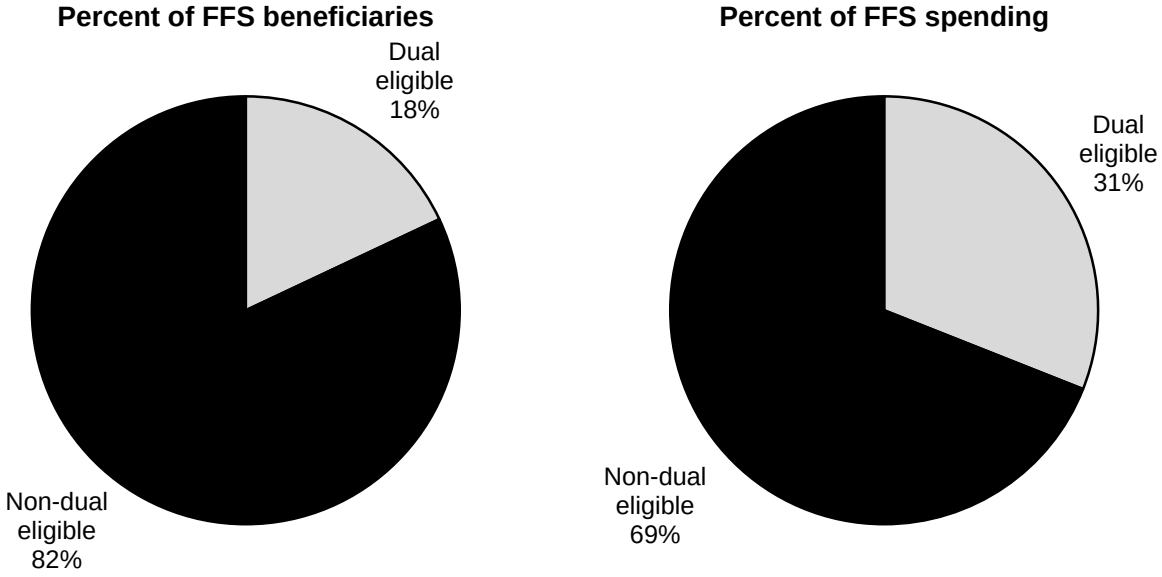
SECTION 4

Dual-eligible beneficiaries

Chart 4-1. Dual-eligible beneficiaries accounted for a disproportionate share of Medicare spending, 2012

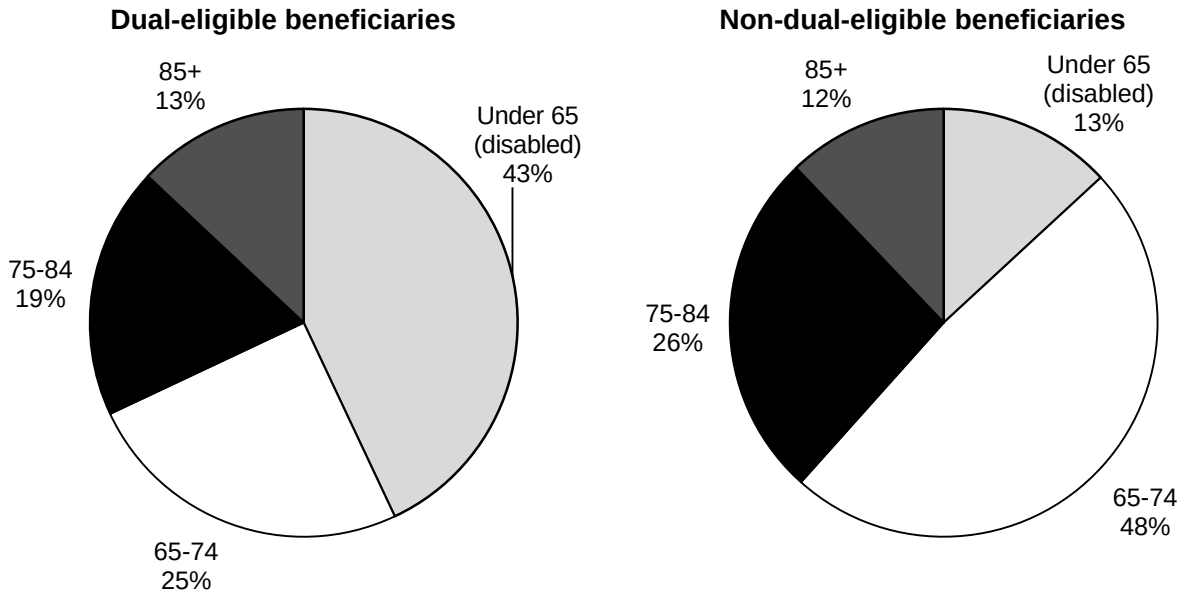


Note: FFS (fee for service). Dual-eligible beneficiaries are designated as such if the months they were enrolled in Medicaid exceeded the months they were enrolled in supplemental insurance.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file 2012.

- 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 2012, they represented 31 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 2012, $17,847 was spent per dual-eligible beneficiary, and $8,568 was spent per non-dual-eligible beneficiary (data not shown).
- In 2012, average total spending—which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending across all payers—for dual-eligible beneficiaries was $30,619 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, 2012

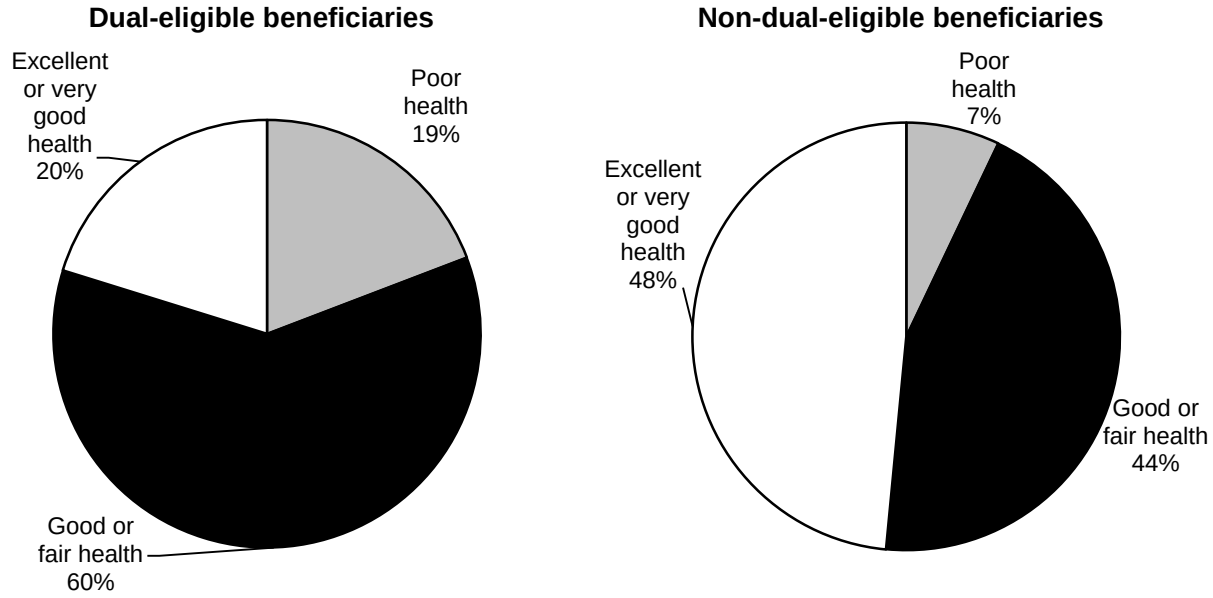


Note: Beneficiaries who are under age 65 qualify for Medicare because they are disabled. Once disabled beneficiaries reach age 65, they are counted as aged beneficiaries. Dual-eligible beneficiaries are designated as such if the months they were enrolled in Medicaid exceeded the months they were enrolled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

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2012.

- 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 2012, 43 percent of dual-eligible beneficiaries were under age 65 and disabled compared with 13 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, 2012



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 or nonresponse to survey question.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file 2012.

- Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to report poorer health status. In 2012, 19 percent of dual-eligible beneficiaries reported being in poor health compared with 7 percent of non-dual-eligible beneficiaries.

- Almost half of non-dual-eligible beneficiaries (48 percent) reported being in excellent or very good health in 2012. In comparison, only one-fifth (20 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, 2012

Characteristic	Percent of dual-eligible beneficiaries	Percent of non-dual-eligible beneficiaries
Sex		
Male	39%	46%
Female	61	54
Race/ethnicity		
White, non-Hispanic	58	78
African American, non-Hispanic	18	8
Hispanic	16	9
Other	8	5
Limitations in ADLs		
No limitations in ADLs	38	65
Limitations in 1–2 ADLs	27	23
Limitations in 3–6 ADLs	35	12
Residence		
Urban	70	78
Rural	30	22
Living arrangement		
Institution	17	2
Alone	31	28
With spouse	14	53
Children, nonrelatives, others	39	17
Education		
No high school diploma	45	17
High school diploma only	28	28
Some college or more	25	54
Income status		
Below poverty	61	9
100–125% of poverty	18	7
125–200% of poverty	15	20
200–400% of poverty	5	35
Over 400% of poverty	1	28
Supplemental insurance status		
Medicare or Medicare/Medicaid only	92	19
Medicare managed care	4	33
Employer-sponsored insurance	<1	30
Medigap	<1	16
Medigap/employer	0	1
Other*	4	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 2012, poverty was defined as income of $11,011 for people living alone and $13,892 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/hhes/www/poverty/data/threshld/).
*Includes public programs such as the Department of Veterans Affairs and state-sponsored drug plans.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2012.

- Dual-eligible beneficiaries qualify for Medicaid due in part to low incomes. In 2012, 61 percent of dual-eligible beneficiaries lived below the federal poverty level, and 94 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, 2012

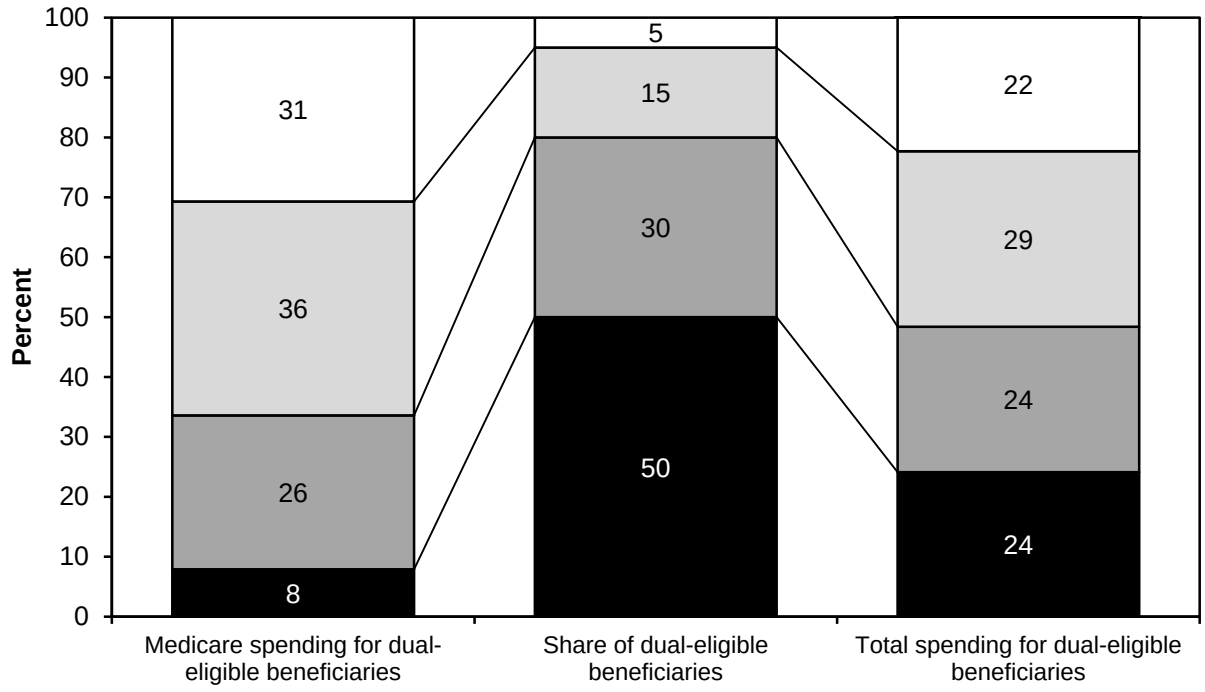
Service	Dual-eligible beneficiaries	Non-dual-eligible beneficiaries
Average FFS Medicare payment for all beneficiaries		
Total Medicare FFS payments	$17,847	$8,568
Inpatient hospital	5,041	2,690
Physician[a]	3,377	2,414
Outpatient hospital	2,412	1,167
Home health	681	386
Skilled nursing facility[b]	1,335	521
Hospice	546	254
Prescribed medication[c]	4,439	1,130
Share of FFS beneficiaries using service		
Share using any type of service	97.4%	85.5%
Inpatient hospital	25.8	14.8
Physician[a]	92.8	80.1
Outpatient hospital	80.0	59.4
Home health	11.5	7.8
Skilled nursing facility[b]	8.5	3.9
Hospice	4.4	1.8
Prescribed medication[c]	77.2	49.2

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.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file 2012.

- Average per capita Medicare FFS spending for dual-eligible beneficiaries was more than twice that for non-dual-eligible beneficiaries—$17,847 compared with $8,568.
- For each type of service, average Medicare FFS per capita spending is 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, 2012



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.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use files 2012.

- Annual Medicare FFS spending on dual-eligible beneficiaries is concentrated among a small number. The costliest 20 percent of dual-eligible beneficiaries accounted for 67 percent of Medicare spending and 51 percent of total spending on dual-eligible beneficiaries in 2012. In contrast, the least costly 50 percent of dual-eligible beneficiaries accounted for only 8 percent of Medicare spending and 24 percent of total spending on dual-eligible beneficiaries.

- On average, total spending (including Medicaid, medigap, etc.) for dual-eligible beneficiaries in 2012 was about twice that for non-dual-eligible beneficiaries—$30,619 compared with $15,583 (data not shown).