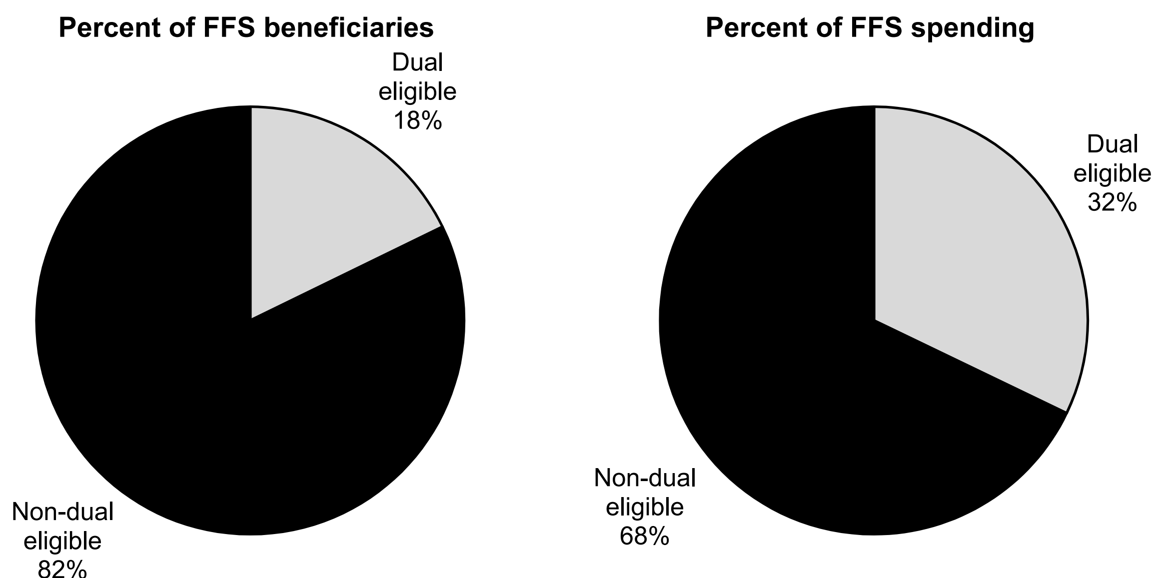
SECTION 4

Dual-eligible beneficiaries

Chart 4-1. Dual-eligible beneficiaries accounted for a disproportionate share of Medicare spending, 2013

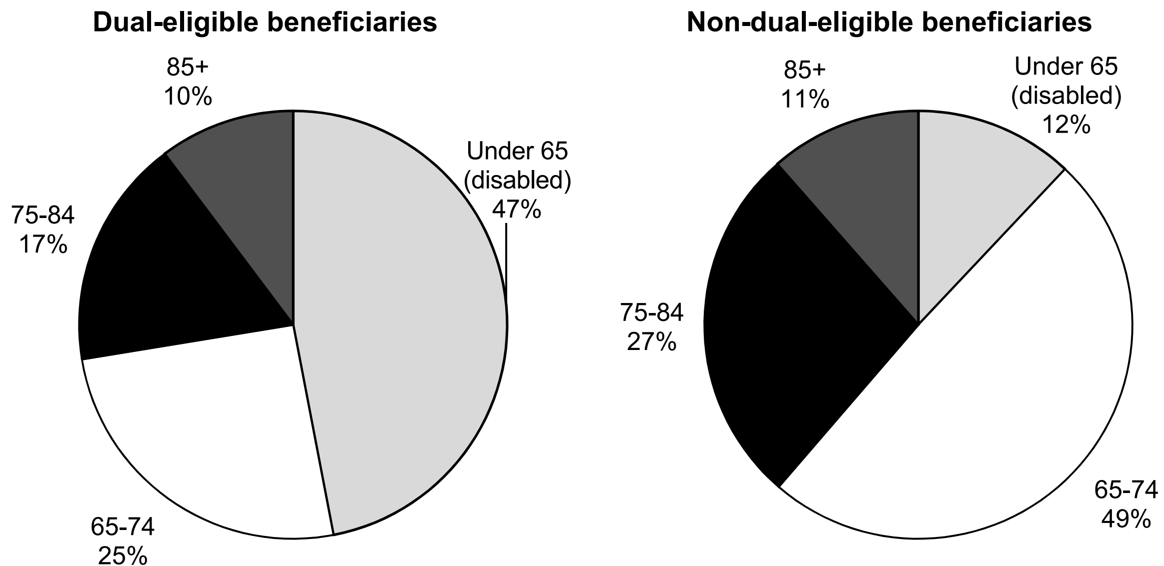


Note: FFS (fee-for-service). Dual-eligible beneficiaries are designated as such if the months they were enrolled in Medicaid exceeded the months they were enrolled in supplemental insurance.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, ONLY PART OF THE MEDICARE CURRENT BENEFICIARY SURVEY (MCBS), WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART, HAD BEEN RELEASED FOR 2015. THIS CHART REFLECTS MEDPAC ANALYSIS OF THE 2013 MCBS COST AND USE FILES, WHICH ARE THE MOST RECENT AVAILABLE. (THERE ARE NO MCBS DATA FOR 2014.) THE READER IS ADVISED TO CONSULT THE 2015 MCBS DIRECTLY, WHEN THE COMPLETE SURVEY BECOMES AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

- Dual-eligible beneficiaries are those who qualify for both Medicare and Medicaid. Medicaid is a joint federal and state program designed to help people with low incomes obtain needed health care.
- Dual-eligible beneficiaries account for a disproportionate share of Medicare FFS expenditures. Although they were 18 percent of the Medicare FFS population in 2013, they represented 32 percent of aggregate Medicare FFS spending.
- On average, Medicare FFS per capita spending is more than twice as high for dual-eligible beneficiaries compared with non-dual-eligible beneficiaries: In 2013, $19,789 was spent per dual-eligible beneficiary, and $9,035 was spent per non-dual-eligible beneficiary (data not shown).
- In 2013, average total spending—which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending across all payers—for dual-eligible beneficiaries was $31,894 per beneficiary, about twice the amount for other Medicare beneficiaries (data not shown).

Chart 4-2. Dual-eligible beneficiaries were more likely than non-dual-eligible beneficiaries to be under age 65 and disabled, 2015

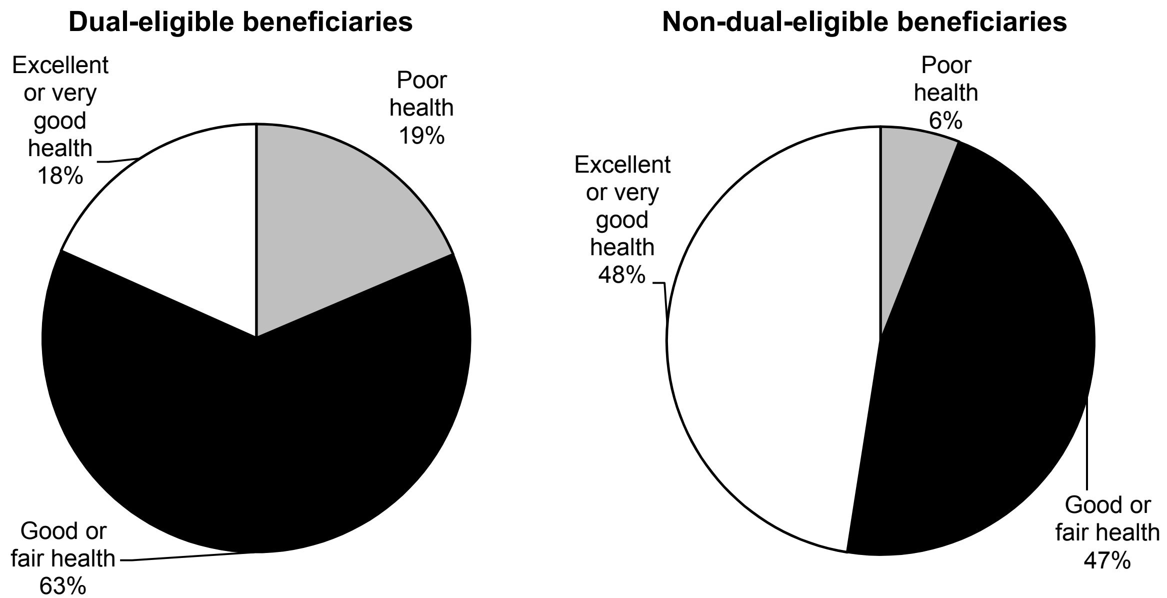


Note: Beneficiaries who are under age 65 qualify for Medicare because they are disabled. Once disabled beneficiaries reach age 65, they are counted as aged beneficiaries. Dual-eligible beneficiaries are designated as such if the months they were enrolled in Medicaid exceeded the months they were enrolled in supplemental insurance. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Survey file 2015.

- Disability is a pathway for individuals to become eligible for both Medicare and Medicaid benefits.
- Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to be under age 65 and disabled. In 2015, 47 percent of dual-eligible beneficiaries were under age 65 and disabled compared with 12 percent of the non-dual-eligible population.

Chart 4-3. Dual-eligible beneficiaries were more likely than non-dual-eligible beneficiaries to report poorer health status, 2015



Note: Dual-eligible beneficiaries are designated as such if the months they were enrolled in Medicaid exceeded the months they were enrolled in supplemental insurance. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Survey file 2015.

- Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to report poorer health status. In 2015, 19 percent of dual-eligible beneficiaries reported being in poor health compared with 6 percent of non-dual-eligible beneficiaries.
- Almost half of non-dual-eligible beneficiaries (48 percent) reported being in excellent or very good health in 2015. In comparison, less than one-fifth (18 percent) of dual-eligible beneficiaries reported being in excellent or very good health.

Chart 4-4. Demographic differences between dual-eligible beneficiaries and non-dual-eligible beneficiaries, 2015

Characteristic	Percent of dual-eligible beneficiaries	Percent of non-dual-eligible beneficiaries
Sex		
Male	41%	45%
Female	59	55
Race/ethnicity		
White, non-Hispanic	54	77
African American, non-Hispanic	18	9
Hispanic	15	8
Other	13	6
Limitations in ADLs		
No limitations in ADLs	40	66
Limitations in 1–2 ADLs	30	23
Limitations in 3–6 ADLs	30	11
Residence		
Urban	73	80
Rural	27	20
Living arrangement		
Institution	13	2
Alone	34	28
With spouse	14	53
With children, nonrelatives, others	38	17
Education		
No high school diploma	41	15
High school diploma only	32	27
Some college or more	28	58
Income status		
Below poverty	54	9
100–125% of poverty	22	7
125–200% of poverty	19	19
200–400% of poverty	4	30
Over 400% of poverty	1	35
Supplemental insurance status		
Medicare or Medicare/Medicaid only	87	16
Medicare managed care	5	38
Employer-sponsored insurance	<1	25
Medigap	1	19
Medigap/employer	0	1
Other*	6	1

Note: ADL (activity of daily living). Dual-eligible beneficiaries are designated as such if the months they were enrolled in Medicaid exceeded the months they were enrolled in other supplemental insurance. “Urban” indicates beneficiaries living in metropolitan statistical areas (MSAs). “Rural” indicates beneficiaries living outside of MSAs. In 2015, poverty was defined as annual income of $11,367 for people living alone and $14,342 for married couples. Totals may not sum to 100 percent due to rounding and exclusion of an “other” category. Poverty thresholds are calculated by the U.S. Census Bureau (https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html).
*Includes public programs such as the Department of Veterans Affairs and state-sponsored drug plans.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Survey file 2015.

- Dual-eligible beneficiaries qualify for Medicaid due in part to low incomes. In 2015, 54 percent of dual-eligible beneficiaries lived below the federal poverty level, and 95 percent lived below 200 percent of the poverty level. Compared with non-dual-eligible beneficiaries, dual-eligible beneficiaries are more likely to be female, be African American or Hispanic, lack a high school diploma, have greater limitations in activities of daily living, reside in a rural area, and live in an institution. They are less likely to have sources of supplemental coverage other than Medicaid.

Chart 4-5. Differences in Medicare spending and service use between dual-eligible beneficiaries and non-dual-eligible beneficiaries, 2013

Service	Dual-eligible beneficiaries	Non-dual-eligible beneficiaries
Average FFS Medicare payment for all beneficiaries		
Total Medicare FFS payments	$19,789	$9,035
Inpatient hospital	6,340	2,821
Physician[a]	3,445	2,377
Outpatient hospital	2,283	1,307
Home health	771	387
Skilled nursing facility[b]	1,608	573
Hospice	473	231
Prescribed medication[c]	4,740	1,322
Share of FFS beneficiaries using service		
Share using any type of service	97.9%	86.1%
Inpatient hospital	25.4	14.7
Physician[a]	93.6	81.6
Outpatient hospital	78.5	61.1
Home health	13.5	8.1
Skilled nursing facility[b]	9.3	4.1
Hospice	3.9	1.9
Prescribed medication[c]	80.5	53.6

Note: FFS (fee-for-service). Data in this analysis are restricted to beneficiaries in FFS Medicare. Dual-eligible beneficiaries are designated as such if the months they were enrolled in Medicaid exceeded the months they were enrolled in supplemental insurance. Spending totals derived from the Medicare Current Beneficiary Survey (MCBS) do not necessarily match official estimates from CMS Office of the Actuary. Total payments may not equal the sum of line items due to omitted “other” category.
[a] Includes a variety of medical services, equipment, and supplies.
[b] Individual short-term facility (usually skilled nursing facility) stays for the MCBS population.
[c] Data from Medicare Advantage–Prescription Drug plans and stand-alone prescription drug plans.

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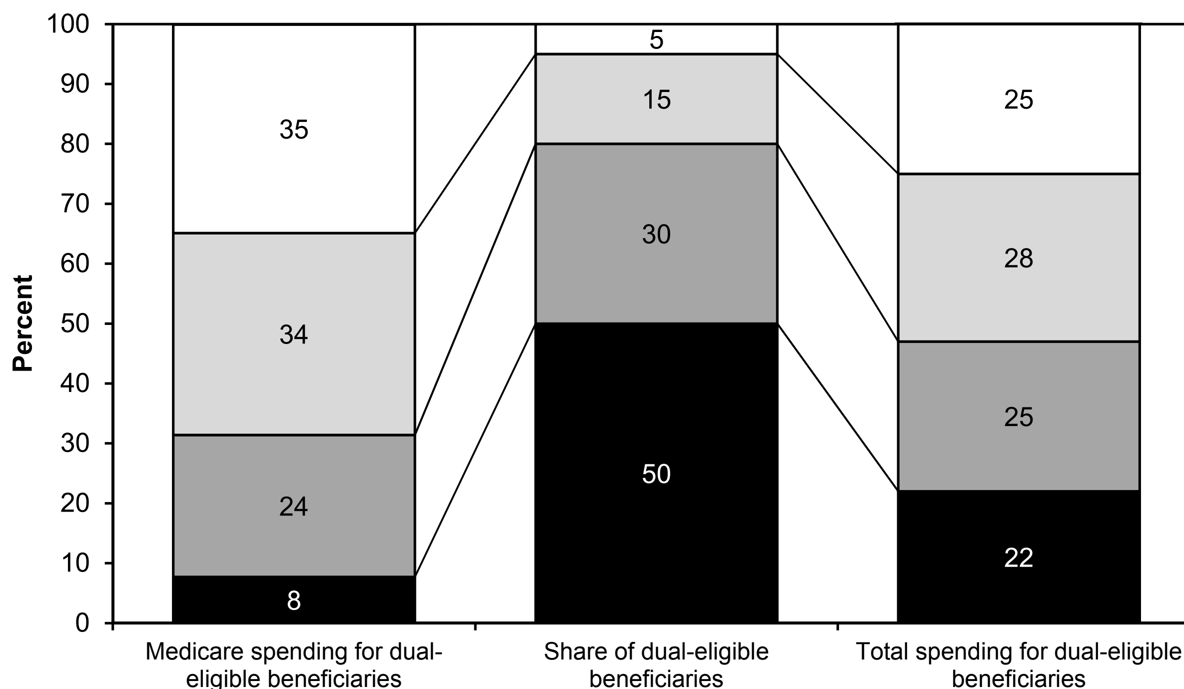
- In 2013, average per capita Medicare FFS spending for dual-eligible beneficiaries was more than twice that for non-dual-eligible beneficiaries—$19,789 compared with $9,035.
- For each type of service, average Medicare FFS per capita spending was higher for dual-eligible beneficiaries than for non-dual-eligible beneficiaries.
- Higher average per capita FFS spending for dual-eligible beneficiaries is a function of a higher use of these services by dual-eligible beneficiaries compared with their non-dual-eligible counterparts. Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to use each type of Medicare-covered service.

Chart 4-6. Both Medicare and total spending were concentrated among dual-eligible beneficiaries, 2013



Note: "Total spending" includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending. Dual-eligible beneficiaries are designated as such if the months they were enrolled in Medicaid exceeded the months they were enrolled in supplemental insurance. Totals may not sum to 100 percent due to rounding.

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- Annual Medicare fee-for-service spending on dual-eligible beneficiaries is concentrated among a small number. The costliest 5 percent of dual-eligible beneficiaries accounted for 35 percent of Medicare spending and 25 percent of total spending on dual-eligible beneficiaries in 2013. In contrast, the least costly 50 percent of dual-eligible beneficiaries accounted for only 8 percent of Medicare spending and 22 percent of total spending on dual-eligible beneficiaries.

- On average, total spending (including Medicaid, medigap, etc.) for dual-eligible beneficiaries in 2013 was about twice that for non-dual-eligible beneficiaries—$19,789 compared with $9,035, respectively (data not shown).