

CHAPTER 4

MEDICARE

MEDICARE BY THE NUMBERS (2007)

Part A: Total Beneficiaries	44.1 million
Elderly beneficiaries	36.9 million
Disabled beneficiaries	7.2 million
Total Income	\$ 461.9 billion
Hospital Insurance Part A	\$ 223.7 billion
Supplementary Medical Insurance Part B	\$ 188.7 billion
Supplementary Medical Insurance Part D	\$ 49.5 billion

Source: Centers for Medicare & Medicaid Services. *2008 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds* (Baltimore, MD: Centers for Medicare and Medicaid Services, 2008).

Introduction

Medicare is the federal health care insurance program for the elderly and disabled. Medicare was created in 1965 as part of President Lyndon Johnson's Great Society and helps pay the medical bills of nearly all Americans over age 65 as well as those receiving disability benefits or those with serious kidney problems. As a result, a higher percentage of senior citizens have health insurance than any other age group in American society.

Medicare is divided into three parts:

- *Part A*, which basically pays for inpatient hospital care. It is funded by taxes paid by current employers and employees and is automatically made available to eligible Americans.
- *Part B*, which covers outpatient services including physician visits. Those eligible have the option of participating by paying a monthly premium. This covers approximately one-quarter of the program's annual cost. The government uses general revenues to pay the remainder of the bill.
- *Part D*, which pays for non-hospital prescription drugs. It is funded by beneficiary premiums, transfer payments from the federal treasury, and transfers from state governments. Premiums are to cover 25.5 percent of Part D costs.

Medicare is administered by the Centers for Medicaid & Medicare Services (CMS), an agency within the U.S. Department of Health and Human Services (HHS). Prior to a restructuring in 2001, CMS was known as the Health Care Financing Administration (HCFA).

The History

The idea of some sort of national health insurance program was left over from the New Deal of the 1930s and had been on the political agenda intermittently since the end of World War II. Beyond philosophical and financial challenges, the possibility created several thorny political questions. One was whether the government could pay for services without nationalizing the health care delivery system, an idea for which there was scant enthusiasm. Another was whether the program should be a broad-based one that provided benefits to all or a welfare plan that aided only those who could not afford to pay their own health care bills. A subsidiary argument involved whether governmental control should be exercised at the state or national level.

Pressure to overcome these obstacles culminated during the mid-1960s with enactment of a massive bill amending the Social Security Act that included the following provisions:

- Creation of the Medicare program for those already covered by Social Security, basically providing health insurance for those over age 65.
- Medicare benefits would be paid through Part A (basically hospital benefits), which was universal, and Part B (generally outpatient benefits), which was optional.
- Medicare would reimburse costs in much the same way that traditional commercial medical insurance had done.
- Another new medical assistance program, Medicaid, would be created to provide health insurance for the indigent (including older Americans who required nursing home care they could not afford). This program would be administered by the states, which would have substantial leeway in setting rules as to who was eligible for coverage of what costs, and which of them would also be partly responsible for the costs.

From the start, Medicare was very popular, since about half of the senior population lacked health insurance at the time the program was enacted. Also from the start, Medicare was much more expensive than anticipated. The effort to keep income and costs in balance led to regular debates about how to restrain reimbursements to health care providers. There has never been any serious political discussion about reducing benefits, which have been expanded over the years.

Eligibility

Most Medicare beneficiaries are individuals over age 65, with a work history adequate to make them eligible for Social Security retirement payments, and their eligible dependents. Younger former workers become eligible after receiving Social Security disability for two years. While Medicare taxation was initially linked to inclusion in Social Security, it was broadened in 1994 to include the minority of workers who remain outside the Social Security program.

Additionally, Medicare benefits are available as part of the End-Stage Renal Disease (ESRD) program for individuals who would otherwise be eligible for the disability program, and their dependents, if they have kidney disease serious enough to require dialysis or a transplant. Those in the ESRD program are in Medicare but do not receive cash benefits and may work as much as they choose to. Those in the disability program, by contrast, receive cash payments comparable to Social Security retirement in addition to their health insurance, and must be unable to do substantial gainful work.

Financing

Part A—Medicare Part A is financed by a 2.9 percent payroll tax, split evenly between employers and employees (1.45 percent each). The self-employed are required to pay the full amount, but receive some tax relief. The original rate, first collected in 1966, was 1 percent. Initially, payroll subject to the Medicare tax was capped at the same figure used by the Social Security retirement plan, but a higher limit was set in 1991 and the upper limit was removed entirely in 1994. As a result, some upper-income workers face Medicare taxes that exceed their Social Security tax payments. The current tax rate became effective in 1986. Those who do not have a sufficient work history to qualify have the option of buying Part A coverage by paying a premium that is adjusted annually (in 2009, it was \$443 monthly for those with fewer than 30 quarters of covered work and \$244 monthly for those with 31–39 quarters of covered work). In recent years, Part A has typically collected more than was required for operations and has loaned that money to the government to finance other programs.

Part B—Approximately three-fourths of Part B spending comes from the federal Treasury out of general revenues. The remainder, less interest payments earned, comes from monthly premiums (\$96.40 in 2009) paid by beneficiaries who choose to buy this coverage. As a rule, this is a one-time election made when the beneficiary becomes eligible for Part A. If no election is made, the beneficiary is automatically enrolled in Part B. Nearly everyone eligible chooses Part B coverage.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires the Medicare Part B premium to be related to income starting in 2007. By 2011, premiums will increase with income. Medicare beneficiaries with income under \$85,000 (\$170,000 for a married couple) will continue to be required to pay 25 percent of the cost of Part B (\$96.40 in 2009). However, beneficiaries with income between \$85,001 and \$107,000 will be required to pay 35 percent of the premium (\$134.90 in 2009), and beneficiaries with income of at least \$213,000 will be responsible for 80 percent of the premium (\$308.30 in 2009) to enroll in Part B. These income levels will also be indexed to general inflation.

Part D—Part D will be financed by beneficiary premium payments, transfers from the general fund of the Treasury and transfers from state governments. Premiums are to account for 25.5 percent of the total costs of Part D. The national average monthly premium for the basic Medicare drug benefit in 2009 is projected to be approximately \$28. (Centers for Medicare & Medicaid Services, 2008a).

Medicare Reimbursement

Part A—At the outset, Medicare basically reimbursed hospitals for their costs. In addition to requiring a substantial bureaucracy to audit the accuracy of submitted reimbursement requests, this system created an inherent upward pressure on costs because there was no incentive for hospitals to contain them: If costs were reduced, reimbursements would drop as well (reimbursements were on a cost-plus basis). While Medicare created new demand for health care services (as anticipated), nonetheless, there was soon an oversupply of hospital beds caused both by government capital subsidies for hospital construction during prior decades and by medical improvements that reduced the average hospital stay. The Medicare reimbursement system helped support hospitals with low occupancy rates or low payment rates (those that provided a lot of uncompensated care). Because there was a widespread belief that declining occupancy rates were driving Medicare costs up, the government responded with increasingly comprehensive regulations in an effort to restrain Medicare costs.

Finally, in 1983, the system had gotten so complex and creaky that a basic change was made in which the government paid a set price without regard to actual hospital costs. In other words, a price was set for a given diagnosis for a type of patient in a particular location (say a 70-year-old otherwise healthy man in New York City with a broken leg), and the government paid a fixed amount, regardless of the costs the hospital actually incurred to treat the patient. If actual hospital costs were lower, it could keep the difference. If they were higher, the hospital would suffer a loss and would

be reimbursed only if the case was significantly expensive to be classed as an “outlier” (lying outside the established norm for length of stay and total cost of care).

Embedded in this reimbursement system—called diagnostic related groups (DRGs)—were assumptions about the average hospital stay required for a given diagnosis. This led to complaints from some patients who claimed they were being discharged from hospitals prematurely because Medicare refused to pay for a longer stay.

The DRG system was designed to reward efficient hospitals. But it also gave the government a formula that could be used to restrain total reimbursement costs regardless of the actual costs incurred by any particular hospital. This system is the basis of Part A reimbursement today.

Part B—From the start, Medicare used the same basic system for reimbursing physicians that private health insurance used, but with the requirement that a physician’s total bill not exceed the Medicare limit. With most private insurance, plan payments were limited, but physicians were free to bill the patient for amounts that significantly exceeded that amount. For instance, if a physician charged \$200 for a procedure and insurance only paid him \$25, he was free to bill the patient for the other \$175. But Medicare imposed caps: If the Medicare allowable amount for a procedure was \$100 and the plan paid \$80, the physician could bill the patient no more than \$20, regardless of what non-Medicare patients were being billed for the same procedure. Individual physicians could decide whether to participate in Medicare, but had to make a single election for their entire practice.

The pre-existing system had a bias toward surgical intervention rather than diagnostic skill, which led to relatively low payments for physicians doing internal medicine and other specialties classed as cognitive (this reflected the fact that the private health insurance system was originally structured to pay for large unanticipated expenses, like surgery, and not for preventive medicine like vaccinations). An indirect—and expensive—outcome of this bias was that Medicare beneficiaries were more likely to resort to surgical interventions for any given problem.

In 1992, the government imposed a new equilibrium by adopting a resource-based relative value scale (RBRVS) that compensated physicians based on the resources that their services required and tended generally to reward cognitive specialists at the expense of surgeons. As a result, all physician reimbursement under Medicare Part B rises at the same rate, and the ratio between one type of service and another remains constant over time. As with the introduction of the DRG system earlier in the decade, this change also gave the government greater control over program-wide spending.

Benefits

Part A—A Medicare beneficiary who requires hospitalization is required to pay a deductible (adjusted annually, \$1,068 in 2009). After 60 consecutive days of hospitalization, the beneficiary must pay a daily copay (adjusted annually, \$267 in 2009) through the 90th day. If continuing hospitalization is required, the patient can draw on a lifetime reserve of 60 added days by paying a higher daily copay (\$534 daily in 2009, adjusted annually). The average hospital stay for a Medicare beneficiary is less than a week.

Medicare does not provide catastrophic protection. Such coverage was added along with some prescription drug reimbursement in 1988, but the responsible legislation was repealed the following year after some senior citizens complained about having to help pay for the extra charges.

Post-hospital nursing home care is covered for up to 100 days if the beneficiary requires nursing care or rehabilitation services. Starting with day 21, a copay is required (\$133.50 daily in 2009, adjusted annually). However, Medicare does not pay for long-term custodial nursing home care. As a rule of thumb, Medicare will only pay for a nursing home stay that improves the beneficiary's condition and returns him or her to the community.

Part A also pays for some home health care and for hospice care services for terminal patients (those expected to live less than six months). The use of Medicare benefits is calculated based on benefit periods and reserve days. The benefit period is the block of time used to determine how much of a deductible and/or co-pay the beneficiary owes. A benefit period begins and ends when he or she has been out of the hospital for 60 consecutive days. For example, if a beneficiary enters the hospital on November 10, 2009, and is released on November 24, 2009, he or she is liable for \$1,068. If the beneficiary is re-admitted to the hospital on December 20, 2009, and released on December 26, 2009, he or she does not have to pay another \$1,068. The beneficiary is liable to pay the deductible per benefit period, not per admission. The benefit period on this example runs until January 24, 2010.

Part B—After a \$135 annual deductible is met, Part B partially pays for physician services, x-rays and tests, some preventive services, a few drugs (including 36 months of immuno-suppressive drugs) after an organ transplant, and some home health services. As a general rule, Part B pays 80 percent of the approved Medicare fee for a given service and beneficiaries are responsible for the remainder. As a condition of participating in the program, providers are barred from charging more than the fee set by Medicare.

Part D—The following are the cost-sharing provisions for Part D estimates for 2009:

- A deductible of the first \$295.

- On drug purchases of \$296 through \$2,680, Medicare pays 75 percent of the costs, and beneficiaries pay the remaining 25 percent.
- On drug purchases of \$2,681 through \$4,350, Medicare does not pay anything, meaning beneficiaries pay 100 percent of the cost of prescription drugs.
- On drug purchases above \$4,350, Medicare pays 95 percent of the costs, and beneficiaries are responsible for only 5 percent.

Medigap Coverage

A Medigap policy is health insurance sold by private insurance companies to fill the “gaps” in original Medicare plan coverage, covering some of the health care costs that the original Medicare plan doesn’t cover.¹ Insurance companies can sell only a “standardized” Medigap policy, which must have specific benefits listed so they can be compared easily. Beneficiaries may be able to choose up to 12 different standardized Medigap policies (Medigap Plans A through L), which must follow federal and state laws and must be clearly identified on the policy cover as “Medicare Supplement Insurance.” Each plan, A through L, has a different set of basic and extra benefits, but the benefits are the same from any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Because costs can vary, Medigap policies should be compared carefully. Generally, in order to buy a Medigap policy, you must have both Medicare Part A and Part B, and will have to pay the monthly Medicare Part B premium as well as a premium to the Medigap insurance company. Each spouse wanting Medigap coverage must buy an individual policy.

Medicare Advantage

Over the past 40 years, Congress has enacted various laws (often aimed at controlling costs) that permit Medicare beneficiaries to choose to receive their Medicare benefits through private health plans, as opposed to the original fee-for-service arrangement. In 1997, the Balanced Budget Act established the Medicare+Choice program, which expanded private plan options and changed payment schedules that ultimately resulted in a decline in enrollment. In 2000, the Benefits Improvement and Protection Act created Medicare payment floors for urban areas, enhancing payments. In 2003, the Medicare Modernization Act renamed the “Medicare+Choice” program the “Medicare Advantage” program, further increasing payments and authoriz-

¹ For more information on Medigap, see www.medicare.gov/medigap/default.asp. A CMS publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, is available online at www.medicare.gov

ing two additional plan types. In 2008, additional changes were included in the Medicare Improvements for Patients and Providers Act.²

Medicare Advantage Plans include:

- Medicare health maintenance organizations (HMOs).
- Preferred provider organizations (PPOs).
- Private fee-for-service plans.
- Medicare special needs plans.

Generally, most of these plans have extra benefits and lower copayments than the original Medicare plan, but require beneficiaries to see doctors that belong to the plan or go to certain hospitals to get services.

In order to join a Medicare Advantage Plan, you must have Medicare Part A and Part B, will have to pay your monthly Medicare Part B premium to Medicare, and in addition might have to pay a monthly premium to the Medicare Advantage plan for the extra benefits they offer.

Medigap policies do not function with a Medicare Advantage plan, which means they won't pay any deductibles, copayments, or other cost-sharing expenses under your Medicare health plan. While beneficiaries have a legal right to keep their Medigap policy, many choose to drop the Medigap policy if they join a Medicare Advantage plan.³

Bibliography

Centers for Medicare & Medicaid Services. Office of the Actuary, 2008
Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds. Baltimore, MD: 2008b.
www.cms.hhs.gov/ReportsTrustFunds

Centers for Medicare & Medicaid Services and the National Association of Insurance Commissioners, 2009 *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*. Baltimore, MD: 2008c.
www.medicare.gov/Publications/Pubs/pdf/02110.pdf

² See the Kaiser Family Foundation fact sheet on Medicare Advantage programs at www.kff.org/medicare/upload/2052-11.pdf

³ For more information, see www.medicare.gov/Choices/Advantage.asp

Additional Information

Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
(800) 633-4227
www.cms.gov
www.medicare.gov