

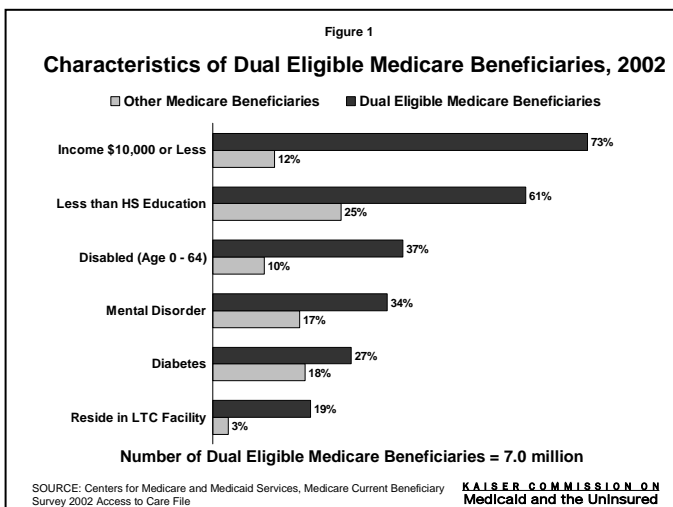
February 2006

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

Almost 7.5 million Medicaid beneficiaries are “dual eligibles” – low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. While Medicare covers basic health services, including physician and hospital care, dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as long-term care. As of January 1, 2006, prescription drug coverage for dual eligibles has shifted from Medicaid to Medicare Part D plans.

### Who Are Dual Eligibles?

Dual eligibles account for 14% of Medicaid enrollees, including virtually all elderly and over one-third of non-elderly beneficiaries with disabilities. Most dual eligibles have very low incomes: 73% have annual income below \$10,000 compared to 12% of all other Medicare beneficiaries. Most dual eligibles also have substantial health needs as over half are in fair or poor health, twice the rate of others on Medicare. Dual eligibles are also more likely to have mental health needs and to live in nursing homes when compared to other Medicare beneficiaries (Figure 1). Given their poorer health status, dual eligibles are more likely to rely on prescription drugs than others on Medicare.



### How Do Dual Eligibles Qualify for Medicaid?

Medicare beneficiaries who have low incomes and limited assets can obtain Medicaid 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 or have exhausted their resources paying for health and long-term care (sometimes known as “medically needy” or “spend-down”). These dual eligibles receive assistance with Medicare premiums and cost sharing and coverage of Medicaid benefits. While some protections exist for spouses, individuals 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 cost of their care and assets must be below \$2,000.

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 the “Medicare Savings Programs.” Qualified Medicare Beneficiaries (QMBs) have incomes up to the poverty line (assets up to \$4,000 for an individual) and receive help with Medicare premium and cost-sharing obligations. Specified Low-Income Medicare Beneficiaries (SLMBs) have slightly higher incomes (100-120% of FPL) and receive help with Medicare premiums only.

### Why Do Medicare Beneficiaries Need Medicaid?

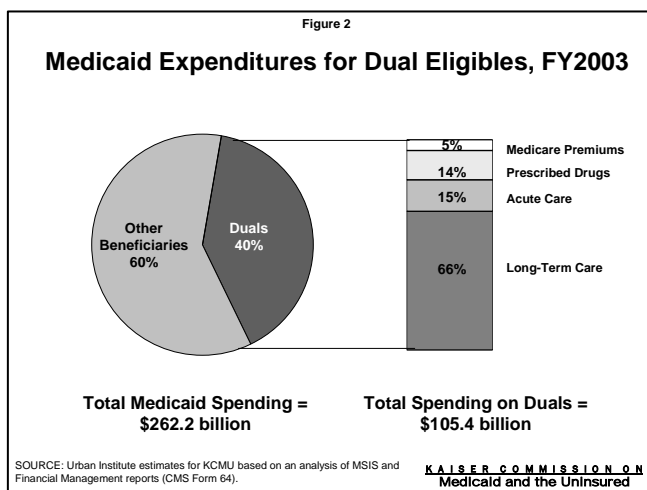
For 18% of Medicare beneficiaries, Medicaid fills Medicare’s significant gaps in coverage. For those who qualify, Medicaid pays the Medicare Part B premium (\$88.50/month in 2006); pays the cost-sharing charged for many Medicare services; and covers a range of benefits not covered by Medicare, such as long-term care, dental and vision care, and until this year, prescription drugs.

The majority of dual eligibles (6.2 million) receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing. The remaining dual eligibles (1.3 million) only receive assistance with their Medicare premiums and cost-sharing.

### Spending on Dual Eligibles

Dual eligibles account for a large share (40%) of total Medicaid spending. On average, total health care costs for dual eligibles are double those of other Medicare beneficiaries. Medicare covers less than half (43%) of total costs, while Medicaid covers 38% and out-of-pocket spending accounts for the remainder of spending.

In 2003, the majority of Medicaid expenditures for dual eligibles were for long-term care services (66%); other acute care services to supplement Medicare accounted for 15% and payment of Medicare premiums accounted for 5% of spending (Figure 2). Prescription drug spending accounted for 14 percent of Medicaid expenditures on dual eligibles. Although dual eligibles are now being covered for prescription drugs through Medicare Part D plans, Medicaid is still responsible for financing Part D coverage through “clawback” payments to the federal government.



### Transitioning to Medicare Drug Coverage

Beginning January 1, 2006, drug coverage for over 6 million dual eligibles was switched from Medicaid to Medicare through private Part D plans. Dual eligibles have access to dozens of plan options depending on their state. To facilitate this transition, the federal government randomly assigned dual eligibles to Part D plans offering coverage for a

premium below \$32/month (the benchmark premium for the low-income subsidy). This subsidy gives dual eligibles access to roughly 30% of the plan options available to Medicare beneficiaries. Dual eligibles are fully subsidized for their Part D premium, but can face co-payments of \$1 to \$3 for generics and up to \$5 for brand name drugs.

There have been problems early in this transition as plans and pharmacists were unable to verify coverage and some dual eligibles were not able to secure their medications or were overcharged. Over half of the states have instituted temporary contingency plans to help fill in these gaps in prescription drug coverage. Additionally, plans have been instructed by CMS to provide non-formulary medications when needed during this period. After the transition, dual eligibles may face additional challenges as they face potentially stricter formularies and higher co-payments than they did under Medicaid.

### Future Issues

Medicaid's coverage of almost 7.5 million dual eligibles provides an important supplement to Medicare. Medicaid helps assure that access to care for dual eligibles, who are substantially sicker and poorer than other Medicare beneficiaries, is not jeopardized by the gaps in Medicare coverage. State Medicaid programs continue to fill Medicare's gaps in coverage by paying for long-term care and Medicare's Part B premium and cost-sharing for dual eligibles. Meeting these responsibilities contributes to ongoing budget pressures. The tension between the federal and state governments over fiscal responsibility for dual eligibles is likely to grow as the population ages and costs grow.

The historic shift of prescription drug coverage from Medicaid to private Part D plans under Medicare is important to evaluate in order to understand how beneficiaries fare over time and to assess the impact on state Medicaid programs. Access to medications is essential for many dual eligibles to manage their conditions, to work, and to function. Given the health needs of dual eligibles, it is important that their access to needed care be considered when changes to Medicaid coverage are proposed.

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