Medicare's Role in Financing Long-Term Care

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Basic facts about Medicare and LTC

- Medicare's primary function is to finance medical care
  - Medicare outlays: $592 B in 2013, $8 trillion in 2014–23
- Medicare finances **post-acute care**, not LTC
  - SNF: $29 B in 2013, $430 B in 2014–23
  - Home health: $19 in 2013, $250 B in 2014–2023
- Medicare finances medical care for dual eligibles
  - 10 million duals in 2011
  - Diverse needs—relatively healthy, moderately to severely disabled (ADLs), cognitive impairment, multiple chronic conditions
  - 2009: Medicare FFS $15,743/dual , Medicaid $13,564/dual

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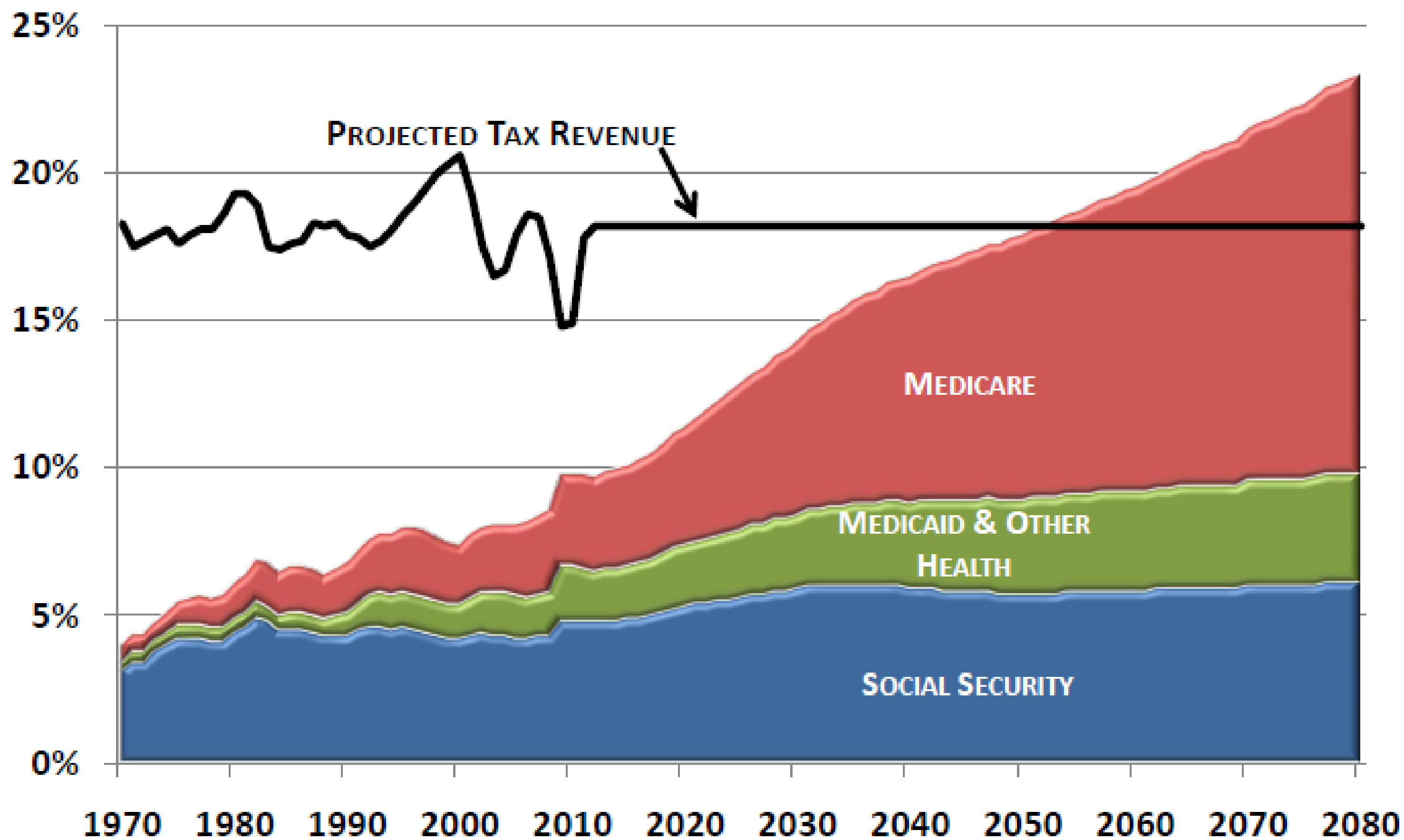
Coordinating medical, social, LTC

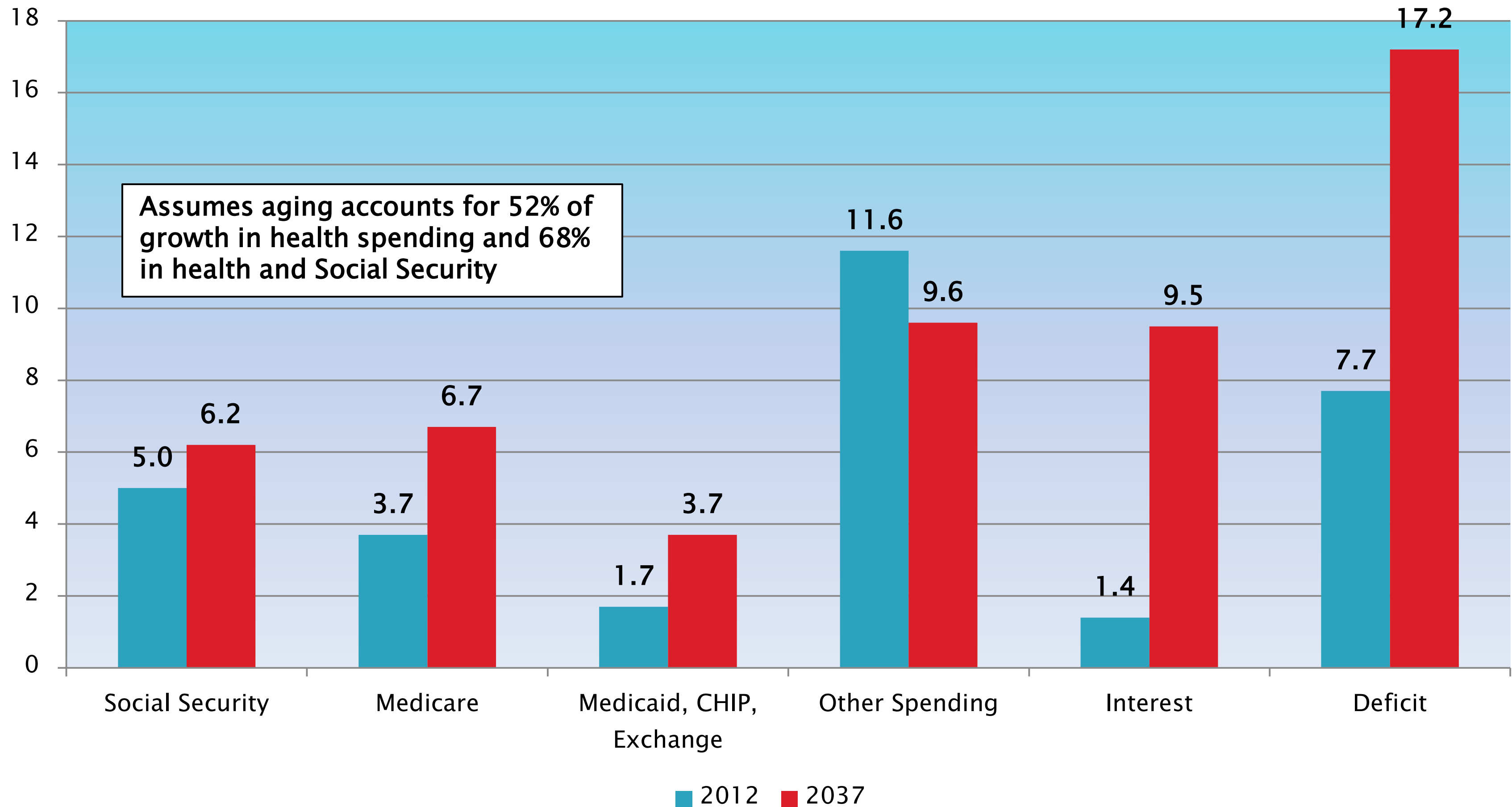
- Social managed care plans (aka SHMOs)
  - SCAN, KP Portland, Elderplan, Health Plan of Nevada
- Programs of All-Inclusive Care for the Elderly (PACE)
- Special Needs Plans (SNPs)
- State demonstrations to integrate care for dual eligibles
- **Do they work?**
- **Are they replicable?**

Issues

- Escalation of services
- Proper medical treatment can reduce hospitalization
- Need coordination across the spectrum of medical, social, LTC services
  - Financial coordination
  - Coordination of care
- Today's good idea is tomorrow's disaster
- Top-down solutions vs. market solutions


WHAT DRIVES OUR DEBT?
(GOVERNMENT SPENDING AS SHARE OF ECONOMY)
25%
20%
15%
10%
5%
0%
PROJECTED TAX REVENUE
MEDICARE
MEDICAID & OTHER HEALTH
SOCIAL SECURITY
1970
1980
1990
2000
2010
2020
2030
2040
2050
2060
2070
2080
SOURCE: CBO

Federal health spending and the budget



*Assumes Medicare physician fees held at 2012 level, IPAB does not take effect, current law reductions in per-person exchange subsidies not enforced, other automatic spending reductions not enforced.

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Outlook: Cuts and copays

- Medicare physician payment fix – need pay-fors
  - MedPAC (2011) – 22% of cuts from PAC – $49 B
- Obama 2014 budget – 25% of cuts from PAC
  - Reduce payment update for SNF, HH, IRF, LTCH – $79.0 B
  - Targeted IRF reductions – $4.5 B
  - Targeted SNF reduction (readmits) – $2.2 B
  - Bundled payment for PAC – $8.2 B
  - Phase in HH copayments – $730 million

Outlook: Consolidation

- Moving away from fee-for-service
- ACA creates ACOs
  - Risk-based payment
  - Incentive to tighten service use
  - Weak model – no savings for enrollment, no push on providers, one-sided risk (share savings only) allowed
- Bipartisan Policy Center promotes ACOs on steroids
  - Join or else – discount for beneficiaries, payment freeze in FFS to 2023, 2-sided risk required (savings, costs)
- Transition to defined contribution
  - You don’t have to call it premium support

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