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Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005

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Medicaid plays a critical role filling in the gaps in Medicare's benefit package for low-income Medicare enrollees. These "dual eligibles" are individuals who are entitled to Medicare who are also eligible for some level of assistance from their state Medicaid program. Such assistance ranges from help paying for Medicare's premiums and cost-sharing, to coverage of benefits not offered under Medicare, such as hearing, vision, dental, and long-term care. Because dual eligibles have significant medical needs and a much higher per capita cost than other beneficiaries, they are of great interest to both Medicare and Medicaid policymakers and to the state and federal governments that finance and manage the programs.

This brief uses the latest available data to estimate the share of total Medicaid enrollment and spending attributable to dual eligibles in 2005. It also provides state-level estimates of Medicaid enrollment and expenditures for dual eligibles, together with a breakdown of dual eligible Medicaid expenditures by service category, as well as by age group and Medicaid eligibility groups (elderly or disabled under age 65). Among the findings from this work are:

- Nearly **8.8 million** older Americans and younger persons with disabilities participated in both the Medicare and Medicaid programs in Federal Fiscal Year (FFY) 2005. Although these "dual eligibles" accounted for only **18 percent of Medicaid enrollment, 46 percent of all Medicaid expenditures** for medical services were made on their behalf in 2005. These same individuals also account for more than 25 percent of Medicare spending.[1]
- Dual eligibles as a share of total Medicaid enrollees **ranged from a low of 11 percent in Alaska to a high of 25 percent in Maine**, due to demographic differences and policy preferences across the states. Similarly, spending on dual eligibles as a percentage of total Medicaid spending ranged from a **low of 28 percent in Arizona to a high of 62 percent in North Dakota**.
- **Twenty percent of Medicaid spending for dual eligibles went toward Medicare premiums and cost-sharing in 2005.** Another roughly 20 percent of Medicaid dual eligible spending was for prescription drugs. As of January 2006, this spending was shifted to Medicare Part D, which now provides the prescription drug benefit for dual eligibles, although states fund a large portion of this benefit through monthly "clawback" payments. Four percent was for acute care services not covered by Medicare (e.g. dental, vision and hearing services). The remaining **58% of Medicaid spending for dual eligibles was for long-term care** services which generally are not covered by Medicare or private insurance.
- Nearly **two-thirds of Medicaid spending on dual eligibles was for enrollees age 65 and older**. Although only 15 percent of dual eligibles were in an institutional, long-term care setting in 2005, these enrollees accounted for more than half of all spending on duals. Like health spending more generally, **spending on dual eligibles is skewed toward those with the greatest health care needs** — the 1.6 million dual eligibles who had per capita Medicaid spending of $25,000 or greater in 2005 accounted for more than 70 percent of all dual eligible spending.

Data Sources and Estimation Methods

Most data used in this analysis come from the federal fiscal year (FFY) 2005 Medicaid Statistical Information System (MSIS) maintained by the Centers for Medicare and Medicaid Services (CMS). The MSIS contains demographic, eligibility, and Medicaid expenditure information for every Medicaid enrollee. These source data are person-level and classify each individual's spending into 29 service categories. Enrollees were grouped into four broad eligibility categories: non-disabled adults, non-disabled children, disabled adults and children, and the elderly (all Medicaid enrollees over age 64). This paper focuses on individuals in the disabled and elderly categories, who we further classify as eligible for Medicaid only ("non-duals") or dually eligible ("duals").

All enrollment and eligibility calculations in this paper are based on the FFY 2005 MSIS. Data were limited to the 49.8 million enrollees for whom the FFY 2005 MSIS contains valid information for broad eligibility category, dual eligible status, and age. Total FFY 2005 Medicaid enrollment in the MSIS without these restrictions was 58.9 million. Because the CMS Form 64 is regarded as a more accurate reflection of Medicaid program spending than the MSIS, we adjust MSIS-derived spending levels to those reported in 2005 on the CMS Form 64. In addition, MSIS data do not include premium payments Medicaid makes to Medicare. Premium data from the CMS Form 64 are included in this analysis.

Maine's 2005 MSIS data are not available and its dual eligible indicator was inaccurate in 2004. Therefore MSIS 2003 data are used for Maine throughout this paper. These data have been inflated to FFY 2005 CMS Form 64 spending levels.

An Overview of FFY 2005 Dual Eligible Enrollment and Spending

Who are the Dual Eligibles?

Dual eligibles are individuals who are entitled to Medicare and are eligible for some level of Medicaid benefits. Categories of Medicare participants who are eligible to receive assistance under Medicaid are listed in Table 1. Some dual eligibles qualify for full Medicaid benefits, and Medicaid 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.[2]

Table 1

Common Medicaid Eligibility Pathways for Medicare Beneficiaries

	Income Eligibility	Asset Limit	Medicaid Benefits in 2005
Individuals Eligible for Full Medicaid Benefits			
SSI Cash-Assistance-Related (mandatory)	Generally 74% of the FPL for individuals and 82% of FPL for couples[*a]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Poverty-Related (optional)	Up to 100% of the FPL[*b]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Medically Needy (optional)	Individuals who spend down their incomes to state-specific levels.[b,c]	$2,000 (individual) $3,000 (couple)	"Wrap around" Medicaid benefits (may be more limited than those for SSI recipients). Medicaid may also pay Medicare premiums and cost sharing, depending on income.
Special Income Rule for Nursing Home Residents (optional)	Individuals living in institutions with incomes up to 300% of SSI.[d]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Home and Community Based Service Waivers (optionals)	Individuals who would be eligible if they resided in an institution. Several states do not use the special income rule for waivers, so eligibility levels may be lower than 300% of SSI.		Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid may also pay Medicare premiums and cost sharing.
Medicare Savings Programs			
Qualified Medicare Beneficiaries[f] (QMB) (mandatory)	Up to 100% of the FPL[*b]	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare premiums (Part B and if needed, Part A) and cost sharing.[e]
Specified Low-Income Medicare Beneficiaries[f] (SLMB) (mandatory)	Between 100% and 120% of the FPL.[*b]	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare Part B premium.
Qualified Working Disabled Individuals (QDWI) (mandatory)	Working, disabled individuals with income up to 200% of the FPL.*	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare Part A premium.
Qualifying Individuals[g] (QI) (mandatory)	Between 120% and 135% of the FPL.*	$4,000 (individual) $6,000 (couple)[b]	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 and Centers for Medicare and Medicaid Services (CMS).

* In 2005, 100% of the federal poverty level (FPL) was $798 for individuals and $1,069 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 2005 was $637 per month for individuals and $956 per month for couples. People with incomes below these levels qualify for benefits. SSI disregards the first $20 of income from any source, plus the first $65 and half of all remaining earned income, so eligibility levels can be higher. However, few SSI recipients have earned income, so most qualify at or below the income levels shown. Some states using the "209(b) option" use different (often more restrictive) income or asset requirements for Medicaid eligibility for SSI recipients.

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

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

d) In 2005, 300% of SSI was $1,737 per month for an individual. Several states do not use the Special Income Rule, and a few other states use income lmits that are below 300% of SSI.

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

f) QMB Plus and SLMB Plus categories were created when Congress changed eligibility criteria for QMBs and SLMBs to eliminate the requirement that QMBs and SLMBs could not otherwise qualify for Medicaid. Individuals in these "Plus" categories meet QMB or SLMB eligibility requirements, but also meet the financial criteria for full Medicaid coverage in their state. These individuals DO receive full Medicaid benefits.

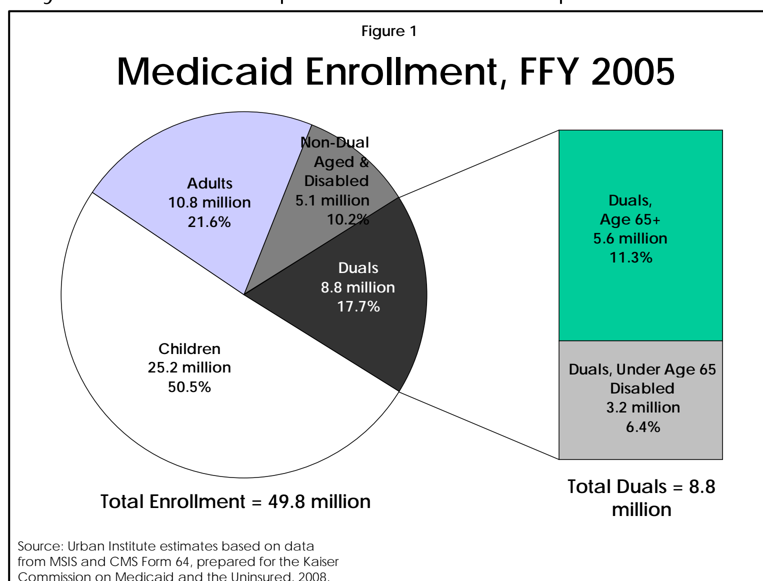
g) Until September 30, 2002, Medicaid paid a small part of the Medicare Part B premium for additional Qualifying Individuals (QI2s) with incomes between 135% and 175% of the FPL. Congress allowed the authority for the QI2 program to expire on that date.

Dual eligibles are among the sickest and poorest individuals covered by either Medicare or Medicaid. Most dual eligibles are very low-income individuals. In 2003, 65 percent of dual eligibles had annual incomes under $10,000, compared to 10 percent of non-dual Medicare beneficiaries. Only 4 percent of duals had annual incomes greater than $20,000. Almost 40 percent required long-term care in either the community or a nursing facility. Seventy-three percent had difficulty with at least one instrumental activity of daily living (such as shopping, using the phone or managing money), and 44 percent had difficulty with at least one activity of daily living (such as dressing, bathing, or eating). The prevalence of many serious health conditions, such as Alzheimer's/dementia, pulmonary disease, heart disease, and affective disorders is significantly higher for duals than for non-duals.[3]

How Many Dual Eligibles are Enrolled in Medicaid?

Nearly 9 million Medicare beneficiaries were enrolled in Medicaid in 2005 (Table 2). This includes both those who received full Medicaid benefits and those who received only assistance with Medicare premiums and cost sharing. Nearly one in five Medicaid enrollees (18 percent) were dual eligibles in 2005 (Figure 1). 7.1 million (81 percent) received full Medicaid benefits, with the remaining 19 percent receiving help only with Medicare's premiums and out-of-pocket costs. These "partial" dual eligibles were not eligible for non-Medicare covered Medicaid services such as prescribed drugs and long-term care.

Figure 1



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

Table 2 contains dual eligible enrollment estimates for all fifty states and the District of Columbia. While dual eligibles account for 18 percent of all Medicaid enrollees nationally, there is significant variation in their share of each state's Medicaid enrollment. Duals account for 23 percent of all Medicaid enrollees in Alabama, Florida, Illinois, and Massachusetts, 24 percent in Wisconsin, and 25 percent in Maine and North Dakota. In other states – Alaska, Arizona, New Mexico, and Utah – duals comprise 12 percent or less of the state's Medicaid enrollees. These variations reflect a state's demographic profile as well as state policy choices affecting the extent of Medicaid coverage they provide to their aged and disabled versus non-disabled adults and children. There is also great variation among states in the share of duals that receives full or partial Medicaid benefits. In states such as Delaware and Illinois, which cover many additional individuals through Medicare Savings Programs, nearly half of all dual eligibles are "partial" dual eligibles. In states such as Alaska and Mississippi, on the other hand, where relatively fewer have been enrolled in Medicare Savings Programs, nearly all duals receive full Medicaid benefits.

Table 2

Dual Eligibles and Full Dual Eligibles by State, 2005

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	8,807,160	18%	63%	7,098,168	81%
Alabama	197,193	23%	66%	104,453	53%
Alaska	11,755	11%	58%	11,592	99%
Arizona	135,670	12%	63%	112,495	83%
Arkansas	101,319	16%	62%	68,357	67%
California	1,119,991	13%	63%	1,102,044	98%
Colorado	70,931	17%	59%	58,049	82%
Connecticut	96,467	21%	77%	77,457	80%
Delaware	21,446	15%	65%	11,333	53%
District of Columbia	20,141	14%	49%	18,819	93%
Florida	549,923	23%	66%	425,106	77%
Georgia	248,343	17%	62%	148,251	60%
Hawaii	30,187	15%	65%	28,127	93%
Idaho	23,771	13%	56%	20,178	85%
Illinois	496,381	23%	75%	247,762	50%
Indiana	140,332	16%	64%	109,432	78%
Iowa	73,246	22%	71%	62,671	86%
Kansas	58,935	21%	67%	48,227	82%
Kentucky	155,900	21%	55%	103,771	67%
Louisiana	174,629	17%	59%	112,052	64%
Maine	96,120	25%	55%	87,606	91%
Maryland	110,745	15%	56%	70,483	64%
Massachusetts	235,119	23%	63%	218,559	93%
Michigan	245,888	17%	61%	226,824	92%
Minnesota	123,250	20%	68%	112,858	92%
Mississippi	152,723	22%	63%	148,497	97%
Missouri	178,854	16%	65%	165,525	93%
Montana	19,129	20%	66%	17,827	93%
Nebraska	39,825	18%	73%	37,172	93%
Nevada	37,633	19%	66%	21,369	57%
New Hampshire	25,864	22%	77%	21,388	83%
New Jersey	189,211	21%	65%	158,303	84%
New Mexico	50,897	11%	60%	37,353	73%
New York	714,545	17%	62%	673,599	94%
North Carolina	295,051	22%	68%	250,136	85%
North Dakota	15,054	25%	79%	12,615	84%
Ohio	268,516	15%	56%	246,240	92%
Oklahoma	104,371	18%	68%	89,495	86%
Oregon	81,854	18%	67%	60,495	74%
Pennsylvania	364,368	21%	55%	318,836	88%
Rhode Island	39,450	20%	63%	35,093	89%
South Carolina	185,196	21%	68%	122,707	66%
South Dakota	18,707	17%	70%	13,290	71%
Tennessee	299,687	21%	63%	262,408	88%
Texas	549,312	17%	65%	362,351	66%
Utah	27,774	12%	61%	25,955	93%
Vermont	30,706	22%	77%	18,375	60%
Virginia	161,428	22%	67%	118,906	74%
Washington	133,500	13%	57%	109,497	82%
West Virginia	64,312	20%	50%	50,214	78%
Wisconsin	212,120	24%	75%	127,439	60%
Wyoming	9,391	15%	68%	6,577	70%

Source: Urban Institute and KCMU estimates based on data from MSIS 2005.

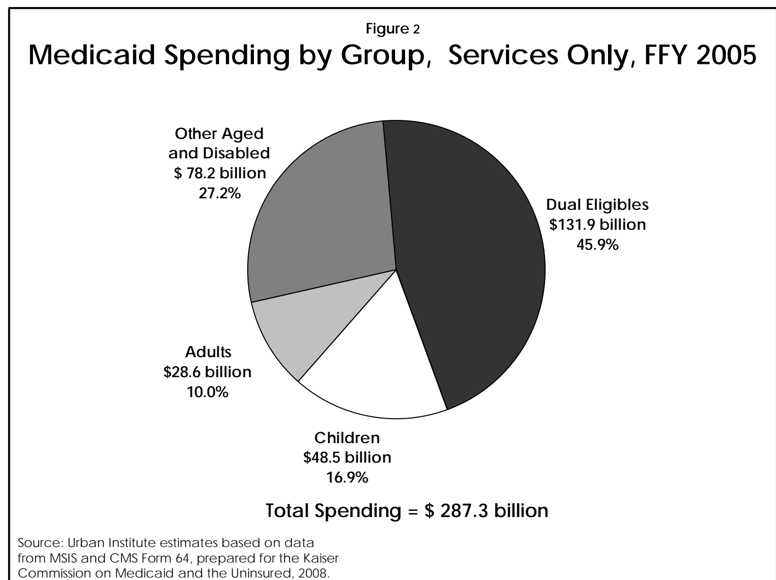
Almost two-thirds of dual eligibles (5.6 million) were individuals age 65 and over, and about one-third (3.2 million) were younger persons with disabilities (Table 3). Only a small share (6 percent) of elderly Medicaid enrollees is not eligible for Medicare. These are individuals whose own or others' work histories were not sufficient to qualify them for Medicare.[4] A much larger share (60 percent) of Medicaid's non-elderly enrollees with disabilities does not meet eligibility criteria for Medicare, a significant portion of whom may be in the 2-year waiting period between first receiving federal Social Security Disability Insurance (SSDI) and becoming eligible for Medicare coverage.[5] The percentage of aged enrollees that was dually eligible was as high as 99 to 100 percent in Alabama, Montana, North Carolina, North Dakota, West Virginia, Wisconsin, and Wyoming. The share of disabled enrollees who were dual eligibles averaged 40 percent nationally, but the share was over 50 percent in Connecticut, Iowa, Minnesota, Nebraska, New Hampshire, North Dakota, and Vermont.

How Much Does Medicaid Spend on Services for Dual Eligibles?

Dual eligibles account for 18 percent of Medicaid enrollment, and due to their more intensive need for services, 46 percent of all Medicaid expenditures for medical services in 2005 were made on their behalf ($131.9 billion) (Table 4a and Figure 2). Again, duals' share of total spending and the way it was distributed across covered services varied significantly across the states. Spending on dual eligibles accounted for more than half of Medicaid spending in thirteen states: Alabama, Connecticut, Indiana, Iowa, Kansas, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, North Dakota, Pennsylvania, and Wisconsin. Over half of Medicaid expenditures for dual eligibles ($76 billion) were for long-term care services (Figure 3). Long-term care spending comprised more than two-thirds of spending on dual eligibles in Connecticut, Delaware, New Hampshire, New York, North Dakota, Ohio, Pennsylvania, and Wyoming (Table 4b).

Figure 2

Medicaid Spending by Group, Services Only, FFY 2005



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

Nearly 20 percent of expenditures for dual eligibles ($24 billion) were for prescription drugs. As noted above, prescription drug spending for dual eligibles was absorbed into Medicare in

Table 3

Aged and Disabled Dual Eligibles by State, 2005

State	Aged Dual Eligibles	Aged Duals as a Share of … All Dual Enrollees	Aged Enrollees	Disabled Dual Eligibles	Disabled Duals as a Share of. . . All Dual Enrollees	Disabled Enrollees
United States	5,638,428	64%	94%	3,168,732	36%	40%
Alabama	122,632	62%	99%	74,561	38%	43%
Alaska	6,597	56%	86%	5,158	44%	41%
Arizona	84,606	62%	94%	51,064	38%	41%
Arkansas	60,872	60%	96%	40,447	40%	40%
California	801,260	72%	89%	318,731	28%	36%
Colorado	43,325	61%	88%	27,606	39%	39%
Connecticut	60,890	63%	95%	35,577	37%	58%
Delaware	12,374	58%	97%	9,072	42%	45%
District of Columbia	12,684	63%	91%	7,457	37%	27%
Florida	367,522	67%	95%	182,401	33%	41%
Georgia	152,494	61%	95%	95,849	39%	40%
Hawaii	21,136	70%	93%	9,051	30%	38%
Idaho	12,070	51%	92%	11,701	49%	40%
Illinois	382,358	77%	97%	114,023	23%	42%
Indiana	74,719	53%	93%	65,613	47%	47%
Iowa	39,594	54%	97%	33,652	46%	54%
Kansas	32,605	55%	97%	26,330	45%	49%
Kentucky	88,854	57%	97%	67,046	43%	35%
Louisiana	108,865	62%	98%	65,764	38%	35%
Maine	66,716	69%	88%	29,404	31%	29%
Maryland	71,362	64%	89%	39,383	36%	34%
Massachusetts	130,491	55%	93%	104,628	45%	46%
Michigan	129,040	52%	98%	116,848	48%	43%
Minnesota	72,027	58%	91%	51,223	42%	51%
Mississippi	92,110	60%	97%	60,613	40%	41%
Missouri	95,909	54%	96%	82,945	46%	47%
Montana	10,932	57%	100%	8,197	43%	46%
Nebraska	22,524	57%	95%	17,301	43%	56%
Nevada	22,894	61%	97%	14,739	39%	44%
New Hampshire	13,527	52%	95%	12,337	48%	64%
New Jersey	127,208	67%	90%	62,003	33%	41%
New Mexico	32,260	63%	96%	18,637	37%	37%
New York	497,285	70%	94%	217,260	30%	35%
North Carolina	176,867	60%	100%	118,184	40%	46%
North Dakota	9,416	63%	99%	5,638	37%	58%
Ohio	144,896	54%	89%	123,620	46%	40%
Oklahoma	62,987	60%	97%	41,384	40%	47%
Oregon	47,050	57%	95%	34,804	43%	48%
Pennsylvania	216,744	59%	95%	147,624	41%	34%
Rhode Island	23,829	60%	96%	15,621	40%	41%
South Carolina	128,529	69%	93%	56,667	31%	42%
South Dakota	11,689	62%	96%	7,018	38%	48%
Tennessee	162,985	54%	94%	136,702	46%	45%
Texas	387,252	70%	96%	162,060	30%	37%
Utah	13,769	50%	94%	14,005	50%	46%
Vermont	20,151	66%	98%	10,555	34%	54%
Virginia	97,583	60%	96%	63,845	40%	46%
Washington	75,022	56%	88%	58,478	44%	39%
West Virginia	33,561	52%	99%	30,751	48%	32%
Wisconsin	151,026	71%	99%	61,094	29%	47%
Wyoming	5,330	57%	99%	4,061	43%	48%

Source: Urban Institute and KCMU estimates based on data from MSIS 2005.

Table 4a

Medicaid Expenditures for Dual Eligibles by State, 2005

		Expenditures for Duals by Service (in Millions)						
State	**Dual Eligible Total**	**Premiums**	**Medicare Acute***	**Acute Care Not Covered by Medicare**	**Prescribed Drugs**	**Long-Term Care**	**Dual Eligible Spending as % of Total Medicaid**	**Spending Per Dual Eligible**
United States	$131,864	$8,670	$17,676	$4,840	$24,395	$76,283	46%	$14,972
Alabama	1,745	176	207	24	304	1,034	51%	8,850
Alaska	292	13	31	13	64	172	30%	24,829
Arizona[1]	1,577	108	1,425	14	2	27	28%	11,621
Arkansas	1,355	180	209	96	191	679	48%	13,377
California	14,813	1,370	2,425	357	3,066	7,595	47%	13,226
Colorado	1,162	48	171	33	211	699	44%	16,386
Connecticut	2,382	187	95	51	342	1,706	62%	24,691
Delaware	342	17	31	10	37	246	39%	15,925
District of Columbia	356	18	40	58	52	189	29%	17,693
Florida	6,161	708	903	145	1,725	2,680	47%	11,204
Georgia	2,781	196	542	79	542	1,421	39%	11,198
Hawaii	434	39	51	10	73	261	42%	14,365
Idaho	401	21	36	31	79	234	40%	16,869
Illinois	4,264	215	401	159	1,307	2,183	42%	8,590
Indiana	2,502	96	237	61	471	1,637	50%	17,829
Iowa	1,297	129	98	62	238	771	54%	17,712
Kansas	973	45	101	31	172	625	51%	16,515
Kentucky	1,577	137	177	27	326	910	38%	10,113
Louisiana	1,783	148	170	46	469	951	40%	10,211
Maine	810	53	75	151	138	393	37%	8,430
Maryland	1,918	110	267	47	320	1,175	37%	17,323
Massachusetts	4,463	248	401	568	689	2,557	50%	18,982
Michigan	3,889	251	858	78	599	2,102	47%	15,815
Minnesota	2,850	102	543	73	248	1,883	51%	23,124
Mississippi	1,553	82	190	110	407	763	49%	10,168
Missouri	2,828	208	294	173	784	1,369	48%	15,814
Montana	354	32	25	13	59	224	51%	18,483
Nebraska	751	72	64	16	110	490	54%	18,868
Nevada	393	35	71	13	64	211	36%	10,455
New Hampshire	583	12	54	7	85	425	59%	22,544
New Jersey	3,816	174	313	192	763	2,374	55%	20,170
New Mexico	745	43	161	28	48	466	32%	14,631
New York	19,451	864	2,346	628	2,413	13,200	48%	27,221
North Carolina	4,022	276	337	189	1,096	2,124	45%	13,632
North Dakota	319	6	24	3	43	242	62%	21,206
Ohio	5,913	220	701	140	813	4,039	50%	22,021
Oklahoma	1,249	88	119	30	288	724	45%	11,963
Oregon	1,131	44	246	30	148	662	40%	13,813
Pennsylvania	7,838	314	1,096	53	696	5,679	52%	21,512
Rhode Island	757	26	107	41	119	465	48%	19,191
South Carolina	1,603	111	268	35	408	781	43%	8,657
South Dakota	279	18	25	3	51	182	45%	14,895
Tennessee	3,045	237	371	38	1,154	1,245	40%	10,159
Texas	6,053	621	458	609	1,308	3,057	37%	11,019
Utah	481	17	92	7	145	221	36%	17,323
Vermont	366	15	25	33	103	190	44%	11,913
Virginia	2,078	141	187	30	418	1,302	48%	12,872
Washington	2,154	136	143	83	442	1,351	40%	16,138
West Virginia	938	65	69	18	189	597	44%	14,583
Wisconsin	2,857	190	386	91	550	1,640	59%	13,471
Wyoming	178	8	11	2	26	131	43%	18,975

Source: Urban Institute estimates based on data from MSIS 2005 and CMS Form 64.

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

[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.

Table 4b

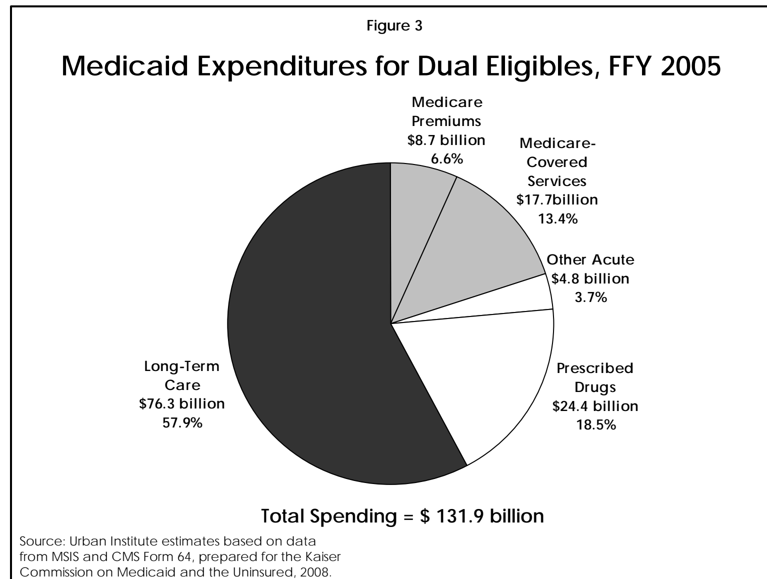
Medicaid Expenditures for Dual Eligibles by State, 2005

State	Premiums	Medicare Acute*	Acute Care Not Covered by Medicare	Prescribed Drugs	Long-Term Care	Total
	Distribution of Spending for Dual Eligibles by Service					
United States	7%	13%	4%	18%	58%	100%
Alabama	10%	12%	1%	17%	59%	100%
Alaska	4%	10%	4%	22%	59%	100%
Arizona[1]	7%	90%	1%	0%	2%	100%
Arkansas	13%	15%	7%	14%	50%	100%
California	9%	16%	2%	21%	51%	100%
Colorado	4%	15%	3%	18%	60%	100%
Connecticut	8%	4%	2%	14%	72%	100%
Delaware	5%	9%	3%	11%	72%	100%
District of Columbia	5%	11%	16%	14%	53%	100%
Florida	11%	15%	2%	28%	44%	100%
Georgia	7%	19%	3%	20%	51%	100%
Hawaii	9%	12%	2%	17%	60%	100%
Idaho	5%	9%	8%	20%	58%	100%
Illinois	5%	9%	4%	31%	51%	100%
Indiana	4%	9%	2%	19%	65%	100%
Iowa	10%	8%	5%	18%	59%	100%
Kansas	5%	10%	3%	18%	64%	100%
Kentucky	9%	11%	2%	21%	58%	100%
Louisiana	8%	10%	3%	26%	53%	100%
Maine	7%	9%	19%	17%	49%	100%
Maryland	6%	14%	2%	17%	61%	100%
Massachusetts	6%	9%	13%	15%	57%	100%
Michigan	6%	22%	2%	15%	54%	100%
Minnesota	4%	19%	3%	9%	66%	100%
Mississippi	5%	12%	7%	26%	49%	100%
Missouri	7%	10%	6%	28%	48%	100%
Montana	9%	7%	4%	17%	63%	100%
Nebraska	10%	8%	2%	15%	65%	100%
Nevada	9%	18%	3%	16%	54%	100%
New Hampshire	2%	9%	1%	15%	73%	100%
New Jersey	5%	8%	5%	20%	62%	100%
New Mexico	6%	22%	4%	6%	63%	100%
New York	4%	12%	3%	12%	68%	100%
North Carolina	7%	8%	5%	27%	53%	100%
North Dakota	2%	8%	1%	13%	76%	100%
Ohio	4%	12%	2%	14%	68%	100%
Oklahoma	7%	10%	2%	23%	58%	100%
Oregon	4%	22%	3%	13%	59%	100%
Pennsylvania	4%	14%	1%	9%	72%	100%
Rhode Island	3%	14%	5%	16%	61%	100%
South Carolina	7%	17%	2%	25%	49%	100%
South Dakota	6%	9%	1%	18%	65%	100%
Tennessee	8%	12%	1%	38%	41%	100%
Texas	10%	8%	10%	22%	50%	100%
Utah	3%	19%	1%	30%	46%	100%
Vermont	4%	7%	9%	28%	52%	100%
Virginia	7%	9%	1%	20%	63%	100%
Washington	6%	7%	4%	21%	63%	100%
West Virginia	7%	7%	2%	20%	64%	100%
Wisconsin	7%	14%	3%	19%	57%	100%
Wyoming	5%	6%	1%	14%	73%	100%

Source: Urban Institute estimates based on data from MSIS 2005 and CMS Form 64.

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

[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.



January 2006 with the implementation of Medicare Part D, however states are required to make a substantial contribution towards this benefit through monthly "clawback" payments to the federal treasury.

Another $26 billion in expenditures on dual eligibles went toward Medicare premiums and cost sharing, including Medicaid's financing of cost-sharing for Medicare-covered acute care services (e.g., hospital services, physician services, and lab/x-ray). Finally, $5 billion was spent for other acute care services that are not covered by Medicare, such as dental care, vision and hearing services.

Medicaid spending per dual eligible for the nation averaged $14,972 (Table 4). However, several states – Alaska, Connecticut, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Ohio, and Pennsylvania – averaged more than $20,000 per dual eligible. Each of these states spent a larger than average share of total dual eligible spending on long-term care; as noted above, some spent over 70 percent of funding for duals on long-term care services. The range of per capita spending on duals is wide. Four states – Alabama, Illinois, Maine, and South Carolina – spent less than $9,000 per dual eligible in 2005.

Sixty-two percent of total Medicaid spending on dual eligibles is for aged beneficiaries. Table 5 and Figure 4 show spending on aged and younger disabled dual eligibles. Spending per disabled dual eligible is slightly higher than spending per aged dual. Even when looking within eligibility group, the range of per capita spending on dual eligibles is wide. Spending per aged dual ranged from $23,000-$28,000 in Alaska, Connecticut, New Hampshire, New York, Ohio, and Pennsylvania to $5,000-$8000 in Illinois, Maine and South Carolina. Among disabled duals, per capita spending ranged from $34,000 in New York and over $25,000 in Alaska, Connecticut, and Minnesota to under $10,000 in Alabama, Kentucky, and Mississippi.

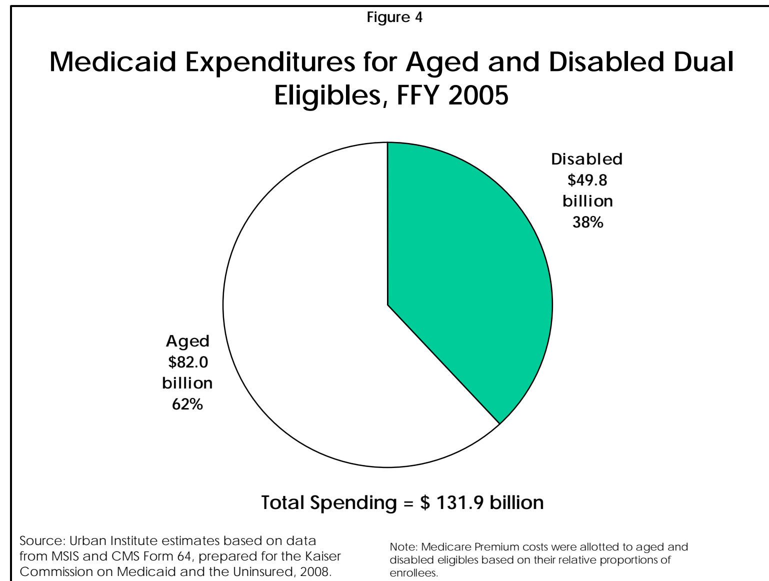
Table 5

Medicaid Expenditures for Aged and Disabled Dual Eligibles by State, 2005 Expenditures

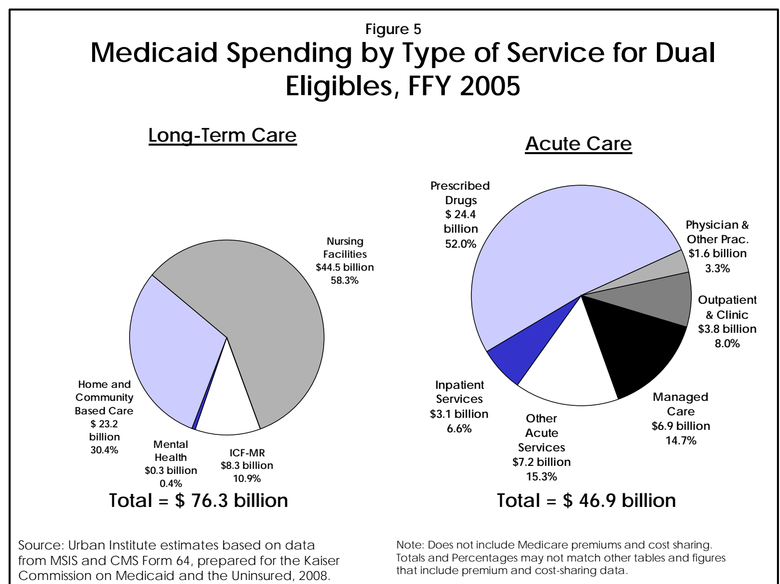
	Aged			Disabled		
State	Total (in millions)	Spending Per Aged Dual Eligible	Percent of Dual Eligible Expenditures	Total (in millions)	Spending Per Disabled Dual Eligible	Percent of Dual Eligible Expenditures
United States	$82,041	$14,550	62%	$49,823	$15,723	38%
Alabama	1,216	9,915	70%	529	7,097	30%
Alaska	160	24,189	55%	132	25,648	45%
Arizona	1,020	12,055	65%	557	10,903	35%
Arkansas	879	14,439	65%	476	11,779	35%
California	9,763	12,185	66%	5,050	15,845	34%
Colorado	693	15,994	60%	469	17,000	40%
Connecticut	1,435	23,568	60%	947	26,612	40%
Delaware	206	16,685	60%	135	14,887	40%
District of Columbia	224	17,682	63%	132	17,711	37%
Florida	4,070	11,074	66%	2,092	11,467	34%
Georgia	1,783	11,690	64%	998	10,416	36%
Hawaii	295	13,961	68%	139	15,309	32%
Idaho	208	17,256	52%	193	16,470	48%
Illinois	2,492	6,517	58%	1,772	15,543	42%
Indiana	1,380	18,469	55%	1,122	17,099	45%
Iowa	664	16,769	51%	633	18,821	49%
Kansas	525	16,116	54%	448	17,009	46%
Kentucky	1,034	11,642	66%	542	8,088	34%
Louisiana	1,056	9,700	59%	727	11,056	41%
Maine	411	6,157	51%	399	13,586	49%
Maryland	1,134	15,894	59%	784	19,914	41%
Massachusetts	2,533	19,411	57%	1,930	18,448	43%
Michigan	2,527	19,585	65%	1,361	11,651	35%
Minnesota	1,500	20,819	53%	1,350	26,364	47%
Mississippi	1,022	11,093	66%	531	8,761	34%
Missouri	1,560	16,269	55%	1,268	15,289	45%
Montana	235	21,464	66%	119	14,508	34%
Nebraska	422	18,744	56%	329	19,028	44%
Nevada	240	10,477	61%	154	10,420	39%
New Hampshire	330	24,385	57%	253	20,525	43%
New Jersey	2,411	18,956	63%	1,405	22,661	37%
New Mexico	456	14,120	61%	289	15,514	39%
New York	12,091	24,314	62%	7,360	33,875	38%
North Carolina	2,447	13,834	61%	1,575	13,331	39%
North Dakota	192	20,352	60%	128	22,632	40%
Ohio	3,489	24,076	59%	2,424	19,612	41%
Oklahoma	713	11,319	57%	536	12,943	43%
Oregon	731	15,530	65%	400	11,492	35%
Pennsylvania	5,728	26,429	73%	2,110	14,293	27%
Rhode Island	437	18,336	58%	320	20,495	42%
South Carolina	983	7,645	61%	621	10,952	39%
South Dakota	171	14,650	61%	107	15,303	39%
Tennessee	1,586	9,733	52%	1,458	10,667	48%
Texas	4,115	10,627	68%	1,938	11,956	32%
Utah	210	15,271	44%	271	19,340	56%
Vermont	220	10,919	60%	146	13,810	40%
Virginia	1,242	12,726	60%	836	13,094	40%
Washington	1,388	18,500	64%	767	13,108	36%
West Virginia	573	17,066	61%	365	11,873	39%
Wisconsin	1,759	11,650	62%	1,098	17,972	38%
Wyoming	93	17,433	52%	85	20,999	48%

Source: Urban Institute and KCMU estimates based on data from MSIS 2005 and CMS Form 64 .

Note: Medicare Premium expenditures were allotted based on the relative proportions of disabled and aged enrollees in the dual population.



Overall, nearly 60 percent of spending on duals in 2005 was for long-term care services. Table 6 and Figure 5 provide detailed data on expenditures by age group and by type of service (excluding Medicare premiums and cost-sharing). Fifty-eight percent of long-term care spending ($44.5 of $76.3 billion) was on nursing facilities. Most of the remaining long-term care spending was on home and personal care services. Prescription drugs accounted for over half of acute care spending on dual eligibles. Other acute care services are covered primarily by Medicare, which explains the relatively low spending on services such as inpatient and outpatient hospital, physicians, and managed care.



Spending on services for duals under age sixty-five was slightly greater for long-term vs. acute care services ($24.6 billion vs. $22.1 billion). About one-fourth of spending on this group was for home and personal care services and another fourth was on long-term care in an institutional setting (ICF-MR or nursing facility). Another quarter was on prescription drugs. The remaining quarter was distributed among the various acute care services. The pattern was somewhat similar for those duals between ages 65 and 75. The main exception was that spending on this age group was more concentrated in institutional rather than community-based long-term care settings, with this age group more reliant on nursing facilities than on ICF-MR. For those 75 and over, 74 percent of expenditures was on long-term care services, and the remainder on acute care services. Sixty percent of the spending on long-term care services for those age 75 and over was on nursing home care. Fourteen percent of spending for this group was for prescription drugs. Overall, those age 75 and over accounted for $56.2 billion in expenditures; those under age 65 counted for $46.7 billion.

Table 6

Medicaid Expenditures for Dual Eligibles by Type of Service, 2005

Service/Service Group	Less Than 65 (in millions)		65 to 75 (in millions)		75 and Above (in millions)		All (in millions)	
Long-term Care Services	**$24,592**	**53%**	**$10,303**	**51%**	**$41,388**	**74%**	**$76,283**	**62%**
Nursing Facilities	4,663	10%	6,168	30%	33,631	60%	44,461	36%
ICF-MR	7,254	16%	657	3%	388	1%	8,299	7%
Mental Health	59	0%	167	1%	106	0%	332	0%
Home and Personal Care	12,615	27%	3,311	16%	7,264	13%	23,190	19%
Acute Care Services	**$22,112**	**47%**	**$10,017**	**49%**	**$14,781**	**26%**	**$46,911**	**38%**
Inpatient Services	1,429	3%	768	4%	902	2%	3,099	3%
Prescribed Drugs	11,151	24%	5,404	27%	7,839	14%	24,395	20%
Physician and Other Practitioners	834	2%	373	2%	348	1%	1,555	1%
Outpatient and Clinic	2,478	5%	742	4%	535	1%	3,755	3%
Managed Care	2,808	6%	1,501	7%	2,603	5%	6,913	6%
Other Acute Services	3,412	7%	1,229	6%	2,554	5%	7,194	6%
Total Spending	**$46,704**	**100%**	**$20,320**	**100%**	**$56,170**	**100%**	**$123,194**	**100%**

Spending per Enrollee

Service/Service Group	Less Than 65		65 to 75		75 and Above		All	
Long-term Care Services	**$7,761**	**53%**	**$4,485**	**51%**	**$12,387**	**74%**	**$8,662**	**62%**
Nursing Facilities	1,472	10%	2,685	30%	10,065	60%	5,048	36%
ICF-MR	2,289	16%	286	3%	116	1%	942	7%
Mental Health	19	0%	73	1%	32	0%	38	0%
Home and Personal Care	3,981	27%	1,442	16%	2,174	13%	2,633	19%
Acute Care Services	**$6,978**	**47%**	**$4,361**	**49%**	**$4,424**	**26%**	**$5,326**	**38%**
Inpatient Services	451	3%	334	4%	270	2%	352	3%
Prescribed Drugs	3,519	24%	2,353	27%	2,346	14%	2,770	20%
Physician and Other Practitioners	263	2%	162	2%	104	1%	177	1%
Outpatient and Clinic	782	5%	323	4%	160	1%	426	3%
Managed Care	886	6%	653	7%	779	5%	785	6%
Other Acute Services	1,077	7%	535	6%	764	5%	817	6%
Total Spending Per Enrollee	**$14,739**	**100%**	**$8,846**	**100%**	**$16,811**	**100%**	**$13,988**	**100%**

Source: Urban Institute and KCMU estimates based on MSIS 2005.
Note: Excludes spending on Medicare premiums and cost sharing. Totals and Percentages may not match other tables and figures that include premium and cost-sharing data.

On a per enrollee basis, spending for those 75 and over amounted to almost $17,000 per year. About $12,000 per year was spent on long-term care services, mostly for nursing home care. Those below the age of 65, i.e., the disabled, averaged about $15,000 per year. About half of this spending was for long-term care services, and half of that ($3,981) was for home and personal care services. Acute care services for disabled duals amounted to $6,978, considerably more than acute care spending for the older age groups. About half of this total was for prescription drugs.

Like health spending more generally, Medicaid spending on dual eligibles is skewed toward those with the greatest health care need . Past research has shown that relatively small numbers of Medicaid enrollees with very high spending account for a significant share of program spending.[6] Table 7 shows how spending on dual eligibles is distributed among individuals in various spending groups, such as those spending under $1,500 per year or those spending over $25,000 per year. About 18 percent of duals (1.6 million) had spending greater than $25,000 in 2005 (Figure 6). Spending for this small group of very high-cost duals totaled $88 billion. This represents more than 70 percent of all spending on duals and nearly one of every three dollars the Medicaid program spent in 2005.

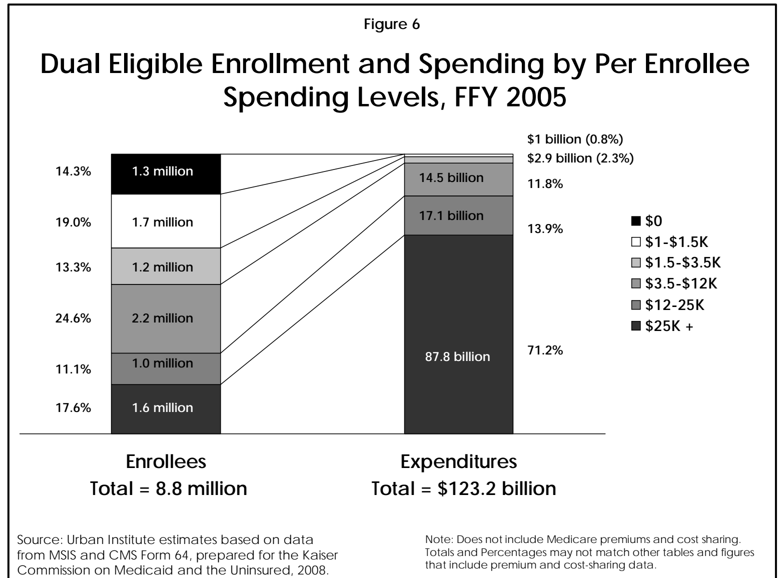


Table 7

Medicaid Enrollment and Expenditures for Dual Eligible by Per Enrollee Spending Level, 2005

	Total Expenditures per Person	Recipients (in thousands)	% of Dual Enrollees	% of All Enrollees	Expenditures (in millions)	% of Dual Expenditures	% of All Expenditures	Spending per Recipient
	United States	**8,807**	**100.0%**	**17.7%**	**$123,194**	**100.0%**	**44.2%**	**$13,988**
	0	1,264	14.3%	2.5%	0	0.0%	0.0%	0
	$0-$1500	1,675	19.0%	3.4%	957	0.8%	0.3%	571
	$1500-$3500	1,173	13.3%	2.4%	2,885	2.3%	1.0%	2,460
ALL DUALS	$3500-$12,000	2,165	24.6%	4.3%	14,478	11.8%	5.2%	6,686
	$12,000-$25,000	977	11.1%	2.0%	17,112	13.9%	6.1%	17,509
	$25,000+	1,553	17.6%	3.1%	87,762	71.2%	31.5%	56,499
	United States	**1,360**	**15.4%**	**2.7%**	**$63,568**	**51.6%**	**22.8%**	**$46,731**
	0	0	0.0%	0.0%	0	0.0%	0.0%	0
	$0-$1500	11	0.1%	0.0%	9	0.0%	0.0%	807
WITH	$1500-$3500	22	0.3%	0.0%	57	0.0%	0.0%	2,552
INSTITUTIONAL	$3500-$12,000	128	1.5%	0.3%	1,004	0.8%	0.4%	7,846
CARE	$12,000-$25,000	208	2.4%	0.4%	3,874	3.1%	1.4%	18,614
	$25,000+	991	11.2%	2.0%	58,624	47.6%	21.0%	59,178
	United States	**7,447**	**84.6%**	**15.0%**	**$59,626**	**48.4%**	**21.4%**	**$8,007**
	0	1,264	14.3%	2.5%	0	0.0%	0.0%	0
	$0-$1500	1,663	18.9%	3.3%	948	0.8%	0.3%	570
WITHOUT	$1500-$3500	1,151	13.1%	2.3%	2,828	2.3%	1.0%	2,458
INSTITUTIONAL	$3500-$12,000	2,037	23.1%	4.1%	13,474	10.9%	4.8%	6,613
CARE	$12,000-$25,000	769	8.7%	1.5%	13,238	10.7%	4.8%	17,210
	$25,000+	563	6.4%	1.1%	29,138	23.7%	10.5%	51,782

Source: Urban Institute and KCMU estimates based on MSIS 2005.
Note: Does not include Medicare premiums and cost sharing and negative expenditures. Totals and Percentages may not match other tables and figures that include premium and cost-sharing data.

The 15 percent of dual eligibles who were in an institutional long-term care setting for some period of FFY 2005 accounted for more than half of all spending on duals (Figure 7). Over 70 percent of institutionalized duals received care that cost more than $25,000 for the year. The average spending for duals with institutional spending was $46,731.

However, about 85 percent of duals never lived in an institutional setting in 2005. These individuals accounted for 21 percent of total Medicaid program spending. More than half of these individuals had spending under $3,500, with spending in this group averaging about $8,000 per capita.

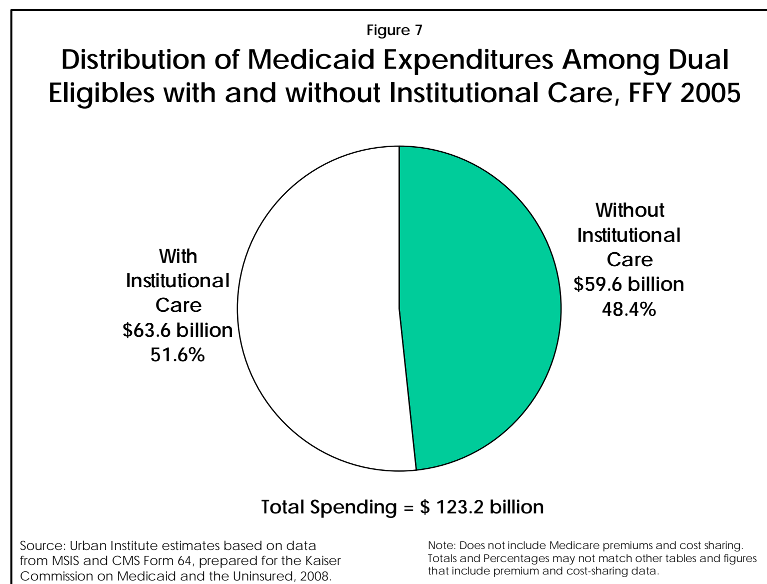


Figure 7

Distribution of Medicaid Expenditures Among Dual Eligibles with and without Institutional Care, FFY 2005

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

Note: Does not include Medicare premiums and cost sharing. Totals and Percentages may not match other tables and figures that include premium and cost-sharing data.

Conclusion

Dual eligibles are among the sickest and poorest individuals covered by either the Medicaid or Medicare programs. This brief has documented that nearly half (46%) of all Medicaid spending is FFY 2005 was on behalf of the 8.8 million Medicare enrollees who qualified for both programs. The majority (48%) of this spending was for long-term care services which generally are not covered by Medicare or private insurance. There also exists significant variation in the dual eligibles share of total Medicaid spending and enrollment across the states, reflecting both variation in states' demographic profiles as well as state policy choices affecting the extent of Medicaid coverage provided to the aged and disabled versus non-disabled adults and children. Across all states, however, improving care coordination and payment structures for dual eligibles will be an essential component in efforts to strengthen both the Medicare and Medicaid programs in the years ahead.

This brief was prepared by John Holahan and Dawn M. Miller of the Urban Institute and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

Notes

[1] Medpac. "A Data Book: Healthcare Spending and the Medicare Program." Section 3.

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

[3] Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey, 2006 Access to Care file.

[4] Medicare eligibility generally requires an individual or his or her spouse to have paid Medicare payroll tax for at least 40 calendar quarters (10 years).

[5] Federal law requires permanently disabled individuals to wait for 24 months after beginning receipt of Social Security Disability Insurance (SSDI) before becoming eligible for Medicare coverage. A 2003 study estimated that 1.2 million disabled non-elderly individuals (nearly 400,000 of whom were uninsured) were currently in the two-year waiting period, and that eliminating this waiting period would save states roughly $1.8 billion (Stacy Berg Dale and James Verdier, "Elimination of Medicare's Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs, the Commonwealth Fund, July 7, 2003).

[6] Sommers A and M Cohen. 2006. "Medicaid's High Cost Enrollees: How Much Do They Drive Medicaid Spending?" Kaiser Commission on Medicaid and the Uninsured, March.

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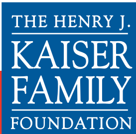

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