



## Health care use in the first six months of Medicare eligibility for elders: Impact of State support

### *Newly Medicare-Eligible Elders*

### Data Points # 12

Since its enactment in 1965, the Medicare program has provided health insurance for older adults who qualify for retirement benefits through Social Security or the Railroad Retirement Board. For these individuals, Medicare hospital services coverage is an entitlement; those who want Medicare coverage for outpatient and physician services must pay annual premiums. All beneficiaries must pay an annual deductible (currently \$162) for physician/outpatient services plus a 20 percent copayment after deductible. Care in hospitals and nursing homes also requires annual deductibles, and longer stays require copayments. Thus, Medicare beneficiaries may face significant costs for their health care. Some older adults face additional economic hardship from high costs for services not covered by Medicare, such as extended stays in a nursing home. Long-term care costs are the primary reason older adults “spend down” their assets and become Medicaid and Medicare eligible. In 1988 and again in 1993, assistance for poor older adults expanded from full Medicaid coverage only to a broader array of options. These options include help with premiums, copayments, and deductibles.<sup>1</sup>

The term commonly applied to individuals who receive full Medicaid and Medicare benefits is “duals.” People who receive assistance with Medicare premiums and copayments, but not full Medicaid benefits, are inconsistently included in this classification as well. Older adults can achieve dual status in several ways. Some become medically poor by spending large sums on medical care, usually as a result of chronic illnesses. Others may already have been on Medicaid by virtue of disability and/or poverty, and then qualify for Medicare on the basis of age. The number of older adults on Medicare who are either dual-eligible or receive some form of assistance has remained relatively stable for the last 10 years. As of 2009, 12.5 percent of older Medicare beneficiaries received some assistance, ranging from premiums to full Medicaid benefits (**Figure 1**).<sup>2</sup>



Approximately 10 percent of newly age-eligible Medicare enrollees receive assistance from States either as full Medicaid benefits or as assistance with Medicare premiums or copayments.

The majority of those over age 69 who are fully Medicare and Medicaid eligible at Medicare enrollment have their Medicare Part A premiums paid by the State. This suggests that these individuals have not fully qualified for Medicare benefits based on their own or their spouse's work history.

Newly age-eligible Medicare enrollees who receive any form of State support are more likely to have comorbidities, use health care services, and have higher Medicare payments associated with the services they use.

Many studies have compared health care usage between dual-eligible and non-dual-eligible beneficiaries. Few, however, have attempted to distinguish between those new to the Medicare program and those who have received Medicare benefits for an extended period of time. Studies of older adults consistently show dual-eligible beneficiaries to be disproportionately high users of Medicare services. For example, a recent Kaiser Commission report noted that the combined Medicare and Medicaid spending for 7.1 million duals exceeded the Medicare spending for the remaining 30.2 million nonduals (\$147.9 billion in 2003 vs. \$137.7 billion).<sup>3</sup>

Typically, attempts to identify factors driving health care usage by dual-eligibles have focused on residents of long-term care facilities who have been forced by the costs of such care to “spend down” their assets. However, community-dwelling dual-eligibles also use disproportionately more health care and may receive long-term care at home. Limited research is available evaluating whether any modifiable factors are associated with increased health care use by dual-eligible older adults.

This report examines the health care use and expenditures for the first six months of eligibility for individuals aging into Medicare. We include patient demographic characteristics (Table 1) and prevalence of select comorbidities (Table 2). We also include information about Medicare enrollees who are also Medicaid eligible, beneficiaries who receive State assistance with their Medicare expenses, and those who receive no State assistance. A previous report, *Newly Medicare-Eligible Disabled*, examined new beneficiaries who qualify for Medicare benefits due to disability. This report examines new beneficiaries who qualify for Medicare benefits due to their age.

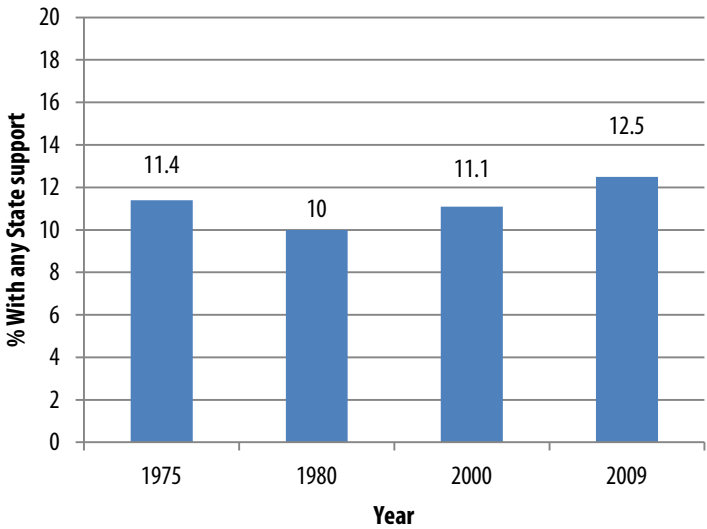
METHODS

Data included Medicare enrollment data for 2007-2009. Subjects were newly age-eligible Medicare beneficiaries in 2007 and 2008 identified by their Medicare start date from the Beneficiary Annual Summary File and Medicare Status Code=10. We included all Medicare claims for the initial six months of eligibility for these individuals.

We categorized beneficiaries who received any State support into three groups: **Full Duals** had full Medicaid coverage, including prescription drugs, for the entire six-month period or until their death (State Reported Dual Eligible Status Code 02, 04, or 08 all 6 months); **Partial Duals** received State support for all six months in the form of premium or copayment assistance (i.e., Specified Low-Income Medicare Beneficiaries [SLMB] or Qualified Medicare Beneficiary [QMB] only, State Reported Dual Eligible Status Code 01, 03, 05, or 06 all six months) or a mix of this support and full Medicaid coverage as defined above; and **Incomplete Duals** received at least one month of some form of State support (either full Medicaid or SLMB/QMB) but less than six months of support (at least one month of State Reported Dual Eligible Code=NA and at least one month State Reported Dual Eligible Code=01, 02, 03, 04, 05, 06, or 08) or whose dual-eligible status was missing (blank, XX, 09, 99). Finally, we classified beneficiaries who received no State assistance as **Nonduals** (State Reported Dual Eligible Status Code NA for all six months).

We used the monthly “State-buy-in” variables to identify whether new beneficiaries had Medicare Part A (hospital and institutional coverage, 1, 3, A, C) and Part B (physician and outpatient services coverage, 2, 3, B, C) for all six months.

Figure 1: State support of older Medicare beneficiaries over time



People without both Parts A and B coverage do not have comprehensive care from the Medicare program. In addition, we had no access to health care usage information for those enrolled in Medicare managed care plans (HMO indicator not 0 or 4).<sup>4</sup> Typically, people with equal months of Parts A and B coverage with no managed care enrollment are considered “likely to have complete claims” and thus the appropriate focus of a Medicare claims-based analysis.<sup>5</sup> Therefore, we restricted our analysis of health care use and diagnoses to individuals likely to have complete claims. Because differences in mortality would complicate assessment of utilization, and because our report specifically examines whether early Medicare experience differs, we excluded those who died during their first six months of Medicare. Using the Chronic Condition Warehouse algorithms, we estimated the frequency of six high prevalence chronic conditions: cancer, Alzheimer’s, chronic obstructive pulmonary disease (COPD), depression, diabetes, and ischemic heart disease.<sup>6</sup> Cancer is indicated if one or more of the following cancers are classified: female breast, colorectal, lung, or prostate. If the first claim for any of these chronic conditions occurred in the initial six months of Medicare eligibility, the chronic condition flag is indicated (**Table 2**).

We report utilization and reimbursement separately by type of service and provider (**Table 3**). “Acute Inpatient” hospitalizations and days are defined as hospitalizations in acute care hospitals that do not include services in a rehabilitation unit. In Acute Inpatient claims, the third digit of the provider number is 0 or the third and fourth digits are 13.

**Table 1:** Characteristics of newly Medicare-eligible elders by level of State support, 2007-2008

	Full Dual	Partial Dual	Incomplete Duals*	Nondual	Total
Total Beneficiaries (n)	173,741	35,027	255,165	4,163,310	4,627,243
<b>Race</b>					
Non-Hispanic White (%)	2.0	0.7	1.3	96.0	100.0
Black / African American (%)	9.1	1.8	5.0	84.1	100.0
Asian / Pacific Islander (%)	16.2	0.6	11.3	71.9	100.0
Hispanic (%)	11.8	1.9	8.0	78.3	100.0
American Indian / Alaska Native (%)	12.8	1.8	4.6	80.8	100.0
Other / Unknown (%)	3.7	0.3	21.0	75.0	100.0
<b>Age (years)</b>					
65-69 (%)	3.4	0.8	5.1	90.7	100.0
70-79 (%)	27.5	0.4	37.5	34.6	100.0
80+ (%)	40.2	0.5	38.2	21.1	100.0

\*Dual / Nondual monthly status changes.

“Other Inpatient” includes both rehabilitation care and long-stay facilities, including psychiatric hospitals, none of which are included in the Acute Inpatient category. “Hospital Outpatient” includes care provided in hospital outpatient departments, including emergency, radiology, and day surgery. “Skilled Nursing Facility” (SNF) includes care provided by such facilities. Likewise, the “Home Health Care” category includes all care provided by home health agencies, and the “Hospice” category includes care provided by Medicare-certified hospices under the Hospice program.

We define utilization of Part B services by the unique combination of line item claim procedure code and Berenson-Eggers type of service (BETOS) for the procedure.<sup>7</sup> CMS developed BETOS codes to provide clinically meaningful groupings of procedures for the purpose of analyzing growth in Medicare expenditures. These codes are added to each line item during processing. Evaluation and Management Codes (E&M) are identified by BETOS codes beginning with M. Procedures are identified by BETOS codes beginning with P. We classified procedure codes not beginning with P or M as “Other Part B Services.”

We calculated average covered days as the average number of days spent over the initial six-month period receiving each type of care, restricted to those beneficiaries receiving any care of that type. We calculated Part B events (E&M, procedures, other Part B services) and durable medical equipment events as the number of distinct dates that services of each type were received. Average Medicare payment amount is the average among users of each type of service and summed across all use in the initial six-month period.

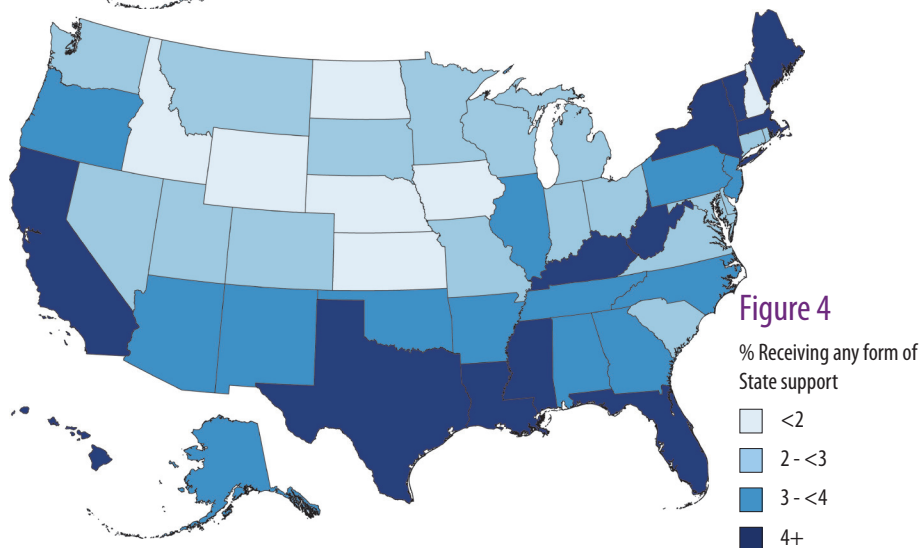
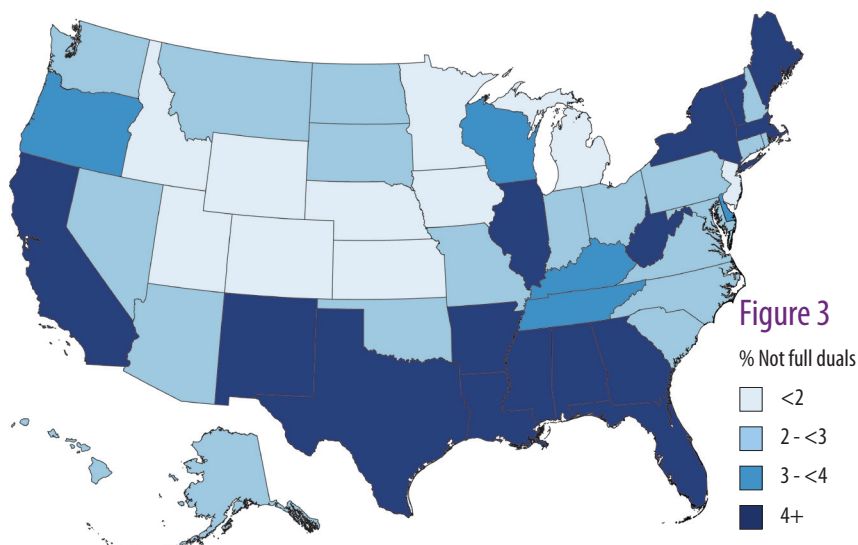
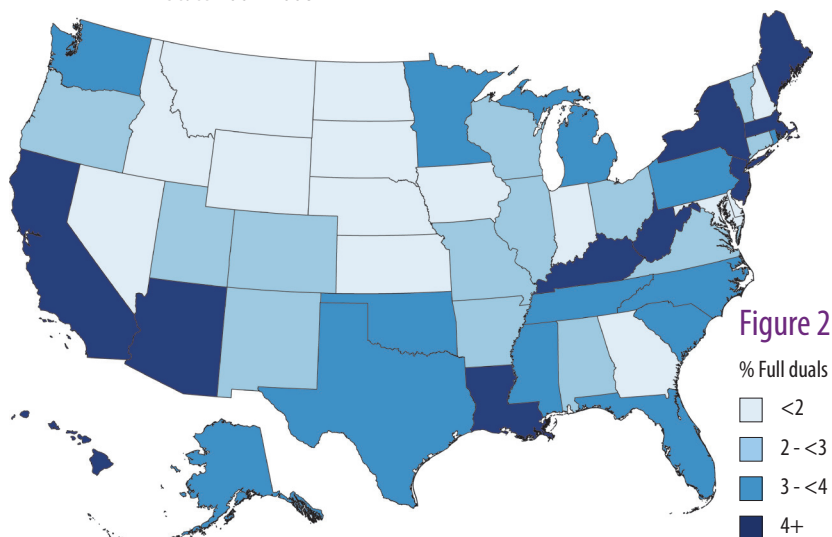
## RESULTS

Each year, about 4.6 million people enroll in the Medicare program because they are age-eligible for benefits. Benefits can start as early as the month prior to turning age 65. While there is no upper age limit for enrolling in the program, the overwhelming majority (98.8%) enroll by age 69 (See **Table 1** for percentage distribution by age and race and see **Appendix A** for number of persons in each age and racial group by level of State support). In fact, 92 percent of new age-eligible beneficiaries enroll immediately prior to turning 65, the earliest they are allowed.

Most of these new enrollees receive no assistance from States in any form (premium, copayment assistance, or full Medicaid benefits) in their first six months on Medicare. Approximately 4 percent receive full Medicare and Medicaid benefits at the time of enrollment. Less than 1 percent of new enrollees receive assistance only for premiums and copayments (QMB/SLMB) for the six-month period. While 6 percent of new enrollees received some form of State support during their first six months of Medicare, almost an equal percentage (5.5%) received State support for less than the full six months (“incomplete duals”).

Older age at Medicare enrollment was strongly associated with receipt of State support. Of those who enrolled between age 64 and 69, only 8.6 percent received State support of any form, a figure that jumped to 65 percent for those who enrolled between 70 and 79, and 79 percent for those 80 or older at enrollment. Of note, most of the full dual enrollees age 80 or older received their Part A benefits through payment of premiums rather than through an entitlement based on work history (BIC=M) (97.7% vs. 29.9% for enrollees between 64 and 69 at enrollment).

**Figures 2-4:** New elderly Medicare enrollees: percentage full dual (fig. 2), not full dual (fig. 3), and receiving any form of State support (fig. 4), by State 2007-2008





**Table 2:** Prevalence of selected chronic conditions in new Medicare enrollees by level of State support, 2007-2008\*

	Full Dual	Partial Dual	Incomplete Dual**	Nondual
Total Beneficiaries	94,103	24,035	66,213	2,312,097
Chronic Conditions	% of Total	% of Total	% of Total	% of Total
Cancer <sup>†</sup>	3.6	3.4	2.9	2.8
Alzheimer's	3.5	1.0	1.4	0.3
COPD	12.0	9.4	6.2	2.5
Depression	12.4	9.3	6.9	4.1
Diabetes	27.8	22.2	18.1	11.3
Ischemic Heart Disease	19.0	15.1	11.5	9.5
Any Comorbidity	50.4	42.2	33.5	24.5

\* Limited to beneficiaries with full Part A, Part B, fee for service coverage, survived six months.

\*\* Dual / Nondual monthly status changes.

<sup>†</sup> Breast, colorectal, lung, or prostate.**Table 3:** Utilization of services by new Medicare enrollees in the initial six months of Medicare coverage by level of State support, 2007-2008\*

	Full Dual	Partial Dual	Incomplete Dual**	Nondual
Total Beneficiaries	94,103	24,035	66,213	2,312,097
Service Type	% of Total	% of Total	% of Total	% of Total
Acute Inpatient	13.7	11.2	10.0	5.0
All Other Inpatient	1.3	0.9	1.0	0.3
Hospital Outpatient	63.4	62.4	50.7	43.3
Skilled Nursing Facility	2.6	1.2	1.7	0.3
Home Health	5.6	4.1	3.2	1.1
Hospice	0.4	0.2	0.2	<0.1
Evaluation and Management Part B Services	78.6	74.7	66.0	71.4
Part B Procedure Services	39.1	36.8	31.3	37.4
Durable Medical Equipment	25.4	21.2	13.8	9.0
All Other Part B Services	74.2	72.3	63.3	68.3
No Services Used	12.6	16.3	24.6	22.5

\* Limited to beneficiaries with full Part A, Part B, fee for service coverage, survived six months.

\*\*Dual / Nondual monthly status changes.

This finding suggests that the States are electing to pay both Part A and Part B premiums so that new enrollees qualify for Medicare benefits. Ethnicity was also associated with receipt of State support. Only 3.3 percent of non-Hispanic Whites receive assistance, compared with 14 percent of African Americans, 27.6 percent of Asian/Pacific Islanders, 20.2 percent of Hispanics, 17.7 percent of American Indians/Alaska Natives, and 24.9 percent of persons classified as “other or unknown.”

Approximately 18.3 percent of these newly Medicare-enrolled elders have some months of Medicare Advantage (i.e., HMO) enrollment. Mortality for these new enrollees is very low at 0.4 percent. Varying percentages of new enrollees experience some time without equal months Part A and B benefits. While 98 percent of partial duals, 74 percent of nonduals, and 67 percent of full duals have full coverage, only 34 percent of “incomplete duals” (whose State support fluctuates over time) have full Part A and B benefits in the first six months of Medicare.

States varied considerably in the percentage of new age-eligible Medicare beneficiaries who received any State support or full Medicaid benefits. We found the lowest levels of full Medicaid enrollment in New Hampshire, Delaware, and Wyoming (all 1% or less), and the highest in the District of Columbia and New York (8.9% and 8.5%, respectively) (**Figures 2, 3, 4, and Appendix C**). Of note, the States with the highest and lowest percentages of full Medicare/Medicaid enrollment also had among the highest and lowest percentages of State support of any form. California presented a notable exception to this pattern, with a high rate (7.6%) of those aging into Medicare being full duals and the highest level among States of new enrollees receiving some form of State assistance at 13.9 percent.

The District of Columbia and New York have the next highest levels of State support at 13.8 and 13.1 percent. As shown in Figures 2, 3, and 4, States provide substantial support for those newly aged into Medicare in the form of full Medicaid benefits or assistance. Both types of support vary considerably across States.

The four groups varied regarding level and presence of comorbidities (see **Table 2** for percentages and **Appendix B** for numbers with each comorbidity by level of State support). Full duals had the highest level of comorbidity (50.4%), followed by partial duals (42.2%). We found the lowest comorbidity levels among nonduals (24.5%). In addition to having the highest aggregate levels of comorbidity, full duals had the highest levels of every individual comorbidity studied. The difference between groups was greatest for Alzheimer's (10-fold difference between full and nonduals), COPD (4-fold difference), and depression (3-fold difference), and the least for cancer (1.3-fold difference).

In addition to having more comorbidity, full duals were also most likely to use services (**Table 3**). During the first six months in the program, 87.4 percent of full duals used some Medicare-reimbursed services. Partial duals had similar overall levels of any service use (83.7%). Of note, the lowest rate of use was not among nonduals (77.5%) but rather among incomplete duals (75.4%), a group that experienced changing patterns of State support over the six-month period. Nonduals had markedly lower rates of acute inpatient hospitalizations over the six-month period (5% vs. 10%-13.7%) and less use of hospital outpatient services, skilled nursing facilities, home health, and durable medical equipment services.

Evaluation and Management services (i.e., routine physician contact) did not vary as markedly between nonduals and incomplete duals. Incomplete duals had the lowest rate of use in this category (66% vs. 71.4% for nonduals and 78.6% for full duals).

Full duals and, to a lesser extent, incomplete duals had the greatest utilization across most categories (**Table 4**). We see some dramatic differences, such as with the average number of SNF days, which were 39.7 for full duals and incomplete duals but only 28.2 for partial duals and 20.4 for nonduals. In other situations, the general ranking held, but the magnitude of the difference was minimal. For example, average number of noninpatient procedures (Part B events) held similar across all four groups (range 4.1-4.6 procedures among those with any).

Average Medicare payment by service type was consistently higher for full duals and incomplete duals than for nonduals (**Table 5**). This is consistent with the comorbidity profiles and differences in intensity of services used by these groups. Partial duals showed more variance, though generally their services are associated with higher levels of reimbursement than nonduals.

## DISCUSSION

Only about 10 percent of adults age 65 and older receive any form of State assistance during their first six months of Medicare, and these beneficiaries differ in ways that have important implications for the program. First, consistent with patterns of poverty and employment among older adults, racial and ethnic minorities are more likely than Whites to receive any State support. Second, they are more likely to be older than age 69 when they enter Medicare. On its face, this pattern is counterintuitive. One expects that those late to join Medicare are still working and therefore have higher incomes. Yet, the increased State support for these groups suggests that, in reality, their delayed enrollment may be because they are still working to amass the required 40 quarters of salaried work, or because they must buy in to Part A. Indeed, almost all of the full duals at entry have a beneficiary identification code indicating that their benefits are justified through a buy-in program.<sup>8</sup> While seldom explicitly discussed, at least two States concluded that the cost of the Part A premiums are more than offset by decreased Medicaid expenditures.<sup>9,10</sup> The Part A buy-in program requires that enrollees have established Part B coverage first. This would explain the observed pattern of unequal Part A and Part B months.

Among new enrollees with observable claims histories, we found a consistently higher percentage of full and partial duals having comorbidities compared with incomplete and nonduals. More than half of full duals have at least one of our target conditions of cancer, Alzheimer's, COPD, depression, diabetes, and ischemic heart disease.

**Table 4:** Utilization of services in the initial six months of Medicare coverage by level of State support, limited to persons served\*

Service Type	Full Dual	Partial Dual	Incomplete Dual**	Nondual
Acute Inpatient (Average Covered Days)	7.5	6.4	7.5	4.6
Other Inpatient (Average Covered Days)	19.2	16.2	19.8	13.5
Skilled Nursing Facility (Average Covered Days)	39.7	28.2	39.7	20.4
Home Health (Average Number of Visits)	35.4	34.7	25.3	15.8
Hospice (Average Covered Days)	93.5	69.0	80.6	75.5
Evaluation and Management (Average # of Part B Events)	7.5	6.2	6.1	4.7
Procedures (Average # of Part B Events)	4.6	4.6	4.4	4.1
Durable Medical Equipment (Average # of Events)	4.4	4.1	3.4	2.8
Other Part B Services (Average # of Events)	10.6	9.9	9.4	8.4

\* Limited to beneficiaries with Full Part A, Part B, fee for service coverage, survived six months.

\*\*Dual / Nondual monthly status changes.

**Table 5:** Average cost of services (\$) among users for newly Medicare eligible elders by level of State support

Service Type	Full Dual	Partial Dual	Incomplete Dual**	Nondual
Acute Inpatient	14,120	12,375	14,787	11,512
All Other Inpatient	19,440	16,877	21,091	15,699
Hospital Outpatient	1,100	971	959	696
Skilled Nursing Facility	13,202	10,166	13,737	8,202
Home Health	4,340	4,129	3,638	2,860
Hospice	13,135	9,762	11,713	10,873
Evaluation and Management Part B Services	509	383	415	236
Part B Procedure Services	782	850	807	636
Durable Medical Equipment	798	642	628	420
All Other Part B Services	607	593	535	444

\*\*Dual / Nondual monthly status changes.

With the exception of cancer, at least twice as many full duals as nonduals had the selected comorbidities. Persons aging into the Medicare program who receive any form of State support are more likely to have multiple comorbidities than those who receive no support. It was beyond our scope to investigate underlying causes of this pattern. While the presence of the comorbidities could explain the Medicaid enrollment, the same pattern of increased prevalence of comorbidities is observed for those who receive some assistance but are not fully dual-eligible. Regardless of whether the comorbidity leads to increased poverty or the poverty contributes to the development of comorbidities, the correlation cannot be ignored.

States varied considerably with regard to both the percentage of older adults new to Medicare who are fully Medicare and Medicaid eligible or who receive State support that is less than six months of full Medicare and Medicaid benefits. Factors related to poverty, disability, and immigration may account for some variation, but State policy cannot be ignored as a driver of these differences. Some of the partial support may reflect attempts to use State policy to control Medicaid growth. For example, States may provide lesser forms of assistance in hopes of maintaining the health of their poorer elders and, ultimately, controlling the size of their Medicaid population.

Programs aiming to control utilization for new Medicare enrollees will need to consider strategies for preventing the onset of comorbidities for those who are apparently free of comorbidity. Likewise, such efforts will require strategic management of comorbid complications for enrollees who have established comorbidity at enrollment. These programs are likely to differently affect full, partial, incomplete, and nonduals.

## AUTHORS

Beth A Virnig, *Ph.D., M.P.H.*<sup>1</sup>

Robert L. Kane, *M.D.*<sup>1</sup>

David Skellan<sup>2</sup>

Brian O'Donnell, *Ph.D.*<sup>2</sup>

<sup>1</sup> University of Minnesota School of Public Health, Division of Health Policy and Management, Minneapolis, MN.

<sup>2</sup> Buccaneer, A Vangent Company, Des Moines, IA.

## REFERENCES

1. Medicare: a timeline of key developments. Menlo Park, CA: Kaiser Family Foundation. Available at: [http://www.kff.org/medicare/timeline/pf\\_90.htm](http://www.kff.org/medicare/timeline/pf_90.htm). Accessed April 26, 2012.
2. 2010 CMS Statistics: Medicaid beneficiaries/State buy-ins for Medicare: Table I.19. Centers for Medicare & Medicaid Services; 2010. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMS-Statistics.html>. Accessed May 21, 2012.
3. Coughlin T, Wadmann T, Watts MO. Where does the burden lie? Medicaid and Medicare spending for dual eligible beneficiaries. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured; April, 2009. Publication 7895.
4. Alper FM, Mann EM. Medicare managed care enrollees and the Medicare utilization files. March 2006, updated June 2011. ResDAC Publication Number TN-009. Available at: [www.resdac.org/Tools/TBs/TN-009\\_MedicareManagedCareEnrolleesandUtilFiles\\_508.pdf](http://www.resdac.org/Tools/TBs/TN-009_MedicareManagedCareEnrolleesandUtilFiles_508.pdf). Accessed April 26, 2012.
5. Nattinger AB, Shapira MM, Warren JL, et al. Methodological issues in the use of administrative claims data to study surveillance after cancer treatment. *Med Care* 2001;40(suppl):IV-69-74.
6. Chronic Condition Categories. Chronic Condition Data Warehouse. Available at: [www.ccwdata.org/chronic-conditions/index.htm](http://www.ccwdata.org/chronic-conditions/index.htm). Accessed April 26, 2012.
7. Berenson-Eggers Type of Service (BETOS). HCPCS Release & Code Sets. Centers for Medicare & Medicaid Services. Available at: [https://www.cms.gov/HCPCSRReleaseCodeSets/20\\_BETOS.asp](https://www.cms.gov/HCPCSRReleaseCodeSets/20_BETOS.asp). Accessed April 26, 2012.
8. The Medicare Part A buy-in. New York, NY: Medicare Rights Center; 2010. Available at: [www.medicareinteractive.org/uploadedDocuments/Part-A-Buy-In-Packet.pdf](http://www.medicareinteractive.org/uploadedDocuments/Part-A-Buy-In-Packet.pdf). Accessed April 26, 2012.
9. Rice B. Medicare Part A buy-in. Memo. New York Office of Medicaid Management; 2004. Available at: [http://www.health.state.ny.us/health\\_care/medicaid/publications/docs/gis/04ma013](http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/04ma013). April 26, 2012.
10. Preserving Medicaid strategies to help maximize State Medicaid dollars. Worcester: University of Massachusetts Medical School; June 2010. Available at: [http://www.umassmed.edu/uploadedFiles/CWM/About\\_Us/Preserving%20Medicaid.pdf](http://www.umassmed.edu/uploadedFiles/CWM/About_Us/Preserving%20Medicaid.pdf). Accessed April 26, 2012.

*This project was funded under Contract No. HHSA290201000131 from the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services as part of the Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) program. The authors of this report are responsible for its content. Statements in the report should not be construed as endorsement by the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services. This project has been approved by the University of Minnesota Institutional Review Board.*

**Acknowledgments:** The authors wish to thank Jessica Zeglin and Mary A. Leonard for their graphic design expertise.

**Suggested Citation:** Virnig BA, Kane RL, Skellan D, et al. Health care use in the first six months of Medicare eligibility for elders: impact of State support. *Newly Medicare-Eligible Elders. Data Points # 12* (prepared by the University of Minnesota DEcIDE Center, under Contract No. HHSA290201000131). Rockville, MD: Agency for Healthcare Research and Quality; June 2012. AHRQ Publication No. 12-EHC085-EF.



### Appendix A: Number of new beneficiaries by race, age, and level of State support, 2007-2008

	Full Dual	Partial Dual	Incomplete Dual*	Nondual
Total Beneficiaries	173,741	35,027	255,165	4,163,310
Race				
Non-Hispanic White	62,763	20,434	41,113	3,010,750
Black or African American	26,837	5,353	14,612	248,070
Asian / Pacific Islander	17,338	682	12,068	76,980
Hispanic	36,835	5,929	24,753	243,410
American Indian / Alaska Native	1,108	160	396	6,990
Other / Unknown	28,860	2,469	162,223	577,110
Age				
65 - 69	156,897	34,792	233,652	4,144,680
70 - 79	13,294	191	18,136	16,770
80 +	3,550	44	3,377	1,860

\*Dual / Nondual monthly status changes.

### Appendix B: Number of new Medicare enrollees with select chronic conditions by level of State support, 2007-2008\*

	Full Dual	Partial Dual	Incomplete Dual**	Nondual
Total Beneficiaries	94,103	24,035	66,213	2,312,097
Chronic Conditions				
Cancer <sup>†</sup>	3,391	809	1,953	64,307
Alzheimer's	3,266	248	951	8,011
Chronic Obstructive Pulmonary Disease	11,266	2,253	4,080	57,189
Depression	11,632	2,246	4,554	95,030
Diabetes	25,971	5,331	11,953	261,468
Ischemic Heart Disease	17,890	3,633	7,587	220,929
Any Comorbidity	47,447	10,132	22,174	565,899

\*Limited to beneficiaries with full Part A, Part B, fee for service coverage, survived six months.

\*\* Dual / Nondual monthly status changes.

<sup>†</sup> Breast, colorectal, lung, or prostate.

## Appendix C: Aged dual and nondual beneficiaries by State, initial Medicare coverage, 2007-2008\*\*

State	Total Beneficiaries	Full Dual (%)	Partial Dual (%)	Nondual (%)	Other* (%)
Alabama	68,410	2.7	2.2	92.4	2.6
Alaska	7,197	3.7	0.1	93.8	2.3
Arizona	88,556	4.9	0.5	92.5	2.0
Arkansas	42,622	2.7	1.3	93.3	2.7
California	446,335	7.6	0.2	86.1	6.1
Colorado	64,857	2.7	0.4	95.7	1.2
Connecticut	52,933	2.2	0.9	95.3	1.6
Delaware	14,424	1.0	1.1	95.9	2.0
District of Columbia	6,725	8.9	0.7	86.2	4.2
Florida	309,047	3.6	1.8	91.6	3.0
Georgia	119,238	1.8	0.6	93.2	4.4
Hawaii	19,872	6.2	0.2	91.7	1.9
Idaho	22,537	2.0	0.5	96.3	1.2
Illinois	172,584	2.4	0.3	92.8	4.4
Indiana	92,530	1.5	1.0	95.7	1.8
Iowa	45,743	1.8	0.9	96.2	1.1
Kansas	38,476	1.5	0.7	96.5	1.3
Kentucky	59,833	5.1	1.7	91.0	2.3
Louisiana	58,565	5.0	3.2	89.6	2.1
Maine	22,935	4.5	3.1	89.1	3.3
Maryland	79,066	1.9	0.6	95.4	2.1
Massachusetts	91,232	4.6	0.3	90.2	5.0
Michigan	152,975	4.0	0.1	94.2	1.7
Minnesota	74,466	3.4	0.5	95.2	1.0
Mississippi	38,550	3.2	3.2	90.5	3.1
Missouri	88,148	3.0	0.5	94.9	1.7
Montana	16,806	1.8	0.6	95.9	1.7
Nebraska	24,864	1.4	0.2	96.9	1.4
Nevada	38,477	1.3	0.6	95.8	2.3
New Hampshire	21,308	0.9	0.6	97.0	1.5
New Jersey	125,241	4.5	0.3	93.7	1.6
New Mexico	28,576	2.8	1.4	92.1	3.7
New York	259,224	8.5	0.5	86.9	4.0
North Carolina	135,282	3.9	0.7	93.6	1.8
North Dakota	9,444	1.4	0.8	96.4	1.3
Ohio	172,939	2.2	0.7	95.0	2.1
Oklahoma	53,707	3.8	0.8	93.7	1.7
Oregon	61,131	3.0	1.3	93.8	1.9
Pennsylvania	195,996	4.0	0.5	93.8	1.7
Rhode Island	14,584	3.2	0.2	94.4	2.1
South Carolina	71,074	3.9	0.4	94.1	1.7
South Dakota	12,702	1.7	0.5	95.9	2.0

State	Total Beneficiaries	Full Dual (%)	Partial Dual (%)	Nondual (%)	Other* (%)
Tennessee	94,640	3.8	1.1	92.2	2.9
Texas	289,444	3.3	1.7	91.8	3.2
Utah	28,045	2.6	0.1	95.7	1.6
Vermont	10,647	2.8	2.0	90.4	4.8
Virginia	111,664	2.6	0.5	95.3	1.6
Washington	95,896	3.1	0.7	94.5	1.8
West Virginia	28,262	4.5	1.1	91.0	3.3
Wisconsin	83,726	2.0	0.4	94.7	2.8
Wyoming	8,370	1.0	0.8	97.0	1.1

\*Dual/Nondual monthly status changes.

\*\*Percentages may not add to 100 due to rounding.