Dual Eligibles and the Value of Medicare Advantage

Background on Dual Eligibles

Who is a "Dual Eligible"? Dual eligibles are low-income seniors or individuals with disabilities who qualify for benefits under both the Medicare program and their state Medicaid program.

What Are the Characteristics of the Dual Eligible Population? The dual eligible population is diverse, and includes many beneficiaries with multiple chronic illnesses, dementia and other forms of cognitive impairment, physical and developmental disabilities, and/or mental illnesses. Dual eligible beneficiaries are more likely to have functional limitations and require long-term care services than non-dual eligible Medicare beneficiaries. This highly complex population requires a comprehensive range of medical and social support services.

Dual Eligibles: By the Numbers

10 million — Approximately 10 million Americans are dual eligibles, representing 20% of the Medicare population.

29% — An estimated 3 million dual eligibles — 29% of all dual eligibles — are enrolled in the Medicare Advantage program.

$20 thousand — 37% of Medicare Advantage enrollees have incomes of $20,000 or below, which includes a significant number of low-income individuals who do not qualify for full Medicaid benefits or assistance with all Medicare cost-sharing.

The Value of Medicare Advantage to Dual Eligibles

Medicare Advantage plans ensure affordability is not a barrier to care for these low-income individuals by offering protection to reduce out-of-pocket costs, which is particularly important for dual eligibles who receive only limited financial assistance with their Medicare benefits.

Medicare Advantage plan activities to detect, treat, and prevent the progression of chronic disease provide the foundation for delivery system reform championed by the Administration, and have been demonstrated to have positive spillover effects that are improving care and reducing costs throughout the Medicare program.[1]

Research also demonstrates health plans have put programs in place that are improving the lives of dual eligibles, who can most benefit from the coordinated care, focus on prevention, and delivery of person-centered care these plans provide.[2]

Sources:Medicare Advantage Demographics Report, 2013. AHIP (January 2016).
CMS Data Tables for Medicare-Medicaid Enrollment and Eligibility Trends (March 2015).

Which Program — Medicare or Medicaid — Pays?

Medicare is the primary payer of acute care for dual eligibles, such as hospital and physician services, as well as post-acute rehabilitation and prescription drugs. Medicaid provides financial assistance with Medicare premiums and cost-sharing (i.e., deductibles, co-insurance, and co-payments) and pays for Medicaid benefits not covered by Medicare, including long-term care.

What Is the Difference between Full and Partial Dual Eligibles?

Full dual eligibles qualify to receive all of the services covered by their state Medicaid programs in addition to financial assistance with Medicare cost-sharing. Partial dual eligibles qualify for financial assistance with Medicare premiums and in some cases cost-sharing but are not entitled to other Medicaid-covered services. Income and financial asset thresholds for full and partial dual eligibility categories vary, as states may expand eligibility beyond the lower limits set by the Federal government. In addition, the degree of Medicare cost sharing assistance varies by eligibility category and state.

Sources:
[1] Baicker, Katherine, Chernew, Michael, Robbins, Jacob. "The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization." *Journal of Health Economics* Vol 32 1289-1300. September 2013.
[2] For example, see JEN Associates, Incorporated, "MassHealth Senior Care Options Program Evaluation: Pre-SCO Enrollment Period CY 2004 and Post-SCO Enrollment Period CY 2005 Nursing Home Entry Rate and Frailty Level Comparisons."
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