Medicare: Program, Procedures and Recommendations

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Executive Summary

This report discusses the question of whether the Medicare program is performing effectively. It discusses the origins and development of Medicare, its mission and reason for the program. Included is the staffing of the Centers for Medicare and Medicaid Services, a center within the Department of Health and Human Services. It discusses the historical, current, and projected funding through FY 2015. Most notably it contains the program performance ratings of Medicare from the White House, CBO, OMB, and CMS.

Medicare is a program that became law in 1965, championed by President Lyndon B Johnson. The program is broken down into four parts: Part A, Part B, Part C, and Part D. Medicare is housed under the Department of Health and Human Services, run by the Centers for Medicare and Medicaid Services which is temporarily led by Andrew Slavitt while a new head is being appointed. In FY 2015, outlays for Medicare are expected to total $529 billion, which was approximately 17% of the total Federal Budget. The President’s budget proposal for FY 2016 calls for Medicare to be $585 billion, which is 16.7% of the FY2016 proposed federal budget. This report concludes that Medicare is considered an effective program by the Office of Management and Budget, the Congressional Budget Office, the Center for Medicare and Medicaid, and the annual performance plan created by the Department of Health and Human Services. Finally, recommendations are given to either cap Medicare spending at the rate it is now, or disband Medicare and create an alternative health insurance plan.

Report

Program Description and Funding

Medicare is a national social insurance program funded by Medicare trust funds, income taxes paid on social security benefits, interest earned on the trust fund investments, and Medicare Part A premiums. It guarantees access to healthcare for Americans aged 65 or over who have paid, throughout their lifetimes, the 2.9% payroll contribution divided between the employer and employee. It also covers citizens two years after the diagnosis of a qualifying disability (Marmor et al, 2013, p.121). Medicare is broken down into four separate sections: Part A, Part B, Part C, and Part D.

The official government website for Medicare, Medicare.gov, defines the different sections as follows: Part A is hospital insurance. It assists in covering inpatient care in hospitals, including coverage for critical access hospitals, and nursing facilities. Part A also aids in covering hospice care and some home health care.

Part B is medical insurance. It assists in covering doctors’ services and outpatient care. It also takes care of some areas that Part A does not cover, like physical and occupational therapy and some additional home health care.
Part D, prescription drug coverage, began on January 1, 2006 under President George W. Bush. It was established to help Medicare-approved citizens cover the cost of prescription drugs. If you have either Part A or Part B, you are eligible for prescription drug coverage. It is also possible to have neither Part A nor Part B and still be able to have Part D coverage.

Approximately 75% of senior citizens benefit from Medicare in the traditional fashion, through Part A, Part B and the prescription drug coverage of Part D, while others choose to participate in for-profit Medicare “Advantage” (Part C). Part C consists of Medicare Advantage Plans. Medicare Advantage Plans are private health insurance plans that are Medicare-approved. Individuals are eligible for these plans if they are enrolled in, or qualify for Part A and Part B. Part C provides all of the benefits of Part A and Part B, but it also may include additional benefits such as vision, dental, or hearing. Occasionally it also provides prescription drug coverage. The biggest difference between the traditional Medicare and Part C is that while Part C sets restrictions on provider choice, it also offers additional benefits not offered under Part A or Part B (Marmor et al, 2013, p. 121-122).

Medicare provided health insurance to over 52 million Americans in 2013, with more than 42 million of those citizens being over the age of 65 and nearly ten million being citizens with disabilities. Medicare is the primary payer for approximately 15.3 million inpatient stays in 2011, which represented 47.2% of total inpatient hospital costs in the United States. Medicare covers approximately half of the cost that is needed by a person on Medicare Insurance; they must pay the other half. These costs vary depending upon the amount of coverage that is needed for the specific medical issue (The Centers for Medicare and Medicaid Services).

Policy History

On November 19, 1945, President Harry Truman asked Congress for legislation to establish a national health insurance plan available to all Americans. Bills were proposed in 1945, 1947, and 1949, but each one died in Congress.

In the 1950’s the United States was facing a rapidly aging population in which two-thirds of the elderly had annual incomes of less than $1,000 and only one in eight had health insurance due to their classification as ‘high-risk’ by private insurance networks (The Centers for Medicare and Medicaid Services). Congress took note of this fact and throughout the 1950s and 1960s, debated the concept of a ‘socialized medicine’ program. During these debates, political leaders operated under the accurate assumption that social insurance programs had a vastly greater public acceptance than an assistance program. The leaders wanted to make sure that Medicare benefits would be ‘earned’ and not given (The Centers for Medicare and Medicaid Services).
In 1961 President John F. Kennedy created a task force which recommended the creation of a national health care plan, specifically for Americans over the age of sixty-five. Then in May 1962, President Kennedy gave a televised speech highlighting the need for Medicare (Centers for Medicare and Medicaid Services). In 1964 a study was conducted by the Senate stating that only half of policies administered to retirees provided comprehensive coverage, and only a quarter of older Americans had adequate hospital insurance (The Centers for Medicare and Medicaid Services). It became clear that the elderly community was facing a health care crisis and Social Security was failing to fight the high cost of medical care.

Finally in 1965, in Independence, MO, Medicare was signed into law as part of President Lyndon B Johnson’s Great Society. The original plan, which focused on Social Security retirees, limited benefits to 60 days of hospital care and physician services were not included. Policy makers did this in hopes of extinguishing medical professionals’ hostility towards the program (Marmor et al, 2013, p. 232).

In the original plan, Part A was based upon social insurance principles of funding, eligibility, and common beliefs, while Part B was an unanticipated afterthought. Medicare Part B was financed by a combination of general revenues and individual flat rate premiums; these premiums were voluntary, but highly subsidized (Marmor et al, 2013, p. 232).

In 1965 a central assumption about the program was that it would expand in coverage and adopt a more unified structure of finance. The future goal of the program was to be universalistic, and benefits were to expand to protect against the major cost of illness in the United States (Marmor et al, 2013, p. 232).

In 1972 Medicare expanded to cover disabled persons under the age of 65, as well as those with end-stage renal disease. The coverage expanded to include chiropractic, speech, and physical therapy, and authorized the use of HMO health care plan payments. In 1983 hospice benefits were added on a part-time trial basis. Benefits were also extended to federal employees (Medicare Coverage. ING Financial Partners, Inc.).

In 1988 under the Reagan Administration, the program was overhauled. The overhaul was aimed at ‘catastrophic illness’ coverage and prescription drugs. This, however, was repealed in 1989 (The Centers for Medicare and Medicaid Services).

Under the Balanced Budget Act of 1997, Medicare + Choice, which is now called ‘Medicare Advantage’ was created, commonly known as Part C. This gave beneficiaries the option of enrolling in a variety of private plans, including HMOs, PPOs and others. (Medicare Coverage. ING Financial Partners, Inc.). This meant that citizens now have the option of using Medicare-approved private health insurance plans. These can be used if an individual wishes to have all of the coverage of both Part A and Part B, but would like additional private plan benefits including coverage in areas like dental or vision.
Another section of the Program was added in 2006. This section has been called ‘the most significant legislative change to Medicare’ by the Centers for Medicare and Medicaid services. The expansion began under President George W. Bush, in 2003, with the Medicare Modernization Act (The Centers for Medicare and Medicaid Services). Most notably this Act added outpatient prescription drug benefits to Medicare, or what is commonly referred to as Part D.

**Program Administration and Staffing**

Medicare is a program under the Department of Heath and Human Services (HHS), run by the Centers for Medicare and Medicaid Services (CMS). It is one of the largest programs in the Department of Health and Human Services, controlling a vast amount of their resources.

Marilyn Tavenner was the head of the CMS until February 2015, when she stepped down. Currently Tavenner’s deputy Andrew Slavitt is leading CMS until a successor is appointed. Typically actuaries, statisticians, health insurance specialists, and technology specialists are employed at CMS. Most of these positions require a GS 12 or higher, with the exception of the statistician which is labeled as a GS 7 (Department of Health and Human Services). All health-related positions require at minimum one to two years of specialized experience in the healthcare field (Department of Health and Human Services). These positions are all career civil servant positions. CMS is located in Baltimore with ten regional offices in major cities throughout the United States, including New York, Chicago, Dallas, and Seattle (The Centers for Medicare and Medicaid Services).

**Proxies**

The responsibilities of the CMS are outlined on their website which states that, “With an expanded role in this new health care environment we are being called to devise creative ways to reposition ourselves to meet the challenges of the new health care environment and achieve our vision. Our strategy sets a clear vision of the future and sets our path to achieving successful results for our beneficiaries’ (The Centers for Medicare and Medicaid Services). The CMS is responsible for the development and growth of Medicare, Medicaid and CHIP programs.” According to the CMS website, the center is designed to expand access to affordable health care and make the U.S. health care system more outcome-driven and cost-effective, the ACA requires that CMS coordinate with States to set up Health Insurance Marketplaces, expand Medicaid, and regulate private health insurance plans’ (Centers for Medicare and Medicaid Services).

In order to implement the Medicare program, CMS contracts out to private insurance companies to serve as mediators between themselves and medical providers. Areas that are contracted out by CMS include claims and payment processing, call center services, clinician enrollment, and fraud investigation.
In most states, in order to determine whether or not a Hospital is able to participate in Medicare, the CMS uses a private non-profit organization called The Joint Commission. The Joint Commission is an organization that is responsible for accrediting Hospitals and other healthcare organizations throughout the United States (The Joint Commission).

With these private insurance agencies there is, unfortunately, a high risk of fraud that occurs. The Government Accountability Office considers Medicare an effective program due to its ability to provide an efficient health care plan, yet also a high-risk program due to the immense vulnerability to fraud, and the continuous fraud that occurs (Congressional Budget Office). In fact less than 5% of Medicare claims are audited (Government Accountability Office).

**Budget**

Medicare is one of the most expensive programs in the federal budget. In FY 2013 Medicare was $492 billion and in FY 2014, Medicare spending reached $505 billion, which amounts to approximately 16% of 2014 federal spending. In FY 2015 Medicare is projected to increase by $24 billion to $529 billion, which accounts for approximately 17% of the estimated federal budget. The President’s budget proposal for FY 2016 calls for Medicare to increase once again to $585 billion, securing 16.7% of the federal budget (Summary Tables). Medicare has consistently accounted for approximately 3% of the GDP since 2013.

According to the Medicare website, the money to fund the distinct parts of Medicare comes from the Medicare trust funds. Revenues that go into these trust funds are from a variety of sources.

Employers and employees fund Medicare Part A with the Hospital Insurance Trust Fund, which is funded through a payroll tax of 2.9% that is paid for equally by each party. Things included in this category are items such as inpatient hospital care, skilled nursing facility care, home health care, and hospice care. It is also paid for by income taxes paid on Social Security benefits, interest earned on trust fund investments, and Medicare Part A premiums from people who are not eligible for premium-free Part A. The current cost of Part A premiums is $407 per month. The Hospital Insurance Trust Fund pays for Part A benefits and Medicare Program administration, including programs to combat fraud and abuse.

Part B, medical insurance is funded through the Supplementary Medical Insurance (SMI) Trust Fund. The SMI is funded through authorizations by Congress, premiums paid by individuals enrolled in Part B and Part D, as well as the interest earned on trust fund investments. The beneficiary premiums, according to the Medicare website, on average, cost $104.90 monthly with a deductible of $147 per year. The SMI pays for Part B and Part D, as well as part of the cost of combatting fraud and abuse.
Part C, Medicare Advantage, is funded through hospital insurance and supplementary medical insurance trust funds. Prescription drug coverage is also paid for in part by the supplementary medical insurance trust fund and beneficiary premiums. The premiums for both Part C and Part D vary depending upon an individual’s yearly income (The Centers for Medicare and Medicaid Services). These premiums also pay for Medicare Program administration, such as costs for paying benefits and for fighting fraud and abuse (The Centers for Medicare and Medicaid Services).

Below we can see a graph denoting the composition of Medicare income by source, how it changed from 1970 to 2014, and the projection for 2050 (Peter G. Peterson Foundation).

Based on the OMB website, since the program’s origins in 1965, funding has constantly increased. This can be seen as little back as the early 2000s when spending was only $175.3 billion, and in a matter of fifteen years the funding has increased by $409.7 billion. This is due in part to Part D being introduced in 2006 as well as an ever-increasing population of U.S. citizens over the age of 65. The projections through 2025 suggest that the cost of the program is only going to rise, with a projected budgetary increase to approximately $954 billion by 2025. This increase would encompass 3.5% of GDP by 2025 and 17.66% of the Federal Budget (Summary Tables). This begs the question as to whether this expensive program is effective or not?
Program Performance

Various agencies and websites rate governmental program performance. Four will be reviewed here: the Office of Management and Budget website, expectmore.gov; the rating produced by the Congressional Budget Office; the performance rating on the CMS website; and the annual performance plan and report created by HHS under the Governmental Performance and Results Act.

Under the George W. Bush Administration, the Office of Management and Budget created a program performance website, expectmore.gov. The rating indicates how well a program is performing. The rating system has four rankings: Effective, Moderately Effective, Adequate, and Ineffective, along with two other categories, Results Not Demonstrated and Total PARTs Completed. It was designed as a way for the public to see how effectively tax dollars were spent. Upon the inauguration of President Obama the website was not kept current, and is now simply considered archived data. Nevertheless, This website is still a good source of information on the effectiveness of Medicare. The website offers a historical view of the program and how it has performed up until 2008, which enables us to have a good foundation of the effectiveness of the program.

Medicare is considered Moderately Effective. This ranking of Moderately Effective is broken down into four assessment sections: Program Purpose and Design where Medicare received a score of 80%, Strategic Planning which received a score of 100%, Program Management which scored at 72%, and Program Results/Accountability which was scored at 67%.

Expectmore.gov states that a program is moderately effective if “in general, a program rated Moderately Effective has set ambitious goals and is well-managed. Moderately Effective programs likely need to improve their efficiency or address other problems in the program’s design or management in order to achieve better results.” Medicare received Moderately Effective because it “is successful in protecting the health of beneficiaries and is strengthening its management practices…in December 2003, the President signed the Medicare Modernization Act…and In its effort to improve linkages between Medicare payment and provider performance, the Centers for Medicare and Medicaid services is conducting a number of demonstration projects, including the Premier Hospital Quality Demonstration and the Physician Group Demonstration” (The White House, expectmore.gov).

This rating coincides with one produced more recently by the Congressional Budget Office. The CBO lists Medicare as an effective system based upon its ability to provide an efficient health care program, the cost of the program, and the amount of people that the program is able to service; however there are reports on cbo.gov stating that to help reduce the deficit, funding for Medicare should be altered. There were quite a
few options given, the two basic options being to cut funding from Medicare and the other being to raise the payroll tax (Congressional Budget Office).

Coinciding with the rating from both the OMB and the CBO, the CMS website, lists their performance as effective. They cite a website satisfaction survey that measures users’ satisfaction. CMS states that the average fourth quarter survey results across local, state, and federal websites was 75.1. They also have posted an audit results summary file. The file contains information from 34 audits. The results show that only five of the 34 audits scored Medicare below a five star review (2015 Star Rating. CMS). The only issue that they discuss is the issue of fraud and fraudulent coverage, which is downplayed.

The annual report released in April 2013 by the Department of Health and Human Services entitled Annual Performance Report and Performance Plan reflects the performance of the program for the year and a growth plan for the following year. The report focuses on four aspects: performance, results, hitting the mark, and success. The report breaks down the HHS structure, performance management and priority goals for the fiscal year. The report continues with a series of objectives to help improve the Department. The section in the report dedicated to Medicare was written by CMS, the department within HHS that is responsible for Medicare and Medicaid.

In their performance review CMS acknowledges the performance goals that HHS has set for CMS, stating that CMS continuously “strives to achieve meaningful progress and find lower-cost ways to achieve positive impacts, in addition to sustaining and spreading information on effectiveness and efficient government programs” (HHS, 2013, p. 12). The report states ”since the implementation of the Government Performance and Results Modernization Act, HHS has instituted significant improvement in performance management since FY 2011” (HHS, 2013, P. 12). The report continues on to state that the overall performance of CMS in regard to Medicare has been effective and they are now striving to make coverage more secure, improve both health care quality and safety, and make coverage affordable to those not insured.

**Recommendations**

For FY 2016 Medicare is proposed to be $585 billion, which is approximated at 3.1% of the GDP and 16.7% of the proposed federal budget (Summary Table). I believe that this is a reasonable projection for the program.

The program has been found effective by numerous evaluators within the government. I recommend the program funding level should be held steady at its current budget and not increased. While Medicare is an effective program, there is the greater issue of an ever-increasing deficit. Medicare accounts for nearly 20% of the federal budget and I believe that if we were able to put a cap on the amount of money it was allowed to receive, we could begin to reduce the deficit. I believe this due to my concern
of fiscal unsustainability. I believe that if spending is to increase as it has over the past fifteen years, we are going to see the United States face an extreme financial crisis.

Although Medicare is rated as an effective program, I however, recommend that serious consideration be given to the French healthcare system. The United States should look into disbanding Medicare and creating a much larger universal healthcare system that encompasses both the recipients of Medicare and the affordable health care act.

France has a national health care plan that is a combination of both public and private sector health care that provides coverage to all French citizens (NCBI). The program operates with individuals receiving health care through their employment with most individuals having supplemental private health insurance. The French government then pays the majority share of the medical bills through payroll and income taxes, and the rest is paid for by the individuals’ private supplemental insurance.

This program works very efficiently in France whose population is approximately 66 million. The United States has a population nearly five times that of France with about 319 million people. If a program like the one in France were to be adopted in the United States, there is the potential for complications due to the much higher scale that the program would be implemented at, however, I believe that the system could be adapted to fit our nation and its needs.

The United States should create a program that mirrors the health care system in France, taking into account the differences in size and individual need that the United States has. This program would not only alter nearly 20% of the annual federal budget, but it would transform one of the largest industries in the United States. This new system has the potential to reduce the cost of healthcare not just for individuals over the age of 65 or individuals with disabilities, but it has the potential to drastically reduce the cost of healthcare for every citizen in the United States (NCBI).