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Medicaid's Role for Dual Eligible Beneficiaries

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Medicaid fills in the gaps in Medicare's benefit package for many low-income Medicare enrollees. These "dual eligibles" are individuals who are entitled to Medicare and 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 long-term care and at state option, hearing, vision, and dental. Because dual eligibles have significant medical needs and a much higher per capita cost on average 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 provides an update of the share of total Medicaid enrollment and spending attributable to dual eligibles using data through 2008. The data in this brief comes from the 2008 Medicaid Statistical Information System (MSIS) maintained by the Centers for Medicare and Medicaid Services (CMS), having adjusted spending to align to CMS Form 64 levels, as well as having incorporated premium data from the CMS Form 64. Further details on the methodology are provided in the appendix. This brief 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 group (elderly or disabled under age 65). Among the findings from this work are:

- Over **9.1 million** older Americans and younger persons with disabilities are covered under both the Medicare and Medicaid programs in Federal Fiscal Year (FFY) 2008. Although these "dual eligibles" accounted for only **15 percent of Medicaid enrollment in 2008, 39 percent of all Medicaid expenditures** for medical services were made on their behalf. Dual eligibles also accounted for 31 percent of Medicare spending in 2008.[1]
- Dual eligibles as a share of total Medicaid enrollees **ranged from a low of 10 percent in Arizona and Utah to a high of 26 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 18 percent in Arizona to a high of 59 percent in North Dakota.**
- **One quarter (25%) of Medicaid spending for dual eligibles went toward Medicare premiums and cost-sharing for Medicare services in 2008.** Five percent of spending for duals was for acute care services not covered by Medicare (e.g., dental, vision, and hearing services). Another 1 percent of Medicaid dual eligible spending was for prescription drugs, a percentage that has fallen significantly since coverage for nearly all prescribed drugs for duals was shifted from Medicaid to Medicare Part D in 2006. The remaining **69% of Medicaid spending was for long-term care services**, which are generally not covered by Medicare or private insurance.
- Nearly **two-thirds (62%) of Medicaid spending on dual eligibles was for enrollees age 65 and older**. Although only 14 percent of dual eligibles were in an institutional long-term care setting in 2008, these enrollees accounted for 69 percent of all spending on duals. Like health spending more generally, **spending on dual eligibles is skewed toward those with the greatest health and long-term care needs** — the roughly 900,000 dual eligibles who were in the top ten percent of spending in 2008 accounted for more than 60 percent of all dual eligible spending.

An Overview of FFY 2008 Dual Eligible Enrollment and Spending

Who are the Dual Eligibles?

Dual eligibles are individuals who are entitled to Medicare and eligible for some level of assistance from their state Medicaid program. Categories of Medicare participants who are eligible to receive assistance under Medicaid are listed in Table 1. Some dual eligibles, referred to as "full" duals, qualify for the full package of Medicaid benefits and also receive assistance from Medicaid with their Medicare premiums and cost sharing.[2] Other duals, referred to as "partial" duals, do 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.[3]

Dual eligibles are among the sickest and poorest individuals covered by either Medicare or Medicaid. Most dual eligibles are very low-income individuals. In 2008, 86 percent of dual eligibles had annual incomes below 150% of the federal poverty level, compared to 22 percent of non-dual Medicare beneficiaries. Only 7 percent of duals had annual incomes greater than 200% of the federal poverty level. Thirteen percent required care in a long-term care facility, such as a nursing home. Forty-six 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 cognitive or mental impairments, depression, and diabetes, is significantly higher for duals than for non-dual Medicare beneficiaries. The composition of Medicare enrollees receiving some level of Medicaid assistance and the services they utilize that are paid for by Medicare are studied in greater detail in the Kaiser Family Foundation brief *Medicare's Role for Dual Eligible Beneficiaries*.[4]

Table 1

Common Medicaid Eligibility Pathways for Medicare Beneficiaries, 2008

	Income Eligibility	Asset Limit	Medicaid Benefits in 2008
Individuals Eligible for Full Medicaid Benefits ("Full Dual Eligibles")			
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, 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)[b]	Full Medicaid benefits, including long-term care, 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)[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)[b]	Full Medicaid benefits, including long-term care, 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 (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 than 300% of SSI.		Full Medicaid benefits, including long-term care, that 'wrap around' Medicare benefits. Medicaid may also pay Medicare premiums and cost sharing.
Medicare Savings Programs ("Partial Dual Eligibles")			
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 Disabled Working Individuals (QDWI) (mandatory)	Working, disabled individuals with income up to 200% of the FPL.[*]	$4,000 (individual) $6,000 (couple)	No Medicaid benefits. Medicaid pays Medicare Part A premium.
Qualifying Individuals (QI) (mandatory)	Between 120% and 135% of the FPL.[*b]	$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 2008, 100% of the federal poverty level (FPL) was $867 for individuals and $1,167 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 2008 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 incomes that are too high to qualify under SSI or poverty-related levels. Unless their incomes fall 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 2008, 300% of SSI was $1,911 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.

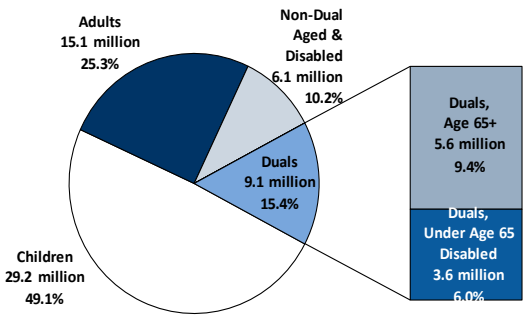
e) States are not required to pay for Medicare cost-sharing if the Medicaid payment rates for a given service are sufficiently lower than the Medicare payment rates.

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.

How Many Dual Eligibles are Enrolled in Medicaid?

Figure 1

Medicaid Enrollment, FFY 2008



Total Enrollment = 59.5 million

Total Duals = 9.1 million

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS, 2012.

Over 9 million Medicare beneficiaries were enrolled in Medicaid in 2008 (Figure 1 and Table 2). This includes both those who qualified for full Medicaid benefits ("full" duals) and those who received only assistance with Medicare premiums and cost sharing ("partial" duals). These "partial" dual eligibles were not eligible for non-Medicare covered Medicaid services, such as hearing, vision, dental, and long-term care. Nearly one in six Medicaid enrollees (15%) was dually eligible in 2008 (Figure 1). Of these dual eligible enrollees, 7 million (77%) were "full" duals while the remaining 23 percent were "partial" duals.

While dual eligibles account for 15 percent of all Medicaid enrollees nationally, there is significant variation in their share of each state's Medicaid enrollment. Duals account for at least 21 percent of all Medicaid enrollees in Maine (26%), Alabama (23%), North Dakota (22%), Kentucky, New Jersey, and Wisconsin (each 21%). In other states – Alaska, Arizona, California, New Mexico, and Utah – duals make up less than 12 percent 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 provided to their aged and disabled residents versus non-disabled adults and children. There is also great variation among states in the share of duals that receive full or partial Medicaid assistance. In states such as Delaware and Alabama, which cover many individuals through Medicare Savings Programs, more than half of all dual eligibles in the state are "partial" dual eligibles. In states such as Alaska and California, on the other hand, where relatively fewer have been enrolled in Medicare Savings Programs, nearly all duals qualify for full Medicaid benefits (Table 2).

Over 60 percent of Medicaid dual eligibles (5.6 million) were "elderly," or individuals age 65 and over, while the remaining duals (3.6 million) were younger individuals with disabilities (Table 3). Eight percent of elderly Medicaid enrollees are not eligible for Medicare, because their own or others' work histories were not sufficient to qualify them for Medicare.[5] A much larger share (61%) of Medicaid's non-elderly enrollees with disabilities do 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.[6] As shown in Table 3, the percentage of aged Medicaid enrollees who were dually eligible was at least 95 percent in 29 states. The share of disabled Medicaid enrollees who were dual eligibles averaged 39 percent nationally, but the share was 50 percent or more in seven states.

Table 2

Dual Eligibles and Full Dual Eligibles by State, 2008

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	9,142,228	15%	60%	7,031,641	77%
Alabama	208,250	23%	64%	99,997	48%
Alaska	13,006	11%	56%	12,710	98%
Arizona	147,966	10%	62%	114,499	77%
Arkansas	118,405	17%	59%	68,793	58%
California	1,201,009	11%	61%	1,174,336	98%
Colorado	69,872	12%	55%	64,521	92%
Connecticut	103,162	19%	75%	78,226	76%
Delaware	23,796	12%	64%	11,095	47%
District of Columbia	22,192	13%	45%	18,806	85%
Florida	601,276	20%	65%	348,735	58%
Georgia	264,172	16%	62%	145,673	55%
Hawaii	32,688	15%	67%	29,734	91%
Idaho	30,889	15%	58%	21,719	70%
Illinois	313,365	13%	60%	274,655	88%
Indiana	155,826	14%	64%	100,567	65%
Iowa	81,382	17%	69%	68,310	84%
Kansas	63,077	18%	61%	46,963	74%
Kentucky	178,381	21%	56%	110,464	62%
Louisiana	180,354	16%	57%	107,123	59%
Maine	91,976	26%	76%	53,332	58%
Maryland	109,905	14%	54%	74,493	68%
Massachusetts	254,979	17%	38%	247,751	97%
Michigan	263,859	13%	58%	233,786	89%
Minnesota	132,224	16%	62%	119,950	91%
Mississippi	150,850	20%	61%	81,354	54%
Missouri	171,506	17%	62%	155,892	91%
Montana	18,446	17%	60%	15,835	86%
Nebraska	41,643	17%	70%	37,674	90%
Nevada	40,009	15%	62%	21,718	54%
New Hampshire	28,783	19%	73%	20,543	71%
New Jersey	203,908	21%	65%	170,771	84%
New Mexico	55,971	11%	59%	39,533	71%
New York	737,161	15%	61%	658,601	89%
North Carolina	310,496	18%	65%	250,178	81%
North Dakota	15,353	22%	76%	11,319	74%
Ohio	303,761	15%	54%	205,501	68%
Oklahoma	113,553	15%	65%	95,020	84%
Oregon	90,355	17%	65%	62,159	69%
Pennsylvania	391,855	18%	51%	333,096	85%
Rhode Island	39,388	20%	59%	33,851	86%
South Carolina	150,973	18%	66%	131,959	87%
South Dakota	20,520	17%	69%	13,760	67%
Tennessee	284,368	19%	62%	216,329	76%
Texas	626,375	15%	63%	384,677	61%
Utah	30,952	10%	59%	28,198	91%
Vermont	31,828	19%	75%	19,951	63%
Virginia	171,256	19%	65%	118,961	69%
Washington	149,782	13%	55%	113,851	76%
West Virginia	79,682	20%	52%	49,523	62%
Wisconsin	211,378	21%	72%	128,311	61%
Wyoming	10,065	13%	64%	6,838	68%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS, 2012.

Table 3

Aged and Disabled Dual Eligibles by State, 2008

State	Aged Dual Eligibles	Aged Duals as a Share of… All Dual Enrollees	Aged Duals as a Share of… Aged Enrollees	Disabled Dual Eligibles	Disabled Duals as a Share of… All Dual Enrollees	Disabled Duals as a Share of… Disabled Enrollees
United States	5,571,054	61%	92%	3,571,174	39%	39%
Alabama	122,712	59%	99%	85,538	41%	43%
Alaska	7,110	55%	85%	5,896	45%	40%
Arizona	87,019	59%	91%	60,947	41%	43%
Arkansas	66,427	56%	95%	51,978	44%	39%
California	850,348	71%	87%	350,661	29%	35%
Colorado	43,458	62%	89%	26,414	38%	34%
Connecticut	63,308	61%	94%	39,854	39%	57%
Delaware	13,215	56%	94%	10,581	44%	46%
District of Columbia	13,456	61%	90%	8,736	39%	25%
Florida	396,623	66%	94%	204,653	34%	40%
Georgia	159,891	61%	96%	104,281	39%	40%
Hawaii	22,662	69%	97%	10,026	31%	39%
Idaho	15,579	50%	95%	15,310	50%	41%
Illinois	181,756	58%	81%	131,609	42%	44%
Indiana	79,371	51%	93%	76,455	49%	48%
Iowa	42,560	52%	99%	38,822	48%	52%
Kansas	33,386	53%	93%	29,691	47%	44%
Kentucky	94,614	53%	99%	83,767	47%	38%
Louisiana	108,406	60%	98%	71,948	40%	35%
Maine	56,360	61%	98%	35,616	39%	56%
Maryland	65,014	59%	89%	44,891	41%	34%
Massachusetts	137,436	54%	85%	117,543	46%	23%
Michigan	133,295	51%	96%	130,564	49%	41%
Minnesota	74,062	56%	78%	58,162	44%	49%
Mississippi	88,317	59%	98%	62,533	41%	39%
Missouri	88,031	51%	94%	83,475	49%	45%
Montana	10,468	57%	99%	7,978	43%	40%
Nebraska	22,605	54%	94%	19,038	46%	54%
Nevada	24,237	61%	97%	15,772	39%	40%
New Hampshire	14,122	49%	94%	14,661	51%	60%
New Jersey	136,093	67%	92%	67,815	33%	41%
New Mexico	34,418	61%	97%	21,553	39%	36%
New York	507,743	69%	90%	229,418	31%	35%
North Carolina	178,915	58%	98%	131,581	42%	44%
North Dakota	9,125	59%	99%	6,228	41%	57%
Ohio	158,225	52%	88%	145,536	48%	38%
Oklahoma	64,654	57%	97%	48,899	43%	45%
Oregon	51,107	57%	97%	39,248	43%	46%
Pennsylvania	221,255	56%	94%	170,600	44%	32%
Rhode Island	23,218	59%	95%	16,170	41%	39%
South Carolina	84,146	56%	100%	66,827	44%	46%
South Dakota	12,415	61%	99%	8,105	39%	48%
Tennessee	146,091	51%	97%	138,277	49%	45%
Texas	423,260	68%	97%	203,115	32%	36%
Utah	14,637	47%	95%	16,315	53%	44%
Vermont	19,314	61%	96%	12,514	39%	56%
Virginia	99,302	58%	95%	71,954	42%	45%
Washington	81,188	54%	91%	68,594	46%	37%
West Virginia	40,783	51%	99%	38,899	49%	35%
Wisconsin	143,895	68%	98%	67,483	32%	46%
Wyoming	5,422	54%	98%	4,643	46%	46%

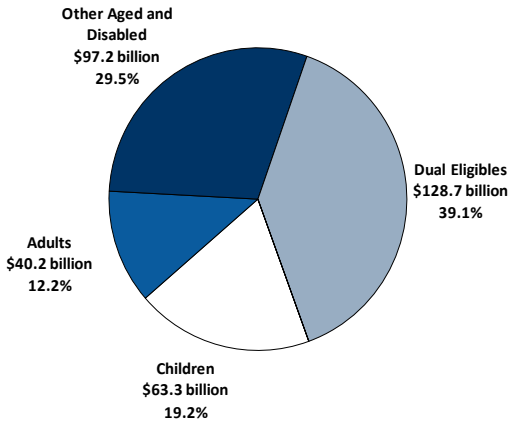
Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS, 2012.

How Much Does Medicaid Spend on Services for Dual Eligibles?

Dual eligibles account for 15 percent of Medicaid enrollment, and due to their more intensive need for services, 39 percent ($128.7 billion) of all Medicaid expenditures for medical services (including Medicare premiums) were made on their behalf in 2008 (Figure 2). Sixty-nine percent of Medicaid expenditures for dual eligibles ($89 billion) were for long-term care services (Figure 3).

Figure 2

Medicaid Spending by Group, Services Only[1], FFY 2008



Total Spending = $329.5 billion

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

1. Expenditures include Medicare premiums.

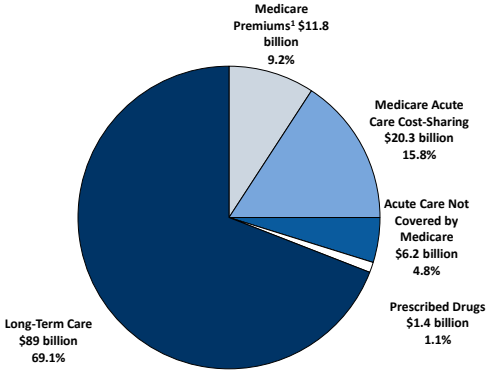
Only 1 percent of 2008 expenditures for dual eligibles ($1.4 billion) were for prescription drugs, as nearly all prescription drug spending for dual eligibles was absorbed into Medicare in January 2006 with the implementation of Medicare Part D. However, states are required to make a substantial contribution towards this benefit through monthly "clawback" payments to the federal treasury.[7]

Another $32 billion in expenditures on dual eligibles went toward Medicare premiums ($11.8 billion) and Medicaid's financing of Medicare-covered acute care services (e.g., hospital, physician, and lab/x-ray services) ($20.3 billion). Finally, approximately $6 billion was spent on other acute care services that are not covered by Medicare, such as dental care, vision, and hearing services.

As with enrollment, duals' share of total spending and the distribution of spending on dual eligibles across services varied significantly across the states (Tables 4a and 4b). Spending on dual eligibles accounted for at least half of Medicaid spending in Connecticut, North Dakota, and Wisconsin. Long-term care spending was at least 80 percent of spending on dual eligibles in Connecticut, Kansas, New Hampshire, North Dakota, and Pennsylvania.

Figure 3

Medicaid Expenditures for Dual Eligibles, FFY 2008



Total Spending = $128.7 billion

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

1. "Medicare Premiums" also includes cost-sharing for Qualified Medicare Beneficiaries only.

Table 4a

Medicaid Expenditures for Dual Eligibles by State, 2008

State	Dual Eligible Total (in Millions)	Expenditures for Duals by Service (in Millions): Medicare Premiums[1]	Medicare Acute Care Cost-Sharing	Acute Care Not Covered by Medicare	Prescribed Drugs	Long-Term Care	Dual Eligible Spending as % of Total Medicaid	Spending Per Dual Eligible Per Year
United States[2]	128,735	11,786	20,307	6,242	1,438	88,962	39%	16,087
Alabama	1,589	221	191	21	14	1,142	42%	8,591
Alaska	249	18	26	17	2	186	28%	21,117
Arizona[3]	1,298	156	N/A	N/A	N/A	N/A	18%	10,161
Arkansas	1,517	251	322	163	15	767	45%	14,612
California	15,341	1,913	3,631	443	235	9,119	41%	14,207
Colorado	1,194	72	187	38	6	892	39%	19,883
Connecticut	2,501	225	142	87	37	2,010	58%	27,704
Delaware	360	26	38	12	3	282	31%	17,098
District of Columbia	502	22	37	186	3	253	36%	26,301
Florida	6,131	964	1,161	121	84	3,802	41%	12,260
Georgia	2,263	244	263	110	19	1,628	32%	9,783
Hawaii	427	55	29	16	6	321	36%	15,001
Idaho	413	31	56	31	3	292	34%	15,197
Illinois	3,358	297	561	194	45	2,262	29%	12,220
Indiana	2,190	139	361	81	19	1,591	38%	16,933
Iowa	1,391	175	126	78	11	1,001	48%	19,653
Kansas	948	64	97	23	9	756	42%	17,580
Kentucky	1,653	194	242	35	36	1,147	34%	10,688
Louisiana	1,833	211	192	87	27	1,317	34%	11,254
Maine	1,064	84	59	266	12	643	47%	12,925
Maryland	1,978	148	280	57	14	1,479	35%	20,867
Massachusetts	4,804	303	790	882	30	2,798	44%	21,276
Michigan	3,268	352	696	84	26	2,109	34%	14,469
Minnesota	3,157	124	766	78	14	2,176	46%	27,754
Mississippi	1,538	241	208	65	14	1,010	41%	11,510
Missouri	2,448	274	396	221	40	1,516	37%	16,969
Montana	364	35	30	15	3	282	46%	24,444
Nebraska	732	90	87	22	8	525	45%	20,329
Nevada	426	82	45	18	5	276	34%	12,715
New Hampshire	518	17	58	8	4	430	49%	21,629
New Jersey	3,946	253	341	270	47	3,036	49%	21,551
New Mexico[4]	733	56	74	28	-1	575	24%	15,021
New York	20,402	1,058	2,786	761	152	15,646	45%	31,752
North Carolina	3,407	323	381	297	51	2,354	34%	12,269
North Dakota	323	9	22	3	2	287	59%	24,822
Ohio	5,229	310	579	170	41	4,129	42%	20,363
Oklahoma	1,299	122	190	34	9	944	36%	13,291
Oregon	1,302	95	173	32	8	993	41%	16,564
Pennsylvania	6,789	429	476	82	40	5,762	43%	20,138
Rhode Island	762	34	117	76	6	530	47%	22,011
South Carolina	1,578	144	396	29	25	984	38%	11,737
South Dakota	255	24	31	3	2	197	38%	14,264
Tennessee	2,403	307	488	28	23	1,557	33%	9,379
Texas	6,244	835	893	646	69	3,801	30%	11,007
Utah	392	13	102	12	8	258	26%	15,037
Vermont	390	6	32	47	12	293	40%	14,051
Virginia	2,109	190	218	47	19	1,635	40%	13,996
Washington	2,056	216	158	97	30	1,555	34%	16,123
West Virginia	867	90	63	16	13	685	37%	12,580
Wisconsin	2,578	233	559	95	138	1,553	52%	13,836
Wyoming	214	10	47	3	1	153	43%	24,964

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

1. The "Medicare Premiums" column also includes cost-sharing for Qualified Medicare Beneficiaries only.

2. The national totals include Arizona spending by service.

3. Expenditures for Arizona are not shown by service because most expenditures for duals in Arizona are covered under the Arizona Long-Term Care System (ALTCS), which is a capitated program, and cannot be separated out by service type.

4. Spending totals include negative amounts, which reflect adjustments to the 2007 data. The negative spending for prescribed drugs in New Mexico indicates that for this service, the amount adjusted was greater than spending in 2008.

Table 4b

Medicaid Expenditures for Dual Eligibles by State, 2008

	Distribution of Spending for Dual Eligibles by Service					
State	Medicare Premiums[1]	Medicare Acute Care Cost-Sharing	Acute Care Not Covered by Medicare	Prescribed Drugs	Long-Term Care	Total
United States[2]	9%	16%	5%	1%	69%	100%
Alabama	14%	12%	1%	1%	72%	100%
Alaska	7%	10%	7%	1%	75%	100%
Arizona[3]	12%	N/A	N/A	N/A	N/A	N/A
Arkansas	17%	21%	11%	1%	51%	100%
California	12%	24%	3%	2%	59%	100%
Colorado	6%	16%	3%	0%	75%	100%
Connecticut	9%	6%	3%	1%	80%	100%
Delaware	7%	10%	3%	1%	78%	100%
District of Columbia	4%	7%	37%	1%	50%	100%
Florida	16%	19%	2%	1%	62%	100%
Georgia	11%	12%	5%	1%	72%	100%
Hawaii	13%	7%	4%	1%	75%	100%
Idaho	8%	14%	8%	1%	71%	100%
Illinois	9%	17%	6%	1%	67%	100%
Indiana	6%	16%	4%	1%	73%	100%
Iowa	13%	9%	6%	1%	72%	100%
Kansas	7%	10%	2%	1%	80%	100%
Kentucky	12%	15%	2%	2%	69%	100%
Louisiana	12%	10%	5%	1%	72%	100%
Maine	8%	6%	25%	1%	60%	100%
Maryland	7%	14%	3%	1%	75%	100%
Massachusetts	6%	16%	18%	1%	58%	100%
Michigan	11%	21%	3%	1%	65%	100%
Minnesota	4%	24%	2%	0%	69%	100%
Mississippi	16%	14%	4%	1%	66%	100%
Missouri	11%	16%	9%	2%	62%	100%
Montana	10%	8%	4%	1%	77%	100%
Nebraska	12%	12%	3%	1%	72%	100%
Nevada	19%	11%	4%	1%	65%	100%
New Hampshire	3%	11%	2%	1%	83%	100%
New Jersey	6%	9%	7%	1%	77%	100%
New Mexico	8%	10%	4%	0%	78%	100%
New York	5%	14%	4%	1%	77%	100%
North Carolina	9%	11%	9%	2%	69%	100%
North Dakota	3%	7%	1%	1%	89%	100%
Ohio	6%	11%	3%	1%	79%	100%
Oklahoma	9%	15%	3%	1%	73%	100%
Oregon	7%	13%	2%	1%	76%	100%
Pennsylvania	6%	7%	1%	1%	85%	100%
Rhode Island	4%	15%	10%	1%	70%	100%
South Carolina	9%	25%	2%	2%	62%	100%
South Dakota	9%	12%	1%	1%	77%	100%
Tennessee	13%	20%	1%	1%	65%	100%
Texas	13%	14%	10%	1%	61%	100%
Utah	3%	26%	3%	2%	66%	100%
Vermont	1%	8%	12%	3%	75%	100%
Virginia	9%	10%	2%	1%	78%	100%
Washington	10%	8%	5%	1%	76%	100%
West Virginia	10%	7%	2%	1%	79%	100%
Wisconsin	9%	22%	4%	5%	60%	100%
Wyoming	5%	22%	1%	0%	72%	100%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

1. The "Medicare Premiums" column also includes cost-sharing for Qualified Medicare Beneficiaries only.

2. The national totals include Arizona spending by service.

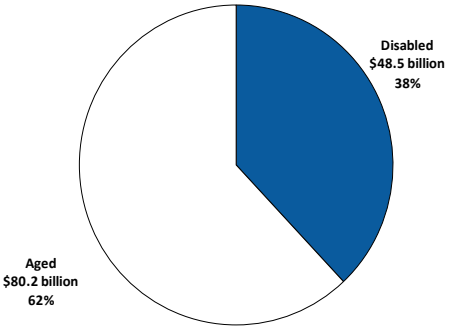
3. Expenditures for Arizona are not shown by service because most expenditures for duals in Arizona are covered under the Arizona Long-Term Care System (ALTCS), which is a capitated program, and cannot be separated out by service type.

Medicaid spending per dual eligible per year (which reflects spending per full-year-equivalent, dual eligible enrollee) averaged $16,087 for the nation in 2008 (Table 4a). However, several states – Connecticut, the District of Columbia, Minnesota, and New York – averaged more than $25,000 per dual eligible per year. The range of per capita spending on a per enrollee, per year basis is wide. Several states – Alabama, Georgia, and Tennessee – spent less than $10,000 per dual eligible per year in 2008.

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 aged dual eligible per year is slightly higher than spending per disabled dual per year. Even when looking within eligibility groups, the range of per capita spending on dual eligibles across states is wide. Spending per aged dual per year ranged from more than $25,000 in Connecticut, Minnesota, Montana, New York, and Pennsylvania to less than $10,000 in Arizona and Tennessee. Among disabled duals, per capita spending ranged from more than $39,000 in New York to under $7,000 in Alabama.

Figure 4

Distribution of Medicaid Expenditures Among Aged and Disabled Dual Eligibles, FFY 2008



Total Spending = $128.7 billion

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

Note: Medicare premium costs were allotted to aged and disabled eligibles based on their relative proportions of enrollees.

Table 5

Medicaid Expenditures for Aged and Disabled Dual Eligibles by State, 2008

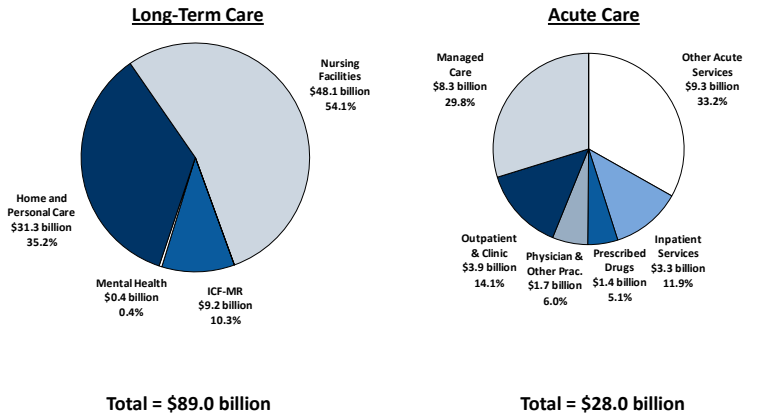
	Aged			Individuals with Disabilities		
State	Total (in millions)	Spending Per Aged Dual Eligible Per Year	Percent of Dual Eligible Expenditures	Total (in millions)	Spending Per Disabled Dual Eligible Per Year	Percent of Dual Eligible Expenditures
United States	$80,198	$16,465	62%	$48,537	$15,499	38%
Alabama	1,117	10,206	70%	472	6,252	30%
Alaska	140	21,730	56%	109	20,376	44%
Arizona	733	9,738	56%	565	10,769	44%
Arkansas	912	15,657	60%	605	13,278	40%
California	10,411	13,553	68%	4,930	15,818	32%
Colorado	744	20,113	62%	450	19,514	38%
Connecticut	1,548	28,219	62%	953	26,907	38%
Delaware	212	18,073	59%	148	15,871	41%
District of Columbia	280	23,942	56%	222	30,032	44%
Florida	3,964	11,832	65%	2,167	13,128	35%
Georgia	1,553	11,037	69%	711	7,838	31%
Hawaii	296	15,030	69%	131	14,937	31%
Idaho	222	16,562	54%	191	13,872	46%
Illinois	1,854	11,726	55%	1,505	12,887	45%
Indiana	1,212	18,810	55%	977	15,068	45%
Iowa	719	20,129	52%	672	19,169	48%
Kansas	520	18,749	55%	428	16,342	45%
Kentucky	1,043	12,661	63%	610	8,440	37%
Louisiana	1,051	10,787	57%	783	11,948	43%
Maine	599	11,954	56%	465	14,437	44%
Maryland	1,226	21,918	62%	752	19,352	38%
Massachusetts	2,912	24,470	61%	1,892	17,716	39%
Michigan	2,220	19,815	68%	1,048	9,207	32%
Minnesota	1,611	25,989	51%	1,546	29,868	49%
Mississippi	1,021	12,996	66%	517	9,389	34%
Missouri	1,361	18,452	56%	1,087	15,417	44%
Montana	259	31,306	71%	105	15,872	29%
Nebraska	404	21,190	55%	328	19,361	45%
Nevada	273	13,273	64%	153	11,830	36%
New Hampshire	286	24,714	55%	232	18,744	45%
New Jersey	2,498	20,555	63%	1,448	23,516	37%
New Mexico	429	14,220	59%	304	16,319	41%
New York	12,671	28,503	62%	7,731	39,048	38%
North Carolina	2,005	12,599	59%	1,403	11,827	41%
North Dakota	189	24,949	59%	134	24,645	41%
Ohio	3,023	22,859	58%	2,206	17,711	42%
Oklahoma	730	13,174	56%	569	13,444	44%
Oregon	882	20,251	68%	419	11,976	32%
Pennsylvania	5,032	26,774	74%	1,757	11,778	26%
Rhode Island	445	22,007	58%	317	22,017	42%
South Carolina	981	13,078	62%	597	10,045	38%
South Dakota	156	14,640	61%	99	13,709	39%
Tennessee	1,283	9,899	53%	1,119	8,847	47%
Texas	4,115	10,696	66%	2,129	11,661	34%
Utah	173	14,227	44%	219	15,746	56%
Vermont	229	13,535	59%	160	14,862	41%
Virginia	1,209	13,887	57%	900	14,145	43%
Washington	1,263	18,430	61%	794	13,444	39%
West Virginia	548	15,703	63%	319	9,372	37%
Wisconsin	1,610	12,764	62%	968	16,086	38%
Wyoming	107	23,688	50%	107	26,396	50%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

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

Figure 5

Medicaid Spending by Type of Service for Dual Eligibles, FFY 2008



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

Note: Does not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

When Medicare premiums are excluded, 76 percent of Medicaid spending on duals in 2008 was for long-term care services. Table 6 and Figure 5 provide detailed data on expenditures by type of service (excluding Medicare premiums). Fifty-four percent of long-term care spending ($48.1 billion of $89.0 billion) was on nursing facilities. Most of the remaining long-term care spending was on home and personal care services, which are composed of home and community-based services, home health, and personal care. Since prescription drugs and some acute care services are covered primarily by Medicare, there is relatively low Medicaid spending on prescription drugs and on services such as inpatient and outpatient hospital and physician services.

Among duals under age sixty-five, spending was greater for long-term care than for acute care services ($31.0 billion vs. $12.9 billion). Almost 40 percent of spending on this group was for home and personal care services and another 31 percent was on long-term care in an institutional setting (ICF-MR, nursing facility, or mental health facility). The remaining 29 percent of spending was distributed among the various acute care services.

The composition of spending for those aged 65 to 74 was similar to those younger than 65, with the notable exception that spending for those aged 65 to 74 was more concentrated in institutional rather than community-based long-term care settings. In addition, this age bracket was more reliant on nursing facilities than on ICF-MRs. In older age cohorts, this concentration in institutions and reliance on nursing home facilities grows more pronounced. For those aged 75 to 84, 79 percent of expenditures were on long-term care services and the remainder on acute care services. Among those aged 85 and older, 86 percent of expenditures were towards long-term care services. The share of expenditures on nursing homes increased from 39 percent among the 65 to 74 year olds to 57 percent among the 75 to 84 year olds, and then to 71 percent among the 85 year olds and older. Overall, duals age 75 and over accounted for $54.6 billion in expenditures; those under age 65 accounted for $43.9 billion.

Per enrollee per year spending varies widely across age categories. On a per enrollee per year basis, spending for those aged 85 and older amounted to over $28,000 per year. Of this total, about $24,000 per year was spent on long-term care services, mostly for nursing home care. Per enrollee spending among those aged 75 to 84 and among those below the age of 65 averaged more than $14,000 per enrollee per year. However, the distribution of spending between long-term care and acute care differed between these two age brackets. For those younger than 65 (i.e., individuals with disabilities), more than 70 percent of this spending was for long-term care services, and more than half of that (56% or $5,529) was for home and personal care services. Acute care services for duals with disabilities amounted to $4,125 per enrollee per year, more than acute care spending for the older age groups. For

those 65 to 74 years old, per enrollee per year spending was far lower, $8,878, reflecting a lower level of health care need compared to either the older groups or those eligible due to disability.

Table 6

Medicaid Expenditures for Dual Eligibles by Type of Service and Age Group, 2008

Service/Service Group	Less Than 65 Years Old		65 to 74 Years Old		75 to 84 Years Old		85 Years Old and Older		All		65 Years Old or Older	
	(in millions)		(in millions)		(in millions)		(in millions)		(in millions)		(in millions)	
Long-term Care Services	**$31,013**	**71%**	**$12,661**	**69%**	**$20,002**	**79%**	**$25,286**	**86%**	**$88,962**	**76%**	**$57,949**	**79%**
Nursing Facilities	5,671	13%	7,100	39%	14,345	57%	20,984	71%	48,101	41%	42,429	58%
ICF-MR	7,971	18%	821	4%	328	1%	79	0%	9,200	8%	1,229	2%
Mental Health	57	0%	198	1%	89	0%	17	0%	361	0%	305	0%
Home and Personal Care	17,315	39%	4,541	25%	5,240	21%	4,206	14%	31,301	27%	13,986	19%
Acute Care Services	**$12,920**	**29%**	**$5,741**	**31%**	**$5,219**	**21%**	**$4,106**	**14%**	**$27,987**	**24%**	**$15,067**	**21%**
Inpatient Services	1,524	3%	832	5%	594	2%	370	1%	3,320	3%	1,796	2%
Prescribed Drugs	810	2%	332	2%	183	1%	113	0%	1,438	1%	627	1%
Physician and Other Practitioners	901	2%	385	2%	258	1%	126	0%	1,670	1%	768	1%
Outpatient and Clinic	2,603	6%	776	4%	407	2%	163	1%	3,950	3%	1,346	2%
Managed Care	2,972	7%	1,854	10%	1,948	8%	1,552	5%	8,326	7%	5,354	7%
Other Acute Services	4,108	9%	1,563	8%	1,831	7%	1,782	6%	9,284	8%	5,175	7%
Total Spending	**$43,933**	**100%**	**$18,402**	**100%**	**$25,221**	**100%**	**$29,393**	**100%**	**$116,949**	**100%**	**$73,016**	**100%**

Spending Per Enrollee Per Year

Service/Service Group	Less Than 65 Years Old		65 to 74 Years Old		75 to 84 Years Old		85 Years Old and Older		All		65 Years Old or Older	
Long-term Care Services	**$9,903**	**71%**	**$6,108**	**69%**	**$11,391**	**79%**	**$24,265**	**86%**	**$11,117**	**76%**	**$11,897**	**79%**
Nursing Facilities	1,811	13%	3,425	39%	8,169	57%	20,137	71%	6,011	41%	8,711	58%
ICF-MR	2,545	18%	396	4%	187	1%	76	0%	1,150	8%	252	2%
Mental Health	18	0%	96	1%	51	0%	17	0%	45	0%	63	0%
Home and Personal Care	5,529	39%	2,191	25%	2,984	21%	4,036	14%	3,911	27%	2,871	19%
Acute Care Services	**$4,125**	**29%**	**$2,770**	**31%**	**$2,972**	**21%**	**$3,941**	**14%**	**$3,497**	**24%**	**$3,093**	**21%**
Inpatient Services	487	3%	401	5%	338	2%	355	1%	415	3%	369	2%
Prescribed Drugs	259	2%	160	2%	104	1%	108	0%	180	1%	129	1%
Physician and Other Practitioners	288	2%	186	2%	147	1%	121	0%	209	1%	158	1%
Outpatient and Clinic	831	6%	375	4%	232	2%	156	1%	494	3%	276	2%
Managed Care	949	7%	895	10%	1,109	8%	1,490	5%	1,040	7%	1,099	7%
Other Acute Services	1,312	9%	754	8%	1,043	7%	1,710	6%	1,160	8%	1,062	7%
Total Spending	**$14,029**	**100%**	**$8,878**	**100%**	**$14,363**	**100%**	**$28,206**	**100%**	**$14,614**	**100%**	**$14,990**	**100%**

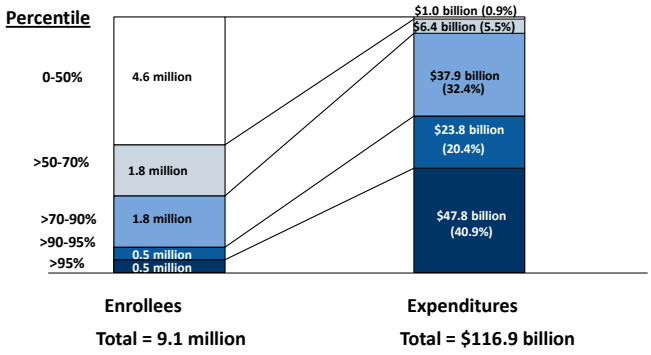
Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 and CMS-64 reports, 2012.

Note: Expenditures do not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data. There were a small number of aged dual enrollees whose exact age was not provided, and as a result could not be included in the "65 to 74 Years Old", the "75 to 84 Years Old", or the "85 Years Old and Older" groups. However, their spending was small and the effect of omitting these enrollees is non-observable.

Like health spending more generally, Medicaid spending on dual eligibles is skewed toward those with the greatest health and long-term care needs. Past research has shown that relatively small numbers of Medicaid enrollees account for a significant share of program spending.[8] Table 7 and Figure 6 demonstrate that spending on dual eligibles is highly concentrated, with the top 10 percent of spenders accounting for more than 60 percent of all spending, and the top 5 percent accounting for more than 40 percent. Spending for this small group of very high-cost duals totaled nearly $48 billion, accounting for over 15 percent of all 2008 Medicaid expenditures. The 4.6 million dual eligibles in the bottom 50 percent of the spending distribution accounted for less than 1 percent of all Medicaid spending on dual eligibles.

Figure 6

Dual Eligible Enrollment and Medicaid Spending by Per Enrollee Spending Percentile, FFY 2008



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

Note: Does not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

This skewed spending is illustrated in the percentile distributions of per enrollee spending on per year basis (Table 7). Dual eligibles above the 95th percentile of per enrollee per year spending had an average of $109,012 in Medicaid spending. Those in the 90 to 95th percentiles of spending had $54,668 in per enrollee per year spending, those in the 70th to 90th percentiles had $23,906 in per enrollee per year spending, and those in the 50th to 70th percentiles had $3,956 in per enrollee per year spending. The bottom half of spenders averaged just $257 per enrollee per year.

The 14 percent of dual eligibles who were in an institutional long-term care setting for some period of FFY 2008 accounted for more than half (54.8%) of all spending on duals and just over a fifth (20.2%) of all Medicaid expenditures. Duals with institutional spending spent an average of $58,009 per enrollee per year.

However, 86 percent of duals did not have any institutional care in 2008. These individuals accounted for the remaining 45.2 percent of dual expenditures and 16.7 percent of total Medicaid program spending. Medicaid spending in this group averaged $7,670 per enrollee per year in 2008.

Table 7

Medicaid Enrollment and Expenditures for Dual Eligibles by Per Enrollee Spending Percentile, 2008

	Per Enrollee Expenditure Percentile	Enrollees (in thousands)	% of Dual Enrollees	% of All Enrollees	Expenditures (in millions)	% of Dual Expenditures	% of All Expenditures	Spending Per Enrollee Per Year
ALL DUALS	**United States**	**9,142**	**100.0%**	**15.4%**	**$116,949**	**100.0%**	**36.8%**	**$14,614**
	>95%	457	5.0%	0.8%	47,813	40.9%	15.1%	109,012
	>90-95%	457	5.0%	0.8%	23,831	20.4%	7.5%	54,668
	>70-90%	1,828	20.0%	3.1%	37,901	32.4%	11.9%	23,906
	>50-70%	1,828	20.0%	3.1%	6,394	5.5%	2.0%	3,956
	0-50%	4,571	50.0%	7.7%	1,011	0.9%	0.3%	257
WITH INSTITUTIONAL CARE	**United States**	**1,310**	**14.3%**	**2.2%**	**$64,034**	**54.8%**	**20.2%**	**$58,009**
	>95%	306	3.4%	0.5%	31,343	26.8%	9.9%	106,347
	>90-95%	334	3.6%	0.6%	17,486	15.0%	5.5%	54,815
	>70-90%	567	6.2%	1.0%	14,811	12.7%	4.7%	34,074
	>50-70%	88	1.0%	0.1%	394	0.3%	0.1%	8,341
	0-50%	14	0.2%	0.0%	0	0.0%	0.0%	0
WITHOUT INSTITUTIONAL CARE	**United States**	**7,832**	**85.7%**	**13.2%**	**$52,915**	**45.2%**	**16.7%**	**$7,670**
	>95%	151	1.6%	0.3%	16,470	14.1%	5.2%	114,472
	>90-95%	124	1.4%	0.2%	6,345	5.4%	2.0%	54,268
	>70-90%	1,261	13.8%	2.1%	23,090	19.7%	7.3%	20,065
	>50-70%	1,740	19.0%	2.9%	5,999	5.1%	1.9%	3,824
	0-50%	4,557	49.8%	7.7%	1,011	0.9%	0.3%	258

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012
Note: Expenditures do not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

Looking Forward

Dual eligibles are among the sickest and poorest individuals covered by either the Medicaid or Medicare programs. This brief documents that 39 percent of all Medicaid spending in FFY 2008 was on behalf of the 9.1 million Medicare enrollees who qualified for both programs. Other analysis has demonstrated that combined per capita Medicaid and Medicare spending is much higher for dual eligibles than for non-duals.[9]

There 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.

Discussions of strategies to address spending growth in both programs invariably include dual eligibles due to their high costs, complex health needs, and reliance on both programs. However, these strategies also need to take into account a challenging array of physical and mental health issues uncommon in other populations, together with service delivery systems that are often challenged by Medicaid and Medicare's bifurcated financing structure. Efforts to improve care delivery for this population require adequate safeguards to ensure that this fragile population does not experience unavoidable disruptions in their care. Recognition also needs to be given to the challenge of reducing the heavy reliance of dual eligibles on institutional care, particularly among those seniors over age 75.

Much of Medicaid's spending on dual eligibles (69%) was for long-term care services, which generally are not covered by Medicare or private insurance and have high ongoing rather than episodic costs. Some states have been moving forward with efforts to improve integration of care for this population, including providing new options for beneficiaries who are in need of long-term services and supports to receive such services while remaining in their community, thereby reducing reliance on institutional care.

The Patient Protection and Affordable Care Act (ACA) further encourages this shift and creates several new initiatives that may help improve coordination of acute and long-term care for Medicare and Medicaid dual eligibles.[10] The ACA establishes two new federal entities that will be involved in efforts to study and improve care for dual eligible beneficiaries: the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation (CMMI), both housed within the Centers for Medicare and Medicaid Services (CMS). The Medicare-Medicaid Coordination Office brings together staff from the Medicare and Medicaid programs within CMS to improve coordination between Medicare and Medicaid, and the federal government and the states. This office is charged with ensuring that dual eligibles have full access to the benefits and long-term services to which they are entitled under the Medicare and Medicaid programs. In conjunction with the Medicare-Medicaid Coordination Office, CMMI will test innovative payment and delivery models to lower costs and improve quality for all Medicare and Medicaid beneficiaries, including initiatives to integrate care for the dual eligibles.[11]

Given their complex health needs, high level of spending, and use of long-term services and supports, dual eligibles will continue to be a focus of state and federal policy. Improving care coordination and payment structures across the range of acute and long term-services for dual eligibles while assuring beneficiary safeguards will be an essential component of efforts to strengthen both the Medicare and Medicaid programs in the years ahead.

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Appendix: Data Sources and Estimation Methods

Most data used in this analysis come from the federal fiscal year (FFY) 2008 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 enable classifying each individual's spending into 30 service categories. Enrollees were grouped into five broad eligibility categories: non-disabled adults, non-disabled children, disabled adults and children, the elderly (all Medicaid enrollees over age 64), and those eligible for Medicaid through unknown paths. This paper focuses on individuals who are dually eligible for Medicaid and Medicare ("duals"), comparing them to those who are eligible for Medicaid only ("non-duals"). The duals are composed of individuals in the disabled and elderly categories.

All enrollment and eligibility calculations in this paper are based on the FFY 2008 MSIS. Data were limited to the 59.5 million enrollees that had valid information for one of the broad eligibility categories. From this base Medicaid population, dual eligibles were defined as beneficiaries that had valid information indicating dual eligibility. Of the total base population, there were 825 enrollees with missing dual eligibility information. Their expenditures totaled to $5,147,320. 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 2008 on the CMS Form 64. In addition, MSIS data do not include premium payments that Medicaid makes to Medicare. Premium data from the CMS Form 64 are included in this analysis.

Notes

[1] Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries,* April 2012, available at: http://www.kff.org/medicare/8138.cfm.

[2] Some full duals may receive a more limited set of Medicaid benefits.

[3] Medicare consists of Part A, which primarily covers inpatient care; Part B, which pays for physician services, outpatient care, lab and x-ray services, durable medical equipment and some other services; and Part D, which provides coverage for prescription drugs. Each part requires participants to pay premiums, deductibles and coinsurance for services they receive. Dual eligibles receive Medicaid assistance with premiums and out-of-pocket costs for Medicare Parts A and B.

[4] Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries,* 2012.

[5] 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).

[6] Federal law requires permanently disabled individuals to wait 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).

[7] States also have the option of providing (and receiving federal matching funds for) Medicaid coverage of drugs that were explicitly excluded from Medicare Part D by statute. A list of these drugs or classes of drugs (with the exception of smoking cessation drugs, which are included under the Medicare prescription drug benefit) can be found in section 1927(d)(2) of the Social Security Act. For more information on state coverage of these excluded drugs, see https://www.cms.gov/Reimbursement/EDC/list.asp.

[8] Sommers and Cohen, *Medicaid's High Cost Enrollees: How Much Do They Drive Medicaid Spending?*, Kaiser Commission on Medicaid and the Uninsured, March 2006, available at http://www.kff.org/medicaid/upload/7490.pdf.

[9] See Coughlin et al. in *Medicaid and Medicare Utilization and Spending for Dual Eligibles*, Kaiser Commission on Medicaid and the Uninsured, April 2012.

[10] For more information on the ACA's long-term services and supports provisions, please see *Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law*, June 2010, available at http://www.kff.org/healthreform/uploa d/8079.pdf.

[11] See Kaiser Commission on Medicaid and the Uninsured, *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS* (Aug. 2011), available at http://www.kff.org/Medicaid/8215.cfm; Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Models for Dual Eligibles: An Update* (Nov. 2011), available at http://www.kff.org/medicaid/upload/8260.cfm.

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