23. MEDICARE

Table 23–1. FEDERAL RESOURCES IN SUPPORT OF MEDICARE
(In millions of dollars)

Function 570	1996 Actual	Estimate					
		1997	1998	1999	2000	2001	2002
Spending:							
Discretionary Budget Authority	2,939	2,598	2,755	2,751	2,728	2,727	2,728
Mandatory Outlays:							
Existing law	171,272	191,556	208,641	228,211	248,760	271,089	295,065
Proposed legislation			–4,310	–11,390	–22,150	–27,820	–34,550

Created by the Social Security Amendments of 1965 (and expanded in 1972), Medicare is a Nation-wide health insurance program for the elderly and certain people with disabilities. The program, which will spend an estimated $211 billion in 1998 on benefits and administrative costs, consists of two complementary but distinct parts, each tied to a trust fund: (1) Hospital Insurance (Part A) and (2) Supplementary Medical Insurance (Part B).

Over 30 years ago, Medicare was designed to address a serious, national problem in health care—the elderly often could not afford to buy health insurance, which was more expensive for them than for other Americans because they had higher health care costs. Through Medicare, the Federal Government created one insurance pool for all of the elderly while subsidizing some of the costs, thus making insurance much more affordable for almost all elderly Americans.

Medicare has very successfully expanded access to quality care for the elderly. Its trust funds, however, face financing challenges as the Nation approaches the 21st Century. Along with legislative proposals discussed elsewhere in the budget, the Health Care Financing Administration (HCFA) is working to improve Medicare through its regulatory authority and demonstration programs.

Part A

Part A covers almost all Americans age 65 or older, and most persons who are disabled for 24 months or more and who are entitled to Social Security or Railroad Retirement benefits. People with end-stage renal disease (ESRD) also are eligible for Part A coverage. About 99 percent of Americans aged 65 or older are enrolled in Part A, along with an estimated 93 percent of ESRD patients. Part A reimburses providers for the inpatient hospital, skilled nursing facility, home health, and hospice services provided to beneficiaries. Part A's Hospital Insurance (HI) Trust Fund receives most of its income from the HI payroll tax—2.9 percent of payroll, split evenly between employers and employees.

Part B

Part B coverage is optional, and it is available to almost all resident citizens 65 years of age or older and to people with disabilities who are entitled to Part A. About 96 percent of those enrolled in Part A have chosen to enroll in Part B. Enrollees pay monthly premiums that cover about 25 percent of Part B costs, while general taxpayer dollars subsidize the remaining costs. For most beneficiaries, the Government simply deducts the Part B premium from their monthly Social Security checks.

Part B pays for medically necessary physician services; outpatient hospital services; diagnostic clinical laboratory tests; certain durable medical equipment (e.g., wheelchairs) and medical supplies (e.g., oxygen); and physical and occupational therapy, speech pathology services, and outpatient mental health services. Part B also covers kidney dialysis and transplants for ESRD patients.

Fee-for-Service vs. Managed Care

Beneficiaries can choose the coverage they prefer.

Under the "traditional," fee-for-service option, beneficiaries can go to virtually any provider in the country. Medicare pays providers primarily based on either an established fee schedule or reasonable costs. About 90 percent of Medicare beneficiaries now opt for fee-for-service coverage.

Alternatively, beneficiaries can enroll in a Medicare managed care plan, and the 10 percent who do are concentrated in a few geographic areas. Generally, enrollees receive care from a network of providers, although Medicare managed care plans are starting to offer a point-of-service benefit, allowing beneficiaries to receive certain services from non-network providers. Most managed care plans receive a monthly, per enrollee "capitated" payment that covers the cost of Part A and B services.

Successes

Medicare dramatically increased access to health care for the elderly—from slightly over half when the program began in 1966 to almost 100 percent today.

Ninety-six percent of Medicare beneficiaries reported no trouble obtaining care in 1994.[1] Further, less than one percent of beneficiaries reported trouble getting care because a physician would not accept Medicare patients. Medicare beneficiaries have access to the most up-to-date medical technology and procedures.

Medicare also gives beneficiaries a choice of managed care plans. Today, managed care is a major, and growing, part of Medicare. As of December 1, 1996, over 4.7 million beneficiaries have enrolled in 336 Medicare managed care plans. In 1995, enrollment in the capitated managed care plans called "risk contracts" grew by 36 percent, and by an annualized rate of 30 percent in the first six months of 1996. Managed care plans can potentially provide coordinated care that is focused on prevention and wellness.

In addition, Medicare is working to protect the integrity of its payment systems. Building on the success of Operation Restore Trust, a five-State demonstration aimed at cutting fraud and abuse in home health agencies and nursing homes, Medicare is increasing its efforts to root out fraud and abuse. Recent legislation provided more Federal funds and authority to prevent inappropriate payments to fraudulent providers, and to seek out and prosecute providers who continue to defraud Medicare and other health care programs.

Spending and Enrollment

With no changes in law, net Medicare outlays will rise by an estimated 54 percent from 1997 to 2002—from $191.6 billion to $295.1 billion.[2] Net Medicare outlays will grow by an average of nine percent a year over this period. Part A outlays are larger than Part B outlays, and grow more slowly. Nevertheless, Part A outlays will grow by an estimated 46 percent over the period—from $135.1 billion to $197.7 billion—or an average of 7.9 percent a year. Part B outlays will grow by an estimated 72 percent—from $55.9 billion to $96.4 billion—or an average of 11.5 percent a year.

Medicare has consumed a growing share of the budget, and it will continue to under current law. In 1980, Federal spending on Medicare benefits was $31 billion, comprising 5.2 percent of all Federal outlays. In 1995, Federal spending on Medicare benefits was $156.6 billion, or just over 10 percent of all Federal outlays. By 2002, assuming no changes in current law, Federal spending on Medicare benefits will total an estimated

[1] Physician Payment Review Commission, 1996 Annual Report to Congress.

[2] These figures cover Federal spending on Medicare benefits, but do not include spending financed by beneficiaries' premium payments or administrative costs.

$295.1 billion, or almost 16 percent of all Federal outlays.

Medicare enrollment will grow slowly until 2010, then take off as the baby boom generation begins to reach age 65. From 1995 to 2010, enrollment will grow at an estimated average annual rate of 1.4 percent, from 37.6 million enrollees in 1995 to 46.4 million in 2010. But after 2010, average annual growth will almost double, with enrollment reaching an estimated 78 million in 2030—one in five Americans.

The Two Trust Funds

HI Trust Fund: As discussed above, the HI Trust Fund is financed by a 2.9 percent payroll tax, split evenly between employers and employees. In 1995, HI expenditures began to exceed the annual income to the Trust Fund and, as a result, Medicare is drawing down the Trust Fund's accounts to partially finance Part A spending. The Government's career actuaries predict that the HI Trust Fund would become insolvent in 2001 in current law, but the President's proposals to strengthen the Trust Fund would push back the date into 2007. (For a detailed discussion of the proposals, see Chapter 1.)

Beyond the impending insolvency, Medicare also faces a longer-term financing challenge. The baby boomers' retirement, starting in 2010, will cause Medicare spending to grow significantly. From 2010 to 2030, enrollment is expected to double while the workforce shrinks. As a result, only 2.2 workers will be available to support each beneficiary in 2030—compared to the current four workers per beneficiary. The President proposes to work with Congress on a bipartisan basis to develop a long-term solution to this financing challenge.

SMI Trust Fund: The SMI Trust Fund receives 75 percent of its income from general Federal revenues, 25 percent from beneficiary premiums. Unlike HI, the SMI Trust Fund is really a trust fund in name only—the law lets the SMI Trust Fund tap directly into general revenues to ensure its annual solvency. Nonetheless, the trustees of the SMI Trust Fund noted in 1996 "that program costs have been growing faster than the GDP and that this trend is expected to continue under present law."

Demonstrations

HCFA also conducts demonstration programs to determine the efficacy of new service delivery or payment approaches. For instance, it is launching a Choices demonstration project to allow provider-sponsored organizations in certain areas to enroll Medicare beneficiaries. The plans will offer new benefit structures to beneficiaries. Another demonstration project, Centers of Excellence, has experimented with bundled payments for hospital and physician costs, for selected procedures performed at certain high-quality facilities.

Regulations

Through its regulatory authority, HCFA continually improves Medicare. In the last year, HCFA issued regulations to address concerns about the payment incentives that managed care plans offer to physicians that, in turn, may encourage physicians to deny services. Specifically, it barred health plans that contract with Medicare from limiting physicians' ability to discuss all appropriate treatment options with Medicare enrollees. In addition, the Administration is focusing more on patient health outcomes and giving information to consumers that should boost competition among health plans, generating higher-quality care and a more cost-effective Medicare program.