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Dual Eligibles: Medicaid Expenditures for Prescription Drugs and Other Services

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Summary

The term "dual eligibles" refers to individuals who qualify for both Medicare and Medicaid. Generally, persons qualify for Medicare if they or their spouse (or, in some cases, their parent) have worked and paid Medicare taxes, and they are either over age 65 or are a younger person with blindness or a disability. Persons qualify for Medicaid because they have limited income and resources and meet other federal and state requirements such as age or disability. In addition to qualifying for Medicare benefits, most dual eligibles also qualify for Medicaid services provided by the state. Medicaid covers certain services for most dual eligibles that Medicare does not cover including outpatient prescription drugs and long-term care.

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA, P.L. 108-173), enacted in December 2003, made several major changes to Medicare including adding a voluntary outpatient prescription drug benefit effective January 1, 2006. This new benefit will significantly change the prescription drug coverage of dual eligibles. To assist in understanding these changes, the purpose of this report is to provide background and information on the *current* prescription drug coverage of dual eligibles under Medicaid. It should be noted that the largest category of Medicaid spending for dual eligibles is long-term care including nursing facilities, home and community-based services, institutions for individuals with mental retardation, and other long-term care services ($49.0 billion, 69% of total spending for dual eligibles).

In FY2000, total Medicaid service spending was $168.1 billion. Of this amount, $70.8 billion (42%) was attributed to dual eligibles in payment for Medicaid covered benefits and in deductibles and coinsurance for Medicare services. An additional $4.2 billion in Medicaid expenditures were for Medicare premiums for dual eligibles. While Medicaid payments for dual eligibles represented a fairly large portion of total Medicaid expenditures, dual eligibles represented only 14.6% of all Medicaid beneficiaries.

Medicaid provides coverage for dual eligibles for many services not covered by Medicare including, at state option, outpatient prescription drugs. As of November 2002, all 50 states and the District of Columbia covered prescription drugs for at least some Medicaid beneficiaries. However, most states limited the quantity of the prescription that could be filled (e.g., 30-day supply), the total number of refills, or the total number of prescriptions within a given time period.

In FY2000, Medicaid paid for prescription drugs for 76% of dual eligibles totaling $10.7 billion. The average per-capita prescription drug payment for dual eligibles was $2,249. The percentage of dual eligibles who had Medicaid prescription drug costs ranged, in most states, between 70 and 90%. This report will be updated as needed.

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Who Are the Dual Eligibles?

The term "dual eligibles" generally refers to individuals who qualify for both Medicare benefits and those Medicaid benefits offered in their state.[1] However, some groups (including the Centers for Medicare and Medicaid Services (CMS)) also include in the definition of "dual eligibles" certain low-income Medicare beneficiaries for whom Medicaid *only* covers some Medicare cost-sharing obligations. All data on dual eligibles provided in this report include both those with full Medicaid benefits and the low-income Medicare beneficiaries receiving only cost-sharing assistance from Medicaid.[2]

Persons qualify for Medicare if they or their spouse (or in some cases, their parent) have worked and paid Medicare taxes, and they are either over age 65 or are a younger person with blindness or a disability. Persons qualify for Medicaid because they have limited income and resources and meet other federal and state requirements related to, for example, age or disability.[3] In FY2000, 90% of all aged Medicaid beneficiaries were dually eligible; 41% of Medicaid beneficiaries who were blind or had a disability were dually eligible.[4]

For a Medicare beneficiary to qualify for all state Medicaid benefits, he or she must meet the Medicaid eligibility criteria. A common pathway into Medicaid for a Medicare beneficiary is through eligibility for the Supplemental Security Income (SSI) program which, in most states, provides automatic Medicaid eligibility. Another common eligibility pathway for Medicare beneficiaries is through the "medically needy" option. Under this option, the state sets an income standard and allows certain individuals whose income exceeds that standard to "spend down" to

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[1] For additional information on dual eligibles see CRS Report RL30813, *Federal and State Initiatives to Integrate Acute and Long-term Care: Issues and Profiles,* by Edward Alan Miller.

[2] The data used in this report, provided by CMS, does not differentiate between Medicaid service expenditures and expenditures for Medicare co-payments and deductibles.

[3] Though most (over 98%) of dual eligibles qualify for Medicaid as elderly or having blindness or a disability, about 1.6% are children and adults who qualify under other eligibility pathways.

[4] Many Medicaid beneficiaries with disabilities do not qualify for Medicare because they do not have a sufficient work history in which they paid Medicare taxes; many of these individuals include persons with mental retardation and/or developmental disability.

eligibility by incurring medical expenses. The state may also set a resource standard that the individual must meet.[5]

The majority of dual eligibles are eligible for both Medicare benefits[6] and all Medicaid benefits that the state provides within state guidelines. In general, Medicaid is the last payer. For those benefits covered by both Medicare and Medicaid, Medicare is the primary payer. Medicaid covers those costs in excess of what is covered by Medicare. Medicaid benefits not available under Medicare (e.g., long-term care services, medical transportation) are paid by Medicaid unless there is a third-party to cover the cost.

Some Medicare beneficiaries are only eligible for Medicaid coverage of a portion of their Medicare premiums and cost-sharing.[7] States are required to cover certain Medicare cost-sharing expenses for four categories of dual eligibles:

- Qualified Medicare Beneficiaries (QMB) are Medicare beneficiaries whose income is no greater than 100% of the federal poverty level (FPL) and whose assets are no greater than $4,000 for an individual and $6,000 for a couple.
- Specified Low-Income Medicare Beneficiaries (SLMB) are those individuals who meet QMB criteria, except that their income is greater than 100% of FPL, but does not exceed 120% FPL.
- Qualifying-Individuals (QI-1) are Medicare beneficiaries whose income is between 120% and 135% FPL. States are required to pay the monthly Medicare Part B premium for these individuals until the federal allotment provided for this purpose is depleted.[8,9]
- Qualified Disabled and Working Individuals (QDWIs). States are required to pay the Medicare Part A premiums for persons who were entitled to Medicare on the basis of a disability, but lost their entitlement due to earned income and continue to have a disabling

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[5] For additional information see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone.

[6] Medicare benefits are separated into Part A and Part B. Part A covers inpatient hospital services, up to 100 days of post-acute care in a skilled nursing facility following a hospital stay, some home health services, and hospice services. Part B covers services such as physicians, outpatient hospital, laboratory, durable medical equipment and some home health care.

[7] For additional information see the Centers for Medicare and Medicaid Services (CMS) website at [http://www.cms.hhs.gov/dualeligibles/ftshhmpg.asp]

[8] In general, Medicaid payments are shared between the federal government and the states according to a matching formula. However, expenditures under the QI-1 program are paid 100% by the federal government up to a state allocation level. This temporary program, originally slated to end Dec. 31, 2002, has been extended through Sept. 30, 2004.

[9] From Jan. 1, 1998 to Dec. 31, 2002, there was an additional group referred to as "Qualifying Individuals (QI-2)." This group covered individuals whose income was between 135% and 175% of FPL for Part B premium increases attributable to home health care. This group is represented in the FY2000 data in this report.

condition. Such persons may only qualify if their income is below 200% of FPL and resources are below $4,000.

States also have the option of paying the Medicare Part A and/or Part B premiums for other Medicaid beneficiaries who qualify for Medicare under a buy-in agreement authorized under Section 1839 of the *Social Security Act*. These individuals are also considered "dual eligibles."

Medicaid Spending for All Dual Eligibles

Both Medicare and Medicaid offer comprehensive coverage for acute medical care benefits. Currently, Medicaid covers many additional benefits not covered by Medicare including prescription drugs and long-term care.[10] Within broad federal guidelines, states can design the scope and availability of Medicaid benefits. Medicaid law requires states to provide certain services including, for example, hospital and physician services. Within federal guidelines, states may, at their option, cover other services, and limit the amount, duration or scope of any Medicaid service. For example, a state may limit Medicaid coverage of a particular service to a certain number of hours or days or make a service available only to those with a particular condition (e.g., individuals who need 10 hours of personal care per week).

In FY2000, total Medicaid service spending was $168.1 billion. Of this amount, $70.8 billion (42%) was attributed to dual eligibles in payment for Medicaid covered benefits and in deductibles and coinsurance for Medicare services. An additional $4.2 billion in Medicaid expenditures were for Medicare premiums for dual eligibles.[11] While Medicaid payments for dual eligibles represented a fairly large portion of total Medicaid expenditures, dual eligibles represented only 14.6% of all Medicaid beneficiaries.

Medicaid prescription drug spending for dual eligibles totaled $10.7 billion in FY2000. However, the largest category of Medicaid spending for dual eligibles in FY2000 was long-term care which totaled $49.0 billion including nursing facilities, home and community-based services, intermediate care facilities for individuals with mental retardation (ICF/MR), and other long-term care services (**Table 1**).

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[10] Starting in 2006, dual eligible individuals will no longer be eligible for the state's prescription drug benefit provided under Medicaid. To receive coverage of prescription drugs, dual eligibles must enroll in the Medicare Part D benefit. These changes were made by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (P.L. 108-173). For additional information on the effect of this legislation see CRS Report RS21837, *Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs*, by Karen Tritz.

[11] Data on Medicaid spending on Medicare premiums based on Centers for Medicare and Medicaid Services, Form 64, FY2000.

Table 1. Medicaid Spending on Services and Medicare Co-Payments for Dual Eligibles by Category, FY2000

Category of service	Total spending (in millions)	Percentage of total
Nursing facility	$28,851	40.8
Prescription drugs	$10,725	15.2
HCBS and other[a]	$7,207	10.2
ICF-MR	$5,775	8.2
Personal care services	$3,382	4.8
All other services	$14,841	21.0
Total	**$70,781**	**100.0**
Medicare premiums	$4,204	n/a

Source: Congressional Research Service (CRS) based on the Centers for Medicare and Medicaid Services (CMS), Medicaid Statistical Information System (MSIS), FY2000, and Form 64 (for Medicare premium data only).

[a] Includes Home and Community-Based Waiver services (HCBS) provided under Section 1915(c) of the Social Security Act (totaling approximately $6.1 billion) and several other services such as prosthetic devices and optical care (totaling approximately $1.1 billion).

Medicaid Prescription Drugs for Dual Eligibles

Currently, Medicaid provides coverage for dual eligibles for many services not covered by Medicare including, at state option, outpatient prescription drugs. As of November 2002, all 50 states and the District of Columbia covered prescription drugs for at least some Medicaid beneficiaries.[12] However, most states limited the quantity of the prescription that could be filled (e.g., 30-day supply), the total number of refills, or the total number of prescriptions within a given time period.[13]

The specific types of prescription drugs covered under Medicaid are very broad. States may create lists of preferred drugs or require advance (prior) approval for non-preferred drugs, but statutory requirements insure that Medicaid covers a comprehensive list of drugs. Most states also cover some categories of non-prescription, over-the-counter drugs.[14]

In FY2000, Medicaid paid for prescription drugs for 76% of dual eligibles totaling $10.7 billion. The average per-capita prescription drug payment for dual

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[12] Coverage of drugs dispensed while a Medicaid beneficiary is hospitalized is mandatory. Expenditures for inpatient drugs are reported by states as part of inpatient services.

[13] *Pharmaceutical Benefits Under State Medical Assistance Programs*, National Pharmaceutical Council, 2001.

[14] There are 10 categories of prescription drugs that states are allowed to exclude from coverage under Medicaid (e.g., weight loss, fertility, relief from coughs and colds.) For additional information see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

eligibles was $2,249. The percentage of dual eligibles who had Medicaid prescription drug costs ranged, in most states, between 70 and 90% (**Tables 2** and **3**).

The number of enrollees and amounts shown in **Tables 2** and **3** do not include prescription drugs for Medicaid beneficiaries enrolled in a Medicaid managed care program. For example, due to a large enrollment in managed care, Tennessee and Arizona reported very low numbers of dual eligibles who received Medicaid prescription drugs. Under managed care, states pay an organization a fixed, monthly payment per enrollee to provide all the services specified under the managed care contract. Data reported to the federal government generally show only the fixed, monthly, per-person payment amount and do not itemize expenditures for specific services. In FY2000, 33.6% of dual eligibles were enrolled in managed care for at least a portion of their Medicaid services.

The amounts shown in **Table 3** do not reflect rebates paid to states by pharmaceutical manufacturers. Under federal law, manufacturers seeking to have their drugs available for Medicaid beneficiaries must enter into rebate agreements with the Secretary of Health and Human Services (HHS), on behalf of the states.[15,16] States may also enter into rebate agreements with pharmaceutical manufacturers for additional discounts. In FY2000, Medicaid drug expenditures for all beneficiaries (i.e., about $20.6 billion) were offset by 19.4% due to manufacturer rebates.[17]

Table 2. Medicaid Enrollees and Dual Eligibles by State, FY2000

(in thousands)

State	Total Medicaid enrollees	All dual eligibles[a]	Dual eligibles with Medicaid drug spending	% of dual eligibles with Medicaid drug spending
Alaska	96.4	8.4	7.6	90%
Alabama	619.5	122.7	96.8	79%
Arkansas	489.3	109.1	83.1	76%
Arizona[b]	681.3	59.1	1.2	2%
California	7,915.5	860.7	637.3	74%
Colorado	381.0	60.7	43.7	72%
Connecticut	419.9	74.4	66.5	89%
Dist. of Col.	138.7	15.1	11.5	76%
Delaware	115.3	11.7	8.5	73%
Florida	2,360.4	315.5	270.6	86%
Georgia	1,289.8	161.3	122.6	76%
Hawaii[c]	203.8	51.9	21.4	41%
Iowa	313.6	57.2	49.9	87%

[15] Omnibus Budget Reconciliation Act of 1990, P.L. 101-508

[16] Under these agreements, manufacturers must pay state Medicaid agencies rebates on drugs paid for Medicaid beneficiaries. In return for entering into agreements with the Secretary, state Medicaid agencies are required to cover all of the drugs marketed by participating manufacturers.

[17] CRS analysis of data from the Centers for Medicare and Medicaid Services (CMS), Form 64.

State	Total Medicaid enrollees	All dual eligibles[a]	Dual eligibles with Medicaid drug spending	% of dual eligibles with Medicaid drug spending
Idaho	131.1	10.7	8.6	80%
Illinois	1,516.1	169.5	149.6	88%
Indiana	704.6	100.3	87.8	88%
Kansas	262.6	39.8	35.9	90%
Kentucky	770.5	193.5	137.1	71%
Louisiana	761.2	114.9	94.5	82%
Massachusetts	1,047.4	185.5	170.5	92%
Maryland	664.6	75.8	66.8	88%
Maine	191.6	40.6	38.1	94%
Michigan	1,351.7	183.2	149.4	82%
Minnesota	559.5	89.8	56.5	63%
Missouri	890.3	139.3	126.5	91%
Mississippi	605.1	118.3	113.8	96%
Montana	103.8	14.5	13.1	90%
North Carolina	1,208.8	222.8	206.7	93%
North Dakota	60.9	12.6	11.1	88%
Nebraska	229.0	32.4	30.5	94%
New Hampshire	96.9	18.3	17.0	93%
New Jersey	822.4	138.1	128.8	93%
New Mexico	375.6	33.2	21.7	65%
Nevada	138.1	19.7	14.3	73%
New York	3,419.9	537.7	418.9	78%
Ohio	1,304.9	194.9	172.5	89%
Oklahoma	507.1	76.0	63.7	84%
Oregon	542.4	63.4	43.9	69%
Pennsylvania[c]	1,554.4	352.2	169.8	48%
Rhode Island	178.9	28.7	26.0	91%
South Carolina	685.1	110.6	96.5	87%
South Dakota	102.0	16.9	11.5	68%
Tennessee[b]	1,568.3	243.5	0.0	0%
Texas	2,602.6	389.4	315.5	81%
Utah	224.3	17.2	15.5	90%
Virginia	627.2	116.2	89.0	77%
Vermont	138.9	24.7	23.7	96%
Washington	895.3	91.9	84.7	92%
Wisconsin	576.6	110.2	99.7	90%
West Virginia	335.0	44.9	34.7	77%
Wyoming	46.4	6.7	5.2	78%
United States	42,825.6	6,285.8	4,769.7	76%

Source: Congressional Research Service (CRS) based on analysis of Centers for Medicare and Medicaid Services (CMS) Medicaid Statistical Information System (MSIS) data, FY2000.

[a] Includes all dual eligibles except those in which Medicaid *only* paid for Medicare premiums.

[b] Medicaid drug spending in Arizona and Tennessee is primarily included in capitation payments under managed care. As described in this report, under managed care, data on drug spending may not be itemized.

[c] The figures for Hawaii and Pennsylvania represent FY1999 due to missing data.

Table 3. FY2000 Medicaid Expenditures for Dual Eligibles

(total expenditures in millions)

State	Total spending all Medicaid enrollees	Total Medicaid spending for dual eligibles (except Medicare premiums)	Total Medicaid prescription drug spending for dual eligibles	
			Total	Per-capita
Alaska	$470	$112	$21	$2,783
Alabama	$2,391	$1,046	$171	$1,769
Arkansas	$1,510	$795	$137	$1,646
Arizona[a]	$2,112	$579	$1	$574
California	$17,060	$6,156	$1,310	$2,055
Colorado	$1,809	$811	$97	$2,225
Connecticut	$2,839	$1,822	$179	$2,691
Dist. of Columbia	$793	$227	$25	$2,182
Delaware	$528	$189	$21	$2,503
Florida	$7,350	$2,964	$753	$2,783
Georgia	$3,578	$1,242	$256	$2,091
Hawaii[b]	$535	$207	$28	$1,286
Iowa	$1,476	$727	$110	$2,206
Idaho	$594	$125	$24	$2,795
Illinois	$7,807	$2,379	$375	$2,509
Indiana	$2,976	$1,473	$267	$3,042
Kansas	$1,226	$633	$97	$2,700
Kentucky	$2,913	$1,585	$317	$2,313
Louisiana	$2,631	$1,001	$219	$2,318
Massachusetts	$5,397	$2,868	$372	$2,179
Maryland	$3,586	$1,079	$152	$2,278
Maine	$1,307	$521	$95	$2,488
Michigan	$4,881	$1,451	$274	$1,836
Minnesota	$3,277	$1,746	$128	$2,264
Missouri	$3,270	$1,605	$362	$2,865
Mississippi	$1,807	$837	$224	$1,970
Montana	$433	$168	$30	$2,320
North Carolina	$4,830	$2,180	$460	$2,227
North Dakota	$356	$221	$25	$2,228
Nebraska	$958	$435	$76	$2,482
New Hampshire	$651	$375	$47	$2,797
New Jersey	$4,707	$2,329	$348	$2,702
New Mexico	$1,249	$315	$40	$1,827
Nevada	$515	$155	$26	$1,842
New York	$26,148	$12,375	$1,013	$2,418
Ohio	$7,090	$3,537	$446	$2,586
Oklahoma	$1,604	$680	$114	$1,781
Oregon	$1,700	$600	$87	$1,993
Pennsylvania[b]	$6,137	$2,506	$355	$2,090
Rhode Island	$1,070	$581	$58	$2,243
South Carolina	$2,672	$931	$176	$1,821

State	Total spending all Medicaid enrollees	Total Medicaid spending for dual eligibles (except Medicare premiums)	Total Medicaid prescription drug spending for dual eligibles	
			Total	Per-capita
South Dakota	$401	$189	$25	$2,190
Tennessee[a]	$3,491	$680	0	0
Texas	$9,075	$3,770	$546	$1,731
Utah	$959	$212	$42	$2,711
Virginia	$2,484	$1,134	$216	$2,423
Vermont	$479	$200	$53	$2,247
Washington	$2,432	$757	$208	$2,455
Wisconsin	$2,906	$1,680	$233	$2,338
West Virginia	$1,392	$492	$71	$2,057
Wyoming	$214	$102	$13	$2,508
United States	$168,076	$70,781	$10,725	$2,249

Source: Congressional Research Service (CRS) based on analysis of Centers for Medicare and Medicaid Services (CMS) Medicaid Statistical Information System (MSIS) data, FY2000.

[a] Medicaid drug spending in Arizona and Tennessee is primarily included in capitation payments under managed care. As described in this report, under managed care, data on drug spending may not be itemized

[b] The figures for Hawaii and Pennsylvania represent FY1999 due to missing data.