23. MEDICARE

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

Function 570	1997 Actual	Estimate					
		1998	1999	2000	2001	2002	2003
Spending:							
Discretionary Budget Authority	2,623	2,724	2,648	2,640	2,627	2,609	2,652
Mandatory Outlays:							
Existing law	187,441	195,383	204,691	214,249	230,075	232,504	253,450
Proposed legislation	.....	.....	–79	–33	–152	–257	–326

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 $207 billion in 1999 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. Medicare was expanded in 1972 to address a similar problem of access to insurance for people with disabilities. Through Medicare, the Federal Government created one insurance pool for all of the elderly and eligibile disabled individuals while subsidizing some of the costs, thus making insurance much more affordable for almost all elderly Americans and for certain people with disabilities.

Medicare has very successfully expanded access to quality care for the elderly and people with disabilities. Still, even though the Balanced Budget Act (BAA) of 1997 improved Medicare's financial outlook for the near future, its trust funds face financing challenges as the Nation moves into the 21st Century. Along with legislative proposals discussed elsewhere in the budget, the Health Care Financing Administration (HCFA), which runs Medicare, is working to improve Medicare through its regulatory authority and demonstration programs.

The Department of Health and Human Services (HHS), which houses HCFA, is the Federal Government's lead agency for health programs. HHS' Strategic Plan states the agency mission as: "to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services."

Medicare supports HHS' first, second, third, and fourth strategic goals, as described in Chapter 22, "Health."

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 care related to a hospital

stay, 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 age 65 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); home health care; physical and occupational therapy; speech pathology services; and outpatient mental health services. Part B also covers kidney dialysis and other services 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 prospective payment, an established fee schedule, or reasonable costs. About 87 percent of Medicare beneficiaries now opt for fee-for-service coverage.

Alternatively, beneficiaries can enroll in a Medicare managed care plan, and the 13 percent who do are concentrated in several geographic areas. Generally, enrollees receive care from a network of providers, although Medicare managed care plans may 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. As of June 1997, 67 percent of all Medicare beneficiaries lived in a county served by at least one Medicare managed care plan.

Due to the BBA, Medicare managed care (renamed "Medicare+Choice" or Part C) will provide new health plan options for Medicare beneficiaries, including provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). Part C also will feature improved beneficiary information and will be fully operational by January 1, 1999.

Successes

Medicare has dramatically increased access to health care for the elderly—from slightly over 50 percent of the elderly in 1966 to almost 100 percent today.

According to the Physician Payment Review Commission's latest report, 96 percent of Medicare beneficiaries reported no trouble obtaining care. Further, less than 1 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 an attractive choice of managed care plans. Today, managed care is a major, and growing, part of Medicare. As of December 1, 1997, over 5.2 million beneficiaries have enrolled in 307 Medicare managed care plans. During the 12-month period ending December 1, 1997, enrollment in the capitated managed care plans called "risk contracts" grew by 27 percent. Managed care plans can 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, nursing homes, and durable medical equipment suppliers, Medicare is increasing its efforts to root out fraud and abuse. Recent legislation provides mandatory Federal funds and greater 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

Net Medicare outlays will rise by an estimated 30 percent from 1998 to 2003—from $194.2 billion to $252 billion.[1] Part A outlays will grow by an estimated 23 percent over the period—from $130.3 billion to $160 billion—or an average of 4.2 percent a year. Part B outlays will grow by an estimated 44 percent—from $63.8 billion to $92 billion—or an average of 7.6 percent a year.

Medicare is consuming a growing share of the budget. 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 2003, assuming no changes in current law, Federal spending on Medicare benefits will total an estimated $252 billion, or almost 13 percent of all Federal outlays.

Medicare enrollment will grow slowly until 2010, then explode as the baby boom generation begins to reach age 65. From 1995 to 2010, enrollment will grow at an estimated average annual rate of 1.5 percent, from 37.6 million enrollees in 1995 to 46.9 million in 2010. But after 2010, average annual growth will almost double, with enrollment reaching an estimated 61.3 million in 2020.

The Two Trust Funds

HI Trust Fund: As noted earlier in this chapter, 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 began drawing down the Trust Fund's accounts to help finance Part A spending. Prior to the BBA, the Government's actuaries predicted that the HI Trust Fund would become insolvent in 2001. The BBA, however, ensured the solvency of the Trust Fund for another nine years—until 2010.

Medicare Part A still faces a longer-term financing challenge. Since current benefits are paid by current workers, Medicare costs associated with the retirement of the baby boomers, starting in 2010, will be borne by the relatively small number of people born after the baby boom. As a result, only 2.2 workers will be available to support each beneficiary in 2030—compared to today's four workers per beneficiary. The President plans to work with Congress and the Medicare Commission to develop a long-term solution to this financing challenge.

SMI Trust Fund: The SMI Trust Fund receives about 75 percent of its income from general Federal revenues and about 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.

Demonstrations and Regulations

HCFA also conducts demonstration programs to determine the efficacy of new service delivery or payment approaches. For example, Phase II of the Social Health Maintenance Organization demonstration project is testing alternative mechanisms for adjusting the managed care capitated payment, including the beneficiary's functional status. In another demonstration project, Centers of Excellence, HCFA has experimented with bundled payments for hospital and physician costs for selected procedures performed at certain high-quality facilities.

Through its regulatory authority, HCFA continually improves Medicare. For example, HCFA has finalized regulations specifying additional standards that home health agencies must meet to participate in Medicare, including securing surety bonds, and it expects to issue similar regulations for durable medical equipment suppliers this year. By reducing the amount of fraud and abuse in the program, the Administration is making important changes to strengthen Medicare.

Performance Plan

HCFA has developed a comprehensive set of performance goals to measure its progress in ensuring that Medicare beneficiaries receive the highest quality health care. HCFA's 22 performance goals relate to quality assurance, access to care for the elderly and disabled,

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

administrative efficiency, and a reduction in fraud and abuse—four areas critical to the administration of Medicare.

For example, HCFA's 1999 goals include:

- Increasing the percentage of Medicare beneficiaries who receive a mammogram once every two years from 49 percent in 1994 to 59 percent in 1999 and 60 percent in 2000;
- Increasing the number of Medicare beneficiaries receiving vaccinations for influenza from 41 percent in 1995 to 59 percent;
- Reducing the payment error rate under Medicare's fee-for-service program from 14 percent in 1996 to 13 percent, with a five-year goal of 10 percent;
- Continuing to shift Medicare contractors' nine different claims processing systems to one Part A and one Part B standard system (by the end of 1999, HCFA will have one Part A system and two Part B systems, with the final Part B transition coming later); and
- Ensuring that no significant interruptions to Medicare claims payments occur because information systems under HCFA's control were not year 2000 compliant. For systems not under HCFA's direct control, HCFA will continue to work with its Medicare contractor community and perform oversight activities directing them to achieve and verify compliance. HCFA will again seek legislative changes to increase its control over contractor systems.