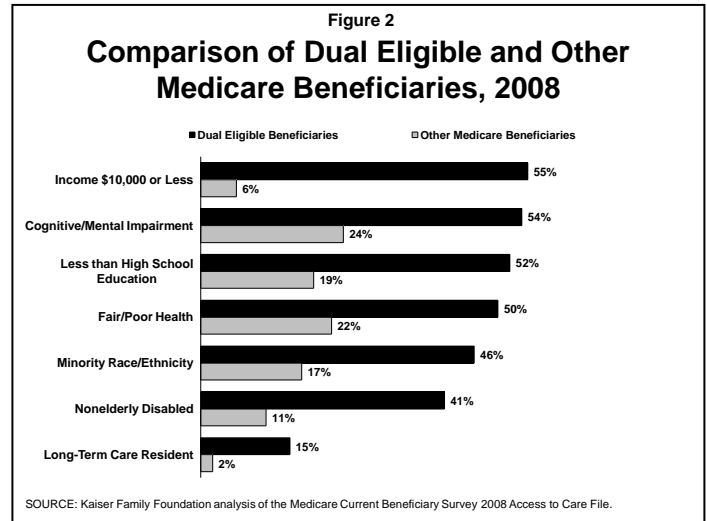
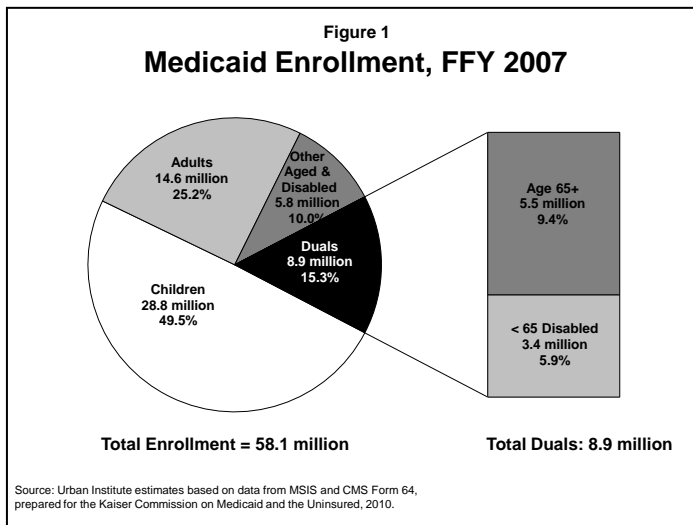


Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries

Nearly 9 million Medicaid beneficiaries are “dual eligibles” – low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. Dual eligibles are among the sickest and poorest individuals covered by either the Medicaid or Medicare programs. They must navigate both Medicare and Medicaid to access services, and rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as 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 fund and manage the programs.

Who Are Dual Eligibles?

Dual eligibles account for 15% of Medicaid enrollees. About six in ten dual eligibles (5.5 million) were individuals age 65 and over, and more than a third (3.4 million) were younger persons with disabilities. (Figure 1) Most dual eligibles have very low-incomes: 55% have annual income below \$10,000 compared to 6% of all other Medicare beneficiaries. Most dual eligibles have substantial health needs: half are in fair or poor health, more than twice the rate of others on Medicare. Dual eligibles are also more likely to have mental health needs and to live in nursing homes compared to other Medicare beneficiaries. (Figure 2)



How Do Dual Eligibles Qualify for Medicaid?

Medicare beneficiaries who have low incomes and limited assets can obtain Medicaid coverage through different eligibility “pathways,” and the kind of assistance that Medicaid provides varies accordingly. Most dual eligibles qualify for Supplemental Security Income (SSI) cash assistance – generally 75% of the FPL for individuals – or have exhausted their resources paying for health and long-term care (sometimes known as “medically needy” or “spend-down”). These individuals receive assistance with Medicare premiums and cost sharing and coverage of Medicaid benefits. While some protections exist for spouses, those who spend down to receive assistance with nursing home care must apply all of their income, except for a small personal needs allowance, toward the costs of their care and assets must be below \$2,000 for an individual and \$3,000 for a couple in most states.

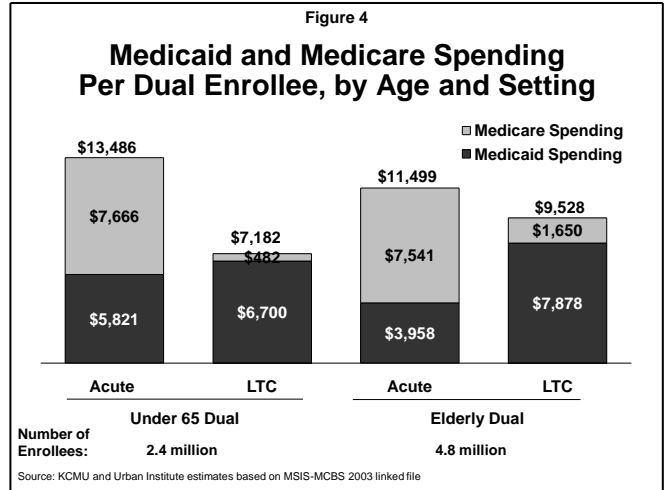
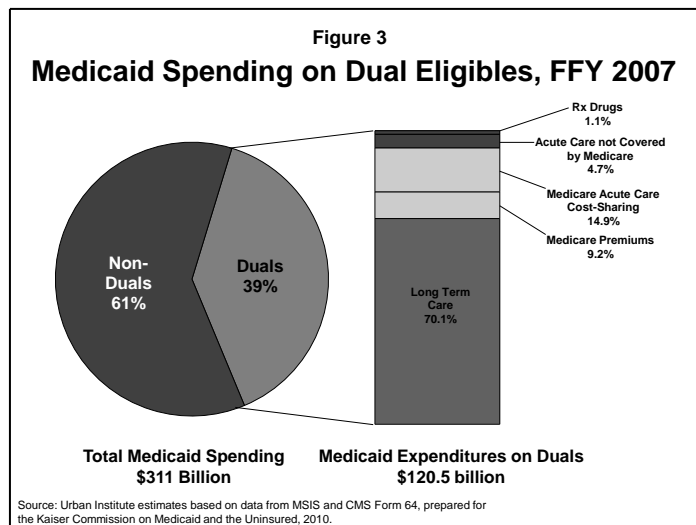
For Medicare beneficiaries with income or resources just above the federal poverty level, Medicaid’s assistance is more limited, primarily covering Medicare premiums. This assistance is referred to as “Medicare Savings Programs.” Qualified Medicare beneficiaries (QMBs) have incomes up to the poverty line (with assets up to \$6,600 for an individual and \$9,910 for a couple) and receive help with Medicare premium and cost sharing obligations. Specified Low-Income Beneficiaries (SLMBs) have slightly higher incomes (100-120% of FPL) and receive help with Medicare premiums only.

What Services Does Medicaid Provide for Duals?

For 21% of Medicare beneficiaries, Medicaid fills in the gaps in Medicare coverage. For those who qualify, Medicaid pays the Medicare Part B premium (Medicare part B premiums are \$96.40/month for most beneficiaries in 2010); pays the cost sharing charged for many Medicare services; and covers a range of benefits not covered by Medicare such as long-term care, dental care, and eyeglasses. The majority of dual eligibles (6.9 million) receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing. The remaining dual eligibles (2.0 million) receive assistance only with their Medicare premiums and cost-sharing. Most dual eligibles, whether eligible for full or partial Medicaid benefits, have very low incomes and significant health care needs.

Medicaid Spending for Dual Eligibles

Dual eligibles account for a large share (39%) of total Medicaid spending, although they represent just 15 percent of Medicaid enrollment. In 2007, more than two-thirds (70%) of Medicaid expenditures for dual eligibles were for long-term care services; payments for cost sharing on Medicare-covered services accounted for about 15 percent; payment of Medicare premiums accounted for 9 percent of spending; and an additional 5 percent were for other acute services that Medicare does not cover. (Figure 3) Prescription drug spending accounted for just 1 percent of Medicaid spending on dual eligibles. In 2006 prescription drug spending for the duals was absorbed into Medicare Part D, but states are still required to make a contribution towards this benefit. States' spending on duals varies, and is largely determined by the mix of institutional versus home and community based long-term care, and the share of duals who are receiving full versus partial Medicaid benefits.



Dual eligibles are a high-cost population, with combined Medicaid and Medicare spending totaling nearly \$200 billion in 2005. Medicare and Medicaid spending averaged over \$20,000 per dual, about five times greater than spending on other Medicare beneficiaries. This higher level of spending reflects their greater health needs and utilization of services compared to other Medicare beneficiaries. Medicare predominantly pays for acute care spending for dual eligibles while Medicaid finances the majority of long term care, since Medicare's coverage is limited to short term post acute care. (Fig. 4) Dual eligibles often have multiple chronic conditions and are more likely to be hospitalized, use emergency rooms and require long-term care than other Medicare beneficiaries. Younger duals who are disabled and the oldest duals who rely on long-term care are the most expensive. Dual eligibles with certain conditions, including cerebral palsy, Alzheimer's, and multiple sclerosis have substantially higher per capita spending than other duals.

Looking Forward

The Affordable Care Act establishes two new federal entities—the Federal Coordinated Health Care Office (Duals Office) and the Center for Medicare and Medicaid Innovation (Innovation Center)—that will be involved in efforts to study and improve care for dual eligible beneficiaries. The Duals Office and Innovation Center recently issued 15 design contracts, of \$1M each, to states to begin developing proposals for better coordinating care for dually eligible individuals. Looking forward, improving care coordination and payment structures for dual eligibles across the range of acute and long-term services while assuring beneficiary safeguards will be important elements in improving access and quality of care, and efforts to strengthen both the Medicare and Medicaid programs in the years ahead.

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