MBA 581
Managed Care Systems, Insurance, and Regulations
Lecture 5

Medicare, Medicaid, and Military

Medicare – elderly and disabled primarily. 100% federal government/tax funded (Buchbinder, Shanks, & Buchbinder, 2014; Kongstvedt, 2013).

To understand the impact of Medicare is to understand the millions of men, women, and children who receive insurance coverage under this program. Since 1966, Medicare has provided coverage primarily to the senior citizens of the United States. Although the program was developed as a concept to protect the most vulnerable of the older population, with the passage of time, more groups have been added under the umbrella of Medicare. Medicare also covers other medical concerns that are not age related, such as End Stage Renal Disease (ESRD). Today, Medicare is considered an entitlement program with no limits on growth in the foreseeable future. The impact of Medicare is significant. Senior citizens are living longer, they are healthier, and they certainly want the best that medicine and technology can provide. At the other end of the spectrum are the vulnerable children, women, and medically fragile who are covered under Medicaid and who are also looking for funding from the same wallet that is used for Medicare. Indeed, Medicare has implemented a number of programs aimed at corralling healthcare costs, providing appropriate care, and developing and implementing outcomes management while remaining consistent with the original intent of the Medicare program. On the horizon, however, is another more pressing problem related to the fiscal solvency of Medicare funding which is estimated to become bankrupt by 2026.

The United States realizes that, with all of the money and technology that is being provided to the recipients of Medicare, the number of men and women working in healthcare has declined. Specifically, there are fewer nurses, and the average age continues to increase well above the mid-40s. Fewer physicians are choosing to specialize in primary care or in care related to older adults. Many factors influence this decline; however, stress, compensation, and increasing regulatory requirements are the top reasons why physicians are not choosing primary care as a specialty. With a declining work force and an increasing patient population, a collision course is all but certain. Although the focus this week is on Medicare, Medicaid, and other social programs, it is important to understand the impact of the work force on the delivery of care to not only Medicare and Medicaid populations, but also to all the men and women seeking care.

- Established in 1966, Part A is hospital insurance provided by Medicare. Most people do not pay a premium for this coverage. Part A covers inpatient care in skilled nursing facilities, critical access hospitals, and hospitals. Hospice and home healthcare are also covered by Part A.
- Established in 1966, Part B is medical insurance to pay for medically necessary services and supplies provided by Medicare. Most people will have to pay a premium to receive this coverage. Part B covers outpatient care, doctor's services, physical or occupational therapists, and additional home healthcare.
- Established in 1996, Part C (Medicare Advantage Plan also known as Choice and largely based on managed care tenets of HMOs). Part C is the combination of Part A and Part B. The main difference in Part C is that it is provided through private insurance companies approved by Medicare. With this program, you may have lower costs and receive extra benefits.

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- Established in 2003, Part D is stand-alone prescription drug coverage insurance. Most people do have to pay a premium for this coverage. Plans vary and cover different drugs, but all medically necessary drugs are covered. You can choose what drug plan will be best suited to your needs. Pay-4-performance incentives are also part of this Medicare plan.

Medicaid – those below poverty level primarily. 50/50 funded by federal and state government/taxes (Buchbinder, Shanks, & Buchbinder, 2014; Kongstvedt, 2013).
Medicaid was developed as the principal program of healthcare for people who had low incomes. It was originally patterned after private insurance; however, costs were far above estimates, and the plan was challenged by rapid growth in membership, along with the cost of medical care and the associated inflation.

Medicaid enrolls three distinct populations:

- healthy men, women and children who meet certain poverty level income requirements;
- older, as well as younger, people with chronic illness and disability; and
- institutionalized men, women, and children, as well as those who require 24-hour per day care that cannot be adequately delivered in a private home setting.

With the astonishing growth in these distinct populations, and with the associated financial cost of care, several states began looking to managed care models to address the delivery of care, access to care, cost of care, and quality of care outcomes management and expectations. Medicaid has experienced growth in overall program participation. However, problems with provider reimbursement, quality outcomes, and unstable patient populations have resulted in declining provider participation. This decline in provider participation has contributed to the domino effect of limited access to primary and preventative care services, thus forcing Medicaid beneficiaries to use inappropriate sites for care, such as Emergency Departments. To address rising cost concerns, quality, and appropriate access, many states have looked to managed care as a way to gain control of the overall delivery of healthcare to the Medicaid population. States have had mixed results regarding the overall transition of their Medicaid populations to managed care models. Most programs with successes are related to children's health plans (CHIP or SCHIP) and health outcomes. These transitions have required a great deal of planning and research, as well as time for preparation and implementation. Deliberate consideration has be given to the types of care models needed, eligibility requirements, a process for enrollment, communicating choice options, contract specifications, compensation and rates, provisions for quality monitoring, and oversight. Without a doubt, communication is key to any successful transition. The current feedback is that many states have had difficulties transitioning Medicaid recipients into managed care models. On the positive side, Medicaid managed care has made successful gains in several areas, including access, cost, quality and outcomes, consumer satisfaction and responsiveness, accountability, and devolution. Medicaid has improved the overall effectiveness of its administrative services, and it has addressed the concerns of special-needs groups. Despite its many successes, Medicaid has fallen short in a number of areas, including providing measurable, positive outcomes.

As Medicaid looks to the future, like other managed care programs, it will have to face new, as well as renewed, challenges. Some of these include rising premiums, higher expectations from customers, an increase in regulatory mandates, stricter policies, provider consolidation and provider withdrawals from the program, hostile contracting environments, and rates that may vary widely. In essence, the future of Medicaid managed care will depend on the development of key long-term issues, such as the following:

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- Developing stronger relationships with policy makers
- The realistic alignment of consumer and organizational expectations with the ability to pay
- Developing sustainable relationships with high-quality managed care plans
- Maximizing the efforts to mainstream Medicaid beneficiaries, where possible, while appropriately maintaining the safety net providers
- Continuing to evaluate the value of care compared to the cost of care

Military – active duty and retired military primarily. 100% federally funded by tax monies (Buchbinder, Shanks, & Buchbinder, 2014; Kongstvedt, 2013).
Air Force, Army, Marines, Navy, Coast Guard, Army National Guard, Army Reserve, Marine Corps Forces Reserve, Navy Reserve, Air National Guard, Air Force Reserve, Coast Guard Reserve, Veterans Affairs – VA, and other select Department of Defense personnel comprise nearly 10% of the entire U.S. population (~2.5 million active in 2014) at some point in their lives and provided healthcare through military facilities (e.g., Walter Reed National Medical Center, Brook Army Medical Center, and many more); private healthcare providers paid for by CHAMPUS/CHAMPVA or Tricare insurance. This is a unique governmental health program and despite the fact that the population is comprised of relatively young and healthy individuals, the costs spent on military/VA healthcare far exceed those spent on Medicare. Why? Think about the exorbitant costs associated with the surgeries, long-term care requirements of our veterans wounded in combat (we have been in some kind of conflict with military casualties and injuries since February 1991 with the liberation of Kuwait for Iraq occupancy and still deployed in Iraq, Afghanistan, and other countries). According to the Congressional Budget Office (CBO) 2014, the U.S. spent $52 billion on military related healthcare in 2012. While that is a lot of money, Medicare spent nearly 10 times more ~$500 billion, but on a much larger population ~50 million individuals. When calculated on the individual population for military and Medicare programs, the military spends about the same amount per individual as Medicare does ~$10,000 per individual per year on healthcare. Again, that may not sound like an exorbitant amount until you start multiplying by millions of individuals who qualify for those programs…all of which must be supported by our tax dollars. Room for improvement?

Yes, room for improvement for all government programs (Medicare, Medicaid, and Military). There is a unique opportunity to cut healthcare costs, but provide a more realistic (reasonable and necessary) reimbursement to providers to avoid cost shifting which only serves to exacerbate health insurance costs and healthcare costs in general. Part E Medicare?

(Oestmann, 2014)

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