MEDICARE SPENDING AND FINANCING

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Overview

Medicare, a federally funded health insurance program, provides medical benefits to retirees and certain individuals with disabilities in the United States (MNT, 2013). This program helps 50 million Americans to pay for hospitalization, physician visits, prescription drugs, and other acute and post-acute services (TKFF, 2013). A national health insurance program was initially proposed by President Truman. He insisted that federal government should participate in health care. According to him "The health of American children, like their education, should be recognized as a definite public responsibility." This proposal targeted to insure all communities regardless of their income and provide access to doctors and hospitals (L&M, 2013). His request for national health insurance was introduced but died in congress three times. In 1961, President John F. Kennedy specifically recommended a national health insurance program that would cater to individuals over the age of 65 years. This population was main focus due to high poverty and lower insurance rate. In 1964, President Lyndon Johnson urged Congress to create a bill for the Medicare Program. Finally in 1965, Medicare bill was passed by Congress and Senate. It was signed into law by President Johnson on July 20, 1965. The program went into effect on July 1, 1966. Initially, more than 19 million Americans with age of 65 or more were enrolled in the Medicare program. In 1972, President Richard M. Nixon extended the eligibility of Medicare to individuals under age of 65 who have long term disabilities or end-stage renal disease. In 2003, President George W. Bush extended Medicare including prescription drug benefits by signing the Medicare Modernization Act (Susan, 2013).

This program is formed of two principle parts: Part A and Part B. Program also include two supplementary parts: Part C and Part D (MNT, 2013). Medicare Part A is a Hospital Insurance (HI) which covers inpatient care, skilled nursing facility care, hospice care, and home health care. It is available to eligible participants without a monthly premium. This portion is
covered by the contributions of taxpayers. Part B is a Supplementary Medical Insurance (SMI) which covers services from doctors and other health care providers, outpatient care, home health care, durable health equipment, and some preventive services. It is voluntary program and requires a monthly payment (Department of Health and Human Services, 2013).

Part C, also known as Medicare Advantage Plans, provide all benefit and services covered by Part A and Part B to eligible participants. It allows individuals to setup their own customized health plan that may or may not include participation from health maintenance organizations, preferred provider organizations, or other private insurance companies. Part D, administrated by Medicare-approved private companies, covers prescription drug cost. It allows insurance companies to offer different plans, covering a variety of drugs at different pricing options (Department of Health and Human Services, 2013; MNT, 2013).

**Medicare Spending**

In 2012, 16 percent of the federal budget was consumed by Medicare. Medicare has significant role in health care system counting 21 % of national health care spending, 28% of hospital care, and 24% on physician services in same year. Medicare benefit payments of $536 billion was consist of two-thirds for Part A and Part B services, more than 20% is for Part C, and 10% for the Part D (Figure 1). While this program is necessary for many individuals to get adequate medical care, the Medicare and Medicaid expenditures are projected to increase from the current 6 percent of GDP to 15 percent in 2040 with current trend. About 75 percent of this increase is due to faster rising health care cost as compared to GDP growth. Medicare spending are expected to increase annually by about 7.5 percent between 2008 and 2017 while increase in GDP will be 3.2 percent to 4 percent in same time period (The Henry Kaiser Family Foundation, 2013).
Figure 1: Medicare Benefit Payments by Type of Service, 2012

Source: The Henry Kaiser Family Foundation, 2013

Medicare Financing

The Centers for Medicare & Medicaid Services (CMS) which is branch of the Department of Health and Human Services (HHS) runs the Medicare program. Government gets revenue from various sources such as Medicare payroll tax, general revenue (primarily federal income taxes), premiums collected from beneficiaries, a tax on Social Security benefits (Figure 2). Mainly, two trust funds are used to finance Medicare program: Hospital Insurance (HI) Trust Fund and Supplementary Medical Insurance (SMI) Trust Fund. This trust gets funds from payroll taxes paid by most employees, employers, and people who are self-employed, income taxes paid on Social Security benefits, interest earned on the trust fund investments, and Medicare Part A premiums from ineligible individuals. Supplementary Medical Insurance mainly gets funds from premiums from people enrolled in Medicare Part B, Medicare prescription drug coverage (Part D), and interest earned on the trust fund investments. HI and SMI Trust Funds are used to pay
private Medicare Advantage plans to provide benefits under Parts A and B and, sometimes Part D to enrollees (Medicare, 2013; AAA, 2011).

**Figure 2: Estimated Source of Medicare Revenue, 2012**

![Figure 2](image)

Source: The Henry Kaiser Family Foundation, 2013

**Factors Affecting Medicare Spending Growth**

Rapidly increasing Medicare cost represent a flaw in the program when it is reviewed in the context of the federal budget. When discussion on health spending has expended, financing for Medicare is seen as reflection of the nation’s overall health care cost trends. Many other factors also contribute to increasing part of the economy devoted to health care. These include spending for high-need population and geographic variation in health spending. Growth in health spending is major contributor of Medicare spending growth, some other factors are significant drivers such as increased enrollment and aging population, enrollment in Medicare Advantage (MA), physician payment, Medicare Part D, and administrative costs (Potetz & Cubanski, 2009).

Number of individuals eligible for Medicare is increasing over time with an average of 587,000 per year. Individuals born during the Great Depression and World War II are enrolled in Medicare program from 1995 to 2008. Another generation, born in post World War II years, has become eligible for enrollment in the program. Net annual enrollment is anticipated to increase
with an average of 1.6 million from 2010 to 2030. It will represent not only more enrollees but also few workers will contribute to cover Medicare cost (Figure 3). Medicare Part D prescription drug benefit, enrollment in Medicare Advantage, and physician payment also contribute significantly in Medicare spending growth. However, administrative cost is the only factor which does not help to increase Medicare spending. It remains lower in long run, typically less than 2 percent, and covers all expenses by government in administering Medicare program (Potetz & Cubanski, 2009; Potetz et al., 2011).

**Figure 3: Worker-to-beneficiary ratio, selected years 1960–2060**

Source: Reznik et al. (2006)

**Conclusion**

To preserve Medicare financing in long run, a policy which either reduce Medicare care spending or increase revenue is required. Reducing spending will also help to lessen the federal budget deficit and debt. Therefore, a major challenge for policy maker is to discover methods to constrain Medicare spending growth without influencing patient care, placing fair price of plans etc. President Obama has looked at health reforms to deal with these challenges faced by Medicare. The American Recovery and Reinvestment Act of 2009 provides funding for
comparative effective research and implementation of electronic health records etc to improve the efficiency of health care. The 2010 health reform law includes various changes which planned to reduce the growth in Medicare spending, at the same time improving the quality health care.
References


