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Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government

by Brian Bruen and John Holahan

Introduction

More than 7 million older Americans and younger persons with disabilities participate in both Medicare and Medicaid. Often referred to as "dual eligibles," these individuals account for a small share of total Medicaid enrollment but more than 40 percent of Medicaid expenditures for medical services. The high per capita costs of dual eligibles have made these individuals a center of attention for states given their current fiscal problems.

Medicaid plays different roles for different types of dual eligibles. Most dual eligibles qualify for full Medicaid benefits. For these individuals, Medicaid helps to fill in some of the gaps in Medicare coverage by paying for services that are not part of the standard Medicare benefit package, such as prescription drugs and most long-term services. These individuals account for most of the costs to Medicaid for dual eligibles. For other dual eligibles that do not qualify for full Medicaid benefits, Medicaid helps to make Medicare more affordable by providing assistance with Medicare premiums, deductibles and other coinsurance requirements. Whether they qualify for full benefits or more limited assistance, most dual eligibles are very low-income individuals with significant health care needs.

Coverage for dual eligibles is a difficult issue for states and the federal government. States, which are facing revenue shortfalls and rapidly escalating Medicaid outlays, want the federal government to absorb more of the expense of covering these individuals. Members of the National Governors' Association's (NGA) 2003 task force on Medicaid reform agreed unanimously that dual eligibles should be a federal responsibility (Kempthorne et al., 2003; Patton et al., 2003). The federal government, which is responsible for most of the costs of Medicare and is also facing record budget deficits, has been unwilling to take on this expense.

One of the key issues to be resolved by federal legislators trying to reach an agreement on Medicare prescription drug coverage is whether to allow Medicaid enrollees to participate.[1] The debate over who should pay for health care for dual eligibles is likely to continue regardless of the outcome. Aging baby boomers are projected to push the number of adults age 50 and over from under 82 million in 2003 to almost 108 million by 2015 (U.S. Census Bureau, 2000).

[1] The Senate bill, S. 1, requires Medicaid to bear full responsibility for prescription drug coverage for dual eligibles that qualify for full Medicaid benefits. The House bill, H.R. 1, includes these individuals in the Medicare prescription drug benefit, allowing states to shift some of their prescription drug costs for dual eligibles to the federal government. However, H.R. 1 reduces federal Medicaid payments to states over the next several years, offsetting some of the fiscal relief that states would receive. A side-by-side of both bills, prepared by Health Policy Alternatives for the Kaiser Family Foundation, is at http://www.kff.org.

As they age, this population will be more likely to become disabled and/or develop chronic health problems, subsequently increasing demand for medical care. Individuals in Medicare with low incomes or high out-of-pocket medical expenditures are likely to turn to Medicaid to help pay for their care, and thus continue to put significant upward pressure on Medicaid spending.

To provide perspective for the debate, this analysis uses Medicaid administrative data to 1) estimate the share of current Medicaid enrollment and spending attributable to dual eligibles and 2) illustrate the fiscal effects of hypothetical reforms where the federal government takes up some or all of 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). 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 separate 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) 2000, but, as has been widely reported, Medicaid enrollment and expenditures increased considerably between 2000 and 2002.[3] To address this issue, we calculated enrollment and spending using the FFY 2000 MSIS data and then projected the results forward to FFY 2002 levels. For enrollment, we based our growth factors on the Congressional Budget Office's (CBO) estimates of Medicaid enrollment in FFY 2002. For expenditures, we first estimated spending per enrollee in FFY 2000 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 2002) 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 2002. We then use these spending per enrollee estimates to project expenditures for each enrollment group and category of service in FFY 2002.

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]

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[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 2000 and 2002, and the factors influencing these trends, see John Holahan and Brian Bruen, *Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002*, The Kaiser Commission on Medicaid and the Uninsured, September 2003, Publication #4139, available at www.kff.org.

[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

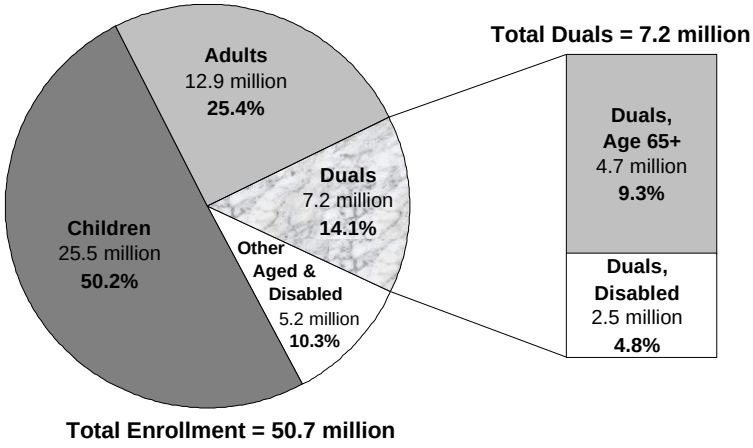
Most dual eligibles are very low-income individuals: 77 percent of dual eligibles have annual incomes under $10,000, compared to 18 percent of all other Medicare beneficiaries. Many also have significant health care needs: Nearly one-quarter of dual eligibles are in nursing facilities, compared to three percent of other Medicare beneficiaries. Over half 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 12% 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 7.2 million Medicare beneficiaries also enrolled in Medicaid in 2002, either to receive assistance with Medicare premiums and cost sharing or to obtain full Medicaid benefits. Dual eligibles were a relatively small share of all Medicaid enrollees, accounting for about 14 percent of all Medicaid enrollees in 2002 (Figure 1). About two-thirds of dual eligibles (4.7 million) were individuals age 65 and older, and one-third (2.5 million) were younger persons with disabilities. Even among aged and disabled enrollees, dual eligibles are a relatively slim majority (58 percent). However, rates of dual eligibility within these two populations are very different. More than 90 percent of Medicaid enrollees ages 65 and older are dual eligibles; a much smaller share (34 percent) of younger persons with disabilities are dual eligibles.

Figure 1

Medicaid Enrollment, FFY 2002



Source: Urban Institute estimates based on data from MSIS

Most dual eligibles qualify to receive full Medicaid benefits. In a previous analysis for the Kaiser Commission on Medicaid and the Uninsured, we estimated that, nationwide, 85 percent of dual eligibles qualified for full Medicaid benefits in 2000 (Guyer, 2003). Assuming that this percentage remained the same, more than 6.1 million dual eligibles qualified for full Medicaid benefits in 2002. The remaining dual eligibles would have received assistance with Medicare's out-of-pocket costs, but they would not have been eligible for non-Medicare-covered services such as prescribed drugs and long-term care. Table 2 shows our estimated numbers of dual eligibles and "full" dual eligibles for all 50 states and the District of Columbia in 2002.

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some other services. Both Part A and Part B require participants to pay premiums, deductibles and coinsurance for services they receive.

[5] Kaiser Commission on Medicaid and the Uninsured analysis of MCBS Cost and Use File, 2000.

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)	"Wrap around" Medicaid benefits including long-term care and prescription drugs. 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]	"Wrap around" Medicaid benefits including long-term care and prescription drugs. 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)	"Wrap around" Medicaid benefits including long-term care and prescription drugs. 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.		"Wrap around" Medicaid benefits including long-term care and prescription drugs. Medicaid may also pay Medicare premiums and cost sharing, depending on income.
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.
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 incomes up to 200% of the FPL.*	$4,000 (individual) $6,000 (couple)	No Medicaid benefits. Medicaid pays Medicare Part A premium.
Qualifying Individuals [e] (QI) (optional)	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) is $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 much higher. However, very 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 or resources that are too high to qualify under SSI or Poverty-Related levels. Unless their income or resources fall below their state's medically needy standards for their family size, these individuals must incur sufficient medical expenses to reduce their income or resources below those standards. Most states use medically needy income limits that are below SSI eligibility levels.

d) In 2003, 300% of SSI is $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) 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, 2002

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	7,200,000	14%	58%	6,126,000	85%
Alabama	162,000	22%	59%	121,000	75%
Alaska	9,000	7%	53%	9,000	98%
Arizona	65,000	8%	49%	57,000	87%
Arkansas	121,000	21%	75%	98,000	81%
California	932,000	10%	58%	904,000	97%
Colorado	71,000	16%	61%	59,000	84%
Connecticut	83,000	17%	71%	76,000	92%
Delaware	15,000	10%	55%	9,000	64%
District of Columbia	19,000	11%	44%	17,000	90%
Florida	406,000	16%	56%	354,000	87%
Georgia	180,000	13%	51%	129,000	72%
Hawaii	27,000	11%	63%	26,000	96%
Idaho	12,000	7%	33%	10,000	80%
Illinois	221,000	11%	51%	171,000	77%
Indiana	125,000	14%	65%	103,000	83%
Iowa	67,000	19%	66%	55,000	82%
Kansas	46,000	15%	55%	39,000	85%
Kentucky	209,000	25%	73%	172,000	82%
Louisiana	142,000	15%	50%	109,000	77%
Maine	49,000	21%	64%	42,000	85%
Maryland	92,000	11%	51%	71,000	78%
Massachusetts	216,000	17%	61%	193,000	89%
Michigan	216,000	14%	54%	190,000	88%
Minnesota	103,000	15%	67%	92,000	90%
Mississippi	136,000	20%	58%	133,000	98%
Missouri	161,000	14%	64%	138,000	86%
Montana	16,000	14%	56%	15,000	93%
Nebraska	37,000	14%	68%	35,000	93%
Nevada	29,000	16%	60%	18,000	63%
New Hampshire	20,000	16%	72%	19,000	93%
New Jersey	171,000	18%	59%	140,000	82%
New Mexico	39,000	8%	52%	27,000	69%
New York	605,000	16%	54%	537,000	89%
North Carolina	272,000	19%	66%	225,000	83%
North Dakota	15,000	21%	75%	13,000	86%
Ohio	219,000	13%	51%	179,000	82%
Oklahoma	94,000	14%	65%	77,000	82%
Oregon	68,000	10%	63%	56,000	82%
Pennsylvania	335,000	18%	54%	306,000	91%
Rhode Island	33,000	16%	59%	27,000	82%
South Carolina	120,000	13%	58%	117,000	97%
South Dakota	18,000	16%	65%	14,000	78%
Tennessee	248,000	14%	56%	191,000	77%
Texas	489,000	16%	66%	363,000	74%
Utah	19,000	8%	49%	17,000	89%
Vermont	28,000	17%	73%	22,000	77%
Virginia	149,000	19%	62%	101,000	68%
Washington	107,000	10%	53%	93,000	87%
West Virginia	51,000	13%	41%	36,000	72%
Wisconsin	123,000	17%	60%	115,000	93%
Wyoming	9,000	14%	62%	6,000	72%

Source: Urban Institute estimates based on data from MSIS.

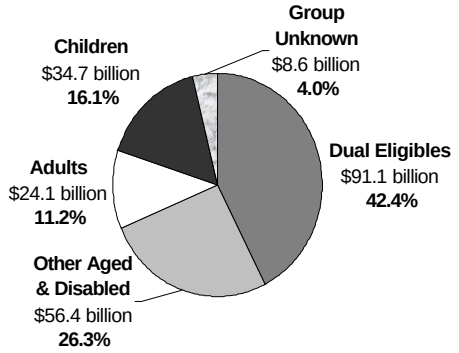
* The percentages of full duals as a share of all duals are based on unrounded estimates of dual eligibles and "full" dual eligibles, and may differ somewhat from calculations that use the rounded estimates shown in this table.

How Much Does Medicaid Spend on Services for Dual Eligibles?

Although less than 15 percent of Medicaid enrollees were dual eligibles in 2002, they accounted for a significant share of Medicaid expenditures. By our estimates, forty-two (42) percent of Medicaid's expenditures for medical services in FFY 2002 were attributable to dual eligibles (Figure 2). The vast majority of these expenditures were for dual eligibles that also qualified for full Medicaid benefits (not shown).

Figure 2

Medicaid Expenditures by Group, Services Only FFY 2002



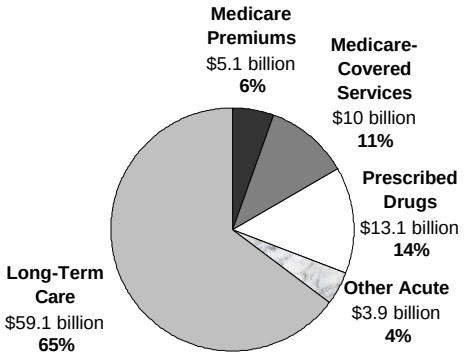
Total Expenditures = $214.9 billion

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

Aggregating expenditures into broad service categories, we find that most of the expenditures for dual eligibles are for long-term care services, such as nursing homes and home and community-based waiver programs (Figure 3).[6] The second largest category of expenditures was outpatient prescribed drugs. This pattern is exactly what one should expect to see. When Medicare and Medicaid both cover a service, Medicare is the primary payer and Medicaid can pick up dual eligibles' out-of-pocket costs. Medicare rarely pays for long-term care services or outpatient prescribed drugs, so Medicaid must pay the full cost for dual eligibles—and then, only for those that qualify for full Medicaid benefits. There is considerable overlap between Medicare and Medicaid in coverage of acute care services, which is reflected in the relatively low Medicaid expenditures for acute care services for dual eligibles, with the exception of drugs.

Figure 3

Expenditure for Dual Eligibles, FFY 2002



Total Expenditures = $91.1 Billion

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

Tables 3 and 4 provide data on expenditures for dual eligibles for all 50 states and the District of Columbia. Note that for these tables, we combine Medicare premiums and spending for acute care services that may be covered by Medicare in whole or in part to approximate the cost to states from Medicare premiums and cost sharing requirements.

[6] Definitions of the service categories shown in Figure 3 are provided in the Technical Appendix.

Table 3

Medicaid Expenditures for Dual Eligibles by State, 2002

State	Total	Expenditures (in Millions)				Spending Per Dual Eligible
		Premiums & Medicare Acute*	Prescribed Drugs	Other Acute Care	Long-Term Care	
United States	$91,056	$15,119	$13,177	$3,929	$58,831	$12,647
Alabama	$1,349	$214	$193	$10	$933	$8,312
Alaska	$144	$29	$24	$8	$83	$15,366
Arizona	$765	$157	$91	$61	$456	$11,693
Arkansas	$1,010	$285	$151	$45	$528	$8,316
California	$8,290	$1,952	$1,652	$536	$4,150	$8,891
Colorado	$1,014	$115	$137	$72	$690	$14,306
Connecticut	$2,252	$148	$201	$74	$1,829	$27,000
Delaware	$236	$32	$24	$9	$172	$16,061
District of Columbia	$287	$48	$29	$17	$194	$15,276
Florida	$3,933	$761	$937	$99	$2,135	$9,694
Georgia	$1,622	$342	$298	$23	$959	$9,027
Hawaii	$250	$68	$32	$9	$141	$9,340
Idaho	$163	$31	$28	$17	$88	$13,318
Illinois	$2,976	$324	$423	$114	$2,116	$13,466
Indiana	$1,828	$275	$301	$65	$1,187	$14,671
Iowa	$911	$96	$124	$28	$663	$13,615
Kansas	$792	$63	$109	$7	$613	$17,271
Kentucky	$1,961	$544	$418	$89	$910	$9,388
Louisiana	$1,300	$226	$252	$39	$783	$9,176
Maine	$645	$73	$106	$108	$357	$13,116
Maryland	$1,368	$255	$182	$27	$904	$14,940
Massachusetts	$3,638	$440	$408	$305	$2,485	$16,818
Michigan	$1,891	$239	$358	$65	$1,228	$8,739
Minnesota	$2,194	$215	$232	$64	$1,684	$21,236
Mississippi	$1,092	$230	$258	$54	$550	$8,031
Missouri	$1,983	$285	$408	$100	$1,190	$12,345
Montana	$207	$27	$33	$11	$136	$12,880
Nebraska	$533	$62	$82	$13	$376	$14,241
Nevada	$208	$49	$33	$7	$119	$7,232
New Hampshire	$455	$62	$52	$6	$335	$22,500
New Jersey	$2,684	$360	$381	$105	$1,838	$15,703
New Mexico	$405	$71	$47	$34	$253	$10,411
New York	$15,217	$2,414	$1,200	$447	$11,157	$25,137
North Carolina	$2,824	$473	$527	$156	$1,667	$10,366
North Dakota	$272	$15	$28	$7	$222	$18,136
Ohio	$4,401	$615	$496	$119	$3,172	$20,111
Oklahoma	$869	$157	$123	$15	$575	$9,250
Oregon	$766	$115	$156	$84	$411	$11,227
Pennsylvania	$3,339	$559	$554	$187	$2,038	$9,954
Rhode Island	$715	$157	$63	$7	$488	$21,837
South Carolina	$1,199	$357	$192	$40	$610	$9,998
South Dakota	$240	$31	$29	$3	$177	$13,617
Tennessee	$2,058	$359	$197	$169	$1,332	$8,310
Texas	$4,956	$1,060	$654	$49	$3,193	$10,127
Utah	$263	$27	$52	$20	$164	$13,882
Vermont	$248	$28	$58	$13	$149	$8,782
Virginia	$1,450	$227	$243	$207	$774	$9,757
Washington	$1,007	$176	$239	$51	$541	$9,423
West Virginia	$634	$94	$77	$10	$453	$12,509
Wisconsin	$2,082	$168	$274	$118	$1,522	$16,884
Wyoming	$128	$13	$15	$1	$99	$14,982

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 4

Medicaid Expenditures for Dual Eligibles by State, 2002

	Percent of Total			
State	Premiums & Medicare Acute*	Prescribed Drugs	Other Acute Care	Long-Term Care
United States	17%	14%	4%	65%
Alabama	16%	14%	1%	69%
Alaska	20%	17%	6%	58%
Arizona	20%	12%	8%	60%
Arkansas	28%	15%	4%	52%
California	24%	20%	6%	50%
Colorado	11%	14%	7%	68%
Connecticut	7%	9%	3%	81%
Delaware	13%	10%	4%	73%
District of Columbia	17%	10%	6%	67%
Florida	19%	24%	3%	54%
Georgia	21%	18%	1%	59%
Hawaii	27%	13%	4%	56%
Idaho	19%	17%	10%	54%
Illinois	11%	14%	4%	71%
Indiana	15%	16%	4%	65%
Iowa	11%	14%	3%	73%
Kansas	8%	14%	1%	77%
Kentucky	28%	21%	5%	46%
Louisiana	17%	19%	3%	60%
Maine	11%	16%	17%	55%
Maryland	19%	13%	2%	66%
Massachusetts	12%	11%	8%	68%
Michigan	13%	19%	3%	65%
Minnesota	10%	11%	3%	77%
Mississippi	21%	24%	5%	50%
Missouri	14%	21%	5%	60%
Montana	13%	16%	6%	66%
Nebraska	12%	15%	2%	70%
Nevada	24%	16%	3%	57%
New Hampshire	14%	11%	1%	74%
New Jersey	13%	14%	4%	68%
New Mexico	18%	12%	8%	63%
New York	16%	8%	3%	73%
North Carolina	17%	19%	6%	59%
North Dakota	5%	10%	2%	82%
Ohio	14%	11%	3%	72%
Oklahoma	18%	14%	2%	66%
Oregon	15%	20%	11%	54%
Pennsylvania	17%	17%	6%	61%
Rhode Island	22%	9%	1%	68%
South Carolina	30%	16%	3%	51%
South Dakota	13%	12%	1%	74%
Tennessee	17%	10%	8%	65%
Texas	21%	13%	1%	64%
Utah	10%	20%	7%	62%
Vermont	11%	23%	5%	60%
Virginia	16%	17%	14%	53%
Washington	17%	24%	5%	54%
West Virginia	15%	12%	2%	71%
Wisconsin	8%	13%	6%	73%
Wyoming	10%	12%	1%	77%

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.

Simulations of Medicaid Reform Options Involving Dual Eligibles

Overview

Proposals that shift some or all of the costs of dual eligibles from states to the federal government will likely arise in future Medicaid reform debates. To illustrate the potential fiscal effects of such proposals, we modeled several hypothetical reforms. All of the Medicaid reform options that we simulate "federalize" a portion of the program for dual eligibles—that is, we assume that the federal government would pay the full cost of coverage for services for dual eligibles that it currently shares with states under Medicaid.

The first option that we consider is one where the federal government no longer requires Medicaid to pay Medicare premiums (either Part A or Part B) for dual eligibles.[7] Note that this option affects Medicare *premiums* only—states would continue to be responsible for Medicare deductibles and coinsurance for full dual eligibles and QMBs. In our second option, the federal government takes over services for dual eligibles for which Medicare may already provide full or partial coverage. This option provides the closest estimate of Medicaid's payments for Medicare deductibles and coinsurance.[8] We combine these two options in Tables 3 and 4 to approximate Medicaid's total expenditures for Medicare premiums and Medicare-covered services.

Our remaining options expand federal coverage into services that the current Medicare program generally does not offer. One option is where the federal government takes up states' current prescription drug expenditures for dual eligibles. In another, the federal government picks up coverage for acute care services that currently are covered by Medicaid but not by Medicare. In a third, the federal government pays for long-term care services for dual eligibles. Lastly, we examine the costs if the federal government was to take on the full cost of Medicaid's current coverage for dual eligibles, including all medical services, premiums, deductibles and coinsurance.[9]

In all of our simulations, we assume that current state expenditures for dual eligibles in Medicaid shift to the federal government. For example, suppose a state spends a total of $100 million for physicians' services for dual eligibles in its Medicaid program and has a 50 percent Federal Medical Assistance Percentage (FMAP). The state pays half of the total cost of these services, or $50 million, and the federal government provides the other $50 million. If the federal government took on the full cost of physicians' services, then federal spending would increase from $50 million to $100 million, and the state would save $50 million.

The assumption that expenditures will shift from states to the federal government but remain at current levels is a simplifying assumption. Federal law allows states to determine, within federal limits, which services to provide in their Medicaid programs (although several services are mandatory) and how much to pay providers. As a result, states' Medicaid benefit packages and provider payment rates vary considerably. If the federal government were to offer coverage to dual eligibles under a nationwide program, such a program might be very different from the existing Medicaid program. Therefore, the results of this analysis are best used to compare the relative fiscal effects of our reform options and to evaluate potential savings to states. Costs to the federal government are more likely to differ from these estimates.

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[7] More complete descriptions of the service categories are provided in the Technical Appendix.

[8] Because our source data do not allow us to precisely separate Medicare deductibles and cost sharing reported in some service categories from other spending in that same category for services that Medicare would not pay for at all, this option likely overstates actual cost sharing amounts.

[9] Any policy change for dual eligibles would likely apply to enrollees in both fee-for-service and managed care settings. Therefore, we distributed payments to HMOs to the various Medicaid services. For more information on the methodology, see the Technical Appendix.

Comparing the Reform Options

Effects at the National Level

Table 5 shows the fiscal effects of each of each of our hypothetical reform options in terms of the amount of money shifted from states to the federal government and the resulting percentage decreases in states' Medicaid expenditures for medical services for dual eligibles and all Medicaid beneficiaries. Because we make the simplifying assumption that the federal government takes on states' current levels of spending, the dollar amount shifted to the federal government is the estimated state share of Medicaid spending in 2002 for those services that is attributable to dual eligibles. The percentage decrease in state spending for dual eligibles reflects the shares of current spending for dual eligibles accounted for by the affected services. The percentage decrease in state spending for all Medicaid beneficiaries, shown in the last column, reflects the level of spending for dual eligibles relative to other enrollees.

Table 5

Fiscal Effects of Hypothetical Medicaid Reform Options in FFY 2002 Dollars

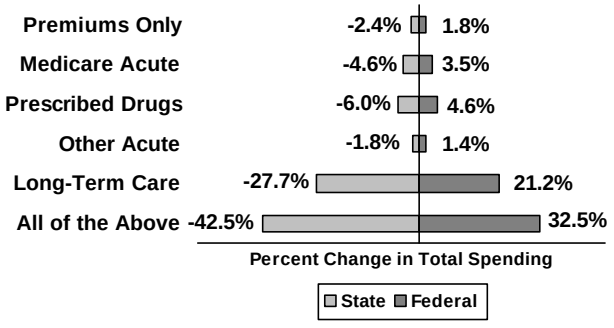
Option	Dollar Amount Shifted to Federal Government (in billions)	Percentage Decrease in State Spending For… Dual Eligibles	Percentage Decrease in State Spending For… All Medicaid Enrollees
Medicare premiums	$2.2	(5.5%)	(2.4%)
Medicare-covered services*	$4.3	(10.8%)	(4.6%)
Prescribed drugs	$5.6	(14.2%)	(6.0%)
Other acute care services	$1.7	(4.3%)	(1.8%)
Long-term care	$25.8	(65.1%)	(27.7%)
All of the above	$39.6	(100.0%)	(42.5%)

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.

Figure 4

Percentage Changes in Federal and State Spending Under Each Option



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

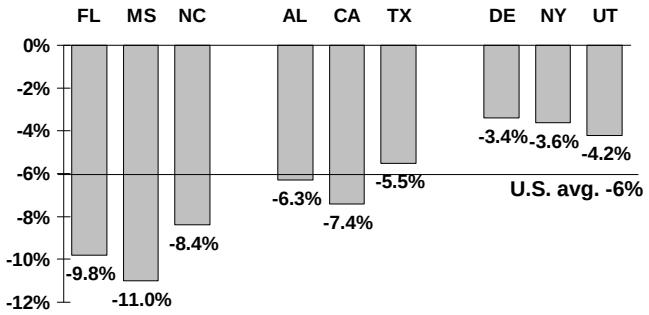
Figure 4 presents our results from a somewhat different perspective, showing the percentage changes in federal and states' expenditures (again, for medical services only) for each reform option. Comparing the relative lengths of the bars on opposing sides of the central axis, one can see that the federal percentage increase for each option is always smaller than state percentage decrease. This pattern reflects the fact that, on average, the federal government is responsible for a greater share of total Medicaid spending (roughly 57 percent) than states (43 percent). Figure 4 also highlights the importance of Medicaid's long-term care and prescription drug benefits for dual eligibles.

State-Level Effects

Focusing on national data alone ignores the reality that Medicaid programs differ from state to state, and therefore the fiscal effects of our hypothetical reforms would also vary by state. To illustrate the factors behind this variance, Figure 5 presents selected state-level results from a hypothetical reform where the federal government takes up all of the states' current spending for prescribed drugs for dual eligibles. Specifically, the graphic shows the percentage change in states' Medicaid expenditures resulting from this reform. The average decline in state spending is 6 percent. In the selected states, the fiscal relief to states varies from around 3 or 4 percent of total state Medicaid spending up to 10 percent or more.[10]

Figure 5

Percentage Change in State Medicaid Spending if Prescription Drug Spending for Duals is Federalized



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

Why is there so much variation in savings among states? For any of our reforms, the relative level of fiscal relief for each state—and the additional cost to the federal government—depends on several factors. One factor is the number of dual eligibles in the state relative to other types of Medicaid enrollees. As shown in Table 2, dual eligibles account for relatively large shares of all enrollees in North Carolina and Mississippi, an average share in Texas, and relatively low shares in Delaware and Utah. These results correspond with the relative levels of fiscal relief observed for these states in Figure 5. But other states in this example complicate matters: Florida gets a high level of fiscal relief but has an average percentage of duals. Alabama and California fall close to the average level of fiscal relief, but have very high (AL) and very low (CA) percentages of duals, respectively. New York gets a below average level of fiscal relief, but has an average share of duals. Clearly, more than one factor affects the level of savings for a particular state.

A second factor, closely related to the first but not quite the same, is the share of dual eligibles in the state that receive full Medicaid benefits. While Alabama has a large number of dual eligibles, MSIS data suggest that roughly a quarter of these individuals do not qualify for full Medicaid benefits and are eligible only for the more limited Medicare Savings Programs outlined in Table 1. The low percentage of dual eligibles that qualify for prescription drug coverage explains why Alabama achieves an average level of savings from the prescription drug reform despite having above-average numbers of dual eligibles.

The share of dual eligibles that receive full Medicaid benefits is a separate factor from the number of dual eligibles relative to other Medicaid enrollees because these factors may reflect different characteristics of each state. For example, a state may have a large number of dual eligibles for demographic reasons, such as a large population over age 65 with incomes under 125 percent of poverty. However, the share of those individuals who qualify for full Medicaid benefits depends on the state's Medicaid eligibility standards—for example, whether the state has expanded coverage to all individuals age 65 and older and younger persons with

[10] Note that these results are not based on current Medicare drug benefit legislation and are not intended to model changes that would occur under these bills. The only intent is to illustrate the varying degrees to which prescription drug reforms for dual eligibles could affect state Medicaid spending.

disabilities with incomes under 100 percent of poverty, or only covers persons below SSI income levels (about 74 percent of poverty for an individual).

A third factor is how much each state spends for the service that the federal government takes on, relative to the state's expenditures for other Medicaid services. Florida and California spend relatively low amounts for long-term care services—not just for dual eligibles, but other enrollees as well. As a result, prescription drugs account for a larger share of total expenditures in these states, and both Florida and California achieve greater percentage savings when drug expenditures are shifted to the federal government. On the other hand, New York spends a much larger amount on long-term care than the average state and therefore realizes lower percentage savings when drug spending shifts to the federal government. The share of spending for any given service is affected by a number of other features, including the state's benefit package, payment rates, and service utilization patterns.

The last set of state-specific results that we present are estimates of state savings from two of the reform options described earlier and a third option that is the combination of two of the earlier reforms. These results appear in Table 6. The first column of data in the table shows estimated state savings if the federal government were to take up spending for Medicare premiums and also acute care spending for services that may already be covered by Medicare in whole or part. This is a combination of two of the reform options shown earlier. We present them together here because, as noted in the discussion of Tables 3 and 4, this is the closest approximation of the current amount that states pay for Medicare premiums and cost sharing. The other columns show results if the federal government were to take up prescription drug expenditures only or long-term care expenditures only. The results emphasize the magnitude and variation in fiscal relief to states under these different scenarios.

The Influence of the FMAP

For any of our hypothetical reforms, the savings to any single state is the amount that state spends for those services that are shifted to the federal government. As discussed in the last section, the amount of savings as a share of current state spending will vary depending on the relative size of the dual eligible population and the level of spending for those services relative to other Medicaid services. The story is more complicated at the federal level, where the change in federal expenditures going to each state also depends in part on the state's FMAP.

State FMAPs range from 50 percent (the legislated minimum) up to about 77 percent, with the national average falling around 57 percent. In reforms such as those modeled in this analysis, the FMAP affects the dollar amount saved by each state and, more importantly, the additional cost to the federal government. In brief, the federal government will pick up a greater share of current expenditures for states with low FMAPs, and a lower share of current spending for states with high FMAPs.

Table 6

Savings to States When the Federal Government Covers Additional Services

State	Savings to State (in Millions)			Savings as a Percentage of Total Medicaid Expenditures		
	Premiums & Medicare Acute*	Prescribed Drugs	Long-Term Care	Premiums & Medicare Acute*	Prescribed Drugs	Long-Term Care
United States	$6,478	$5,621	$25,763	7%	6%	28%
Alabama	$63	$57	$276	7%	6%	30%
Alaska	$12	$10	$35	5%	4%	13%
Arizona	$55	$32	$160	6%	3%	16%
Arkansas	$78	$41	$145	15%	8%	27%
California	$949	$803	$2,017	9%	7%	19%
Colorado	$58	$69	$345	5%	6%	30%
Connecticut	$74	$100	$915	4%	6%	51%
Delaware	$16	$12	$86	5%	3%	25%
District of Columbia	$14	$9	$58	5%	3%	19%
Florida	$332	$408	$930	8%	10%	22%
Georgia	$140	$122	$393	7%	6%	20%
Hawaii	$30	$14	$62	10%	4%	20%
Idaho	$9	$8	$25	4%	4%	12%
Illinois	$162	$211	$1,058	3%	4%	21%
Indiana	$104	$114	$450	7%	8%	31%
Iowa	$36	$46	$246	5%	7%	35%
Kansas	$25	$43	$244	4%	7%	40%
Kentucky	$163	$126	$274	15%	11%	24%
Louisiana	$67	$75	$233	7%	7%	23%
Maine	$25	$35	$119	4%	6%	22%
Maryland	$127	$91	$452	6%	4%	20%
Massachusetts	$220	$204	$1,242	6%	6%	36%
Michigan	$104	$156	$536	4%	6%	19%
Minnesota	$107	$116	$842	5%	6%	40%
Mississippi	$55	$62	$132	10%	11%	24%
Missouri	$111	$159	$463	7%	10%	29%
Montana	$7	$9	$37	5%	6%	24%
Nebraska	$25	$33	$152	5%	7%	31%
Nevada	$24	$16	$60	7%	5%	18%
New Hampshire	$31	$26	$167	8%	6%	41%
New Jersey	$180	$190	$919	6%	6%	30%
New Mexico	$19	$13	$68	4%	3%	16%
New York	$1,207	$600	$5,578	7%	4%	34%
North Carolina	$182	$203	$643	8%	8%	27%
North Dakota	$4	$9	$67	3%	6%	49%
Ohio	$254	$204	$1,307	7%	6%	36%
Oklahoma	$46	$36	$170	8%	6%	28%
Oregon	$47	$63	$168	5%	7%	18%
Pennsylvania	$253	$251	$924	10%	10%	38%
Rhode Island	$74	$30	$232	12%	5%	36%
South Carolina	$109	$59	$187	10%	5%	17%
South Dakota	$11	$10	$60	6%	6%	34%
Tennessee	$131	$72	$484	6%	3%	22%
Texas	$422	$260	$1,272	9%	6%	27%
Utah	$8	$16	$49	2%	4%	13%
Vermont	$10	$21	$55	5%	10%	24%
Virginia	$110	$118	$376	7%	8%	24%
Washington	$87	$119	$269	5%	7%	17%
West Virginia	$23	$19	$112	5%	4%	26%
Wisconsin	$70	$114	$631	5%	7%	42%
Wyoming	$5	$6	$38	5%	6%	37%

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 7 illustrates the effect of the FMAP in terms of the percentage change in federal spending if all Medicaid expenditures for dual eligibles were shifted to the federal government. The column headed "dual eligibles only" shows the percentage change in federal expenditures for dual eligibles under such a reform. Because the federal government takes on the entire amount that each state currently spends for dual eligibles, these percentages are determined by a single factor: each state's FMAP. Connecticut, Minnesota and New York are all 50 percent FMAP states, so federal spending attributable to dual eligibles doubles (i.e., increases by 100%) when the federal government picks up the state share. On the other hand, Mississippi has the largest FMAP of the states in the table (76.09%). Because the federal government is already responsible for more than three-quarters of Mississippi's total expenditures, the increase in federal spending for dual eligibles is only 31 percent (=(1/.7609)-1=.31).

For all enrollees, even at the federal level, the FMAP is only one of several factors that affect the percentage increase/savings under the various reforms. Note that even for states with identical FMAPs, the percentage change in federal spending for all Medicaid enrollees if dual eligibles were fully financed by the federal government varies by state (Table 7). This variation occurs because the change in federal spending for all enrollees in a state reflects both the effect of the FMAP and the share of Medicaid spending attributable to dual eligibles.

Table 7

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

State	FMAP, FFY 2002	Percentage Change in Federal Spending for…	
		Dual Eligibles Only	All Medicaid Enrollees
Connecticut	50.00%	100%	63%
Minnesota	50.00%	100%	52%
New York	50.00%	100%	46%
California	51.40%	95%	35%
U.S. Average	56.70%	76%	33%
Texas	60.17%	66%	28%
Mississippi	76.09%	31%	15%
South Carolina	69.34%	44%	15%

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

Discussion

The 7.2 million dual eligibles account about 14 percent of Medicaid enrollees, but they account for over 42 percent of Medicaid expenditures for medical services. Most of these expenditures are for long-term care services and prescription drugs—services that Medicare rarely covers. It is no wonder that this population has drawn the attention of state and federal officials as they try to solve their budget woes. It is not surprising that states want the federal government to assume a greater responsibility to pay for coverage for these individuals, nor is it surprising that the federal government is reluctant to take on such an expense. The stage is set for a tug-of-war between states and the federal government, with major budgetary ramifications for the "winners" and "losers."

In this paper, we presented six hypothetical restructuring options where the federal government assumes a larger role in the financing of care for dual eligibles. Our options were chosen to provide easy-to-follow examples and were not modeled on existing proposals, and they rely on a simplifying assumption—that current levels of state spending will simply shift over

to the federal government unchanged—that is unlikely to reflect what would occur under an actual future reform. Yet the results are informative in that they allow clear-cut comparison of the relative fiscal effects of potential reforms.

Our findings indicate that the cost to the federal government of assuming more costs for dual eligibles is substantial. The states' share of Medicaid spending for dual eligibles was an estimated $39.6 billion in 2002, and all indications are that this amount will continue to grow at a relatively fast pace into the foreseeable future. The bulk of these expenditures are for long-term care services, for which Medicaid is the dominant public financing source and Medicare's role has traditionally been limited.

From our findings, it is also apparent that states' current effort to include dual eligibles in any potential Medicare drug benefit could provide them with significant fiscal relief. If the states were left with no costs for prescription drugs for dual eligibles, they would have saved about 6 percent of their state expenditures for Medicaid, on average. This amounted to $5.6 billion in 2002. While the Medicare prescription drug legislation under consideration would not eliminate states' prescription drug costs for dual eligibles, the potential savings are significant.

Lastly, we find that there are equity issues involved when the federal government takes over Medicaid services for dual eligibles. Variation in state Medicaid programs leads the federal government to provide more relief to some states than others when it takes on more of the costs for dual eligibles. Some of this variation is due to differences resulting from the freedom given to states to design their Medicaid programs, which leads to different benefit packages, eligibility requirements, provider payment rates, and other program characteristics. Some variation is due to the structure of the Medicaid FMAP, which causes the federal government to pick up a greater share of current expenditures for states with low FMAPs and a lower share of current spending for states with high FMAPs. Other, harder-to-measure influences such as the level of outreach, public knowledge of Medicaid eligibility options, and general attitudes/perceptions of Medicaid among potential enrollees may also contribute to state-level variations.

In conclusion, the debate over whether the federal government should assume more of the financial burden of caring for the dual eligible population is just beginning. Both the current effort to add a prescription drug benefit to Medicare and future Medicaid reforms could hinge on the treatment of dual eligibles. This paper has attempted to provide some perspective for this debate by illustrating the magnitude of dollars involved. The stakes already are high for all of the parties involved, and as the population ages and baby boomers close in on retirement, the stakes will only grow higher. The enormous fiscal implications have the potential to become the dominant issue in future Medicaid reform debates. However, it is important that both state and federal policymakers not lose sight of the fact that there are millions of people with significant health care needs that are caught in the middle of this fiscal tug-of-war.

Resources

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Kaiser Commission on Medicaid and the Uninsured. 2003. “Dual Enrollees: Medicaid’s Role for Low-Income Medicare Beneficiaries.” Pub. no. 4091 (Washington, DC: Kaiser Commission on Medicaid and the Uninsured). February.

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Patton, Governor Paul (KY), Governor Tom Vilsack (IA), Governor Frank O’Bannon (IN), Governor Bob Holden (MO) and Governor Bill Richardson (NM). 2003. Joint statement from the Democratic governors on the NGA Medicaid Reform Task Force. June 12.

Technical Appendix

Descriptions of Medicaid Reform Options

Medicare Premiums

The first option that we consider is one where the federal government no longer requires Medicaid to pay Medicare premiums for dual eligibles. As shown in Table 1, under current law, states pay some or all of the monthly premiums for Medicare's Part A and Part B programs for individuals enrolled in Medicare Savings Programs. Most beneficiaries do not pay Part A premiums because they or a spouse have sufficient work history to eliminate the premium requirement. However, some people with insufficient work history may pay either full or reduced premiums, depending on the length of their work history.[1] Part B has a monthly premium of $58.70 in 2003. We implicitly assume that the federal government subsidizes premiums for these individuals at the same levels that states were required to contribute, so that any cost savings to the state will be fully offset by increased costs to the federal government.

Acute Care Services that Medicare Already Covers in Whole or Part

The second option that we consider is one where the federal government takes over all services for dual eligibles where Medicare and Medicaid both provide coverage. Medicare covers a number of services that are also covered by Medicaid, the most notable being inpatient and outpatient hospital, physician, lab and x-ray services.[2] Again, when Medicare and Medicaid both cover a service, Medicare is the primary payer and Medicaid may pick up remaining charges. In these instances, Medicaid may pay some or all of the deductibles and coinsurance for dual eligibles. For example, Medicare beneficiaries must pay the Part A deductible for each inpatient hospitalization ($840 in 2003) and coinsurance amounts for longer stays.[3] For Part B, beneficiaries must pay a deductible of $100 per year and coinsurance of 20 percent of the Medicare approved amount after meeting the deductible.

The level of aggregation for expenditures in our source data prevents us from precisely separating expenditures for Medicare cost sharing from expenditures for services that Medicare does not cover, when both amounts are reported under the same service category (for example, other practitioners). As a result, the expenditures shifted under this hypothetical option likely include more than just cost sharing.

Prescribed Drugs

The third option that we consider is if the federal government were to take up states' current prescription drug expenditures for dual eligibles. Medicare rarely pays for outpatient prescribed drugs (i.e., those purchased by a beneficiary from a pharmacy), but Medicaid provides coverage for drugs for dual eligibles who also are eligible for full Medicaid benefits. States and the federal government get rebates for outpatient prescribed drugs paid for by Medicaid, yet spending for prescribed drugs reported on MSIS reflects pre-rebate amounts. To

[1] People with less than 30 quarters of Medicare covered employment pay the full premium for Part A ($316/month in 2003). Those with 30-39 quarters pay reduced premiums ($174/month).

[2] Additional services that might be covered by both Medicare and Medicaid include clinics, rehabilitative services, physical and occupational therapy, treatment for speech/hearing/language disorders, hospice, nurse and other licensed practitioners, and religious non-medical care.

[3] For an inpatient hospital stay up to 60 days, a Medicare beneficiary would be required to pay a total of $840 (the deductible). Over 60 days, he/she would pay $210 per day for days 61-90 and $420 per day for days 91-150. After 150 days, he/she would pay all costs.

account for the rebates, which reduce drug spending by an average of about 19% nationwide, we calculated the average rebate for each state in FFY 2000 using data from Medicaid Financial Management Reports, and applied this average rebate to all reported drug expenditures in the state.[4]

Other Acute Care Services that Medicare Does Not Cover

The fourth option that we consider is that the federal government begins to offer coverage for dual eligibles for acute care services that currently are covered by Medicaid but not by Medicare (at least, not typically). These services include dental care, private duty nursing, and transportation, among others.[5] As with the prescription drug benefit, we simply assume that states' current levels of spending for these services would be passed on the federal government. There is considerable variation among states in the extent to which Medicaid covers these services.

Long-Term Care Services

Under this option, we assume that the federal government pays for long-term care services for dual eligibles. Long-term care includes nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), home health, personal care, targeted case management, services provided under home and community-based waivers, inpatient psychiatric facility services for individuals age 21 and under, and other mental health facility services for individuals age 65 or older. With the exception of limited coverage for nursing facility services following hospital stays and some home health care, Medicare generally does not cover these services. Medicaid is a major funding source for long-term care, particularly for nursing facilities and other institutions.

Payments to Managed Care Organizations

Any policy change for dual eligibles would likely apply to enrollees in both fee-for-service and managed care settings. Therefore, we distributed payments to managed care organizations among the various Medicaid service categories described above except for long-term care services, which are rarely included in capitated programs. For most states, the allocations are based on fee-for-service spending for dual eligibles in the state. In states where payments to HMOs account for larger shares of total spending, we allocate spending based on the combined spending patterns for all states with smaller shares of spending in payments to HMOs.

Arizona pays for nearly all of its services through capitated managed care plans. We estimated the share of managed care expenditures in Arizona for long-term care services using information published by the state, shifted that amount into long-term care, and allocated the remaining payments to other services using the same method as other states with large managed care programs.

[4] Medicaid Financial Management Reports contain information from CMS Form 64, which tracks states' actual Medicaid expenditures by date of payment.

[5] Additional services that are not generally covered by Medicare but may be covered by Medicaid include sterilization, abortions, nurse midwives, and other services that do not meet the definitions for any other category described in the text (examples include, but are not limited to, prosthetic devices and eyeglasses). This category also includes prepaid health plans (PHPs) and primary care case management (PCCM).

1330 G Street NW, Washington, DC 20005
Phone: 202-347-5270, *Fax:* 202-347-5274,
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