SOCIETY OF ACTUARIES

Article from:

In The Public Interest

June 2013 – Issue 8

A BRIEF SURVEY OF DUAL ELIGIBLES AND THE ACA

By Rebecca A. Owen

In the world of social insurance in the United States, beneficiaries who qualify for both Medicare, due to age or disability, and Medicaid, due to low income, hold a special place. Known as dual eligibles, they are a vulnerable, highly needy population, who must navigate two systems that do not always work well together. These beneficiaries are more likely (than the general population) to have been disabled for much of their life, to have multiple chronic health conditions and to have difficulty in advocating for their own needs. A portion of the Affordable Care Act (ACA) is devoted to dual eligible coverage needs and to improving the coordination between the federal and state governments to deliver better, more cost efficient and more consistent care.

Dual eligibility means Medicare covers the bulk of a dual eligible's medical costs for physician and hospital services, while Medicaid coverage (which depends on the reason the beneficiary qualified) includes premiums and cost-sharing from the states. Usually, Medicaid also covers benefits, notably long-term care costs, not covered by Medicare.

Some statistics on dual eligibles are enlightening and highlight how distinctive this population is.

- In 2008 there were nine million dual eligible beneficiaries nationwide.
- Nearly one-third of the population is disabled and many have complex mental health issues.
- More than three-quarters of the costs of services are for members with five or more chronic conditions.
- Dual eligibles are more likely to be in long-term care and are much more likely to be functionally impaired.
- Nearly 20 percent of Medicare beneficiaries are dual eligible; in 2008, they accounted for 31 percent of Medicare spending.
- On average, dual eligibles comprise 15 percent of the Medicaid enrollment; in 2008, they accounted for 39 percent of the spending—there is considerable variation in the composition of the population from state to state.

As can be imagined with two payers so disparate as CMS and state Medicaid plans, the care that these beneficiaries receive is not well-coordinated. The care currently given is fragmented and there is poor communication between the states (Medicaid) and the federal government (Medicare). Not only can this be confusing to the beneficiary, but there can be conflicting incentives to the payers. For example, Medicare costs are, generally, reduced with fewer and shorter acute hospital stays, but Medicaid, which pays for long-term care, has increased costs when patients are returned to a lower acuity setting sooner.

There are other problems with the care that dual eligible beneficiaries receive. Uncoordinated care can arise when the variety of specialists, needed to treat multiple complex conditions, overlook care or duplicate care. It is possible for beneficiaries to fall through the cracks between acute and long-term care. There are often problems

CONTINUED ON PAGE 16

Rebecca A. Owen, FSA, MAAA, is director, Actuarial and Analytics at ODS Health Plans in Portland, Ore. She can be contacted at *owenfsa@gmail.com*.

with access to care due to transport problems or the availability of practitioners. Beneficiaries may not be able to assess their own condition or to communicate their needs to their caregivers. They may have difficulty understanding how to navigate the system to receive the care they need, and they often rely on others to do this for them. This is a challenging population to serve, and the lack of communication between the two government payers makes it harder to find solutions.

Medicaid managed care plans and Medicare Special Needs Plans (SNPs) evolved to help improve the level of coordination, as well as to better manage complex conditions. In 2009, fewer than 30 percent of dual eligibles were enrolled in either a managed care plan or an SNP. These two kinds of plans do a good job of coordinating services within their coverage provisions, particularly for acute care. However, they have not been as effective in coordinating or contracting with long-term care providers, and this is an area of concern.

Long-term care (LTC) needs are an important component of the dual eligible population. More than three-quarters of the Medicaid spending on these beneficiaries is for LTC, either in an institutional or community setting. The demand for long-term care needs is expected to grow as the population ages. In addition, the prevalence of long-term chronic diseases such as diabetes, obesity and heart disease in an aging population means that beneficiaries may live longer, but are also likely to be infirm. Long-term care facilities and community support are already in short supply, and there are widespread problems with the quality of care. These health issues will be occurring at the same time as a lack of retirement income, coupled with much less provision for long-term care expenses. The result will be to push retirees into such dire financial straits and there will be an upward trend in those who will be eligible for both Medicaid and Medicare. The policy implications are considerable.

The Accountable Care Act (ACA) has some provisions that elevate this issue, bringing it to the attention of both policy makers and the public. The Federal Coordinated Health Care Office was established within CMS to improve coordination of care for dual eligible beneficiaries. The mandate for the office is clear; "Supporting state efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program."

CMS has funded demonstration projects in more than a dozen states to try to find a better way to serve this population. These projects will test either a modified fee-for-service or a capitation model. They will work on coordinating acute care, as well as long-term care, and on smoothing communication lines between the two funding sources.

Here are a few examples of demonstration projects:

- California has the Cal MediConnect Program, starting this year, which "aims to create a seamless service delivery experience for dual eligible beneficiaries, with the ultimate goals of improved care quality, better health and a more efficient delivery system."
- The Illinois version seeks "to provide Medicare-Medicaid enrollees with a better care experience by testing a person-centered, integrated care program that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services."
- Ohio will use Integrated Care Delivery System (ICDS) plans, which will be paid a capitation to "coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating Medicare-Medicaid enrollees."
- Washington will use a "managed-fee-for-service care model that will build upon its planned Medicaid Health Homes targeting Medicare-Medicaid enrollees with chronic health conditions."

While these demonstration projects have similar descriptions, the reader should note that there is

wide geographic variation in the composition of the dual eligible population. State Medicaid plans differ broadly. The only generalization that can be made is that there is no single solution that can be applied to all the states. Solutions will emerge from the demonstration projects. However, solutions will take a while to develop, are likely to be localized in nature and, most likely, will require modification to be implemented in other locations.

The press has featured numerous articles on expansion of Medicaid and how each state will integrate Medicaid with the exchanges, but coordination of care for the dual eligible population has not been as popular a topic. Coordination poses a thorny problem, particularly in the area of long-term care. The impact is widespread and very large. There are several websites that will help the reader stay apprised of the emerging policy issues. The Kaiser Family Foundation site, http://www.statehealthfacts.org/, is an excellent source. The Medicaid.gov site, *http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html,* gives the specifics of the provisions of the act as it relates to the dual eligible population. Further specifics on the Demonstration projects will be detailed in a Health Watch article to be published this summer by the Society of Actuaries Health Section.

There are several websites that will help the reader stay apprised of the emerging policy issues.