

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - A-06
(June 2006)

Subject: Medicare/Medicaid Dual Eligibles

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1 As a follow-up to Council on Medical Service Report 6 (I-05), “Policy Options for Addressing
2 Medicaid Long-Term Care,” the Council on Medical Service agreed to investigate policy options
3 for addressing the costs associated with providing care to Medicare beneficiaries who are also
4 eligible for Medicaid. Known as “dual eligibles,” almost 7.5 million low-income Americans obtain
5 their medical care through the federally administered Medicare program, while obtaining access to
6 long-term care services and, until recently, prescription drugs, through the Medicaid program.
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8 This report, which is presented for the information of the House of Delegates, examines the dual
9 eligible population, a focus of recent policy and fiscal debates between federal and state
10 governments. In 2003, although dual eligibles comprised less than one-fifth of the population of
11 either the Medicare (17%) or Medicaid (14%) programs, they consumed a substantial portion of
12 each program’s resources (29% and 40% respectively). The majority of Medicaid expenditures for
13 dual eligibles are for long-term care services (66%) which, generally, are not covered under
14 Medicare. The tension between federal and state governments over fiscal responsibility for this
15 population will likely continue to grow as the baby boom generation becomes eligible for the
16 Medicare program.
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18 DEFINING DUAL ELIGIBILITY

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20 The federal Medicare program is responsible for insuring health care for virtually all Americans
21 age 65 or older, regardless of income, and for certain younger people with disabilities after they
22 qualify for disability benefits under Social Security. Funding for Medicare is from a mix of the
23 Medicare Trust fund, tax revenues, and beneficiary premiums. Unlike Medicare, Medicaid was
24 established as a joint federal and state venture. As such, states have considerable flexibility in
25 designing their Medicaid programs, benefits, and eligibility criteria. Medicaid eligibility rules and
26 benefits also may vary among categories of individuals (e.g. nursing home residents).
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28 The Centers for Medicare and Medicaid Services (CMS) defines dual eligibles as individuals who
29 are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.
30 CMS maintains seven separate categories of individuals who collectively are known as dual
31 eligibles. There are generally two distinct pathways to qualify for both Medicare and some level of
32 Medicaid benefits. The poorest Medicare beneficiaries receive a full range of Medicaid benefits
33 because they are eligible for Supplementary Security Income (SSI) or they have exhausted their
34 resources paying for health and long-term care (also known as “medically needy” or those who
35 have qualified for Medicaid through a “spend-down” of their assets). Medicare beneficiaries with
36 income or resources just above the federal poverty level qualify for Medicaid assistance to cover
37 Medicare premiums.

1 Of the 7.5 million Medicare beneficiaries enrolled in Medicaid in 2003, an estimated 6.2 million
2 (83%) received full Medicaid benefits. The remaining dual eligibles received help with Medicare
3 premiums and out-of-pocket costs, but were not eligible for services such as long-term care.
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5 ADDRESSING THE MEDICAL AND LONG-TERM CARE NEEDS OF DUAL ELIGIBLES

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7 The Medicare and Medicaid programs are complex and difficult for dual eligible patients and their
8 health care providers to navigate. According to the Kaiser Commission on Medicaid and the
9 Uninsured, compared to Medicare or Medicaid recipients, the dual eligible population is more
10 likely to be sicker, poorer, minority, and single (a large majority of whom are women):
11

- 12 • About two-thirds (66%) are 65 and older;
- 13 • Nearly three-quarters (73%) have \$10,000 or less in income;
- 14 • 61% have less than a high school education;
- 15 • More than one-third (37%) are disabled;
- 16 • More than one-third (34%) have a mental impairment;
- 17 • More than one-quarter (27%) have diabetes; and
- 18 • Nearly one-fifth (19%) reside in a long-term care facility.

19
20 The fragmented payment system for services received under the Medicare and Medicaid programs
21 has serious consequences for quality and continuity of care. In recent testimony to the House Ways
22 and Means Committee, geriatrician Meghan Gerety, MD, professor of medicine, geriatrics and
23 extended care, University of Texas Health Science Center at San Antonio, and president of the
24 American Geriatrics Society (AGS), provided the following common patient example to illustrate
25 the challenges of the dual eligible population:
26

27 An-88 year-old woman lives in her home, falls and breaks her hip. She is sent to the
28 hospital where Medicare covers her care. Following her surgery, she is sent to a nursing
29 home for rehabilitation, also covered by Medicare. However, when her therapy is
30 completed she is less independent and therefore cannot return to her home. She qualifies
31 for Medicaid coverage in the nursing facility, but not for enhanced services that would
32 allow her to return safely home. After several months at the nursing home, she develops a
33 urinary tract infection and needs antibiotics and IV therapy. Unfortunately, Medicaid will
34 not cover this service in the nursing home, but Medicare will cover it in the hospital. The
35 woman is transferred back to the hospital. This chaotic, payment-driven approach to care
36 is played out thousands of times each day throughout the country. It does not serve the
37 patient well.
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39 MEDICAID SPENDING ON SERVICES FOR DUAL ELIGIBLES

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41 The Kaiser Commission on Medicaid and the Uninsured estimated that in 2003, less than 14% of
42 total Medicaid enrollees were dual eligibles, yet they accounted for \$105 billion (40.1%) of all
43 Medicaid expenditures. Of the \$105 billion spent, \$69.4 billion was for long-term care (65.8%);
44 followed by \$16.7 billion for Medicare premiums, deductibles, and co-insurance for Medicare
45 acute care services (15.9%); \$15.2 billion for prescription drugs (14.4%); and \$4.1 billion for other
46 acute care services such as dental care, vision and hearing services that are not covered by
47 Medicare (3.9%).

1 These national data do not reflect, however, that there are significant differences in spending on
2 dual eligibles among the states. For example, while national spending per dual eligible averaged
3 \$14,114 in 2003, New York spent \$27,809 per dual eligible, while Nevada spent \$7,793 per dual
4 eligible. These cost differences are primarily attributable to differences in the amount of spending
5 on long-term care services.

6 7 THE MEDICARE MODERNIZATION ACT AND PRESCRIPTION DRUG COVERAGE

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9 A provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
10 (MMA) that went into effect January 1, 2006, has particular significance for over 6 million dual
11 eligibles who receive full Medicaid benefits. Under this new provision, dual eligibles no longer
12 receive their drug coverage from Medicaid, but instead select or are automatically enrolled in
13 private Medicare prescription drug plans. As of January 2006, 5.6 million dual eligibles were
14 automatically enrolled in Medicare Part D.

15
16 A related controversial element of this new provision requires states to contribute to the federal
17 government a portion of what they would have spent on prescription drugs to cover this group.
18 These “phased-down state contributions,” also known as “clawback” payments, approximate the
19 expenditures that the state would make if it continued to pay for outpatient prescription drugs
20 through Medicaid on behalf of dual eligibles. Currently, states are paying the federal government
21 up to 90% of coverage for dual eligibles, but CMS estimates that over time, that amount will be
22 reduced to 75%. Despite new CMS figures lowering the amount states must pay, recent media
23 reports suggest that several states will move ahead with plans to ask the Supreme Court to review
24 the constitutionality of the Medicare drug benefit's clawback formula. In addition to the clawback,
25 states still have the shared responsibility for paying for long-term care, Medicare Part B premiums,
26 and cost-sharing for the dual eligible population.

27 28 LONG-TERM POLICY OPTIONS

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30 A key component of state Medicaid program expenses is the high cost of caring for the very sick,
31 frail, and chronically ill. Medicare/Medicaid dual eligibles are the ultimate “safety net” population,
32 and as such, some state officials have suggested that the federal government should assume greater
33 fiscal responsibility for this population under the Medicare program.

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35 The National Governors Association (NGA) contends that the transition of the pharmacy benefit
36 from Medicaid to Medicare, as a result of the MMA, should be followed by the comprehensive
37 federalization of services for dual eligibles. The NGA believes that federalization will improve
38 care coordination; offset the financial burden of states as a result of the demographic wave of baby
39 boomers, medical inflation, and minimal state revenue growth; equitably distribute the cost among
40 states; and more appropriately relegate the principal responsibility of caring for the retiree and
41 Medicare population to the federal government.

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43 The NGA recommends a transitional process that could occur in the following stages:

- 44
45 (1) Transfer all cost-sharing obligations to Medicare (i.e. co-payments, deductibles and
46 coinsurance of dually-eligible beneficiaries).
47 (2) Transfer all overlapping benefits to Medicare (i.e. home-health, skilled nursing facility care,
48 durable equipment and therapies).

- 1 (3) Transfer institutional long-term care to Medicare.
- 2 (4) Transfer community-based long-term care to Medicare (e.g. respite, assisted living and
- 3 homemaker services).
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5 While not addressing the provision of long-term care, the National Conference of State
6 Legislatures (NCSL) similarly believes that the cost of Medicare coverage should be borne by the
7 federal government and program beneficiaries. The NCSL also believes that the costs associated
8 with providing prescription drug coverage to low-income individuals made eligible for the new
9 Medicare Part D program should be 100% federally funded (i.e. no “clawback” provisions).

10
11 In October 2005, Medicaid reform was the topic of the annual American Medical Association-
12 sponsored multi-organizational forum of the Health Sector Assembly (HSA). The HSA concluded
13 that both Medicaid and Medicare would “substantially benefit from reforms that more clearly
14 distinguish between the two programs and provide clarity of purpose and scope for each of them.”
15 The HSA tentatively developed the following two core concepts:

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- 17 (1) Redefining Medicaid as a program for low-income, non-Medicare-eligible Americans based
- 18 solely on income eligibility rather than on the current complex categorical system.
- 19 (2) Making Medicare responsible for the full range of health care services for the Medicare eligible
- 20 population (i.e., Medicare should cover services currently covered by Medicaid for “dual
- 21 eligible” beneficiaries).
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23 RELEVANT AMA POLICY

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25 Policy H-290.982[1], AMA Policy Database, urges that Medicaid reform not be undertaken in
26 isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the
27 delivery and financing of care results in appropriate access and level of services for low-income
28 patients.

29
30 Policy H-280.991 addresses the need for ensuring access to quality long-term care through a
31 variety of public and private options, including Medicaid, the promotion of long-term care
32 insurance options, tax credits, and government subsidization of private plans for low-income
33 individuals.

34
35 The AMA’s long-term proposal for Medicare reform (Policy H-165.987) advocates that the current
36 Medicare program should be replaced with a self-funded, private-sector approach to financing
37 health care for the elderly, with equitable means testing provisions. The AMA:

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- 39 (1) Supports proposals to shift the funding of Medicare from the current tax financed pay-as-you-
40 go system to a system of mandatory individually-owned private savings, with a required
41 minimum contribution, accumulated tax-free and dedicated to funding post-retirement medical
42 care. The government would provide a contribution to economically disadvantaged individuals
43 making smaller than average contributions to their retirement accounts.
- 44
- 45 (2) Supports establishing incentives to encourage the use of accumulated balances in Medical
46 Savings Accounts for the funding of post-retirement medical care;

- 1 (3) Recognizes that while private sector solutions can address a large portion of the long-term
2 funding of Medicare, there will still be a need and responsibility for support from government
3 or charitable organizations for the economically disadvantaged;
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- 5 (4) Continues to support modernization of the traditional Medicare program by combining the
6 cost-sharing requirements of Parts A and B into a single deductible; and
7
- 8 (5) Continues to support replacing Medicare's systems of price controls with a system of price
9 competition.
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- 11 (6) It is the policy of our AMA that the Federal Employees Health Benefit Program (FEHBP)
12 should be used as a model for restructuring Medicare. This type of program would allow
13 seniors to choose among competing private plans, including a modernized fee-for-service
14 Medicare program, for the plan that best meets their needs. Private retiree health insurance
15 also should be integrated into any FEHBP-modeled system; and
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- 17 (7) It is the policy of our AMA during the transition from the current Medicare program to a
18 system of pre-funding, workers would not only establish private savings accounts for their
19 retirement expenses, but would also continue to support current and soon-to-be retirees through
20 some level of taxation.
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22 Finally, Policy H-165.987 calls for government subsidization on the basis of need in the context of
23 ensuring access to health care for the elderly.
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25 DISCUSSION

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27 The Medicare and Medicaid programs provide medical and long term-services to Americans with
28 multiple chronic health conditions and extremely complex social challenges. Yet, as illustrated by
29 the testimony given to the House Ways and Means Committee by American Geriatric Society
30 President Meagan Gerety, MD, Medicare largely focuses on medical needs and does not support
31 the functional needs that are present in many persons requiring long-term care. Under Medicaid,
32 there are only two mandated long-term care benefits: institutional care and home health care.
33

34 Medicaid funded alternatives to nursing home care (e.g. in-home personal care, adult day care, and
35 assisted living) are highly variable from state to state. While many states have promoted the
36 development of home and community-based alternatives to nursing home care, there are limited
37 private sector alternative solutions available for the poor, high-cost chronically ill, or disabled.
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39 For Medicare/Medicaid dual eligible patients, the fragmentation of these two programs does little
40 to promote access and the highest levels of quality care and patient choice. As suggested by the
41 NGA and NCSL, as well as participants at the recent meeting of the Health Sector Assembly, one
42 option would be to transfer all dual eligibles to the Medicare program.
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44 Clearly, the cost to the federal government of assuming more costs for dual eligibles would be
45 substantial. In November 2003, the Kaiser Commission on Medicaid and the Uninsured found that
46 the state's share of Medicaid spending for dual eligibles was an estimated \$39.6 billion in 2002.
47 Such a significant shift in expenses raises one principal question: Given the combined impact of
48 current Medicare solvency projections, the impending enrollment of the baby boom generation, and

1 the implementation of the new prescription drug benefit, would it be politically and financially
2 possible to initiate such a costly transition to the federal government without making fundamental
3 changes to the Medicare program as well? The Council believes that if Congress were to
4 eventually enact legislation that would transition the current Medicare program to a self-funded
5 private sector program (as suggested in AMA Policy H-165.987), it might become more realistic
6 for a modified Medicare to become the ultimate safety-net program, in which the nation's poorest
7 and sickest would be covered.

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9 In developing this report, it was the Council's intent to describe the characteristics of the dual
10 eligible population; explain the difficulty that this group has navigating the system; review the
11 costs related to their care; and describe the tradeoffs associated with the policy options for the care
12 of this extremely vulnerable group. As policymakers continue to consider approaches to stabilizing
13 and strengthening the Medicaid program, the Council urges careful consideration as to how
14 medical and long-term care for the sickest and poorest Americans may be best integrated. The
15 Council will continue to monitor emerging policy options for current dual eligible patients.