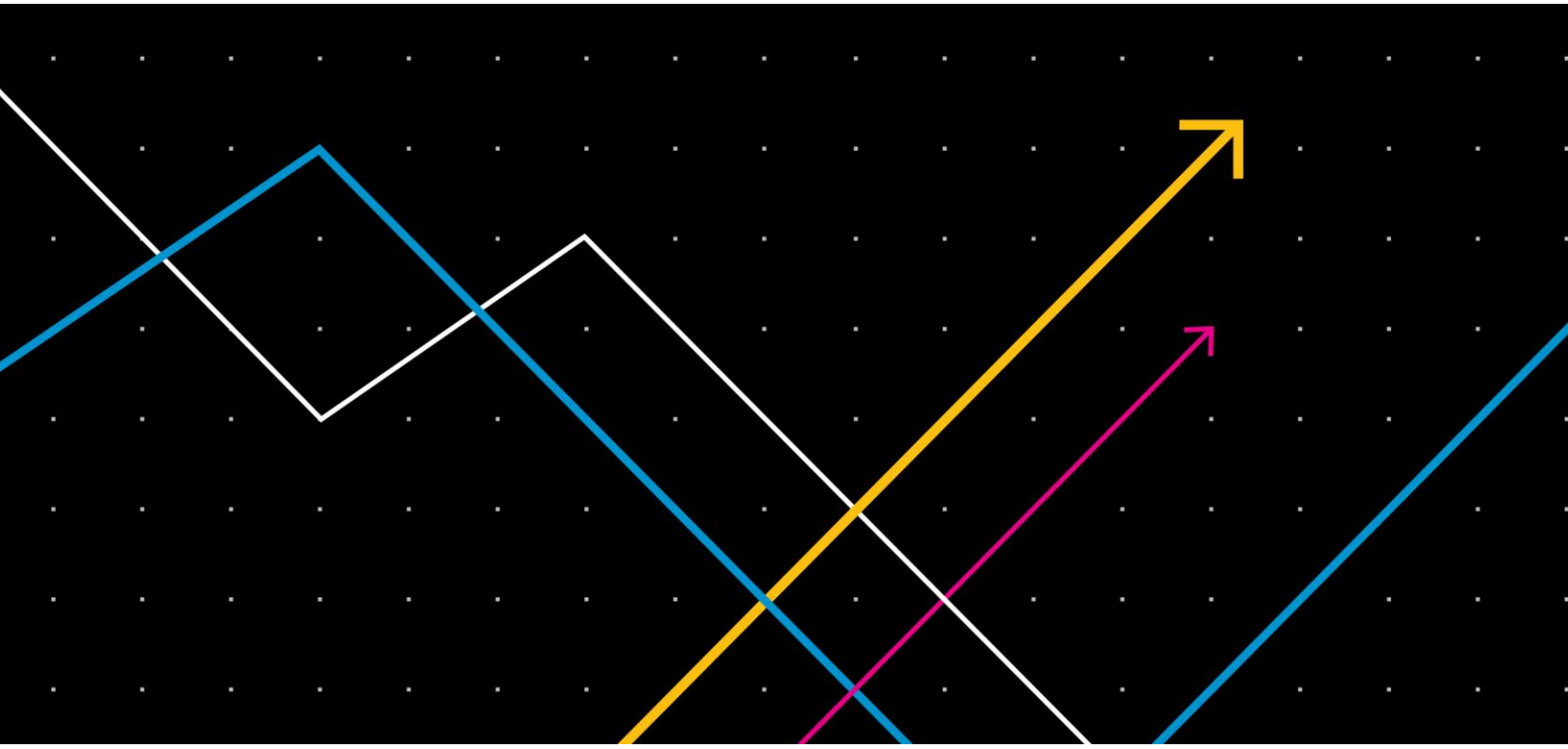

RESEARCH REPORT

The Effect on States of Increasing the Medicare Eligibility Age

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September 2015

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This project was supported by a grant from The SCAN Foundation, which advances a coordinated and easily navigated system that provides high-quality services for older adults and that preserves dignity and independence. For more information, visit www.TheSCANFoundation.org.

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Acknowledgments

Research for this report was supported by a grant from The SCAN Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission. Funders do not, however, determine our research findings or the insights and recommendations of our experts. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

Assistance in obtaining data was provided by ResDAC. The authors would like to thank Judy Feder and Terri Coughlin for their helpful discussions early in the project.

Executive Summary

Proposals to increase the eligibility age for Medicare may have unintended consequences for state government finances. Specifically, the medical care of some Americans who currently receive both Medicaid and Medicare benefits, also known as "dual eligibles," could become the sole responsibility of Medicaid, a program for which states share financial responsibility with the federal government. In this report, we estimate (1) the number of individuals who could lose Medicare coverage in each state because of an increase in eligibility age, and (2) the amount of current Medicare spending that could be shifted to state Medicaid programs.

- Just over 2 percent of all Medicaid beneficiaries nationwide are between the ages of 65 and 69, but compared with the average Medicaid beneficiary, the per capita medical care expenditures of that group are high. Under current law, the Medicare program bears the largest share of costs for that group's care, but an increase in the program's eligibility age could shift those costs to Medicaid. Although a change in the Medicare eligibility age would not affect disabled beneficiaries, many dual eligibles who currently qualify for Medicare solely on the basis of age could still qualify for Medicaid after losing Medicare.
- We estimate that the states' share of Medicaid costs would increase $369 million per year if the Medicare eligibility age is increased to 67 and $1.9 billion per year if the eligibility age is increased to 70.
- Our state-by-state analysis of program administrative data reveals that the financial effect on an individual state depends on (1) its demographic composition, (2) the share of Medicaid expenditures for which the state is responsible, and most important, (3) whether the state has expanded the income eligibility threshold for Medicaid under the Affordable Care Act.

The Effect on States of Increasing the Medicare Eligibility Age

Introduction

Increasing Medicare's eligibility age is a commonly proposed idea to reduce Medicare spending. One basis for this proposal is that as improvements in mortality have increased the life expectancies of retirees, entitlement programs will face increased expected costs per beneficiary. The Social Security program is already in the middle of a gradual increase in the normal retirement age from 65 to 67; this increase began in 2003 and will be completed in 2027. Thus, aligning Medicare eligibility with Social Security is naturally appealing.

Although federal expenditures clearly can be reduced by such benefit cuts, the full cost of such a change may not have been considered. The financial and health implications for individuals who could lose Medicare coverage depend largely on the states' ongoing decisions about whether or not to expand Medicaid. Especially in states that do not expand Medicaid, a change in Medicare eligibility without a viable alternative option for coverage could leave many older Americans at risk.

This report focuses on the group of enrollees in both Medicare and Medicaid, also known as "dual eligibles," who are between the ages of 65 and 69. Those individuals have qualified for Medicare benefits either because of age or disability status, and they have qualified for Medicaid because of low income in addition to either age or disability. Because of their disability and low income, dual eligibles are considered to be, on average, at high risk for acute and long-term care needs. Compared with other Medicare beneficiaries, they are generally, though not uniformly, higher-cost beneficiaries (Coughlin, Waidmann, and Phadera 2012; Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission 2015).

If Medicare's eligibility age is increased, the population of dual eligibles would consequently be reduced. However, unless the disability-related pathway to Medicare eligibility is also changed, dual eligibles who qualified for Medicare on the basis of disability would retain benefits, regardless of age. Those who qualified for Medicare solely on the basis of age, however, would retain eligibility for Medicaid unless Medicaid eligibility rules were also changed. Consequently, those individuals could retain health coverage but would become Medicaid-only beneficiaries.

Such a change would likely shift some of the costs currently borne by Medicare to state Medicaid programs. This report uses administrative data to estimate nationally and by state what the effect of that shift would be if we account for state variations in population, spending, the federal match rate on Medicaid spending, and Medicaid coverage.

Methods and Data

To simulate the effect of increasing the Medicare eligibility age, we estimated the current level of Medicare and Medicaid spending, by state, among 65- to 69-year-old nondisabled dual eligibles, as well as the Medicare Part B premiums paid by Medicaid on behalf of those beneficiaries. Our simulation assumes that beneficiaries who originally qualified for benefits on the basis of disability, rather than age, would retain eligibility for both programs. We assume that those who qualify on the basis of age, conversely, would lose Medicare eligibility but retain Medicaid eligibility.

For beneficiaries enrolled in both programs, Medicaid is currently the payer of last resort, and covers, at most,[1] the deductibles and coinsurance on Medicare-covered services. Medicaid pays for the full amount on any service covered by Medicaid but not Medicare (e.g., long-term nursing facility care). If Medicare eligibility is removed, Medicaid programs would assume the responsibility of covering what had previously been Medicare expenditures (e.g., inpatient and outpatient hospital care, physician services, post-acute institutional and community-based care, and durable medical equipment), but the programs would no longer pay premiums to Medicare. Finally, after accounting for differences in Federal Medical Assistance Percentage rates and the states' Medicaid expansion decisions, we calculate the net effects on federal and state spending in each state and nationally.

For this analysis, we use data from the Medicaid Statistical Information System, the Medicare Master Beneficiary Summary File, and the Medicaid Financial Management Reports (Form 64) (see appendix A for more detail).

Results

Number of Beneficiaries Affected

The analyses reported in table 1 show the numbers of beneficiaries who would be affected by a change in Medicare's eligibility age and the share of each state's Medicaid population those numbers represent. Of the more than 66 million Medicaid beneficiaries nationwide, nearly 1.5 million people, or 2.2 percent, are between ages 65 and 69. By state, the share of Medicaid beneficiaries in this age group ranges from 1.2 percent in Utah to 3.6 percent in Maine.

If Medicare eligibility for nondisabled individuals is limited to people age 67 and older and if Medicaid eligibility rules do not change, 277,000 dual-eligible beneficiaries could convert to Medicaid-only beneficiaries. If the Medicare eligibility age were raised to 70, nearly 915,000 would become Medicaid-only beneficiaries, which is about 62 percent of all beneficiaries in the age group. That share also varies by state, ranging from 34.6 percent in Illinois to 85.1 percent in Vermont. Not surprisingly, given its size, California would account for the largest share (roughly 14 percent) of the beneficiaries who would lose Medicare coverage nationwide.

Medicaid and Medicare Expenditures for Dually Eligible Beneficiaries

Broadly speaking, current law divides responsibility for financing dual eligibles' care: Medicare is the primary payer for acute-care services, whereas Medicaid is the primary payer for long-term care. That pattern largely holds for the population that would be affected by an increase in Medicare's eligibility age. Table 2 shows the total amount spent on the affected population by each program nationwide for four types of service and for Medicare premiums paid by Medicaid programs. Overall, Medicaid currently bears a sizeable responsibility for that population, largely because of the amount spent on long-term care. For 65- and 66-year-olds, Medicaid finances 63 percent of the total spending. For the larger group, which includes 67- to 69-year-olds, Medicare expenditures on hospital expenses and prescription drugs increase significantly, making Medicare responsible for a nearly equal share of total spending.

TABLE 1

Total Medicaid Beneficiaries by Category and State, 2010

State	All Medicaid beneficiaries (number)	All Medicaid beneficiaries ages 65 to 66		All Medicaid beneficiaries ages 65 to 69		Nondisabled dual-eligibles, ages 65 to 66		Nondisabled dual-eligibles, ages 65 to 69	
		Number	% of all beneficiaries	Number	% of all beneficiaries	Number	% of all beneficiaries ages 65 to 66	Number	% of all beneficiaries ages 65 to 69
US total	66,430,495	603,461	0.9	1,480,833	2.2	277,140	45.9	914,657	61.8
Alabama	1,015,576	10,728	1.1	26,942	2.7	4,868	45.4	15,822	58.7
Alaska	127,853	1,001	0.8	2,449	1.9	407	40.7	1,349	55.1
Arizona	1,531,122	10,479	0.7	25,558	1.7	5,092	48.6	16,444	64.3
Arkansas	720,907	6,729	0.9	16,467	2.3	4,579	68.0	13,777	83.7
California	11,428,837	97,452	0.9	250,510	2.2	39,793	40.8	126,359	50.4
Colorado	618,356	4,365	0.7	10,643	1.7	1,957	44.8	6,976	65.5
Connecticut	712,350	6,647	0.9	16,755	2.4	3,418	51.4	12,237	73.0
Delaware	225,426	1,411	0.6	3,352	1.5	839	59.5	2,575	76.8
District of Columbia	214,298	2,151	1.0	5,084	2.4	741	34.4	2,286	45.0
Florida	3,703,391	45,474	1.2	113,796	3.1	21,413	47.1	73,578	64.7
Georgia	1,869,622	18,061	1.0	44,599	2.4	8,694	48.1	27,779	62.3
Hawaii	265,598	2,544	1.0	5,818	2.2	1,621	63.7	4,607	79.2
Idaho	227,849	1,703	0.7	4,196	1.8	1,016	59.7	3,356	80.0
Illinois	2,822,634	20,612	0.7	51,465	1.8	4,926	23.9	17,809	34.6
Indiana	1,213,364	9,352	0.8	22,000	1.8	4,887	52.3	15,635	71.1
Iowa	562,459	3,818	0.7	8,839	1.6	2,183	57.2	7,096	80.3
Kansas	394,417	3,454	0.9	8,209	2.1	1,733	50.2	5,888	71.7
Kentucky	919,870	10,703	1.2	25,747	2.8	3,652	34.1	12,602	48.9
Louisiana	1,204,829	11,565	1.0	28,272	2.3	6,688	57.8	22,640	80.1
Maine	410,743	5,893	1.4	14,702	3.6	2,934	49.8	11,068	75.3
Maryland	975,438	7,021	0.7	17,176	1.8	2,826	40.3	9,304	54.2
Massachusetts	1,692,129	20,003	1.2	43,123	2.5	8,705	43.5	26,646	61.8
Michigan	2,261,732	15,143	0.7	36,665	1.6	9,561	63.1	29,518	80.5

Minnesota	936,488	6,800	0.7	16,392	1.8	3,560	52.4	11,632	71.0
Mississippi	772,166	8,830	1.1	21,454	2.8	2,387	27.0	12,003	55.9
Missouri	1,065,266	9,868	0.9	22,425	2.1	3,332	33.8	12,004	53.5
Montana	128,792	1,046	0.8	2,588	2.0	596	57.0	1,909	73.8
Nebraska	265,540	1,880	0.7	4,549	1.7	943	50.2	3,286	72.2
Nevada	340,520	2,878	0.8	7,288	2.1	1,504	52.3	5,389	73.9
New Hampshire	167,560	1,267	0.8	3,277	2.0	767	60.5	2,616	79.8
New Jersey	1,055,940	10,691	1.0	28,589	2.7	3,057	28.6	11,347	39.7
New Mexico	576,138	4,617	0.8	11,216	1.9	2,151	46.6	6,529	58.2
New York	5,570,094	61,031	1.1	145,574	2.6	21,926	35.9	65,223	44.8
North Carolina	1,813,298	17,289	1.0	40,887	2.3	10,868	62.9	33,966	83.1
North Dakota	82,762	652	0.8	1,585	1.9	375	57.5	1,269	80.1
Ohio	2,308,999	17,260	0.7	42,107	1.8	7,821	45.3	29,753	70.7
Oklahoma	856,835	7,031	0.8	17,043	2.0	4,112	58.5	13,730	80.6
Oregon	643,941	6,372	1.0	15,551	2.4	3,688	57.9	12,242	78.7
Pennsylvania	2,417,096	22,809	0.9	54,924	2.3	11,688	51.2	40,593	73.9
Rhode Island	216,302	2,050	0.9	4,903	2.3	679	33.1	2,391	48.8
South Carolina	922,560	8,790	1.0	20,941	2.3	4,179	47.5	12,956	61.9
South Dakota	133,739	990	0.7	2,445	1.8	270	27.3	1,285	52.6
Tennessee	1,509,354	15,364	1.0	37,703	2.5	5,020	32.7	16,807	44.6
Texas	4,844,337	40,990	0.8	103,452	2.1	25,529	62.3	85,498	82.6
Utah	349,595	1,885	0.5	4,267	1.2	852	45.2	2,714	63.6
Vermont	196,412	2,113	1.1	4,795	2.4	1,459	69.0	4,082	85.1
Virginia	1,027,075	9,954	1.0	24,816	2.4	3,525	35.4	14,695	59.2
Washington	1,352,939	9,838	0.7	23,963	1.8	6,270	63.7	19,864	82.9
West Virginia	416,858	4,832	1.2	11,268	2.7	2,433	50.4	8,350	74.1
Wisconsin	1,253,656	9,431	0.8	23,105	1.8	5,286	56.0	16,094	69.7
Wyoming	87,433	594	0.7	1,359	1.6	330	55.6	1,079	79.4

Source: Authors' calculations, based on analysis of 2012 Medicaid Statistical Information System.
Note: "Dual-eligibles" are those qualified for both Medicare and Medicaid benefits.

TABLE 2

Medicaid and Medicare Expenditures for Nondisabled Dual-Eligible Beneficiaries

($ millions), 2010

	Ages 65 to 66		Ages 65 to 69	
	Medicaid	**Medicare**	**Medicaid**	**Medicare**
Type of service				
Inpatient hospital	82	618	212	2,746
Prescription drugs	28	432	64	2,038
Other acute care	604	659	1,843	2,935
Post-acute and long-term care	1,305	200	4,276	998
Premiums (transfer)	437	-437	1,298	-1,298
Total	**2,455**	**1,471**	**7,694**	**7,418**

Source: Authors' calculations based on the Medicaid Statistical Information System and the Medicare Beneficiary Summary File.
Note: Table columns do not sum to totals because of rounding.

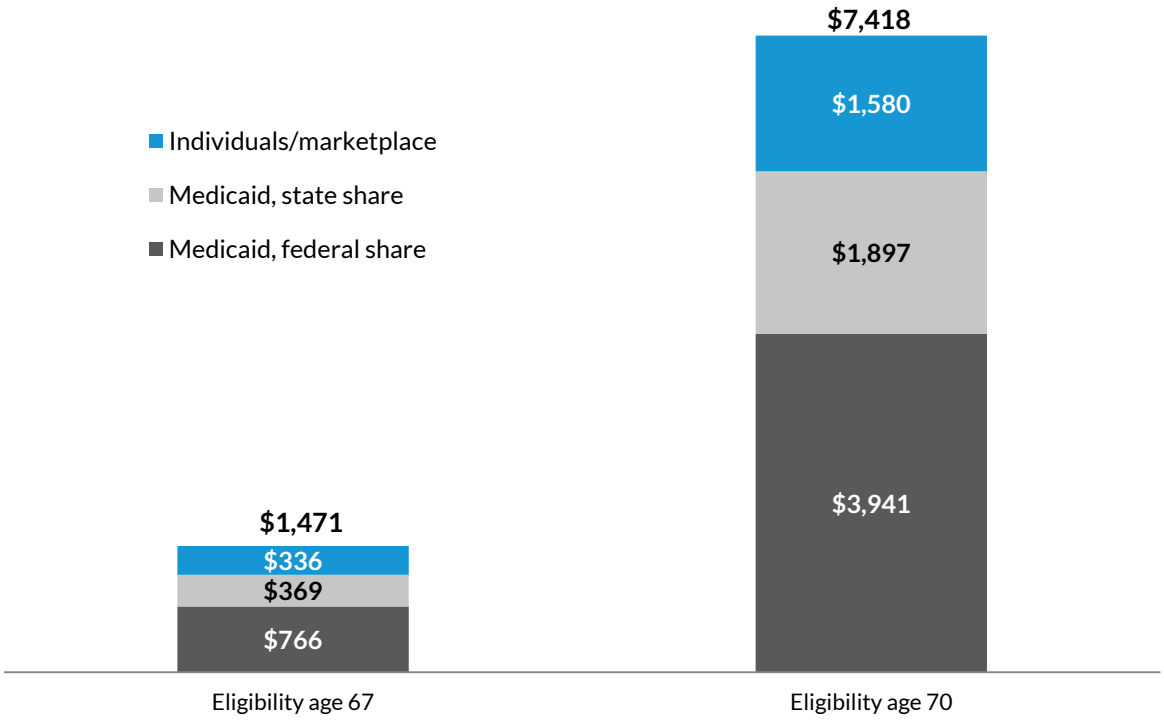
Medicaid Cost Increases

Figure 1 shows how the current Medicare expenditures of nondisabled dual eligibles, as reported in table 2, would change if eligibility ages were increased. If Medicare's eligibility age increased and if Medicaid programs were no longer paying Medicare premiums for the populations described previously but were directly responsible for their Medicare-covered services as well as any cost-sharing they currently contribute, then the result would be a net increase in Medicaid expenditures. Whether the eligibility age is 67 or 70, the largest portion of the new spending distribution still rests with the federal government through its share of Medicaid financing. An eligibility age of 67 would increase federal Medicaid liability nationally by $766 million, and an increase to age 70 would increase federal Medicaid expenditures by $3.9 billion. The states' shares of those increases would be $369 million and $1.9 billion, respectively. The remaining portion of current Medicare spending is attributed to people who would not qualify for Medicaid benefits but would likely qualify for heavily subsidized coverage in state marketplaces. Thus, we estimate that nearly all the costs saved by Medicare for this population would simply be shifted to other government payers.

FIGURE 1

Shifts in Medicare Expenditures with Increased Eligibility Age

For nondisabled dual eligibles, $ millions per year



Source: Authors' calculations, based on Medicare Beneficiary Summary File, 2010.

Tables 3 and 4 present our estimates of the net increase in total Medicaid spending and state Medicaid spending for each state. Nationwide, we anticipate the increases in state spending with an increase in eligibility age to 67 and 70 to be, respectively, 19.7 and 42.8 percent higher than the amount states currently spend on Medicaid beneficiaries in those age ranges (65 to 66 and 65 to 69). Relative to total state spending on Medicaid beneficiaries of all ages, the change is modest: an increase of 0.3 percent at a Medicare eligibility age of 67 and 1.6 percent at an eligibility age of 70. The tables show considerable variation in the additional burdens that would be borne by each state. Those differences are a result of several factors, including (1) the differences in each state's Federal Medical Assistance Percentage, (2) the portion of beneficiaries in the age range who are disabled, (3) the rates of utilization in the affected population, (4) state Medicaid fees, and (5) the states' Medicaid expansion status.

TABLE 3

Change in Medicaid Expenditures if Medicare Eligibility Age Were Increased to 67

State	Net increase in total Medicaid expenditures ($ millions)	Net increase in state portion of Medicaid expenditures ($ millions)	Percent increase in state Medicaid expenditures	
			Ages 65 to 66	All ages
US total	1,135.4	369.2	19.7	0.3
Alabama	6.1	1.4	9.1	0.1
Alaska	2.0	0.7	14.4	0.2
Arizona	24.8	6.0	21.9	0.3
Arkansas	8.5	1.6	12.9	0.2
California	248.0	95.3	32.5	0.6
Colorado	10.3	4.0	18.9	0.3
Connecticut	12.1	4.6	12.7	0.2
Delaware	3.1	1.2	21.3	0.2
District of Columbia	5.7	1.2	17.6	0.3
Florida	77.9	25.2	30.3	0.4
Georgia	13.7	3.4	12.3	0.2
Hawaii	4.9	1.6	24.9	0.3
Idaho	1.2	0.2	7.4	0.1
Illinois	55.3	21.1	25.4	0.4
Indiana	10.8	2.6	12.0	0.2
Iowa	4.2	1.1	10.6	0.1
Kansas	2.0	0.6	5.7	0.1
Kentucky	26.0	5.2	36.5	0.5
Louisiana	18.4	3.4	21.5	0.3
Maine	1.6	0.4	4.1	0.1
Maryland	21.8	8.4	25.4	0.3
Massachusetts	35.3	13.5	18.6	0.3
Michigan	47.9	12.8	41.0	0.4
Minnesota	16.7	6.4	14.9	0.2
Mississippi	9.3	1.4	14.4	0.2
Missouri	18.7	4.8	17.1	0.2
Montana	0.9	0.2	8.4	0.1
Nebraska	2.4	0.8	10.3	0.1
Nevada	9.2	3.3	50.8	0.6
New Hampshire	2.4	0.9	14.0	0.2
New Jersey	36.2	13.9	24.0	0.4
New Mexico	6.3	1.2	36.0	0.2

New York	77.5	29.8	7.6	0.2
North Carolina	29.4	7.4	22.9	0.3
North Dakota	1.1	0.3	10.7	0.2
Ohio	46.5	12.3	18.3	0.3
Oklahoma	13.3	3.1	23.6	0.3
Oregon	10.5	2.8	17.5	0.3
Pennsylvania	61.5	21.0	25.2	0.3
Rhode Island	4.2	1.5	18.4	0.2
South Carolina	15.1	3.1	21.5	0.3
South Dakota	1.1	0.3	13.1	0.1
Tennessee	16.0	3.9	15.2	0.2
Texas	58.3	16.9	20.2	0.2
Utah	2.0	0.4	12.1	0.1
Vermont	2.6	0.8	27.3	0.3
Virginia	13.6	5.2	14.7	0.2
Washington	21.0	7.8	24.9	0.3
West Virginia	10.6	1.8	27.5	0.4
Wisconsin	7.4	2.2	9.3	0.1
Wyoming	0.4	0.2	4.9	0.1

Source: Authors' calculations, based on the Medicaid Statistical Information System and the Medicare Beneficiary Summary File.

If we focus on the results in table 4, the effect on Wyoming's liability for the age group is an increase of 9 percent over that state's current level of expenditure. In Nevada, however, the increase in eligibility age would more than double the amount the state currently spends on this age group (a 104 percent increase). States at the bottom end of the range include several that are not planning to expand Medicaid (Alabama, Kansas, Maine, Montana, Wisconsin, and Wyoming) and a state with a relatively low proportion of affected beneficiaries and relatively low Medicaid fees (New York). The top end of the range includes largely Medicaid expansion states (Kentucky, Michigan, Nevada, and New Mexico).

TABLE 4

Change in Medicaid Expenditures if Medicare Eligibility Age Were Increased to 70

State	Net increase in Medicaid expenditures ($ millions)	Net increase in state Medicaid expenditures ($ millions)	Percent increase in state Medicaid expenditures	
			Ages 65 to 69	All ages
US Total	5,837.9	1,897.3	42.8	1.6
Alabama	38.3	8.6	23.7	0.9
Alaska	11.4	4.3	32.8	0.9
Arizona	112.4	27.1	44.8	1.2
Arkansas	56.9	10.7	35.1	1.5
California	1,160.5	445.8	62.5	2.8
Colorado	50.7	19.5	38.1	1.3
Connecticut	73.6	28.3	32.5	1.3
Delaware	14.6	5.6	44.0	1.1
District of Columbia	27.3	5.7	35.3	1.6
Florida	417.6	135.1	68.9	2.4
Georgia	79.9	20.0	30.0	1.0
Hawaii	23.8	7.8	53.7	1.7
Idaho	11.4	2.4	30.8	0.8
Illinois	282.4	107.7	58.2	1.9
Indiana	58.7	14.3	27.7	1.0
Iowa	30.1	8.3	30.6	0.9
Kansas	15.2	4.6	18.7	0.6
Kentucky	123.6	24.6	77.6	2.2
Louisiana	87.2	16.1	44.1	1.3
Maine	13.1	3.3	14.9	0.6
Maryland	106.3	40.8	52.6	1.5
Massachusetts	164.8	63.3	37.8	1.4
Michigan	235.4	62.9	84.2	2.0
Minnesota	63.3	24.3	24.5	0.8
Mississippi	44.5	6.7	29.3	1.1
Missouri	87.5	22.4	35.1	1.2
Montana	7.5	1.7	23.6	0.8
Nebraska	14.3	4.5	25.3	0.9
Nevada	44.0	15.9	103.9	3.1
New Hampshire	12.5	4.8	30.6	1.1
New Jersey	178.9	68.7	47.4	2.0
New Mexico	36.4	7.1	101.6	1.1

New York	576.8	221.6	24.1	1.1
North Carolina	140.6	35.2	47.5	1.3
North Dakota	6.1	1.8	24.6	0.9
Ohio	225.3	59.8	37.4	1.5
Oklahoma	68.3	15.9	51.5	1.6
Oregon	54.9	14.9	37.3	1.4
Pennsylvania	263.2	89.9	44.6	1.4
Rhode Island	20.9	7.6	40.7	1.2
South Carolina	78.2	16.0	48.3	1.6
South Dakota	5.9	1.7	30.1	0.7
Tennessee	90.1	22.2	37.1	1.0
Texas	334.1	97.1	46.8	1.3
Utah	12.0	2.3	31.9	0.7
Vermont	13.7	4.1	53.1	1.3
Virginia	66.1	25.4	30.3	1.0
Washington	99.1	36.7	49.7	1.4
West Virginia	51.7	8.8	63.5	2.0
Wisconsin	44.6	13.1	20.7	0.8
Wyoming	1.9	0.7	9.0	0.3

Source: Authors' calculations, based on the Medicaid Statistical Information System and the Medicare Beneficiary Summary File.

Discussion

An increase in Medicare's eligibility age would shift some of the responsibility for healthcare financing from the federal government to state governments. Although all states would be affected, the extent of a state's increased burden depends on both the demographic makeup of the state and policy decisions the state has made about its Medicaid programs. A shift in responsibility toward states would likely be met with resistance from the states. So although changing the age of eligibility for Medicaid has not been widely discussed, the legislation necessary to raise Medicare's age could also end up increasing Medicaid's eligibility age.

Were the two changes paired, the increased liability would be passed along to individuals rather than states. Such individuals would likely be higher-income 65- to 66-year-olds or 65- to 69-year-olds who do not currently qualify for Medicaid. Any increase in private insurance pools by people in those age ranges would likely increase premiums for all in the pool already, but adding those who would have been dual eligibles to the pool could have an even greater effect.

A more likely scenario is that a significant share of those who have the lowest incomes and who are out of the labor force or unable to remain in it would lose coverage and become uninsured. Even subsidized marketplace plans could be unaffordable for those individuals. An increase in uninsurance among a relatively high-risk population poses risks not only to those individuals but also to providers, who face legal requirements to treat patients regardless of their ability to pay, and to state and federal governments, which could end up reimbursing providers for part of those costs. Thus, policymakers must include a fuller set of downstream implications when considering making Medicare eligibility cuts.

Appendix A. Methodology

We calculated expenditures for which the Medicaid program would be responsible if a proposed change in the Medicare eligibility age went into effect as follows. We assumed a state's Medicaid expenditures on nondisabled beneficiaries in the affected age range would change in proportion to the share of those beneficiaries' eligible months during which they were either full or partial dual eligibles. Because Medicaid eligibility differs for Medicaid expansion and nonexpansion states, we treated partial dual eligibles (Qualifying Medicare Beneficiaries [QMB] and Specified Low-income Medicare Beneficiaries [SLMB]) differently from full-benefit dual eligibles depending on a state's expansion status. In expansion states, QMB and SLMB beneficiaries meet the Medicaid eligibility criteria, and so in those states, we included both full and partial dual-eligibility months in our calculations. In nonexpansion states, we included only full dual-eligibility months.

Given the lack of availability of Medicare expenditure data corresponding to health maintenance organization (HMO) enrollment, we applied the increase in eligible months between total months with and without HMO months to the corresponding fee-for-service spending, by category, to get adjusted totals that include all enrolled months.

The changes in Medicare premiums paid by Medicaid were calculated from CMS-64 data. Because the states pay only Part A premiums for persons in the Qualifying Disabled Working Individuals (QDWI) program, changes in those premiums were calculated as proportional to the state's share of beneficiary months in QDWI relative to all full and partial dual-eligibility months. Changes in Part B premiums were calculated as proportional to the share of all dual-eligibility months in the Medicaid Statistical Information System data that exclude "QDWIs and Other Dual Eligibles."

Note

1. For any service, if the amount covered under a state's Medicaid fee schedule is below the Medicare-covered amount for the same service, Medicaid is required to reimburse providers only for the difference between the Medicare reimbursement (80 percent of the covered amount) and the state's full-covered amount. For this simulation, however, we assume that Medicaid would be responsible for at least the Medicare-covered amount.

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