22. MEDICARE

Table 22–1. Federal Resources in Support of Medicare
(In millions of dollars)

Function 570	1999 Actual	Estimate					
		2000	2001	2002	2003	2004	2005
Spending:							
Discretionary Budget Authority ...	2,803	3,067	2,977	2,977	3,012	3,087	3,156
Mandatory Outlays:							
Existing law	187,694	199,475	218,251	223,676	241,888	255,403	277,452
Proposed legislation	.....	.....	–690	2,610	–2,730	6,543	6,075

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 $218 billion in 2001 on mandatory benefits (net of beneficiary premiums) 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).

Approximately 35 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 eligible 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, but at an increasing cost. The Balanced Budget Act (BBA) of 1997 improved Medicare's financial outlook for the near future, yet its trust funds face financing challenges as the Nation moves into the 21st Century. The Balanced Budget Refinement Act (BBRA) of 1999 corrected some of the unintended consequences of the BBA. Along with legislative proposals discussed elsewhere in the budget, the Health Care Financing Administration (HCFA), which runs Medicare, is working to reform and modernize the Medicare program.

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. 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 94 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; 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 83 percent of Medicare beneficiaries now opt for fee-for-service coverage.

Alternatively, beneficiaries can enroll in a Medicare+Choice plan, and the 17 percent who do are concentrated in several geographic areas. Generally, enrollees receive care from a network of providers, although Medicare+Choice plans may offer a point-of-service benefit, allowing beneficiaries to receive certain services from non-network providers. Medicare+Choice provides beneficiaries access to additional kinds of managed care plans, including Provider Sponsored Organizations and Preferred Provider Organizations. Most managed care plans receive a monthly, per-enrollee capitated payment that covers the cost of Part A and B services. At the start of 2000, 69 percent of all Medicare beneficiaries lived in a county served by at least one Medicare managed care plan.

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 a recent Medicare Payment Advisory Commission report, 97 percent of Medicare fee-for-service beneficiaries (94 percent for managed care) reported no trouble obtaining care. Further, 88 percent of fee-for-service Medicare beneficiaries (92 percent for managed care) reported having a physician or physician's office as a usual source of care. Medicare beneficiaries have access to the most up-to-date medical technology and procedures.

Under the BBA and other recent legislation, Medicare beneficiaries now have expanded access to many important preventive care services including mammographies, prostate and colorectal cancer screening, bone mass measurements and diabetes self-management services. These benefits will help prevent or reduce the complications of disease for millions of beneficiaries.

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. In 1996, in the first ever comprehensive audit of the Medicare program, the Medicare error rate was an estimated 14 percent of all Medicare fee-for-service payments, or about $23.2 billion. In 1998, the error rate fell to an estimated 7.1 percent, or about $12.6 billion.

Spending and Enrollment

Federal spending on Medicare benefits will rise by an estimated average annual rate of 7.1 percent from 2001 to 2005—from $240 billion to $309 billion.[1] Part A outlays will grow by an estimated 28 percent over the period—from $140 billion to $179 billion—or an average of 6.7 percent a year. Part B outlays will grow by an estimated 30 percent—from $100 billion to $130 billion—or an average of 7.5 percent a year.

Medicare enrollment will grow slowly until 2010, then rapidly increase as the baby

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

boom generation begins to reach age 65 in 2011. From 1995 to 2010, enrollment will grow at an estimated average annual rate of 1.4 percent, from 37.4 million enrollees in 1995 to 46.3 million in 2010. But after 2010, average annual growth will more than double, with enrollment reaching an estimated 61.0 million in 2020.

The Two Trust Funds

Hospital Insurance (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 Medicare Trustees currently project that the HI Trust Fund will remain solvent until 2015, mostly due to the BBA changes and improved efforts to combat fraud and abuse.

Medicare Part A still faces a long-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 2.3 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 to develop a long-term solution to this financing challenge.

Supplementary Medical Insurance (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.

Balanced Budget Act Implementation

HCFA continues to implement the many changes in Medicare payment methodologies and provider options that were mandated in the BBA and then modified in the BBRA. Although HCFA was forced to delay some provisions to enable a smooth transition of systems to the year 2000 (Y2K) computer problem, the agency has issued major rules that implement the new Medicare + Choice program, PSO solvency standards, an interim payment system for home health services and a prospective payment system for skilled nursing facilities.

A Plan to Strengthen HCFA's Management Capacity

HCFA faces the formidable challenge of modernizing its administrative infrastructure, meeting pressing statutory deadlines for program change from the BBA, the BBRA and the Health Insurance Portability and Accountability Act, and perhaps most important, the need to be highly responsive to its customers. The budget continues initiatives first proposed in 2000 to increase HCFA's flexibility to operate as a prudent purchaser of health care while also increasing accountability, as discussed in Chapter 31, "Improving Performance through Better Management".

Performance Plan

HCFA has developed a set of performance goals to measure its progress in ensuring that Medicare beneficiaries receive the highest quality health care. HCFA's performance goals relate to four critical areas: quality assurance; access to care for the elderly and disabled; administrative efficiency; and, a reduction in fraud and abuse. HCFA's 2001 goals include:

- Increasing the percentage of Medicare beneficiaries who receive a mammogram once every two years from 45 percent in 1998 to 51 percent in 2001.
- Decreasing the one-year mortality rate among Medicare beneficiaries hospitalized for heart attacks from 31.4 percent in 1995 to 27.4 percent in 2001.
- Determining and reducing the prevalence of pressure ulcers (bed sores) in long-term care facilities. Pressures ulcers are a good indicator of the quality of care provided by nursing homes, a major concern of the Administration's Nursing Home Initiative. This goal is still developmental, and

HCFA is working to establish a baseline during 2000.

- Increasing the percentage of Medicare beneficiaries 65 and over receiving vaccinations for influenza from 59 percent in 1994 to 72 percent in 2001 and those receiving lifetime pneumococcal vaccinations from 25 percent in 1994 to 55 percent in 2001. This latter goal was developed to further address diseases that have resulted in more deaths per year than all other vaccine-preventable diseases combined, as HCFA has achieved and surpassed its 2000 flu immunization performance measure.
- Reducing the payment error rate under Medicare's fee-for-service program from 14 percent in 1996 to seven percent in the year 2000 and five percent by the year 2002, as noted above. The Administration has made great strides over the last few years to reduce improper Medicare payments to hospitals, doctors, and other health care providers.
- Sustaining the percentage of laboratories regulated under the Clinical Laboratory Improvement Amendment that are properly enrolled and participating in proficiency (accuracy) testing at 95 percent. HCFA will also sustain the current percentage of the total scores reported from laboratories enrolled in proficiency (accuracy) testing that contain no failures at 90 percent.