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Arnold Ventures Dual Eligible Fact Sheet

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.

Today, the dual eligible population accounts for a disproportionate amount of public health care resources yet the outcomes we get for that spending are poor:

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 Medicare population but represent 30% of aggregate Medicare FFS spending which in 2017 amounted to Medicare spending $19,846 per dual-eligible individual compared to $9,415 for non-dual-eligible Medicare-enrolled individuals.[2]
- *Medicaid:* Dual-eligible individuals make up 15% of 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 respectively. [4] We spend more than $300 billion in aggregate providing care and coverage to the dual-eligible population.[5]

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

- 16% of dual-eligible individuals consider themselves in poor health in comparison to only 5% of their non-dual-eligible Medicare-covered 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, compared to 16% of non-dual Medicare individuals.
- 21% of dual eligible individuals have at least one emergency room visit per year, compared to 13% of non-dual Medicare individuals.
- 13% of dual eligible individuals have at least one day of home health care per year, compared to 8% of non-dual Medicare individuals.
- 13% of dual eligible individuals live in a long-term care facility, compared to 1% of non-dual Medicare individuals.

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]

People become eligible for both programs because they cannot afford their care and are over the age of 65 or disabled.

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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 (67.14%) 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 (27.2%) before gaining Medicare as a result of a disability (67%) or turning 65 years old and aging into the program (32%).

Medicaid helps pay for Medicare premiums, cost-sharing, and additional long-term services and supports for a subset of the population. Without this financial assistance, dual-eligible individuals would struggle to pay for their Medicare coverage.

- The majority of dual-eligible individuals have an income at or below the poverty line (55%) which in a two-person home equates to less than $16,000 a year (2017).[10, 11]
- The average Medicare beneficiary spends approximately $5,500 per year on their health coverage, representing over 1/3 of their total income if living in a family of two just at the poverty line. If long-term services and supports are needed which is common amongst dual-eligible individuals, the average Medicare beneficiary spends over $40,000 out-of-pocket in the absence of any Medicaid coverage.[12]
- 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.[13]

The level of financial support and access to additional benefits varies amongst dual-eligible individuals based on income and need.

- Just over 7 in 10 dual-eligible individuals qualify for assistance paying 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.*[14]
- Almost 3 in 10 dual-eligible individuals get 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.*[15]

Dual-eligible individuals rely on the health care system more than their non-dual-eligible Medicare counterparts because they have significant health needs.

Dual eligible individuals are more likely to use health care services than non-dual eligible individuals.[16]

- 93.8% of dual-eligible individuals access health care services, compared to 87.1% of non-dual-eligible Medicare individuals.
- 75.9% of dual-eligible individuals use prescription drugs, compared to 59.9% of non-dual-eligible Medicare individuals.
- 13.1% of dual-eligible individuals use home health services, compared to 7.5% of non-dual eligible Medicare individuals.

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Dual-eligible individuals are more likely to have more chronic conditions than their non-dual-eligible Medicare counterparts.[17]

- 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 amongst the dual-eligible population include heart disease (72%), diabetes/ESRD/other endocrine or renal conditions (45%), mental health (41%), arthritis/osteoporosis/other joint-related conditions (38%), and hearing and visual impairment (24%).[18]

The dual-eligible population is much more likely be frail and have limitations that impact their ability to carry out activities associated with daily living (ADL) (e.g., bathing).)[19]

- 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.

- *Medicaid:* 58% of dual eligible individuals are 65 or older, [20] while 10% of non-dual eligible Medicaid individuals are 65 or older,[21]
- *Medicare:* 42% of dual-eligible individuals are under age 65,[22] while 9% of non-dual eligible Medicare individuals are under the age of 65.[23]

Dual-eligible population is more racially diverse than the Medicare-only population. The services available and program operations, including the way you encourage people to enroll, must reflect the needs and perceptions of the population it aims to serve.

- Dual Eligible Individuals:[24]
  - White/non-Hispanic: 52%
  - African American/non-Hispanic: 20%
  - Hispanic: 18%
  - Other: 9%
- Non-Dual Eligible Medicare Individuals
  - White/non-Hispanic: 81%
  - African American/non-Hispanic: 7%
  - Hispanic: 6%
  - Other: 7%

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The services and supports that the dual eligible population receive are from two disparate programs that were never intended to work together and the result is:

- 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 total cost of care.

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 options
- Ensure that dual-eligible individuals are getting the mix of services that reduces the likelihood care is delivered in last-resort, expensive settings.

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