

The Costs and Policy Implications of Covering Dual Enrollees of Medicaid and Medicare

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The Medicaid Institute at United Hospital Fund provides information and analyses explaining New York's Medicaid program, to help all stakeholders explore options for redesigning, restructuring, and rebuilding the Medicaid program.

**The Medicaid Institute
at United Hospital Fund**

**James R. Tallon, Jr.
President**

**David A. Gould
Senior Vice President for Program**

**Paula Wilson
Vice President for Policy**

**Medicaid Institute at United
Hospital Fund
Empire State Building
350 Fifth Avenue, 23rd Floor
New York, New York 10118-2300
(212) 494-0700
www.medicaidinstitute.org**

MICHAEL BIRNBAUM, Senior Health Policy Analyst, United Hospital Fund

Most recent policy discussions concerning individuals known as “duals”—those enrolled in both the Medicare and Medicaid programs—have been part of the federal debate on Medicare. However, policymakers interested in the Medicaid program, and in New York’s state and local budgets, should be paying close attention—and actively engaging in the debate. Spending on acute and long-term care services for duals accounts for almost half of all Medicaid spending in New York. And even seemingly minor changes to Medicare coverage of duals—changes affecting covered services, cost-sharing requirements, or benefit limits—could have a significant financial impact on New York’s Medicaid program and on state and local budgets.

More than one in five Medicare beneficiaries in New York State rely on Medicaid for secondary health insurance coverage.

This analysis, examining the implications of coverage for duals in New York State, has three purposes. First, it estimates Medicaid's cost of providing coverage to New York's duals, overall and by service area. Second, it estimates the financial responsibility for duals borne by New York's state and local governments. Third, it considers the central issues for New York's policymakers raised by Medicaid's responsibility for duals.

Background: Medicaid's role in covering duals

More than one in five Medicare beneficiaries in New York State rely on Medicaid for secondary health insurance coverage. These individuals are eligible for Medicare because they are either over 65 or disabled and have a work history, and are eligible for Medicaid because they have low incomes and few assets. There are about 643,000 duals in New York; 57 percent (367,000) are elderly and 43 percent (276,000) are disabled, non-elderly individuals.

Among New York's elderly Medicaid beneficiaries, 91 percent are duals—reflecting the fact that the vast majority of seniors are eligible for Medicare coverage through their own or their spouse's work history. Among New York's disabled Medicaid beneficiaries, 39 percent are duals—reflecting the fact that most cannot meet both Medicare's work history requirements and its strict disability standard. Most of New York's duals qualify for both full Medicaid benefits (which include all covered services) and assistance with Medicare cost-sharing (because their annual income falls below the state's Medicaid limit of \$8,305). While those with slightly higher annual incomes (between \$8,305 and the federal income cutoff for Medicare Savings Programs of \$13,236) do not qualify for full Medicaid benefits, they do receive coverage for Medicare cost-sharing.¹

When services are covered by both programs, Medicare is the primary insurer; Medicaid pays the remaining charges that otherwise would be passed on to the beneficiary through premiums, deductibles, and coinsurance. These costs can be substantial for both acute and long-term care services. Medicare's Part A deductible for hospital inpatient services is \$952, and the program charges the beneficiary—or the beneficiary's secondary insurer—

¹ These 2006 Medicaid income limits apply to one-person families. For duals in two-person families, the income limits are \$10,800 for full Medicaid benefits and \$17,820 for cost-sharing benefits. Asset limits ranging from \$4,000 to \$6,000 apply to all duals receiving full Medicaid benefits and some duals—depending on income—receiving cost-sharing benefits.

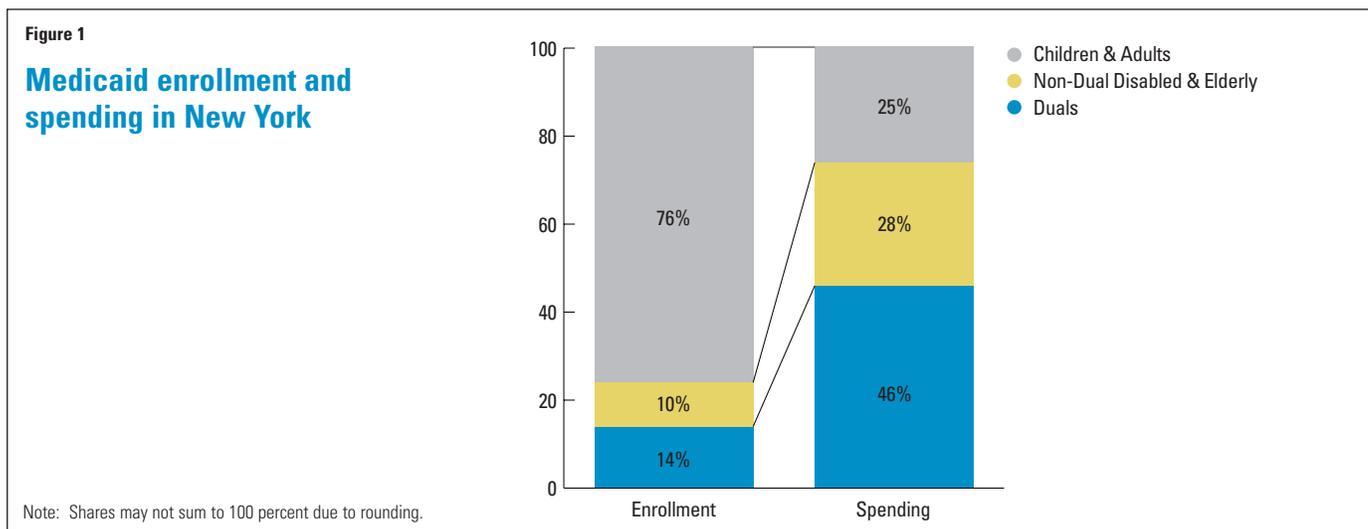
daily co-payments starting at \$238 after the first 60 days of a hospital stay.²

The daily co-payment after the first 20 days in a skilled nursing facility (SNF) is \$119. Medicare's Part B program, which covers hospital outpatient and other professional services, carries a \$124 deductible, an \$88.50 monthly premium, and significant coinsurance for many services.

When services are not covered by Medicare, or when Medicare's benefit limits have been exhausted, Medicaid is the sole payer. For example, when duals require SNF treatment that exceeds Medicare's 100-day limit, Medicaid is responsible for covering the duration of the stay. Examples of services covered by Medicaid rather than Medicare range from a stay in an intermediate care facility (ICF) for the mentally retarded to annual physical exams, screening tests, eye care, dental care, and podiatry, as well as outpatient prescription drugs.³

Medicaid spending on duals

Although 14 percent of New York State's Medicaid beneficiaries, duals accounted for 46 percent of Medicaid spending in federal fiscal year 2004—\$18.0 billion of the \$38.8 billion spent on Medicaid services, not including disproportionate share hospital payments or administration (Figure 1).⁴ Medicaid spent an estimated \$27,936 per dual in 2004, more than ten times the \$2,622 spent per child and adult enrollee. While it is counterintuitive, Medicaid spends more on a per capita basis for duals than for elderly and disabled beneficiaries without Medicare (\$25,253), largely



² Medicare deductibles, co-payments, and premiums cited in this paper are for 2006.

³ Medicare began covering prescription drugs in 2006; however, Medicaid remains responsible for financing most of these costs for duals through direct payments to Medicare.

⁴ Federal fiscal year (FFY) 2004 began October 1, 2003; all years are FFYs unless otherwise noted.

because duals are more likely to require the extensive long-term care that Medicare does not cover.

Long-term care (LTC) accounted for 67 percent (\$12.0 of \$18.0 billion) of Medicaid spending on duals in 2004 (Table 1). These services consisted of SNF care (\$5.5 billion), home-based health and personal care services (\$4.8 billion), and residential care provided in ICFs and mental health facilities (\$1.7 billion). Acute care—including care provided by hospitals and clinics (\$1.7 billion) and outpatient prescription drugs (\$1.7 billion)—accounted for

Table 1

Duals' share of Medicaid spending in New York, 2004

(dollars in millions)	Medicaid Spending	Spending on Duals	Duals' Share of Medicaid Spending
Skilled nursing facilities	\$6,486	\$5,520	85%
Home-based health/personal care	7,579	4,825	64%
Intermediate care facilities and mental health inpatient	3,201	1,689	53%
Long-term care subtotal	\$17,266	\$12,034	70%
Hospital and clinic care	\$9,361	\$1,740	19%
Prescription drugs	3,820	1,669	44%
All other services	8,311	2,508	30%
Acute care subtotal	\$21,492	\$5,917	28%
All services	\$38,759	\$17,951	46%

Note: Categories may not sum to totals due to rounding.

33 percent of spending on duals. Duals accounted for 70 percent of Medicaid's LTC costs and 28 percent of acute care costs.

Duals often need the LTC that Medicare does not cover, leaving Medicaid responsible for some of the costliest services our health care system offers. Duals account for 85 percent of Medicaid enrollees who receive residential care in SNFs. Medicaid's cost of covering these SNF stays, updated to 2004, is \$41,051 per person—not including spending on other services.

New York's state and local responsibility

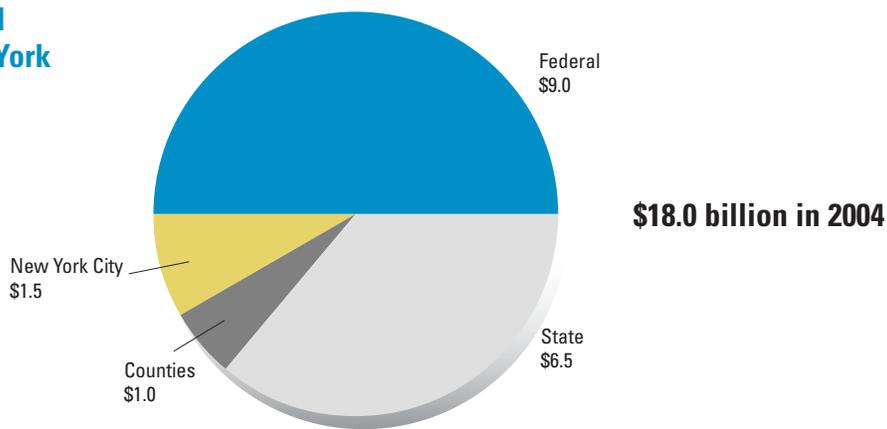
The federal government finances half the cost of providing Medicaid services in New York. The state has required local governments to finance a uniquely high share of Medicaid costs, generally 25 percent for acute care and approximately 10 percent for LTC, with some variation and exceptions. Through the most significant exception, Medicaid "overburden aid," the

state covers the full non-federal cost of services for the long-term mentally disabled.⁵ A revised state policy, enacted in 2005, caps growth in local Medicaid costs starting in 2006.

New York State was responsible for an estimated \$6.5 billion in spending on duals in 2004, 36 percent of the total (Figure 2). Local governments were responsible for the remaining 14 percent, with New York City contributing more (\$1.5 billion) than the state’s 57 other counties combined (\$1.0 billion).

Figure 2

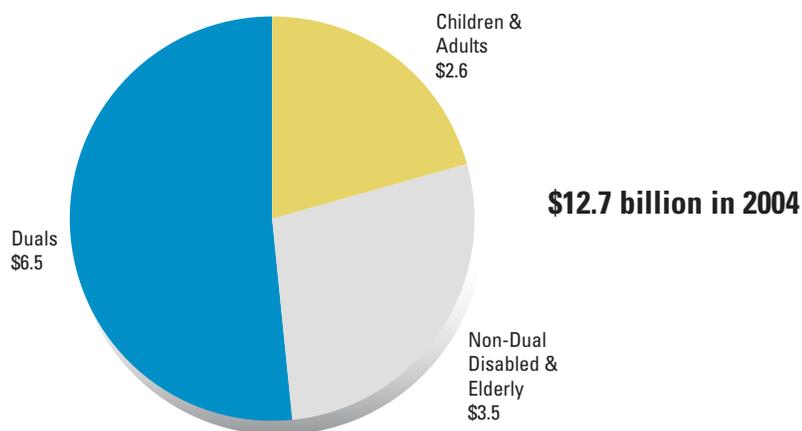
Responsibility for Medicaid spending on duals in New York



Because duals rely heavily on LTC services, and because New York State pays a high share of the cost for LTC services, the State is responsible for a higher share of Medicaid spending on duals, compared to other enrollees.

Figure 3

New York State Medicaid spending by enrollee category



Note: Categories may not sum to totals due to rounding.

⁵ New York State reimburses local governments' share of Medicaid costs for mentally disabled beneficiaries who (1) reside in institutions for the mentally retarded and mentally ill, (2) receive care from a community-based facility on 45 or more days during a calendar quarter, or (3) were discharged from residential care between April 1971 and December 1982 and require 90 days or more of inpatient treatment.

While duals account for 46 percent of overall Medicaid spending, they account for 51 percent of the State's \$12.7 billion in Medicaid contributions (Figure 3). Other disabled and elderly beneficiaries account for 28 percent of state Medicaid spending; children and adults account for the remaining 21 percent.

Of the State's \$6.5 billion in Medicaid spending on duals in 2004, LTC accounted for 77 percent (\$5.0 billion). The State contributed \$2.2 billion to SNF care, \$2.0 billion to home-based care, and \$0.8 billion to care in ICFs and mental health facilities (Table 2). The remaining \$1.5 billion in State Medicaid contributions for duals went to acute care services, including hospital and clinic care (\$0.4 billion) and prescription drugs (\$0.4 billion).

Table 2

Medicaid spending on duals in New York, 2004

(dollars in millions)	Federal	State	Local	Total
Skilled nursing facilities	\$2,760	\$2,242	\$518	\$5,520
Home-based health/personal care	2,412	1,960	453	4,825
Intermediate care facilities and mental health inpatient	845	845	0	1,689
Long-term care subtotal	\$6,017	\$5,047	971	\$12,034
Hospital and clinic care	\$870	\$435	\$435	\$1,740
Prescription drugs	835	417	417	1,669
All other services	1,254	627	627	2,508
Acute care subtotal	\$2,959	\$1,479	\$1,479	\$5,917
All services	\$8,976	\$6,526	\$2,450	\$17,951

Note: Categories may not sum to totals due to rounding.

Because the state has required local governments to pay an equal share of non-federal acute care costs, compared to a much smaller share of LTC costs, 60 percent of local Medicaid spending on duals went toward acute care services. New York's local governments contributed \$1.5 billion toward acute care services for duals in 2004—including \$0.4 billion for hospital and clinic care, and \$0.4 billion for prescription drugs—and \$1.0 billion for all LTC services (Table 2).

Policy implications

Whether the federal government should take on more financial responsibility for duals has been a central tension of both health and budget policy for years. The National Governors Association's 2003 task force voted unanimously that financing Medicaid coverage for duals should be a federal responsibility. This fundamental shift would be a favorable scenario for state and local governments because of the substantial fiscal relief it would generate; however, the policy is not under serious consideration. Nevertheless, other Medicare policies will be debated in Congress as the retirement of the first baby boomers approaches.

Medicaid spending in New York is inextricably linked—through the division of responsibility for duals—to federal Medicare policy, and Medicare's program rules have substantial implications for Medicaid. These rules define the services Medicare covers and, therefore, the responsibilities that may fall to beneficiaries or their secondary coverage, including Medicaid. They determine Medicare's benefit limits and, therefore, when Medicaid takes on sole responsibility for specific services. They also determine Medicare's cost-sharing requirements and, therefore, the premiums, deductibles, and coinsurance Medicaid helps to pay.

Large sums of state Medicaid spending are at stake in federal deliberations on Medicare, even when they give the Medicaid program little explicit consideration. For example, amending Medicare's benefits limits to cover significantly longer SNF stays could reduce Medicaid spending in New York substantially. By contrast, increasing Medicare deductibles and co-payments for hospital services could add to Medicaid spending significantly. Whatever specific policy issues are on the table, Medicare decisions taken at the federal level will largely determine Medicaid's obligations for duals, who account for nearly half of program spending in New York.

Because New York has capped local Medicaid costs by statute starting in 2006, the State is at risk for taking on a greater share of future increases in Medicaid spending. Therefore, moving forward, the State has even more budget relief to gain from promoting changes in Medicare policy that reduce Medicaid's responsibility for duals. New York's policymakers who are concerned about Medicaid spending and future State budgets should take an active role in the federal debate on Medicare.

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Appendix: data and methods

This analysis uses Medicaid Statistical Information System (MSIS) data from the Centers for Medicare & Medicaid Services (CMS) to measure the number of Medicaid beneficiaries by eligibility category enrolled at any point during the year, as well as to measure the shares of Medicaid spending across service areas and by enrollment category, and the number of duals using specific services.

Shares of Medicaid spending recorded by MSIS are applied to actual Medicaid payments by service area, excluding disproportionate share hospital (DSH) payments and administrative costs, as reported on the CMS Medicaid Statement of Expenditures (form 64) to produce updated spending estimates that most accurately reflect the actual payments made by each level of government. State and local responsibility for non-federal Medicaid costs, as detailed by service area in New York State law, are used to allocate responsibility for state and local Medicaid spending. New York State Department of Health (NYS DOH) expenditure data are used to estimate New York City's share of local Medicaid responsibility by service area. The most recent available data are used in all cases. CMS MSIS data are from 2003; CMS form 64 data are from 2004; and NYS DOH expenditure data are from calendar year 2003. All estimates are converted into 2004 dollars.

Medicaid enrollment among duals, as well as among other elderly and disabled beneficiaries, has been stable during 2004; however, less is known about duals' service use during this time. These spending estimates, therefore, reflect 2004 enrollment levels, but do not adjust for any changes in service use after 2003. Estimates of Medicaid spending are for recurring net expenditures; therefore, temporary increases in Medicaid's federal matching rate are not reflected.

Because the available data do not disclose overburden status, payments to state and local Medicaid spending are estimated using aggregate spending data by service category. All residents of ICFs for the mentally retarded and inpatient mental health facilities are counted as eligible for state overburden aid; therefore, local governments are estimated to have no net financial responsibility for these Medicaid costs. Because of a small and declining number of community-based Medicaid beneficiaries eligible for overburden aid (who are eligible because they spent five years institutionalized between 1971 and 1982), these estimates include no overburden aid adjustment for these individuals. Because of the small number of beneficiaries receiving Medicaid services on at least 45 days each quarter, and because the cost of outpatient services for the mentally disabled is a small fraction of the cost of inpatient care, these estimates include no overburden aid adjustment for these individuals.