Arnold Ventures

Dual-Eligibility Facts & Figures

Improving care for 12.2 million people simultaneously enrolled in Medicare and Medicaid[1]—the so called "dual-eligible" population—represents a key opportunity for policymakers who care about government spending and improving care delivery for vulnerable populations alike.

We spend more on care for dual-eligible individuals than other Medicare and Medicaid individuals on average:

- ***Medicare:*** Dual-eligible individuals make up 17% of the Medicare population but represent 30% of aggregate Medicare fee-for-service (FFS) spending which in 2017 amounted to Medicare spending $19,846 per dual-eligible individual compared to $9,415 for Medicare-only individuals.[2]
- ***Medicaid:*** Dual-eligible individuals make up 15% of the Medicaid population but represent 32% of aggregate Medicaid spending which in 2013 amounted to Medicaid spending $11,126 per dual-eligible individual.[3]
- ***Total Spending:*** On average, total spending for dual-eligible individuals in 2017 was almost double their non-dual-eligible counterparts–$30,510 compared with $15,630.[4]

$300 BILLION

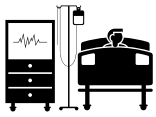
Amount spent, in aggregate, each year on providing care and coverage to the dual-eligible population.[5]

Although preventable hospitalizations are usually identified as drivers of high cost, long-term care costs account for the majority of spending (68%) among the highest cost dual-eligible individuals.[8]

Despite all this spending, the dual-eligible population reports that they are in poorer health than their Medicare-only counterparts.[6]

- 16% of dual-eligible individuals consider themselves in poor health compared to only 5% of their Medicare-only counterparts.
- Unsurprisingly, they are also less likely to report themselves in excellent or very good health compared to Medicare individuals (21% vs. 52%, respectively).

And we see the results of poor health in the way that they use care—more often in last-resort, expensive settings of care.[7]



26%

of dual-eligible individuals have at least one inpatient hospital stay per year

(Medicare: 16%)

21%

of dual-eligible individuals have at least one ER visit per year

(Medicare: 13%)

13%

of dual-eligible individuals have at least one day of home health care per year

(Medicare: 8%)

Dual-eligible individuals are also over-represented in long-term care facilities, and have been identified as one of the populations at greatest risk of becoming infected – and dying – from COVID-19.

DUAL-ELIGIBLE 13%

MEDICARE 1%

People become eligible for both programs because they are low-income and are over the age of 65 or disabled. The vast majority of people that become dual-eligible qualify for one coverage program (i.e., Medicare or Medicaid) before gaining access to the other.[9]

- ***Medicare-to-Medicaid:*** Almost 7 in 10 dual-eligible individuals follow this pathway to enrollment in both programs which commonly includes people over the age of 65 with low incomes and long-term care needs.
- ***Medicaid-to-Medicare:*** Alternatively, almost 3 in 10 dual-eligible individuals first gain access to the Medicaid program before gaining Medicare coverage as a result of a disability (67%) or turning 65 years old and aging into the program (32%).

Dual-eligible indviduals face high costs for their care and needs, compared to Medicare-only beneficiaries.

55%

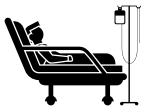
of dual-eligibles live below the poverty line

- The average Medicare beneficiary spends approximately $5,500 per year on their health coverage, representing more than one-third of their total income if living in a family of two. If long-term services and supports are needed, which is common among dual-eligible individuals, the average Medicare beneficiary spends more than $40,000 out-of-pocket in the absence of any Medicaid coverage.[10]
- Dual-eligible individuals rarely have access to other forms of insurance that help pay for these out-of-pocket expenses. Only 1% of dual-eligible individuals have employer-sponsored insurance compared to 23% of non-dual-eligible Medicare individuals and only 3% of dual-eligible individuals have Medigap insurance compared to 23% of non-dual-eligible Medicare individuals.[11]

Financial support and access to additional benefits varies among the dual-eligible population based on income and need.

- Just over **7 in 10** dual-eligible individuals qualify for assistance to pay for their Medicare premiums and co-pays as well as the full range of Medicaid-covered benefits, including long-term services and supports. The 8.7 million people that fall into this category are commonly referred to as *full-benefit dual-eligible individuals*.[12]
- Almost **3 in 10** dual-eligible individuals receive assistance paying for some amount of Medicare cost-sharing and premiums, but are not entitled to the full-range of Medicaid benefits. The 3.5 million people that fall into this category are commonly referred to as *partial-benefit dual-eligible individuals*.[13]

Dual-eligible individuals utilize health care more than their Medicare counterparts because they have significant health needs.[14]



93.8%

of dual-eligible individuals access health care services, compared to **87.1%** of Medicare-only individuals

75.9%

of dual-eligible individuals use prescription drugs, compared to **59.9%** of Medicare-only individuals

54%

of dual-eligible individuals have limitations that impact daily living

Dual-eligible individuals typically have more chronic conditions than their Medicare counterparts.[15]

0 Conditions

10% of dual-eligible individuals; **22%** of Medicare-only individuals.

1–2 Conditions

20% of dual-eligible individuals; **24%** of Medicare-only individuals.

3–4 Conditions

26% of dual-eligible individuals; **29%** of Medicare-only individuals.

≥ 5 Conditions

42% of dual-eligible individuals; **26%** of Medicare-only individuals.

The five most common conditions among the dual-eligible population include:[16]

72%
Heart Disease

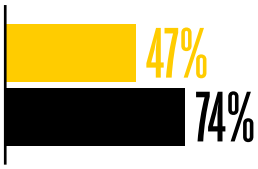
45%
Diabetes/End-Stage Renal Disease/Other Renal Conditions

41%
Mental Health

38%
Arthritis/Osteoporosis/ Other Joint-related Conditions

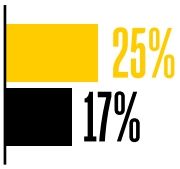
24%
Hearing and Visual Impairment

The dual-eligible population is much more likely to be frail and have limitations that impact their ability to carry out activities associated with daily living (ADL) (e.g., bathing).[17]



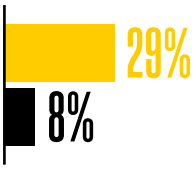
0 Limitations in ADLs

47% of dual-eligible individuals; **74%** of Medicare-only individuals.



Limitations in 1-2 ADLs

25% of dual-eligible individuals; **17%** of Medicare-only individuals.



Limitations in 3-6 ADLs

29% of dual-eligible individuals; **8%** of Medicare-only individuals.

The dual-eligible population is not homogenous and is more diverse than Medicare and Medicaid alone.

Dual-eligible individuals' age span a large spectrum—unlike the Medicare and Medicaid programs alone, meaning a broad range of services and supports are necessary to address disparate needs.

58%

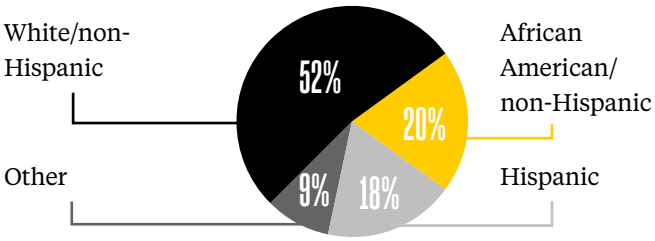
Medicaid: 58% of dual-eligible individuals are 65 or older.[18]

42%

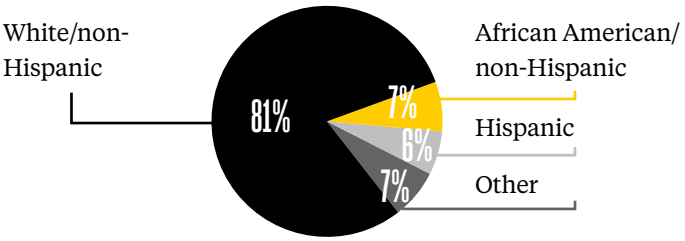
Medicare: 42% of dual-eligible individuals are under age 65.[19]

The dual-eligible population is more racially diverse than the Medicare-only population. The services available and program operations, must reflect the needs and perceptions of the population it aims to serve.

Dual-eligible Individuals:[20]



Medicare-only Individuals



Medicaid and Medicare were never designed to work together, creating a fragmented and uncoordinated experience for the dual-eligible population.

- People must navigate two coverage systems while oftentimes sick with multiple chronic conditions.
- Providers are left to work through two bureaucracies, instead of one, to receive payment for the significant number of services they provide to this complex patient population; and
- Government spending increases because both the states and federal government leverage the other to reduce their program's spending, rather than working together to reduce the total cost of care.

1 IN 10

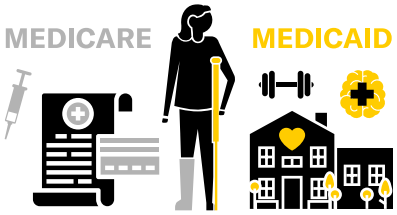
dual-eligible individuals are enrolled in an integrated care plan.

The time to fix the broken incentive structure between Medicare and Medicaid and improve care delivery for the dual-eligible population is now. To do this, we need to:

Increase the degree of

INTEGRATION

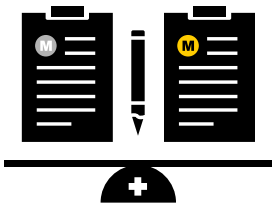
between Medicare and Medicaid



Increase

ENROLLMENT

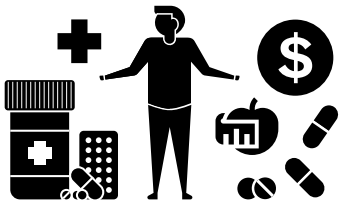
in integrated coverage



Improve access to a

MIX OF SERVICES

including community options instead of institutional care



END NOTES

1 *CMS 2020 Factsheet: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination- Office/Downloads/MMCO_Factsheet.pdf*

2 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0*

3 *MedPAC/MACPAC 2018 Databook: https://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf*

4 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0*

5 *MedPAC/MACPAC 2018 Databook: https://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf*

6 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0*

7 *KFF Medicaid Per Capita Cap: https://www.kff.org/medicare/issue-brief/what-could-a-medicaid-per-capita-cap-mean-for-low-income-people-on-medicare/#:~:text=Under%20a%20Medicaid%20per%20capita,need%20to%20reduce%20Medicaid%20spending.*

8 *Figueroa 2018: https://pubmed.ncbi.nlm.nih.gov/30285049/*

9 *ASPE 2019 Report: https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report#results.*

10 *KFF Medicare Beneficiaries Out of Pocket Spending 2019: https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/.*

11 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0.*

12 *CMS 2020 Factsheet (2018 data): https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.*

13 *CMS 2020 Factsheet (2018 data): https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.*

14 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0*

15 *CMS 2012 Enrollee Information: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf.*

16 *CMS 2012 Enrollee Information: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf.*

17 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0*

18 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0*

19 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0*

20 *MedPAC 2020 Databook: http://www.medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0*