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Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps

In 2000, over 7 million people were "dual eligibles", low-income people who are elderly or have disabilities and are covered by both Medicare and Medicaid. Dual eligibles have extensive health care needs, and rely on both programs to help pay for their care. Medicare pays for their basic health services, such as physician and hospital care, and Medicaid pays for Medicare premiums and cost-sharing and critical benefits that Medicare does not cover, such as long-term care services.

While Medicare is a federal program, Medicaid is financed jointly by the federal and state governments. As states continue to experience severe fiscal stress[1], the nation's governors have called on the federal government to take additional responsibility for more of the costs incurred by dual eligibles.[2] The new Medicare prescription drug law shifts coverage of prescription drugs for dual eligibles from Medicaid to Medicare in 2006, but leaves states responsible for financing most of the cost of prescription drug coverage for dual eligibles.

Dual eligibles account for 42 percent of Medicaid spending, although they comprise only 16 percent of Medicaid enrollees.[3] This large share of Medicaid spending reflects the extensive health care needs of dual eligibles. On average, health care costs of dual eligibles are double those of other Medicare beneficiaries and are over eight times higher than Medicaid spending per low-income child.[4]

Using demographic and expenditure data from the Medicare Current Beneficiary Survey (MCBS), this paper presents a profile of dual eligibles, describes their health care expenditures, and analyzes the distribution of spending on dual eligibles across public programs.

The findings from this study show that dual eligibles that have both Medicare and Medicaid are among the most vulnerable and highest cost beneficiaries in both programs. National data shows that dual eligibles have lower-incomes, are sicker, and have higher health care costs than other Medicare beneficiaries. Since Medicare does not provide many of the services that dual eligibles need, Medicaid fills in the gaps, thereby playing a significant role in financing care for dual eligibles. This analysis highlights the role that long-term care, predominantly care in nursing facilities, plays in Medicaid spending on dual eligibles.

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Methodology

Data for this study were derived from the MCBS Cost & Use file for 2000. The MCBS is a national survey of the Medicare population sponsored by the Centers for Medicare and Medicaid Services (CMS).

Dual eligibles were defined as persons with Medicare and Medicaid coverage during the calendar year. Medicare coverage is based on CMS administrative data indicators of Medicare enrollment. Medicaid coverage is based either on monthly indicators of "state buy-in" also from CMS administrative data (85% of dual eligibles), or on survey respondent report of Medicaid coverage. Survey respondent report of Medicaid coverage in the absence of an administrative data indicator was accepted as valid only when there was additional supporting evidence (e.g. payment by Medicaid for services; known gaps in state reporting of buy-in). The dual eligible population estimate of 7.2 million is based on these indicators and includes beneficiaries with full Medicaid coverage, including premium and cost-sharing assistance, prescription drugs, and long-term care, as well as those who receive more limited Medicaid benefits (e.g. Medicare premium and cost-sharing only).

The estimate of 7.2 million dual eligibles in calendar year 2000 from the MCBS Cost & Use File includes those continuously enrolled in Medicare for 12 months, and persons who were in the Medicare population for only part of the year due to new enrollment (attained age 65 during the year) or death. As a result, this estimate is higher than one based on the MCBS Access to Care File which includes only persons continuously enrolled in Medicare during the calendar year.

Expenditure estimates from the MCBS Cost & Use File made use of person-level summary data and type-of-service summary data. For community-resident individuals, these data are based on information from CMS administrative data for Medicare-covered services, and survey respondent reports for services paid all or in part (e.g. co-payments for Medicare-covered services) by Medicaid, private insurance or out-of-pocket. For Medicare-covered services (e.g. inpatient, physician, outpatient, SNF, some home health), expenditures reflect a blend of information from CMS administrative records and survey report. Expenditures for prescription medicines and dental services are based on respondent report.[5]

Nursing facility residents included both persons in nursing facility settings the entire calendar year (87% of all persons defined as nursing facility residents) and those in a nursing facility for less than the full year, but in a nursing facility for at least 3 months. Expenditure data for these individuals reflect information from CMS administrative data (for Medicare-covered services) and nursing facility payment records. The type-of-service expenditure summary data allow Medicare-covered services for persons in nursing facilities to be classified with those for community-resident individuals for purposes of examining the distribution of expenditures by Medicare and Medicaid payment source. Services to facility residents that are not covered by Medicare, such as facility room and board and prescription medicines,

cannot be disaggregated by service type in the MCBS. As a result, prescription drug payments by Medicaid for nursing facility residents are included with all other payments by Medicaid for nursing facility services. The estimates presented in all tables and figures are representative of the national population of dual eligibles (i.e. based on weighted data) and except where noted include both nursing facility and community residents. Significant testing for tables 1 and 2 and Figure 1 was conducted using SUDAAN to adjust for the complex sample design.

Findings

Who are dual eligibles?

In 2000, two-thirds of dual eligibles were age 65 or older and one-third were nonelderly adults with disabilities (Table 1).[6] Dual eligibles accounted for 18 percent of all Medicare beneficiaries and 16 percent of all Medicaid beneficiaries. Most dual eligibles had very low incomes -- 7 out of 10 had annual incomes below $10,000, compared to only 1 in 10 of other elderly, and 2 in 10 of other nonelderly, Medicare beneficiaries.

Among elderly dual eligibles the proportion that were female was much higher (72%) than among other elderly Medicare beneficiaries (57%). A higher percentage of dual eligibles also were black or Hispanic.

Almost one-quarter of elderly dual eligibles were in nursing facilities, in contrast to only 2 percent of other elderly Medicare beneficiaries. Elderly dual eligibles also were more likely to be in a nursing facility (26%) than were dual eligibles under age 65 (12%). Over half (55%) of dual eligibles age 85 or older were nursing facility residents (data not shown).

Dual eligibles that live in the community were more likely to be living alone, with children, or with others, and less likely to be living with a spouse, than other Medicare beneficiaries. Among elderly dual eligibles, 44 percent lived alone and 23 percent lived with children, compared to 29 percent and 8 percent respectively of other elderly Medicare beneficiaries. Among dual eligibles under age 65, 32 percent lived alone and 37 percent lived with others. Among other disabled Medicare beneficiaries in this age group, 18 percent lived alone and another 18 percent lived with others. Over half of other disabled Medicare beneficiaries lived with a spouse, compared to less than one quarter of dual eligibles.

Table 1: Characteristics of Dual Eligibles and Other Medicare Beneficiaries, by Age, 2000

	Dual Eligibles			Other Medicare Beneficiaries		
	Total 7.2 million	**Under 65 2.4 million**	**65+ 4.8 million**	**Total 33.3 million**	**Under 65 3.1 million**	**65+ 30.2 million**
	Row %					
% of Medicare beneficiaries	18%	6%	12%	82%	8%	74%
% of Medicaid beneficiaries	16%	5%	11%	N/A	N/A	N/A
Characteristics	Column %					
Income						
< $10,000	71%	74%	70%	13%	23%	12%
$10,001-$20,000	22%	19%	24%	32%	35%	32%
$20,001-$40,000	5%	5%	5%	35%	28%	36%
> $40,000	2%	2%	1%	20%	14%	20%
Gender						
Female	64%	48%	71%	55%	40%	57%
Male	36%	52%	29%	45%	60%	43%
Race						
White	58%	61%	56%	85%	74%	86%
Black	19%	21%	19%	7%	12%	6%
Hispanic	16%	14%	17%	5%	9%	5%
Other	7%	4%	8%	3%	5%	3%
Residence						
Nursing Facility	22%	13%	26%	2%	1%	2%
Community	78%	87%	74%	98%	99%	98%
Living Arrangement [a]						
With others	20%	37%	11%	6%	18%	4%
With children	20%	15%	23%	8%	8%	8%
With spouse	21%	16%	22%	57%	56%	58%
Alone	39%	32%	44%	29%	18%	30%

Notes: For all characteristics, differences between Dual Eligibles and Other Medicare Beneficiaries overall, and by age group, were significant at p<.01. In 2000, there were 44 million Medicaid beneficiaries and 40 million Medicare beneficiaries.

[a] Community Residents only.

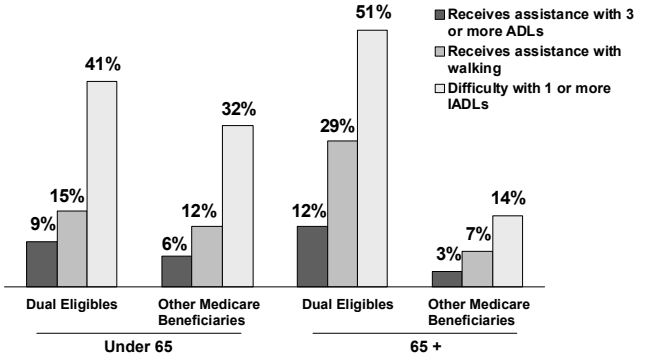
Source: KCMU estimates for percent of Medicaid beneficiaries who are dual eligibles are from CMS Medicaid Statistical Information System (MSIS) Statistical Report 2000; all other estimates are based on KCMU analysis of MCBS Cost & Use 2000.

Dual eligibles have substantial health needs. They were much more likely to rate their health as fair or poor (two-thirds did) than were other Medicare beneficiaries. Table 2 presents data on the prevalence of chronic conditions among dual eligibles and other Medicare beneficiaries. Elderly dual eligibles were more likely to have a chronic condition than other Medicare beneficiaries ages 65 or older. For example, among elderly dual eligibles 31 percent have heart disease and 16 percent had had a stroke, compared to 23 percent and 10 percent respectively of other elderly Medicare beneficiaries. All Medicare beneficiaries who are under age 65, both dual eligibles and others, must meet the disability criteria for coverage. As a result, dual eligibles under age 65 were more similar in health status to other Medicare beneficiaries under age 65 with one exception, 59 percent of the former had a mental or psychiatric disorder compared to 37 percent of the latter.

Dual eligibles also were more disabled than other Medicare beneficiaries (Figure 1). The percentage of dual eligibles with a severe Activity of Daily Living (ADL) disability – those receiving hands-on help or supervision from another person in 3 or more of 5 ADLs (bathing, dressing, transferring, eating, toileting) -- reached 12 percent among elderly dual eligibles, compared to only 3 percent of other Medicare beneficiaries in this age group. Twenty-nine percent of elderly dual eligibles were unable to walk without assistance, and 51 percent had difficulty in 1 or more of 4 Instrumental Activities of Daily Living (light housekeeping, meal preparation, shopping for personal items/groceries, managing bills). Although by definition, all Medicare beneficiaries under 65 have disabilities, dual eligibles in this age group also were more likely to receive ADL assistance or have difficulty with IADLs than other disabled Medicare beneficiaries in this age group.

Figure 1

ADLs, IADLs, and Walking Limitations Among Dual Eligibles and Other Medicare Beneficiaries, by Age



Note: ADLs= activities of daily living and IADLS = instrumental activities of daily living. Differences between Dual Eligibles and Other Medicare Beneficiaries in the same age group are significant at p≤ .01 except for receives asssistance with walking for Under 65.
Source: KCMU estimates based on analysis of MCBS Cost & Use, 2000

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Table 2: Health Status Among Dual Eligibles and Other Medicare Beneficiaries, by Age, 2000

	Dual Enrollees		Other Medicare Beneficiaries	
% with:	**Under 65**	**65+**	**Under 65**	**65+**
Fair/Poor Health Status[a]	63	46[b]	66	20
Hypertension	45[c]	63[b]	51	57
Heart Disease	16[b]	31[b]	24	23
Stroke	11	16[b]	13	10
Diabetes	20	25[b]	20	17
Arthritis	44[b]	60	55	58
Pulmonary Disease	23	18[b]	21	13
Mental Disorders	59[b]	12[b]	37	6
Alzheimer's Disease	--	8[b]	--	3

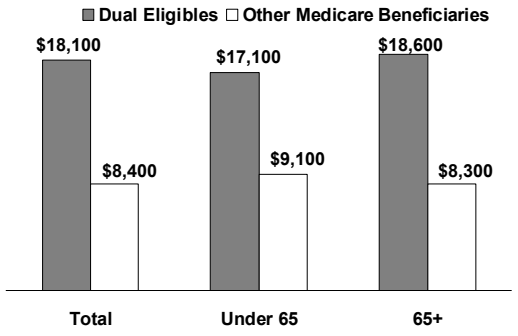
[a] Community residents only. [b] Difference between Dual Eligibles and Other Medicare Beneficiaries in the same age group is significant at p <. 01. [c] Difference between Dual Eligibles and Other Medicare Beneficiaries in the same age group is significant at p <. 05.-- cell size is < 75 cases.
Source: KCMU estimates based on analysis of MCBS Cost & Use, 2000.

What are the health care expenditures for dual eligibles?

Because of their extensive health care needs, dual eligibles require and use more services than others. On average, total health care spending on dual eligibles was more than double spending on other Medicare beneficiaries ($18,100 vs. $8,400) (Figure 2).

Figure 2

Average Per Capita Total Health Care Expenditures for Dual Eligibles and Other Medicare Beneficiaries



Includes expenditures for Medicare-covered services, Medicaid covered services, such as prescription drugs, dental, and nursing home care, and out-of-pocket costs.
Source: KCMU estimates based on analysis of MCBS Cost & Use, 2000

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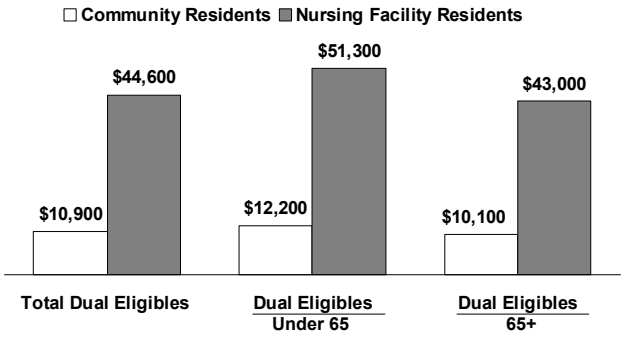
Individuals who reside in nursing facilities have substantially higher health-related expenditures than those who are community residents. Average annual health care expenditures for dual eligibles who were nursing facility residents was $44,600 – over four times as high as spending for dual eligibles in the community (Figure 3). Dual eligibles under the age of 65 had somewhat higher average expenditures than their elderly counterparts in community and nursing facility settings. Nursing facility care accounted for 41 percent of all health care spending on dual eligibles (Figure 4). Another 44 percent was for inpatient and physician/outpatient services. Prescription drug spending comprised 7 percent of expenditures, but this is an underestimate since prescription drug spending for nursing facility residents is bundled with other nursing facility care. Home health services, skilled nursing facility care, and other services accounted for the rest.

Figure 3

Average Per Capita Total Health Care Expenditures, for Dual Eligibles, by Age and Residence



Includes expenditures for Medicare-covered services, Medicaid covered services, such as prescription drugs, dental, and nursing home care, and out-of-pocket costs.
Source: KCMU estimates based on analysis of MCBS Cost & Use, 2000

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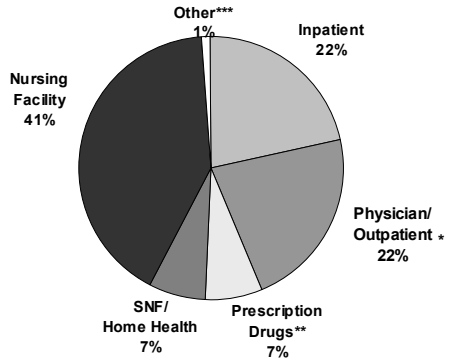
Figure 4

Distribution of Total Expenditures by Type of Service for Dual Eligibles



*Includes:outpatient facility, physician, and other medical providers ** Prescription drug expenditures for community-resident dual eligibles only; prescription drug expenditures for dual eligibles in nursing facilities are included in nursing facility expenditures.
*** includes: dental and hospice.
Source: KCMU estimates based on analysis of MCBS Cost & Use, 2000

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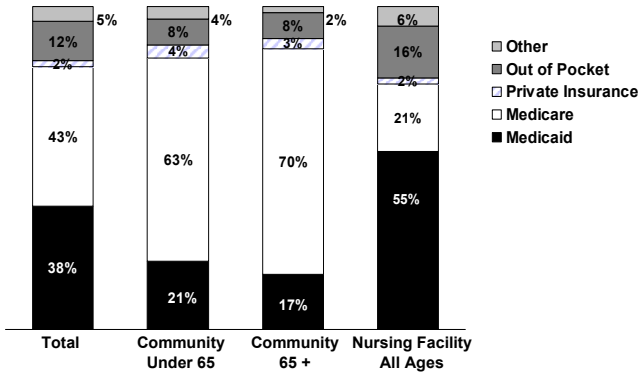
How is spending on duals distributed across public programs?

Of the $131 billion dollars spent on health care for dual eligibles in 2000, Medicaid covered 38 percent, nearly as much as the 43 percent covered by Medicare – with out-of-pocket comprising most of the remainder (12%). The services paid for by the two programs were very different however (Figure 5). Medicaid paid over half (55%) of all health care expenditures for dual eligibles who resided in nursing facilities (this includes prescription drugs). Medicare-covered services, including inpatient hospital care and physician services, accounted for 21 percent of expenditures for those in nursing homes. For dual eligibles in the community, Medicaid covered a smaller percentage --17% for elderly, and 21% for under age 65 dual eligibles -- of health care expenditures for services that included prescription drugs and home and community-based long-term care services. Among dual eligibles who were community residents, Medicare covered 70 percent of expenditures for elderly people and 63 percent for those under age 65.

Figure 5

Total Health Care Expenditures for Dual Eligibles by Source of Payment, by Age and Residence



Source: KCMU estimates based on analysis of MCBS Cost & Use, 2000

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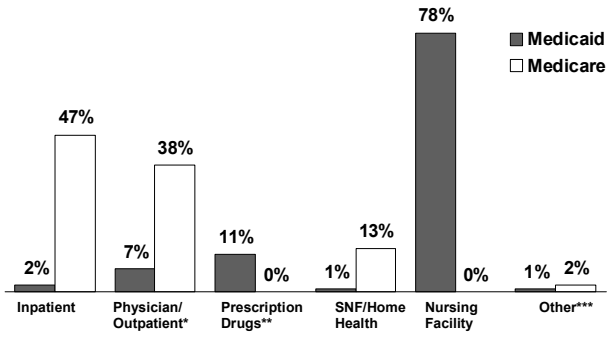
In 2000, almost four-fifths (78%) of Medicaid spending on dual eligibles was for care to persons in nursing facilities (Figure 6). By contrast, 85 percent of Medicare spending on dual eligibles was for inpatient and physician/outpatient care. Prescription drug spending for dual eligibles, residing in the community, accounted for 11 percent of Medicaid expenditures.

Figure 6

Distribution of Expenditures on Dual Eligibles, by Payment Source



*Includes:outpatient facility, physician, and other medical providers ** Prescription drug expenditures for community-resident dual eligibles only; prescription drug expenditures for dual eligibles in nursing facilities are included in nursing facility expenditures. *** includes: dental and hospice.

Source: KCMU estimates based on analysis of MCBS Cost & Use, 2000

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Conclusion

As important as Medicare is to the elderly and people with disabilities whom it covers, the program's premiums, cost-sharing and significant service gaps leave beneficiaries exposed to considerable health care costs. Medicaid helps relieve the financial burdens facing low-income Medicare beneficiaries in two ways. First, it pays their monthly Medicare Part B premium, which now amounts to $800 per year, and pays the cost-sharing charged for many Medicare services. Second, Medicaid covers a range of important benefits excluded from Medicare, notably prescription drugs, long-term care, dental and vision care, and other key services.

Medicaid's coverage helps assure that access to care for dual eligibles, who are sicker and poorer than other Medicare beneficiaries, is not jeopardized by Medicare's shortcomings. Compared to other Medicare beneficiaries, many dual eligibles experience higher rates of chronic diseases, including hypertension, heart disease, stroke, that require monitoring and medical treatment. Mental disorders and Alzheimer's disease, are also more prevalent among dual eligibles than other Medicare beneficiaries, and require appropriate care. Prescription drugs, physician and therapy services, are critical to the management of these conditions. In addition, the high prevalence of ADL and IADL limitations and mobility problems result in the need for services and supports that goes well beyond Medicare's medical model. Dual eligibles do not have the financial resources to obtain services that are not covered by Medicare.

Medicaid's broad benefit package, that spans medical and long-term care services, is an indispensable adjunct to Medicare for dual eligibles.

This analysis spotlights the large role that long-term care, predominately nursing facilities, plays in expenditures on dual eligibles. With the cost of nursing facility care reaching almost $60,000 a year,[7] many Medicare beneficiaries, who need long-term care, quickly exhaust their resources and become eligible for Medicaid. Per capita spending for dual eligibles in nursing facilities averages $44,600, or about four times greater than spending for dual eligibles in the community ($10,900) or for other Medicare beneficiaries ($8,400). Because Medicare does not cover long-term care, the higher costs for the institutionalized fall heavily on the Medicaid program and account for nearly 4 out of 5 dollars that Medicaid spends on dual eligibles.

Developing alternatives to institutional care remains an important public policy priority because home and community-based care is less expensive and is the strong preference of people who need long-term services and supports. Medicare coverage of home care is restricted to post-acute care, while Medicaid covers a broad range of long-term home and community-based alternatives. Although states have increased the availability of home and community-based services in their Medicaid programs rapidly over the last 10 years, the majority of Medicaid long-term care spending is still for institutional care. Fiscal constraints at the state level, and budget-neutrality limits on home and community-based waivers imposed at the federal level, combine to thwart more rapid progress.

The high cost of health care and pressures on state budgets presents challenges for Medicaid that pose special risks for dual eligibles. Many states are now in their fourth year of fiscal stress as the dramatic fall in state tax revenues has created budget shortfalls totaling nearly $70 billion for FY 2004.[8] As the second largest item in state budgets after education, Medicaid has been a target for cost control efforts in all states.[9] While the majority of Medicaid enrollees are children and their parents, dual eligibles account for 42% of Medicaid spending and are unlikely to escape state action to curb Medicaid spending growth. These cost-control efforts may compromise Medicaid's role as a supplement to Medicare for low-income Medicare beneficiaries, and source of health insurance coverage for low-income families.

State policymakers have long maintained that it is inappropriate to rely on jointly financed Medicaid programs to fill gaps in the federal Medicare program. The recently enacted Medicare prescription drug law shifts coverage of prescription drugs for dual eligibles from Medicaid to Medicare, but requires states to continue to pay for much of the prescription drug costs for dual eligibles through "clawback" payments to the federal government. This requirement offsets much of the Medicaid fiscal relief that state policymakers had long expected would accompany the adoption of a prescription drug benefit in Medicare.[10]

The new law raises a number of questions regarding how dual eligibles will fare.[11] As of January 1, 2006, dual eligibles will be expected to obtain their prescription

drug coverage through Medicare under the new "Part D" of the program; Medicaid will no longer provide drug coverage for this population. How dual eligibles, particularly those who reside in nursing facilities, will transition from Medicaid coverage of prescription drugs to a new Part D plan is a key issue that is yet to be resolved.[12] It is also not clear how the coverage under the Part D plans will compare to coverage that dual eligibles currently have under Medicaid, since the new Medicare law does not guarantee equivalent prescription drug coverage for dual eligibles. If dual eligibles do not enroll in a Part D plan or if they need more drug coverage than is provided, states will not be able to secure federal Medicaid matching funds for the cost of providing additional prescription drug benefits.

The tension between the federal and state government over fiscal and social responsibility for dual eligibles is likely to grow as the population ages and fiscal pressure continues to haunt government budgets. At the nexus of this ongoing debate are millions of low-income elderly and people with disabilities who have significant health and long-term care needs and are highly dependent on coverage through Medicare and Medicaid. Given the health needs of dual eligibles, it will be important to assure adequate safeguards are in place to protect access to prescription drugs for the this population as the new Medicare law is implemented and to assure that their needs do not fall through the cracks as other options for Medicaid reform are considered.

This issue brief was prepared by Judy Kasper, Johns Hopkins University, and Risa Elias and Barbara Lyons, Kaiser Commission on Medicaid and the Uninsured.

Endnotes

[1] V. Smith et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50-State Survey* (Washington DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
[2] J. Guyer, *A Prescription Drug Benefit in Medicare: Implications for Medicaid and Low-Income Medicare Beneficiaries* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
[3] J. Guyer, *A Prescription Drug Benefit in Medicare: Implications for Medicaid and Low-Income Medicare Beneficiaries* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
[4] Kaiser Commission on Medicaid and the Uninsured estimates based on MCBS Cost & Use, 2000 and CMS and March 2003 CBO data.
[5] Estimates based on the MCBS differ from estimates based on MSIS and Medicaid Financial Management Reports.
[6] A small percentage of dual eligibles were under age 18, but are not represented in the MCBS.
[7] AARP, The Policy Book: AARP Public Policies 2001, June 2001.
[8] Rockefeller Institute of Government for the Kaiser Commission on Medicaid and the Uninsured.
[9] V. Smith et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50-State Survey* (Washington DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
[10] J. Guyer, *A Prescription Drug Benefit in Medicare: Implications for Medicaid and Low-Income Medicare Beneficiaries* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
[11] V. Smith et al., *Coordinating Medicaid and Medicare Prescription Drug Coverage: Findings from a Focus Group Discussion with Medicaid Directors* (Washington DC: Kaiser Commission on Medicaid and the Uninsured, 2003).
[12] A. Schneider, *Dual Eligibles in Nursing Facilities and Medicare Drug Coverage* (Washington DC: Kaiser Commission on Medicaid and the Uninsured, 2003).

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