



# CRS Issue Statement on Medicare Reform

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**M**edicare is the nation's federal insurance program that pays for covered health services for most persons 65 years and older and for most permanently disabled individuals under the age of 65 years. It consists of four parts, each responsible for paying for different benefits, subject to different eligibility criteria and financing mechanisms.<sup>1</sup> The rising cost of health care, the impact of the aging baby boomer generation, and declining revenues in a weakened economy continue to challenge the program's ability to provide quality and effective health services to its 45 million beneficiaries in a financially sustainable manner.

Similar to other purchases of health care, Medicare spending has been growing much faster than the general economy, and concerns about Medicare's long-term sustainability continue to intensify. Studies by the Congressional Budget Office, the Medicare Payment Advisory Commission and others attribute most of the cost growth to the development and increasing utilization of new treatments and other forms of medical technology. The Medicare trustees estimate that if Medicare benefits and payment systems remain as they are today, the Hospital Insurance trust fund will become insolvent by 2017. These financial pressures are likely to result in Congress considering changes to control Medicare expenditures, such as reducing provider payments or program benefits, and/or to raise additional revenues, such as through increasing taxes or beneficiary cost-sharing.

As an entitlement program, Medicare is required to pay for services provided to eligible persons, so long as specific criteria are met. Medicare is also, by statute, prohibited from interfering in the practice of medicine or the manner in which medical services are provided. Medicare therefore pays for virtually all covered products and services if they are determined to be medically necessary. In such a system, there are inherent incentives for providers and suppliers to focus on the volume of procedures and services provided rather than on beneficiary health outcomes. As part of the broader discussion of health care reform, the 111<sup>th</sup> Congress has explored proposals to create incentives to provide efficient and quality care through such means as care-coordination, quality monitoring, and program oversight.

Congress confronts a delicate balancing act in weighing financing issues against the need to provide and maintain access to appropriate, high quality medical care for Medicare beneficiaries. While Medicare provides coverage for the aged and disabled, it does not guarantee access to care. Beneficiaries under traditional fee-for-service Medicare must seek care from available and accessible providers. However, the decision to participate in Medicare (and the extent of such participation) is at the discretion of the provider or individual practitioner. Recent physician payment freezes and the potential for future reductions have accelerated concern that a growing number of Medicare beneficiaries will be unable to find a provider who will care for them. Patient advocates are concerned that certain groups (racial minorities, lower income individuals

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<sup>1</sup> Part A, the Hospital Insurance program, covers hospital services, up to 100 days of post-hospital skilled nursing facility services, post-institutional home health visits, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of medical services including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Part B also covers some home health visits. Part C provides private plan options, such as managed care, for beneficiaries who are enrolled in both Parts A and B. Part D provides optional outpatient prescription drug coverage.

or beneficiaries in rural areas) may face even greater obstacles in accessing necessary health services.

In the face of ballooning Medicare costs, particular attention is being placed on stemming the rapid growth in program spending. Generally, potential solutions focus on restricting provider payments through curtailing payment updates. Within this framework, payment changes affecting physicians, practitioners, suppliers, and providers are likely to spark discussion and warrant attention. Consideration is also being given to reducing payments to Medicare Advantage plans so that they are more in line with costs under the fee-for-service portion of the program. At the same time, however, policymakers are confronting the challenge of determining how to finance increases in physician payments and improvements to the current benefit structure, such as closing the prescription drug benefit doughnut hole.

Additional changes are being considered to improve financial incentives for providers to produce appropriate, high-quality care at an efficient price. Changes could include the development of new service delivery and payment methods such as bundled payments, value-based purchasing and accountable care organizations (in which a group of providers share responsibility for the cost and care of patients). Methods are also being considered to reduce vulnerabilities in program integrity, such as improving the screening of potential Medicare providers and identifying overpayments more quickly. Health care delivery models established within Medicare could stimulate similar improvements in the broader health care delivery system.

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