

UNDERSTANDING MEDICARE

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Congress created Medicare in the Social Security Act of 1965. In 2011, Medicare provided health insurance to more than 48 million people, including over 1 million Missourians.¹ As our population ages, total enrollment is expected to rise to 64 million by 2020, and 81 million by 2030.² Unlike Medicaid, states do not help fund or administer Medicare; it is an entirely federal program.

This report explains how health insurance under Medicare works, including: (1) benefits; (2) eligibility; (3) cost-sharing; (4) provider reimbursement; and (5) financing and expenditures. Enacted in 2010, the Patient Protection and Affordable Care Act (commonly referred to as the ACA)³ makes a number of reforms to Medicare intended to reduce costs and improve the quality of care. These include:

- Eliminating cost-sharing for preventive services;
- Eliminating the “donut hole” in Part D prescription drug coverage;
- Adding a comprehensive checkup and personalized prevention plan to Part B benefits; and
- Paying hospitals and physicians based, in part, on the quality of care they provide.

Changes to Medicare specific to the ACA are discussed throughout.

Contents

Benefits.....	1
Eligibility.....	3
Cost Sharing	4
Provider Reimbursement	7
Financing and Expenditures.....	9
Summary	10
Online Resources	10

Benefits

There are four parts to Medicare:

- Part A covers inpatient hospital stays,
- Part B covers physician services,
- Part C is Medicare Advantage, and
- Part D covers prescription drugs.

Parts A and B are fee-for-service: enrollees choose their providers, and the government pays providers directly for services. In contrast, Medicare Advantage is a voluntary program in which the government pays a private company to administer Part A and B benefits. The government also pays private companies to provide prescription drug benefits in Part D.

Part A – Hospital Insurance

Part A covers inpatient hospital care, including such costs as rooms, laboratory tests, X-rays, and inpatient prescription drugs. Medicare covers these costs for up to 90 inpatient days in a benefit period, which starts when a person enters the hospital, and stops when no inpatient hospital or skilled nursing

care has been provided for at least 60 consecutive days. Enrollees also have an additional lifetime reserve of 60 days that can be used to cover days 91 and up in a given benefit period.

Part A also covers medically necessary stays in skilled nursing facilities (i.e., nursing homes) if they occur within 30 days of a hospitalization of at least 3 days; the first 100 visits by a home health agency following a 3-day hospital stay or skilled nursing facility stay; and hospice care. Medicaid, not Medicare, pays for most nursing home stays.

Part B – Supplemental Medical Insurance

Part B is a voluntary program that pays for the services of individual providers, such as physicians, psychologists, social workers, and nurse practitioners. Part B also covers other goods and services, including durable medical equipment (DME) for the home, emergency room care, diagnostic tests, and physical and occupational therapy. In 2011, the ACA added a free annual comprehensive wellness visit and personalized prevention plan to covered Part B benefits.

Part C – Medicare Advantage

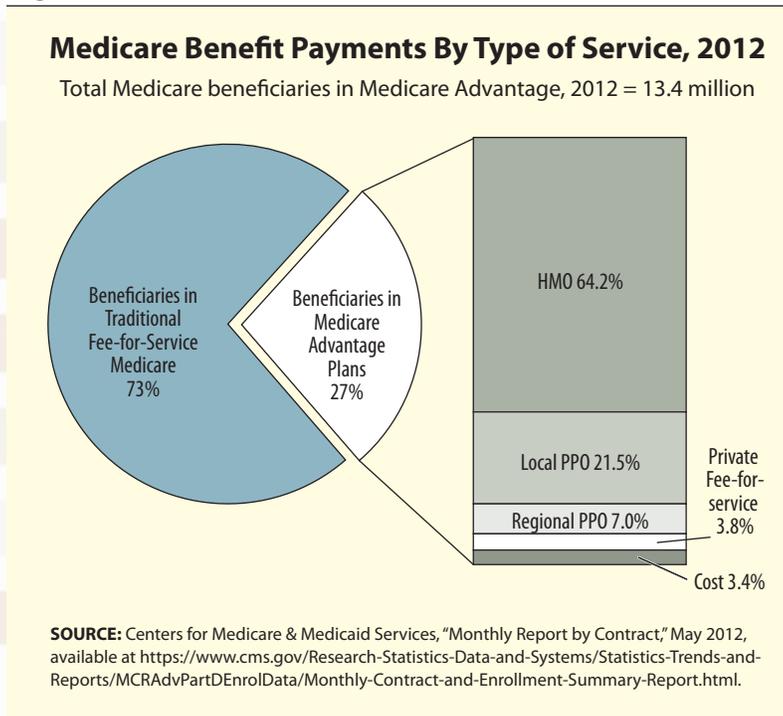
While Medicare has included private plans since the 1970s, enrollment in Medicare Advantage was relatively low until recently.⁴ Since 2005,

participation has more than doubled to 13.4 million people (about 27% of all Medicare beneficiaries).⁵ The percentage enrolled in each state varies, from less than 1 percent in Alaska, to about 43 percent in Minnesota.⁶ Missouri is close to the national average, with about 21 percent of its Medicare recipients enrolled in Medicare Advantage plans.

Medicare Advantage plans must provide services covered by Parts A and B, and may provide additional benefits, such as vision and hearing coverage or smaller premiums. Almost all Medicare Advantage plans—including health maintenance organizations (HMOs) and preferred provider organizations (PPOs) (see Figure 1)—require enrollees to choose providers from an approved list, called a provider network. There are also some Medicare Advantage plans that allow members to go to any provider willing to accept the plan’s payment. Since 2007, all

Medicare enrollees have had access to at least one type of Medicare Advantage plan,⁷ and in 2012, Medicare enrollees will be able to choose from an average of 20 different Medicare Advantage plans.⁸

Figure 1



Part D Prescription Drug Coverage

Prescription drug coverage was added to Medicare in 2003 by the Medicare Prescription Drug, Improvement, and Modernization Act.⁹ All Part D benefits for those who choose to enroll are administered through private companies, either a stand-alone drug plan or a Medicare Advantage plan (about 80% of Medicare Advantage plans provide Part D benefits). As of May 2012, there were 31.6 million people enrolled in Part D, with 19.8 million in stand-alone plans and 11.8 million in Medicare Advantage plans.¹⁰ In Missouri, 625,500 people are enrolled in Part D, with 428,000 in stand-alone plans and 197,500 in Medicare Advantage plans.¹¹ The medications covered may vary significantly between plans, as companies can create lists of covered and non-covered drugs (“drug formularies”), and have other rules to determine coverage and cost-sharing amounts for particular drugs.

Eligibility

Part A

Three groups are entitled to Part A benefits:¹²

- Those age 65 and over who are eligible for Social Security or Railroad Retirement benefits.
- Those under age 65 who have been entitled to Social Security or Railroad Retirement benefits because of a disability for at least 24 months.¹³ The waiting period is waived for those with Amyotrophic Lateral Sclerosis, also known as ALS or Lou Gehrig’s Disease.
- Those with end stage renal disease if they are (or if they are the spouse or dependent child of someone who is) receiving Social Security benefits; considered “fully insured” by Social Security; or entitled to Medicare.

Those 65 and over and some disabled individuals not entitled to Part A benefits can still enroll in Part A by voluntarily paying a monthly premium of \$451 in 2012, reduced to \$248 for those who have at least 30 quarters of Medicare-covered employment, or who are married to such a person.¹⁴

Part B

A person can enroll in Part B if entitled to Part A or age 65 or older.¹⁵

Part C

A person can enroll in Part C if entitled to Part A and enrolled in Part B.¹⁶

Part D

A person can enroll in Part D if entitled to Part A or enrolled in Part B.¹⁷

Cost-Sharing

Health care is not free for Medicare enrollees, who may have out-of-pocket costs. In 2010, those in fee-for-service Medicare had to pay an average of \$1,569 for covered services; Missourians paid an average of \$1,598.¹⁸ When all out-of-pocket spending is included—not just those payments necessary to satisfy Medicare’s cost-sharing requirements (e.g., payments for non-covered nursing home stays and premiums for supplemental coverage)—the average enrollee spent \$4,241 in 2006, and the median enrollee spent more than 16 percent of income on health care (see Figure 2).¹⁹

Out-of-pocket spending can make it difficult for Medicare enrollees to access and pay for health care. A 2007 survey found that 15 percent of elderly and 48 percent of disabled Medicare enrollees had problems paying off medical bills.²⁰ Similarly, 20 percent of elderly and 53 percent of disabled recipients had gone without care in the past year because of costs. Medicare enrollees are also typically poorer and sicker than the general population. For example:²¹

- Nearly half have incomes below 200 percent of the federal poverty level (see box on left),
- 44 percent have three or more chronic health conditions, and
- 29 percent rate themselves in fair or poor health.

What is Meant by “Cost-Sharing”?

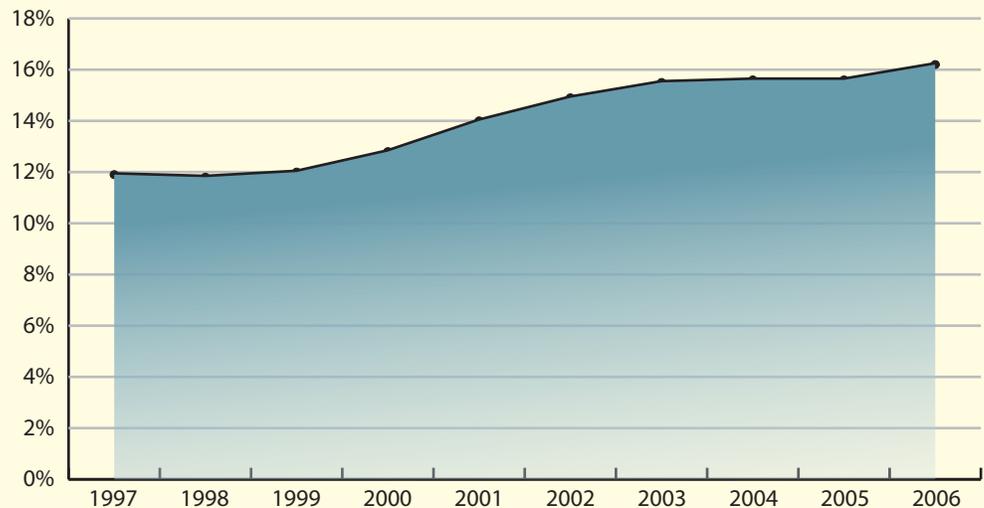
Cost-sharing comes in four basic forms.

- A premium is a fixed amount of money a person must pay to have health insurance in a benefit period. In Medicare, for example, a person must pay a premium each month to stay enrolled in Parts B and D.
- A deductible is a fixed amount of money a person must pay toward his or her health care costs before insurance pays anything.
- Coinsurance is a percentage of a person’s health care costs he or she must pay, usually after any deductible is paid.
- A co-pay is a fixed amount of money a person must pay each time he or she uses a particular service, such as a doctor’s visit or hospital stay.

Figure 2

Financial Burden of Health Spending Among Medicare Beneficiaries, 1997-2006

Median Out-of-Pocket Health Spending as % of Income



NOTE: Difference between 1997 and 2006 is statistically significant at .05 level.

SOURCE: Kaiser Family Foundation, “Medicare: A Primer,” April 2010, <http://www.kff.org/medicare/upload/7615-03.pdf> (based on analysis of Medicare Current Beneficiary Survey Cost and Use files, 1997-2006).

What is the Federal Poverty Level?

The federal poverty level (FPL) is an amount of income, based on family size and composition, below which a family would be unable to meet its basic needs. In 2012, the FPL for a family of two is \$15,130 a year.²²

Part A

In 2012, there is a deductible of \$1,156 for inpatient hospital stays, a co-pay of \$289 for days 61 through 90, and a co-pay of \$578 for lifetime reserve days.²³ For skilled nursing facility stays, there is a co-pay of \$141.50 for days 21 through 100.²⁴ There is no co-pay or deductible for home health visits. Hospice care also has no deductible, but does include small co-pays for drugs (up to \$5) and coinsurance for inpatient respite care (5%). In 2010, fee-for-service enrollees paid a total of \$15.5 billion to receive covered Part A services, an average of \$437 per enrollee.²⁵

Part B

In 2010, Part B enrollees paid \$40 billion for covered services, an average of \$1,242 per enrollee.²⁶ In 2012, there is a deductible of \$140.²⁷ After the deductible is met, enrollees must pay coinsurance on most goods and services, usually set at 20 percent (coinsurance alone accounted for over 63% of all Medicare cost-sharing liability in 2009).²⁸ Enrollees also pay a monthly premium between \$99.90 and \$319.70, depending on their income.²⁹ Further, a Part B enrollee who visits a non-participating provider may be subject to balance billing (see box on right).

As of 2011, the ACA eliminated all cost-sharing for certain preventive services with a Grade A or B recommendation from the U.S. Preventive Services Task Force.³⁰

Part C

In every county, Medicare determines the most it is willing to pay a Medicare Advantage plan for each person the plan enrolls (called a county benchmark). If the plan charges more than the county benchmark, enrollees must pay premiums to cover the difference. If the plan charges less than the county benchmark, there are no premiums (most enrollees pay no Part C premiums), and the plan gets to keep some of the difference (called a rebate) to provide extra benefits to enrollees. In 2012, the ACA began linking the size of a plan's rebate with its quality rating: plans with fewer than 3.5 stars get a 50 percent rebate; those with 3.5 or 4 stars get a 65 percent rebate; and those with 4.5 or 5 stars get a 70 percent rebate.³¹ Medicare Advantage enrollees may also pay a separate Part B or Part D premium.

The ACA also prohibits Medicare Advantage plans from having higher cost-sharing requirements than Parts A and B for some benefits.

Part D

The federal government designs a standard benefit for prescription drug cost-sharing. The plans can adopt the standard benefit or create their own cost-sharing arrangements as long as they are actuarially the same or better than the standard benefit. The standard benefit has been controversial because of the "donut hole," a gap in coverage where the enrollee must pay thousands of dollars out-of-pocket before coverage kicks back in. The donut hole was reached by 31 percent of all Part D enrollees in 2008, a third of whom had no help paying for these costs.³² Enrollees used to be responsible for 100 percent of costs in the gap, but the ACA changed that. In 2010, the ACA gave any prescription drug plan enrollee with spending in the coverage gap a \$250

Balance Billing

Participating providers agree to charge no more than the price Medicare sets for a service. Non-participating providers, however, may charge more than the price Medicare sets and then bill the enrollee for the difference, a practice called balance billing. Medicare enrollees can choose to see only participating providers.

Figure 3

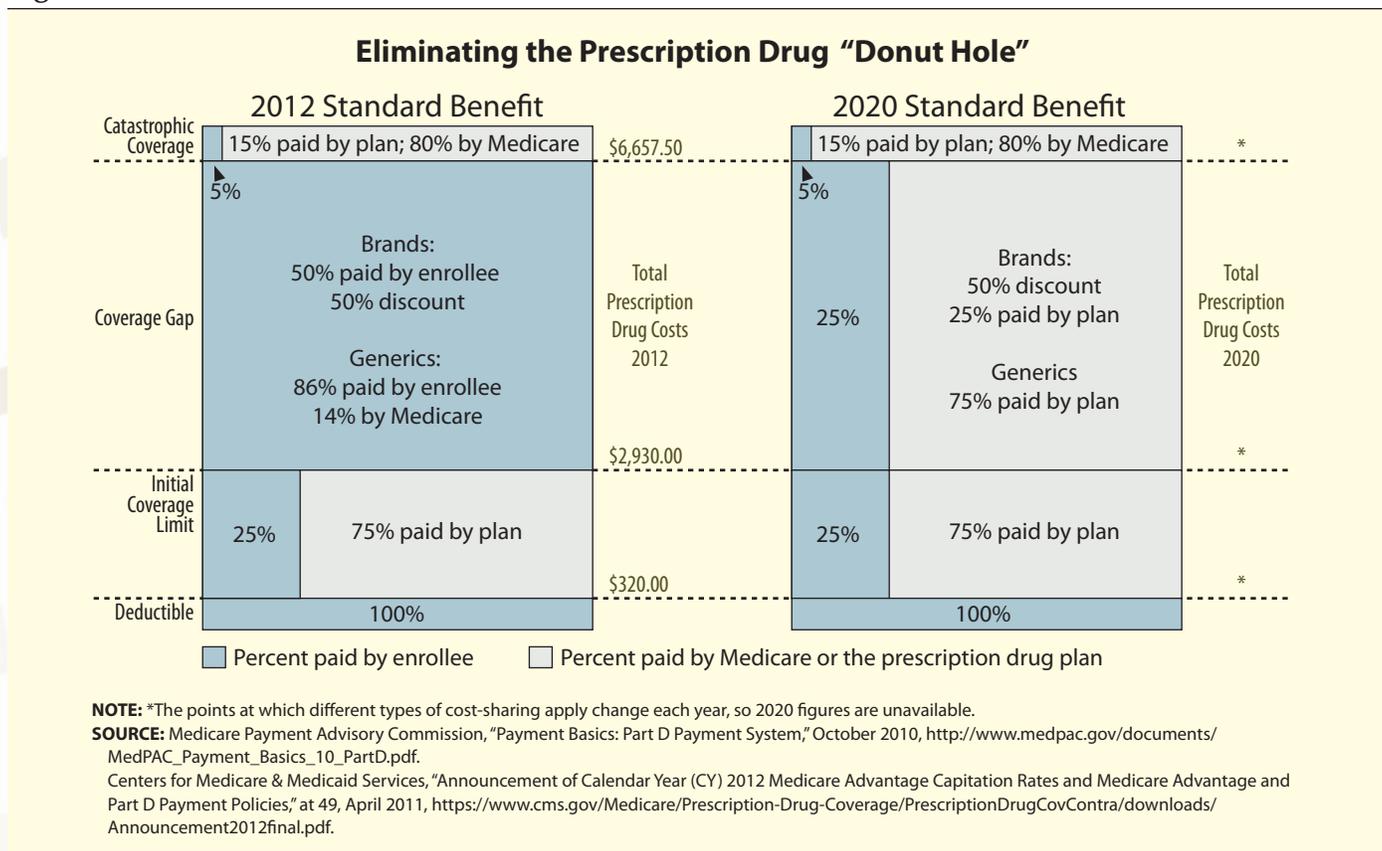
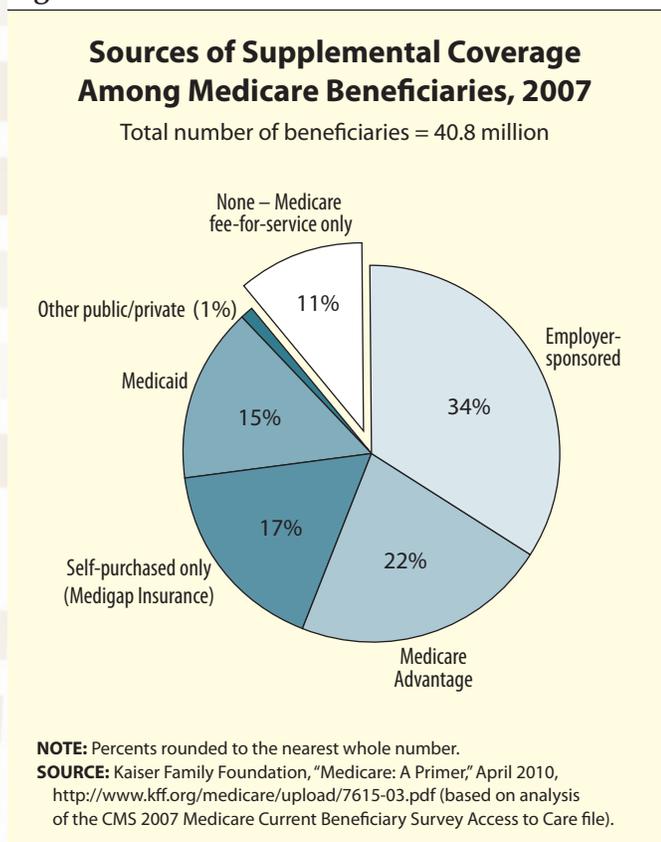


Figure 4



rebate.³³ Discounts for brand name and generic drugs are now being gradually phased in so that, by 2020, enrollees will be responsible for 25 percent of the costs of brand name and generic drugs while in the gap (see Figure 3).³⁴ Closing the donut hole is expected to cost the government \$42.6 billion through 2019.³⁵

Cost-sharing varies greatly from the standard benefit design. In 2012, the average monthly premium for all Part D plans was \$31.08.³⁶ Most premiums in Missouri fall between \$14 and \$35.³⁷ Also, a little less than half of Missouri plans have no deductible, and a fifth provide extra benefits in the coverage gap, such as discounts on generics or brand name medications.³⁸ Plans that charge no deductible usually charge co-pays for each prescription instead.

Supplemental Coverage – Medigap

Private health insurance plans can pay all or part of an enrollee’s cost-sharing (see Figure 4). Such private plans include employer-sponsored plans for enrollees still working, retiree health plans, or

Medigap (optional insurance designed to cover costs not paid by Medicare). There are ten types of Medigap plans companies can offer, called Plans A, B, C, D, F, G, K, L, M, and N (plans E, H, I, and J are no longer offered).³⁹ They all provide certain benefits, such as covering hospital co-pays under Medicare Part A and coinsurance under Medicare Part B. Other benefits are covered by only some of the plans, such as the Part A and Part B deductibles and costs due to balance billing. While the benefits for each plan are set in advance by the federal government, the prices can vary, based on a person's age when issued the policy; a person's current age (so the price can go up as the person ages); or regardless of age, so everyone who has the policy is charged the same amount, called community rating. In 2008, 17 percent of all Medicare beneficiaries had a Medigap plan.⁴⁰

Provider Reimbursement

The following describes how providers are paid in traditional fee-for-service Medicare. As described above, the government does not directly pay providers in Medicare Advantage. Instead, the government pays private plans, and those plans contract with providers and hospitals to provide care.

Part A

Medicare pays hospitals and facilities a one-time, set amount for each admission. The amount of the fee depends on the patient's primary diagnosis upon entering the hospital, where a particular diagnosis-related group (DRG) is assigned. Each DRG reflects what it reasonably should cost to provide care for a typical patient with that diagnosis. The amount is adjusted based on other factors, such as the hospital's location, but not based on the actual cost of providing care. Thus if the actual care costs less than Medicare's fee, the hospital makes money; if the care costs more than the fee, the hospital loses money. Additionally, some hospitals receive payments from Medicare through the Disproportionate Share Hospital Program (DSH), which provides extra financial assistance to hospitals caring for large percentages of low-income patients.⁴¹

The ACA made several changes to hospital reimbursement. Starting in 2013, hospitals will be eligible for bonus payments by providing high-quality care, based on factors such as outcomes for patients admitted with heart failure or pneumonia, and hospital-acquired infection rates.⁴² Additionally, payments under the DSH program will be reduced by 75 percent beginning in 2014, saving \$22.1 billion by 2019.⁴³ In 2012, payments to hospitals are being reduced for certain preventable readmissions. Similarly, in 2015, the 25 percent of hospitals with the highest rates of hospital-acquired infections will have their Medicare payments for these conditions reduced by 1 percent.⁴⁴

Medicare will also experiment with bundled payments starting in 2013.⁴⁵ Currently, physicians and other providers are paid separately from hospitals, but a national pilot program will pay them both with a single fee to cover all expenses during an episode of care, which begins three days before a hospital admission and ends 30 days after discharge.

Physician Fees and the SGR

Physician payments are supposed to be adjusted each year based on a sustainable growth rate (SGR) formula, which tries to ensure such payments do not grow faster than the gross domestic product (GDP). The GDP is the value of all goods and services produced in a country in a period of time, usually a year. The SGR led to payments for physicians being increased each year between 1997 and 2001, but reduced by 4.8 percent in 2002.⁴⁸ The SGR has called for a reduction since 2003, and each year Congress has acted to prevent the reduction. In 2012, a 17.2 percent reduction became a 5.6 percent increase.⁴⁹ In 2013, the reduction is estimated to be 18.9 percent.⁵⁰

Controlling Costs in Medicare Advantage

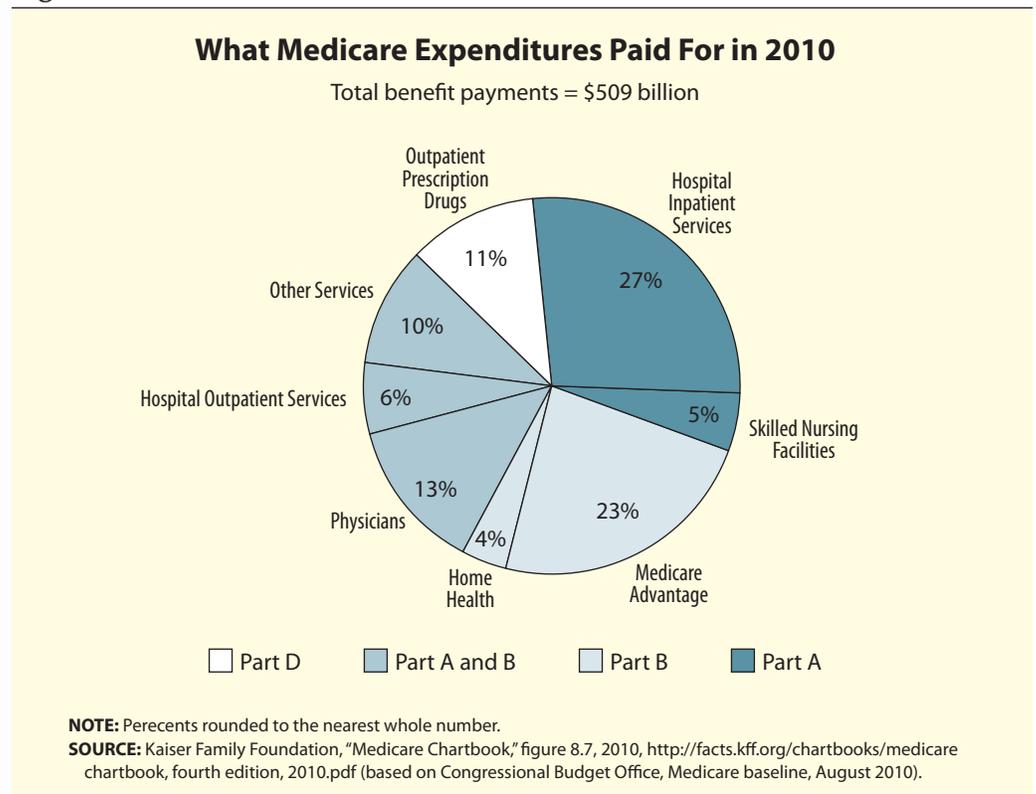
On average, payments to Medicare Advantage plans are 14 percent more than what it would cost to cover an enrollee in fee-for-service Medicare.⁵³ This money pays for plan profits, overhead, and additional benefits for enrollees (every \$1.00 in extra benefits costs the government about \$1.30 in subsidies). The ACA addresses the higher costs by lowering payments to Medicare Advantage plans and aligning them with fee-for-service costs. Also, beginning in 2014, Medicare Advantage plans must have medical-loss ratios of at least 85 percent, meaning plans have to spend at least 85 percent of their Medicare dollars on enrollees' health services.

Part B

Medicare also pays physicians a set fee for each service they provide, according to the Medicare Physician Fee Schedule.⁴⁶ The amount of the fee is based on where the procedure falls on a resource-based relative value scale (RBRVS). The RBRVS sets a price based on the work expense of a procedure (i.e., the time and intensity of the physician's work), the practice expense (i.e., the general costs of maintaining a practice, such as office rent and workers' wages), and the malpractice expense (i.e., malpractice costs associated with maintaining a practice).⁴⁷ As with hospitals, the fee is adjusted based on the provider's location, but not the physician's actual costs.

The ACA made several changes to physician reimbursement. In 2011, the ACA increased payments by 10 percent to primary care providers, as well as general surgeons practicing in health professional shortage areas. The law also created a Center for Medicare and Medicaid Innovation, which will create and test changes to payment or service-delivery in order to reduce costs and improve care. Further, the ACA requires the fee schedule to reflect the quality of care provided, not just costs. This is done through a value-based payment modifier, which will be based on quality measures developed by the Department of Health and Human Services and phased in over two years beginning in 2015.⁵¹

Figure 5



Financing and Expenditures

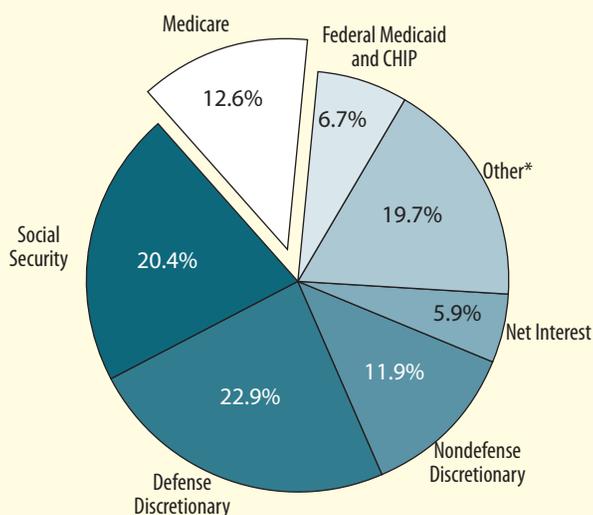
The Hospital Insurance Trust Fund pays for Part A benefits. It is primarily funded by income taxes of 2.9 percent on the self-employed and 1.45 percent each on employers and their employees. Beginning in 2013, individuals earning more than \$200,000 (\$250,000 for joint filers) will be taxed an additional 0.9 percent on all income and 3.8 percent on unearned income.⁵² The Supplemental Medical Insurance Trust Fund pays for both Part B and Part D benefits. The money for Part B comes from enrollee premiums (25%) and general tax revenues (75%). The money for Part D comes from general tax revenues (about 77% in 2010), enrollee premiums (11%), and state Medicaid payments for those enrolled in both Medicare and Medicaid (12%). Part C is paid for using both Trust Funds.

The ACA will help the federal government pay for Medicare in the coming decades. In 2011, Medicare cost \$549.1 billion (about 3.7% of the country's GDP), and it currently takes up 12.6 percent of the entire federal budget.⁵⁴ Before the ACA, Medicare costs were predicted to rise to 11.2 percent of GDP by 2080.⁵⁵ After the ACA, Medicare spending is now predicted to rise to only 6.7 percent of GDP by 2085.⁵⁶ Similarly, before the ACA, Part A's Hospital Insurance Trust Fund would have become insolvent by 2017, but after the ACA it will remain solvent until 2024.⁵⁷ Once the Trust Fund becomes insolvent, Part A's only source of funding would be each year's tax revenues, which would fall short. Without additional funds, there would have to be benefit reductions. The burdens on Parts B and D are also expected to increase substantially in the long term, but both are less likely to become insolvent.

Figure 6

Medicare Spending as a Share of Total Federal Spending in 2012

2012 total federal outlays = \$3.8 trillion



NOTE: Total may not add to 100 percent due to rounding. *Other category includes Troubled Asset Relief Program, Supplemental Nutrition Assistance Program, tax credits, and student loans.

SOURCE: Office of Management and Budget, "Fiscal Year 2012: Budget of the U.S. Government," Table S-5: Proposed Budget by Category, page 210, 2012, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/tables.pdf>

Waste, Fraud, and Abuse in Medicare

Waste, fraud, and abuse lead to improper payments and overpayments in Medicare, costing over \$34 billion in 2011.⁶⁰ The ACA addresses this problem in many ways, including:

- Increased penalties for health care crimes under the Federal Sentencing Guidelines;
- Part D prescription drug plans and Medicare Advantage plans are required to have anti-fraud policies;
- When prescribing durable medical equipment or home health services, providers must have face-to-face encounters with their patients;
- Enrollees can be penalized for knowingly participating in health care fraud;
- Before providing imaging services (e.g., MRIs), a physician must inform a patient in writing that the services can be obtained elsewhere, and provide a list of other area suppliers, in order to prevent unnecessary self-referrals; and
- Part D plans must use uniform drug dispensing techniques to reduce waste in long-term care facilities.

The ACA tries to reduce Medicare expenditures in several ways. First, the law creates a 15-member Independent Payment Advisory Board (IPAB), whose proposals to reduce Medicare spending would automatically go into effect unless Congress enacted an equally cost-reducing alternative. The initial proposal from IPAB is due in 2014. Second, the ACA reduces annual updates in payments to hospitals, nursing facilities, home health agencies, and other non-physician providers, which are expected to save \$156.6 billion through 2019.⁵⁸ Third, the ACA contains several provisions designed to control costs in Medicare Advantage and reduce waste, fraud, and abuse in traditional Medicare (see box on left). Overall, the health care reform law is expected to reduce Medicare expenditures by \$424 billion between 2010 and 2019.⁵⁹

Summary

Medicare is the largest health insurance program in the United States, covering a large and growing group of elderly and disabled Americans who might not otherwise have health coverage. Medicare helps pay for essential services such as inpatient hospital stays, physician services, and prescription drugs. The Affordable Care Act tries to address some of Medicare's shortcomings by closing coverage gaps, improving the quality of care, reducing costs, and extending the financial security of Medicare Part A by almost a decade.

Online Resources

Medicare's official website – <https://www.medicare.gov/>

“Medicare & You” Handbook –
<http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>

Apply to enroll in Medicare – <https://www.ssa.gov/retireonline>

Supplemental Medigap plans available in your area –
<http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx>

Medicare Advantage and prescription drug plans available in your area –
<https://www.medicare.gov/find-a-plan/questions/home.aspx>

Information and statistics from the Centers for Medicare & Medicaid Services –
<http://www.cms.gov/home/medicare.asp>

Information and statistics from the Kaiser Family Foundation –
<http://www.kff.org/medicare/index.cfm>

Endnotes

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- 17 42 U.S.C. § 1395w-101.
- 18 Centers for Medicare & Medicaid Services, "Table 4.3: Medicare Enrollees, Persons Served, and Beneficiary Cost-Sharing Liability, by Area of Residence: Calendar Year 2010," available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2011.html>.
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- 29 76 Fed. Reg. 67574 (November 1, 2011), <http://www.gpo.gov/fdsys/pkg/FR-2011-11-01/pdf/2011-28186.pdf>.
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Understanding Medicare is prepared by Jeff Herman, JD, and edited by Akeiisa Coleman, Health Policy Associate at the Missouri Foundation for Health.

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St. Louis, Missouri 63103
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