Still Changing: Medicare Turns 50

EYE ON WASHINGTON: GAIL R. WILENSKY

MEDICARE HAS SEEN A LOT OF CHANGES OVER THE PAST 50 YEARS, BUT WITH THE DELIVERY OF HEALTH CARE EVOLVING AND THE BABY-BOOMER POPULATION AGING, EVEN MORE CHANGES ARE TO COME.

Recognizing Medicare's 50th birthday is particularly poignant to me because I was the administrator running the program when it had its 25th birthday, which I regarded as a significant milestone for what arguably has been our nation's most important social welfare program. Now, with the passage of another quarter-century, I am struck by how the program has evolved and grown.

When it started in 1966-a year after having been signed into law-Medicare covered 19 million people and spent $1.8 billion. Today, Medicare covers almost 55 million individuals, including about 9 million who are disabled, within a budget (net of Part D premiums) of almost $600 billion in 2015.

An Evolving Healthcare System

One reason the Medicare program has changed so much since its inception is that the nation's entire healthcare system has changed significantly. When Medicare was established, the program resembled plans offered by Blue Cross Blue Shield, the dominant insurer of the mid-1960s. Benefits were primarily focused around inpatient and outpatient hospital care and physician care. Hospitals were paid on a per diem basis, and physicians were paid according to the prevailing *usual, customary, and reasonable* fee schedules of the time.

Added Benefits

A substantial array of benefits has been added over the past 50 years-some reflecting coverage changes occurring in the private sector. These benefit expansions have included various preventive services such as mammography, pneumococcal vaccines, and colorectal screening; expanded home healthcare coverage in the 1980s; and the outpatient prescription drug benefit adopted in 2003.

Some expansions reflect the clear recognition of a sorely needed benefit that other insurers were not providing. In 1972, for example, Medicare extended coverage of end-stage renal disease (ESRD) to individuals of any age after it became clear that the approaches used for covering ESRD in many states were inconsistent and scattershot, with a few states using lotteries to determine who would receive benefits. In 2001, Medicare coverage was extended to individuals under the age of 65 with amyotrophic lateral sclerosis (ALS), often referred to as Lou Gehrig's disease.

Benefit expansions continue to be considered. As recently as July 8, the Centers for Medicare & Medicaid Services (CMS) proposed paying physicians for end-of-life counseling. Today, Medicare covers this type of counseling only if it is part of a routine annual wellness examination. Although a similar proposal triggered a storm of protests in 2009, with charges of government-run "death panels," the current proposal seems to have generated little response to date.

Changing Payment

Medicare also has dramatically changed the way it pays the physicians and institutions that deliver services to beneficiaries. In 1983, the program began moving away from cost-based reimbursement to a system of prospective payment with the adoption of DRGs for inpatient hospital services. Under DRGs, hospitals are paid on the basis of the diagnosis at discharge rather than a per diem charge. This type of prospective payment has since been introduced for outpatient hospital care, episode-based home care, and nursing home care (with payment for the last based on RUGs, or resource utilization groups).

The most recent payment change came this past spring, when Congress passed a bill removing the sustainable growth rate spending limit-which was used to prevent spending on physicians from exceeding the growth rate in the economy-and put in its place a 0.5 percent annual increase over four years while Medicare transitions to an incentive-based payment system. As with the value-based purchasing programs introduced for other parts of Medicare under the Affordable Care Act (ACA), physician payments will be based on a merit-based incentive payment system starting in 2019.

A Slow Departure from Traditional Medicare

The slowest change in Medicare from the 1960s probably has been in its healthcare delivery approach. In the 1980s and 1990s, for instance, even as the rest of health care was moving away from fee-for-service indemnity insurance to HMOs, network plans, and other types of managed care arrangements, the majority of Medicare beneficiaries remained in "traditional" Medicare-and such is the case today. Meanwhile, beneficiaries have been offered an alternative to traditional Medicare since the 1980s, when private insurance plans that contained at least the same benefits as traditional Medicare were first offered under a program now called Medicare Advantage (MA).

Over the years, this program's name evolved with changes in how the plans calculated payments from Medicare. Currently, 31 percent of beneficiaries have chosen to participate in MA, and payment for these beneficiaries' care is based on a competitive-bidding model. Those who choose MA plans tend to be disproportionately minority with low incomes (but above the Medicaid cutoff), and they tend to find MA more attractive than supplementary "Medigap" plans as a means to supplement their basic Medicare benefits.

Challenges Ahead

Although Medicare remains very popular among seniors, it faces serious fiscal challenges. Like all of health care, Medicare has seen slow spending growth these past few years, even declining modestly on a per capita basis. However, much of the healthcare spending slowdown reflects the lingering effects of the extended recession.

Meanwhile, Medicare has been experiencing favorable fiscal effects from large numbers of "young seniors" joining the program and from lower Medicare payments to providers as legislated by the ACA. Whether the legislated reductions in payments continue will depend in part on the feasibility of reducing the cost of delivering services to beneficiaries, which in turn will depend on whether innovative initiatives being pursued in the public and private sectors-such as accountable care organizations, patient-centered medical homes, and bundled payment-can produce sustainable savings. It is too early to know the answer to these questions.

In addition to concerns about Medicare spending per beneficiary, the program also faces enormous fiscal pressure from the shifting demographics of the U.S. population and the aging of the baby boomers. Baby boomers started reaching 65 in 2011. By the time the last of the boomers reaches 65 in 2030, Medicare's rolls will have increased from the current 55 million to 82 million. The enormity of the challenge ahead becomes clear when one considers that the burden of ensuring that Medicare as it exists today continues to serve this growing population will fall upon a shrinking workforce. As with other issues involving the nation's seniors, the sooner we can decide on how to tackle these changes, the better, because earlier action will allow for a more gradual change in program structure. Nonetheless, as with all such changes, the political challenges are even more daunting than the fiscal ones.

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