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Overview

Impact of Affordable Care Act
CLASS Act
Dual Eligibles
Medicaid and Medicare Budget Debates

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Affordable Care Act (ACA)

- More than just an Individual Mandate
- Contains provisions designed to help states rebalance their long-term care systems to spend less on institutional care and more on home- and community-based services.
- More opportunities for states to expand Medicaid coverage for assisted living services. These are optional provisions and states would have to elect to implement them.

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CLASS Act

Voluntary national insurance program that will provide cash benefits to those who have a qualifying disability that limits day-to-day living and meet other eligibility criteria to be determined by HHS Secretary

- Minimum daily cash benefit of $50; can help pay for services and supports to maintain independence in the community, such as home modifications, assistive technologies, home care aides, and personal assistance
- Funded through payroll deduction: no government funding
- Requires 5 years participation for vesting, available after Oct. 2012

CLASS Act (cont.)

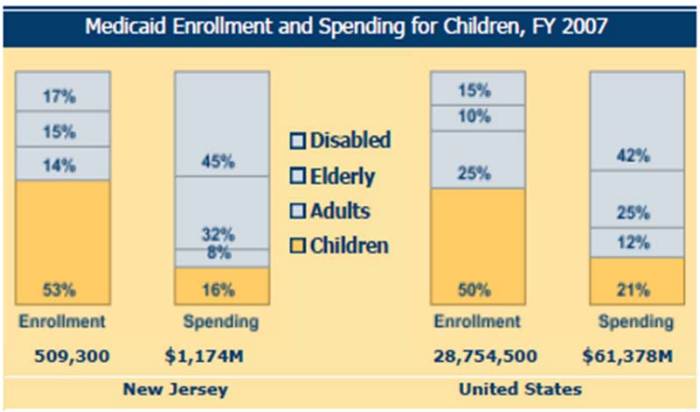
- Implementation concerns
  - Financial sustainability
    - No government subsidy
    - $5 premium for those below 100% FPL
  - Design concerns
    - Adverse selection - premiums cannot be based on health status
    - Will employers offer? Opt-out provision
  - Broad eligibility

CLASS Act (cont.)

HHS has acknowledged concerns:

- Secretary Sebelius testimony before Senate Finance Committee:
  "The program will not start unless we can absolutely be certain that it will be solvent and self-sustaining into the future."
- The Secretary broadly outlined three areas she said HHS could target to improve CLASS: automatic enrollment, premium increases, and changes to eligibility

New Jersey Medicaid Data



http://www.statehealthfacts.org/chfs.jsp?rgn=32&rgn=1

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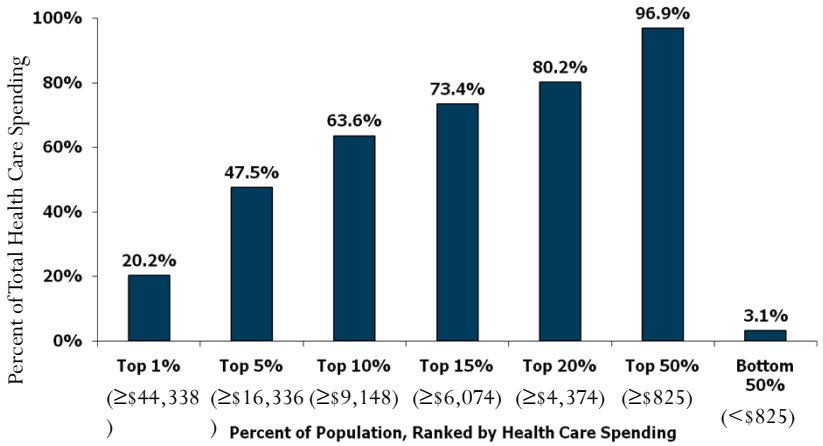
Concentration of Health Care Spending in the U.S. Population, 2008



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.
Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2008.

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Distribution of Average Spending Per Person, 2008

	Average Spending Per Person
Age (in years)	
<5	$1,953
5-17	1,379
18-24	1,650
25-44	2,493
45-64	5,208
65 or Older	9,262
Sex	
Male	$3,300
Female	4,229

Notes: Data is from the MEPS Household and Medical Provider Components and includes direct payments for care provided, including out-of-pocket payments and payment by private insurance, Medicare, Medicare, and other sources; it does not include payment for health insurance premiums, over-the-counter drugs, or indirect payments not related to specific medical events (e.g., Medicaid Disproportionate Share and Medicare Direct Medical Education payments). Includes individuals without any spending in 2008.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2008.

Affordable Care Act: Dual Eligibles

- Dual eligibles are eligible for both Medicare and Medicaid
- 9 million Americans
  - 60% have multiple chronic conditions
  - 15% of Medicaid recipients, but 39% of spending

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Dual Eligibles (cont.)

- Programs not aligned
  - Low-income seniors and people with disabilities must navigate two separate programs: Medicare for coverage of basic acute health care services and drugs, and Medicaid for coverage of supplemental benefits such as long-term care supports and services.
- A lack of alignment between the programs can lead to fragmented or episodic care for people with both Medicare and Medicaid coverage, which can reduce quality and raise costs
- ACA would allow states to work with Medicare and Medicaid-combined funding on coordination of care

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Dual Eligibiles "Alignment Initiative"

- Federal support and flexibility for care coordination – seeking input from stakeholders. Opening for Assisted Living?
- Federal government will also provide Medicare data on beneficiary utilization to states, to improve care coordination

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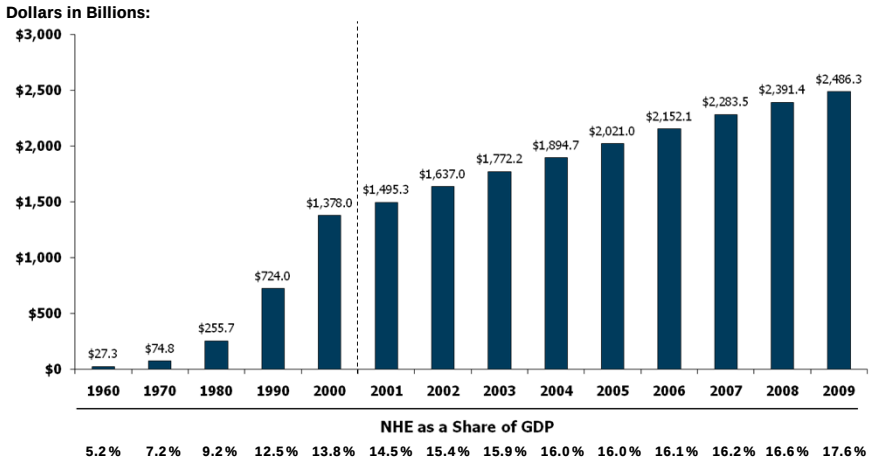
National Health Expenditures and Their Share of Gross Domestic Product, 1960-2009



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2009; file nhegdp09.zip).

Medicare Actuaries Report

- Insolvency sooner than previously estimated (2024)
- Debate on entitlement spending – including proposals to voucher Medicare

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Medicaid

- Ryan plan to block grant
- Proposals to repeal "Maintenance of Efforts" requirements
- Benefit and eligibility changes

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Questions?

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