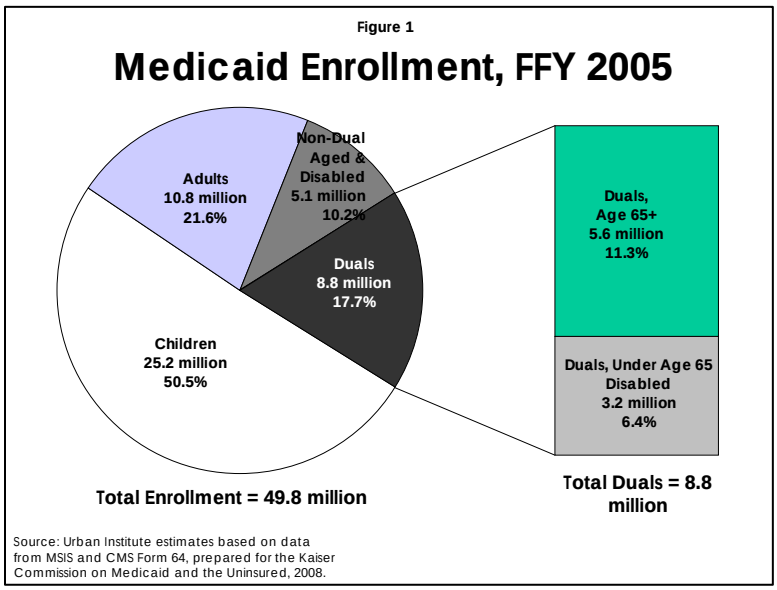
Although this brief examines only the fiscal impact of these options, they each could create new opportunities for improved care management and coordination for our nation's sickest and poorest individuals, who have at times been ill-served by inadequate coordination between the Medicare and Medicaid programs that currently share responsibility for financing and delivering their care.[1] These financing changes could also be explored as part of broader health reform efforts that might consider relieving states of some portion of their burden in funding care for Medicare enrollees in return for their using some or all of their savings to strengthen and expand Medicaid coverage for low-income families and disabled individuals who are not eligible for Medicare.

# Who are the Dual Eligibles?

Dual eligibles are individuals who are entitled to Medicare who are also eligible for some level of Medicaid benefits.[2] Dual eligibles are among the sickest and poorest individuals covered by either Medicare or Medicaid. Some dual eligibles qualify for full Medicaid benefits including medical and long-term care, and Medicaid also pays their Medicare premiums and cost sharing. Other duals qualify for more limited Medicaid benefits and receive assistance from Medicaid with their Medicare premiums and cost sharing. A third group does not receive Medicaid benefits directly. For these duals, Medicaid provides "Medicare Savings Programs" through which enrollees receive assistance with some or all of their Medicare premiums, deductibles, and other cost-sharing requirements.

8.8 million Medicare beneficiaries were enrolled in Medicaid in 2005, representing 18 percent of all Medicaid enrollees (Figure 1). 5.6 million of these dual eligibles were age 65 and older and 3.2 million were disabled individuals under age 65.[3] The 8.8 million total includes 7.1 million (81 percent) who received full Medicaid benefits and 1.7 million (19 percent) who received assistance only with Medicare premiums, cost sharing, and out-of-pocket costs. These "partial" dual eligibles were not eligible for non-Medicare covered Medicaid services such as long-term care and vision or dental.

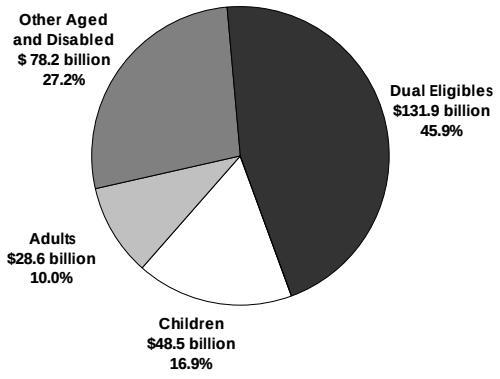
Figure 1




**Nearly half (46%) of all Medicaid expenditures for services in 2005 were made on behalf of dual eligibles (Figure 2).** The state share of this roughly $132 billion in spending totaled more than $57 billion in 2005, 58% of which was for long-term care. This total includes the $10.4 billion states spent on prescription drugs for Medicare enrollees in 2005. Since this spending is no longer included in the Medicaid program following the January 2006 implementation of Medicare Part D, the options that follow exclude this spending. However, the fiscal relief provided to the states through the Part D shift was limited by the requirement that they help finance the new benefit through monthly "clawback" payments to the federal government totaling roughly $6.9 billion in 2006. Although not examined here, one obvious avenue for Medicaid state fiscal relief would be to relieve states of some or all of their "clawback" obligation.

Figure 2

**Medicaid Spending by Group, Services Only, FFY 2005**




**Total Spending = $ 287.3 billion**

Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2008.

# Summary of Options

This section provides more detail on the financial impacts in Federal Fiscal Year (FFY) 2005 dollars of full federal financing for various portions of current Medicaid spending on dual eligibles. Estimates include 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.

These estimates make no assumptions that the federal government would increase spending or payment rates on the services that it takes over. In reality, however, the federal government would almost certainly set minimum standards that would increase spending in states that were below these standards. However, the federal government could also conceivably lower spending in states currently above whatever minimum standards are adopted. Since the design of any such federal policy would be complicated and impossible to predict, estimating the fiscal impact of such standardization is beyond the scope of this analysis.

The results of these estimates are presented in Table 2 below and the state-by-state dollar amounts are shown in Table 3.

Table 2

**Fiscal Effects of Hypothetical Medicaid Reform Options for Dual Eligibles in FFY 2005 Dollars**

| Option | Reduction in State Medicaid Spending (in billions) | Percentage Decrease in State Spending For... Dual Eligibles | Percentage Decrease in State Spending For... All Medicaid Enrollees | Percentage Increase in Federal Spending For... Dual Eligibles | Percentage Increase in Federal Spending For... All Medicaid Enrollees |
|---|---|---|---|---|---|
| Medicare premiums | 3.7 | -7.9% | -3.3% | 6.0% | 2.5% |
| Medicare-covered services* | 7.6 | -16.1% | -6.7% | 12.4% | 5.0% |
| Other acute care services** | 2.1 | -4.4% | -1.8% | 3.4% | 1.4% |
| Long-term care | 33.5 | -71.5% | -29.5% | 54.7% | 22.4% |
| All of the above | 46.8 | -100.0% | -41.3% | 76.5% | 31.3% |
| Aged | 31.3 | -66.8% | -27.6% | 51.1% | 20.9% |
| <65 Disabled | 19.2 | -41.0% | -16.9% | 31.4% | 12.8% |

Source: Urban Institute and KCMU estimates based on data from MSIS and CMS Form 64.

* Acute care services that Medicare may already cover in whole or part.

** Entire table excludes prescription drug spending for duals.

Table 3

**State Expenditures for Services Used by Dual Eligibles, 2005** (in millions)

| State | Medicare Premiums | Medicare-Covered Acute* | Acute Care Not Covered by Medicare** | Long-Term Care | Total | Total as % of State Medicaid Spending |
|---|---|---|---|---|---|---|
| United States | $3,689 | $7,550 | $2,075 | $33,454 | $46,767 | 41% |
| Alabama | 51 | 60 | 7 | 302 | 420 | 46% |
| Alaska | 6 | 13 | 5 | 73 | 97 | 25% |
| Arizona[1] | 35 | 464 | 5 | 9 | 513 | 28% |
| Arkansas | 45 | 53 | 24 | 171 | 294 | 45% |
| California | 685 | 1,213 | 179 | 3,798 | 5,874 | 41% |
| Colorado | 24 | 85 | 17 | 350 | 476 | 39% |
| Connecticut | 94 | 48 | 26 | 853 | 1,020 | 58% |
| Delaware | 9 | 15 | 5 | 122 | 151 | 37% |
| District of Columbia | 5 | 12 | 17 | 57 | 91 | 26% |
| Florida | 291 | 371 | 60 | 1,102 | 1,823 | 39% |
| Georgia | 78 | 214 | 31 | 562 | 886 | 34% |
| Hawaii | 16 | 21 | 4 | 108 | 150 | 37% |
| Idaho | 6 | 11 | 9 | 69 | 95 | 35% |
| Illinois | 107 | 200 | 80 | 1,091 | 1,479 | 33% |
| Indiana | 36 | 88 | 23 | 609 | 756 | 45% |
| Iowa | 47 | 36 | 22 | 281 | 386 | 49% |
| Kansas | 18 | 39 | 12 | 244 | 312 | 46% |
| Kentucky | 42 | 54 | 8 | 277 | 380 | 33% |
| Louisiana | 43 | 49 | 13 | 275 | 381 | 33% |
| Maine | 19 | 26 | 53 | 138 | 236 | 33% |
| Maryland | 55 | 133 | 23 | 587 | 799 | 33% |
| Massachusetts | 124 | 201 | 284 | 1,278 | 1,887 | 45% |
| Michigan | 109 | 372 | 34 | 910 | 1,424 | 43% |
| Minnesota | 51 | 271 | 37 | 942 | 1,301 | 49% |
| Mississippi | 19 | 44 | 25 | 175 | 263 | 41% |
| Missouri | 81 | 114 | 67 | 532 | 794 | 40% |
| Montana | 9 | 7 | 4 | 63 | 83 | 46% |
| Nebraska | 29 | 26 | 6 | 198 | 259 | 50% |
| Nevada | 15 | 31 | 6 | 93 | 145 | 32% |
| New Hampshire | 6 | 27 | 3 | 213 | 249 | 55% |
| New Jersey | 87 | 156 | 96 | 1,187 | 1,527 | 49% |
| New Mexico | 11 | 41 | 7 | 120 | 179 | 30% |
| New York | 432 | 1,173 | 314 | 6,600 | 8,519 | 45% |
| North Carolina | 100 | 123 | 69 | 772 | 1,064 | 38% |
| North Dakota | 2 | 8 | 1 | 79 | 90 | 59% |
| Ohio | 89 | 283 | 57 | 1,628 | 2,056 | 47% |
| Oklahoma | 26 | 35 | 9 | 216 | 287 | 38% |
| Oregon | 17 | 96 | 12 | 258 | 382 | 37% |
| Pennsylvania | 145 | 506 | 25 | 2,621 | 3,297 | 50% |
| Rhode Island | 12 | 48 | 18 | 207 | 285 | 44% |
| South Carolina | 33 | 81 | 11 | 235 | 360 | 36% |
| South Dakota | 6 | 9 | 1 | 62 | 77 | 40% |
| Tennessee | 83 | 130 | 13 | 438 | 665 | 29% |
| Texas | 243 | 179 | 238 | 1,196 | 1,857 | 32% |
| Utah | 5 | 26 | 2 | 62 | 94 | 28% |
| Vermont | 6 | 10 | 13 | 76 | 105 | 36% |
| Virginia | 71 | 94 | 15 | 651 | 830 | 42% |
| Washington | 68 | 71 | 42 | 675 | 856 | 35% |
| West Virginia | 16 | 18 | 4 | 151 | 190 | 38% |
| Wisconsin | 79 | 161 | 38 | 683 | 962 | 54% |
| Wyoming | 4 | 5 | 1 | 55 | 64 | 40% |

Source: Urban Institute and KCMU estimates based on data from MSIS and CMS Form 64.

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

** Entire table excludes prescription drug spending for duals.

[1] Most expenditures for duals in Arizona are covered under the Arizona Long-Term Care System (ALTCS), which is a capitated program. These payments will be reflected in the Medicare acute category and can not be separated out for other service types.

Full federal financing of the costs of Medicare premiums for duals would have reduced state Medicaid spending by an estimated $3.7 billion in FFY 2005. This would have resulted in savings of 3.3 percent to states and would have increased federal Medicaid spending by 2.5 percent (this includes spending on non-Medicare, acute care services in the base, but excludes prescription drug spending on duals in 2005). If the federal government were to have fully funded cost sharing for Medicare covered services as well, federal spending would rise by an additional $7.6 billion or by 5.0 percent, while state spending would have fallen 6.7 percent. The two policies together would have reduced state Medicaid expenditures by about $11.2 billion or 9.9 percent.

Federal assumption of state expenditures for long-term care services for duals would have reduced state Medicaid spending by $33.5 billion in FFY 2005. This translates to a reduction in state spending of 29.5 percent and in increase federal Medicaid outlays of 22.4 percent. Had the federal government assumed full financing of all expenditures for dual eligibles (including long-term care and "other" acute care services not currently covered by Medicare, such as vision, hearing, and dental services) it would have reduced state expenditures by about $47 billion, a decline of roughly 41 percent in total state Medicaid spending and an increase in federal Medicaid spending of about 31 percent. Table 2 also shows that if the federal government had taken over financing for all services for all duals age 65 and older, state costs would have declined by $31 billon or 27.6 percent and federal spending would have risen by 20.9 percent.

The effects of these policies vary considerably across the states, however, due to baseline variation in current state spending patterns on dual eligibles (Table 3). States that spend a large share of their Medicaid budgets on dual eligibles would reap proportionately larger savings from policies that would shift spending on duals to the federal government. Likewise, states in which dual eligibles represent a small share of state Medicaid expenditures would benefit less.

Federal matching rates also impact the dollar amount of fiscal relief states receive under each option. States receiving the federal minimum matching rate of 50%, e.g., Connecticut, Minnesota, and New York, would receive a relatively larger drop in state Medicaid spending since these states finance 50 cents of every dollar spent on their dual eligibles. In contrast, states like Mississippi that have very high federal matching rates would see a smaller reduction since the federal government already pays a substantial share of these states' total expenditures on dual eligibles.

## Discussion and Implications

45 states now face budget shortfalls due to declining revenues in the face of growing demand for many of the services that they help fund, including Medicaid. In recognition of this, federal policymakers in the new Administration and Congress plan to include significant additional federal funds for Medicaid over the next three years as part of the American Recovery and Reinvestment Act of 2009. While the vast majority of these Medicaid funds would flow to states through a short-term increase in the federal share of total program financing –the most straightforward and efficient way to provide Medicaid relief and stimulus to the states – it is instructive to consider other longer-term financing issues facing the program, one of which is Medicaid's role financing care for low-income Medicare enrollees.

**Medicaid funded and provided assistance for an estimated 8.8 million Medicare enrollees in FFY 2005.** State spending in FFY 2005 on dual eligibles totaled more than $57 billion (including prescription drugs), representing 46 percent of all Medicaid expenditures for services.

Shifting some portion of these costs to the federal government could provide significant fiscal relief to states. While states continue to fill in the gaps in Medicare coverage for dual eligibles, they face greater difficulty during a recession maintaining coverage for the growing number of low-income families who, but for Medicaid, would join the growing ranks the nation's uninsured as they lose jobs, health coverage, and income.

The cost of shifting the financing of care for dual eligibles depends on what approach is adopted. Shifting only the cost of paying Medicare premiums would save states $3.7 billion in 2005 dollars. Including Medicare deductibles and co-insurance would reduce state spending by an additional $7.6 billion. Shifting all long-term care services for duals to the federal government would lower state spending by $33.5 billion. Adopting all of these options would have reduced state spending by $47 billion, a decline of roughly 41 percent in what states would have spent on their Medicaid programs, funds that, if desired, could be redirected to finance broader health reform efforts.

These estimates all assume there would be no "clawback" type provision as was required when Medicare began providing prescription drugs to duals in 2006. Such clawback financing would reduce the cost to the federal government, but it would also reduce fiscal relief to the states. However, if the goal is to improve care coordination and management of high-cost cases which contribute disproportionately to overall health spending growth, having one level of government responsible for all care for dual eligibles could help focus the attention of federal policy makers on the most efficient way to care for these populations.

This brief documents that dual eligibles account for a large share of Medicaid spending. Other research has shown that these same individuals account for more than 25 percent of total Medicare spending.[4] The return on investment from disease and chronic care management programs in this population is potentially great, though the evidence on programs implemented to date is currently inconclusive.[5] Moreover, thanks to the low-income subsidy program created to help low-income Medicare enrollees participate in the Medicare Part D drug benefit, the Medicare program now has new tools to identify enrollees who require the type of assistance Medicaid currently provides.

It could be argued that shifting these costs to the federal government and making this population a principal focus of Medicare policy – perhaps through a major package of new demonstration programs – could be an important component of efforts to slow the rate of growth in overall health care spending, while potentially improving outcomes and quality for dual eligibles. Additionally, shifting more of the costs of dual eligibles to the federal government would assure much greater uniformity in eligibility and service provision for our nation's poorest Medicare beneficiaries across the states.

Finding approaches to improving care coordination and payment structures for dual eligibles will be an essential component in efforts to strengthening both the Medicare and Medicaid programs in the years ahead. As noted above, these financing options could be an important component of broader health reform efforts that might involve relieving states of some elements of their current funding for Medicare enrollees' care in return for using some or all of their savings to strengthen and expand Medicaid coverage for low-income families and disabled individuals who are not eligible for Medicare.

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# Notes

[1] According to Medpac, "…current policy toward dual eligibles creates incentives to shift costs between payers, often hinders efforts to improve quality and coordinate care, and may reduce access to care." Medpac. "Report to the Congress: New Approaches in Medicare, Chapter 3", June 2004.

[2] For a detailed overview of dual eligible enrollment and spending in FFY 2005, see "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005," Kaiser Commission on Medicaid and the Uninsured, February 2009.

[3] See "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005" for more detail, including state-by-state estimates of dual eligible enrollment by eligibility group and age.

[4] Medpac. "A Data Book: Healthcare Spending and the Medicare Program." Section 3, June 2008.

[5] Congressional Budget Office. *Key Issues in Analyzing Major Health Insurance Proposals*, Chapter 7, pp. 141-142, December 2008.

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