

Chapter 7:

Medicare

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Medicare is a federal program that helps pay medical bills for people age 65 and older, and a relatively small group of people who are judged to be severely and permanently disabled.

The program was signed into law in 1965 but has since been expanded in terms of services and populations covered. The most important of these expansions were the decision to cover people with end-stage renal disease (ESRD) in 1972 and the coverage of outpatient prescription drugs enacted in 2003.

At age 65, a person automatically becomes eligible for Medicare if he or she is a U.S. citizen or a legal resident (green card holder), and has lived in the U.S. for at least five years in a row.¹ The eligibility rules for people with disabilities are more complicated but generally, if a person qualifies for cash benefits under Social Security Disability Insurance (SSDI), they can qualify for Medicare after a two-year waiting period.² Special rules apply for those with ESRD or ALS, also known as Lou Gehrig's disease.

As with Social Security, eligibility for Medicare does not depend on income. Also like Social Security,

much of Medicare is funded on a "pay-as-you-go basis," which means it depends primarily on today's working population to fund the expenses of today's beneficiaries.

Medicare covers benefits that fall into four parts. (See text box, "What Medicare Covers - And What Beneficiaries Have to Pay - 2009").

Part A, known as the Hospital Insurance (or HI) program, covers inpatient hospital care, skilled nursing care up to 100 days after a hospitalization, home health and hospice care. It is funded by a portion of the wage tax - 2.9 percent, with employers and employees each paying 1.45 percent. Beneficiaries pay a deductible (\$1,068 for each "spell of illness" in 2009), and substantial copayments for extended inpatient hospital or skilled nursing facility stays. If they have worked in the U.S. for 10 years or more (40 quarters of Medicare-covered employment), beneficiaries pay no Part A premium. (See text box, "What Medicare Covers," for Part A premiums charged to those who have worked fewer than 40 quarters of Medicare-covered employment.)

For story ideas on Medicare, see page 81. A list of experts and websites also begins on page 81.

FAST FACTS

- Medicare is a federal program that covered 44.1 million people in calendar year 2007: 36.9 million aged 65 and over and 7.2 million who met Medicare's definition of disability.^a
- The first of the baby boomers will reach age 65 - the Medicare eligibility age for non-disabled people - in 2011. By 2030, when the youngest boomer turns 65, there are expected to be 78 million people on Medicare.^b
- Annual expenditures for Medicare were \$436 billion in 2007 and are expected to rise to \$887 billion in 2018.^c
- Financial assets of the Hospital Insurance Trust Fund that pays for Part A of Medicare are projected to be exhausted by 2019. In early 2009, the Centers for Medicare and Medicaid Services reported that the economic crisis could cause the fund to be depleted even earlier, by 2016.^d
- To finance Part A's expected needs through 2083, the Medicare payroll tax would need to be increased immediately by 122 percent, program outlays would need to be reduced by 51 percent immediately, or some combination of the two, according to the program's trustees.^e
- The American Recovery and Reinvestment Act of 2009 includes Medicare incentive payments to encourage physicians and hospitals to "meaningfully use" electronic health records. The incentives phase out over six years, followed by penalties for non-adopters.^f

What Medicare Covers - And What Beneficiaries Have to Pay - 2009

(Adapted with permission from the Medicare Rights Center - www.medicarerights.org)

Under Medicare Part A - In 2009 You Pay:

Monthly Premium	Nothing if you have worked for 40 quarters (10 years) or more, \$244/month if you have worked 30-39 quarters (between 7.5 and 10 yrs), \$443/month if you have worked fewer than 30 quarters (7.5 yrs)
Inpatient Hospital	\$1,068 deductible per benefit period. No coinsurance for days 1-60, \$267 daily coinsurance for days 61-90, \$534 daily coinsurance for 60 lifetime reserve days
Skilled Nursing Facility	No deductible for each benefit period. No coinsurance for days 1-20, \$133.50 daily coinsurance for days 21-100
Home Health Care	No deductible or coinsurance
Hospice Care	No deductible; small copayment for outpatient drugs and inpatient respite care

Under Medicare Part B - In 2009 You Pay:

Monthly Premium	\$96.40 if your annual income is below \$85,000 (taken out of your Social Security check)
Annual Deductible	\$135
Doctor and other medical services	20% ¹
Outpatient hospital care	Coinsurance or Copayment ²
Home health care, Clinical diagnostic lab services	Nothing
Other diagnostic tests and x-rays ³ ; Diabetes self-mgmt supplies (glucose monitors, lancets, test strips); Durable medical eqpmt (wheelchairs) ⁴ ; Physical therapy services; Ambulance services; Chiropractor services ⁵ , Blood (after first three pints per yr)	20%

Under Medicare Part D - In 2009 You Pay:

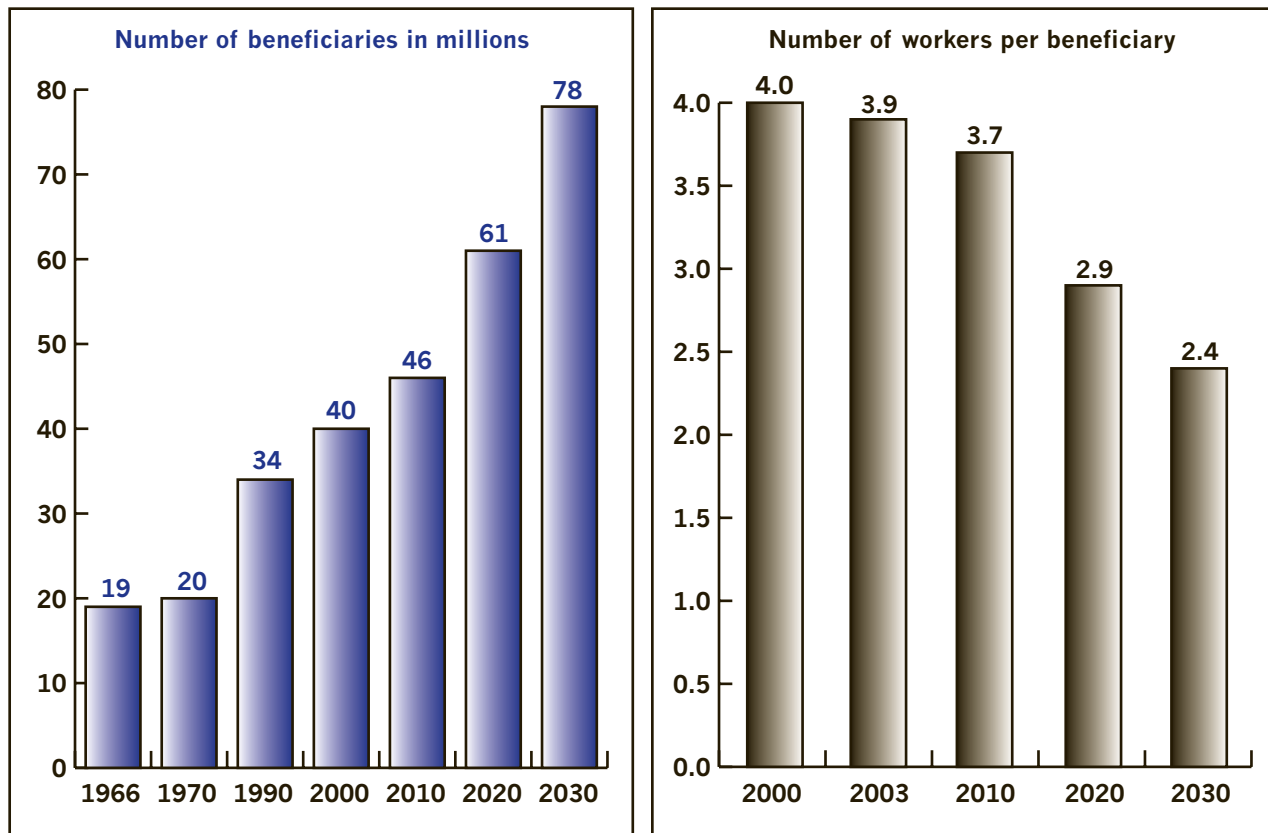
Monthly Premium	Varies by plan. Average national premium is \$30.36.
Annual Deductible	Varies by plan. Cannot be more than \$295 if you do not have Extra Help. \$0 if you have Full Extra Help, \$60 or your plan's standard deductible if you have Partial Extra Help
Coinsurance/ Copayments - If you do not have extra help	Varies by plan and by drug within plan. After spending a pre-determined amount in total drug costs (usually \$2,700), you may have pay 100% of the cost of your drugs until coverage begins again (coverage gap). In all plans, after you have spent \$4,350 out of pocket (not including premium or the costs of drugs not on your plan's list of covered drugs or that you bought in a pharmacy outside the plan's network), you will only pay no more than 5% of the cost (catastrophic coverage), or \$2.40 for generics and \$6.00 for brand-name drugs.
Coinsurance/ Copayments - If you have extra help	If you have Medicaid and your income is below 100% of the Federal Poverty Level (\$10,400 a year in 2009 for individuals and \$14,000 for couples): \$1.10 for generics and \$3.20 for brand-name drugs. After your total drug costs reach \$6,153.75, you will get catastrophic coverage and pay \$0 for each drug for the rest of the calendar year. If you have Full Extra Help: \$2.25 for generics and \$5.60 for brand-name drugs. After your total drug costs reach \$6,153.75 you will get catastrophic coverage and pay \$0 for each drug for the rest of the calendar year. If you have Partial Extra Help: 15% of each prescription or your plan's standard coinsurance (whichever is cheaper). After your total drug costs reach \$6,153.75, you will get catastrophic coverage and pay \$2.40 for generics and \$6.00 for brand-name drugs for the rest of the calendar year.

Medicare does not cover the following services (you must pay the full cost yourself):

Alternative medicine, Dental care, Care outside of the United States, Non-medical services, Most non-emergency transportation, Some preventive care (including most routine physical examinations and tests, immunizations), Cosmetic surgery, Vision (eye) care (except after cataract surgery), Hearing aids (except certain implants for extreme hearing loss), Long-term care

¹ Of Medicare-approved amount for providers who accept assignment. If your doctor does not accept assignment, federal law allows him or her to charge up to 15% above Medicare's approved amount, ² Based on diagnosis, ³ Copies of x-rays are not covered, ⁴ Of Medicare-approved amount for DME suppliers who accept assignment. Medicare does not limit how much suppliers who do not accept assignment can charge above Medicare's approved amount. Your Medigap plan will not cover anything above the Medicare approved amount. ⁵ When you require manual subluxation of the spine

Historical and Projected Number of Medicare Beneficiaries and Number of Workers Per Beneficiary



Source: Neuman, Tricia (2005). "Medicare: The Basics." Presentation for Alliance for Health Reform briefing May 16, 2005. (<http://www.allhealth.org/BriefingMaterials/Neuman-210.pdf>).

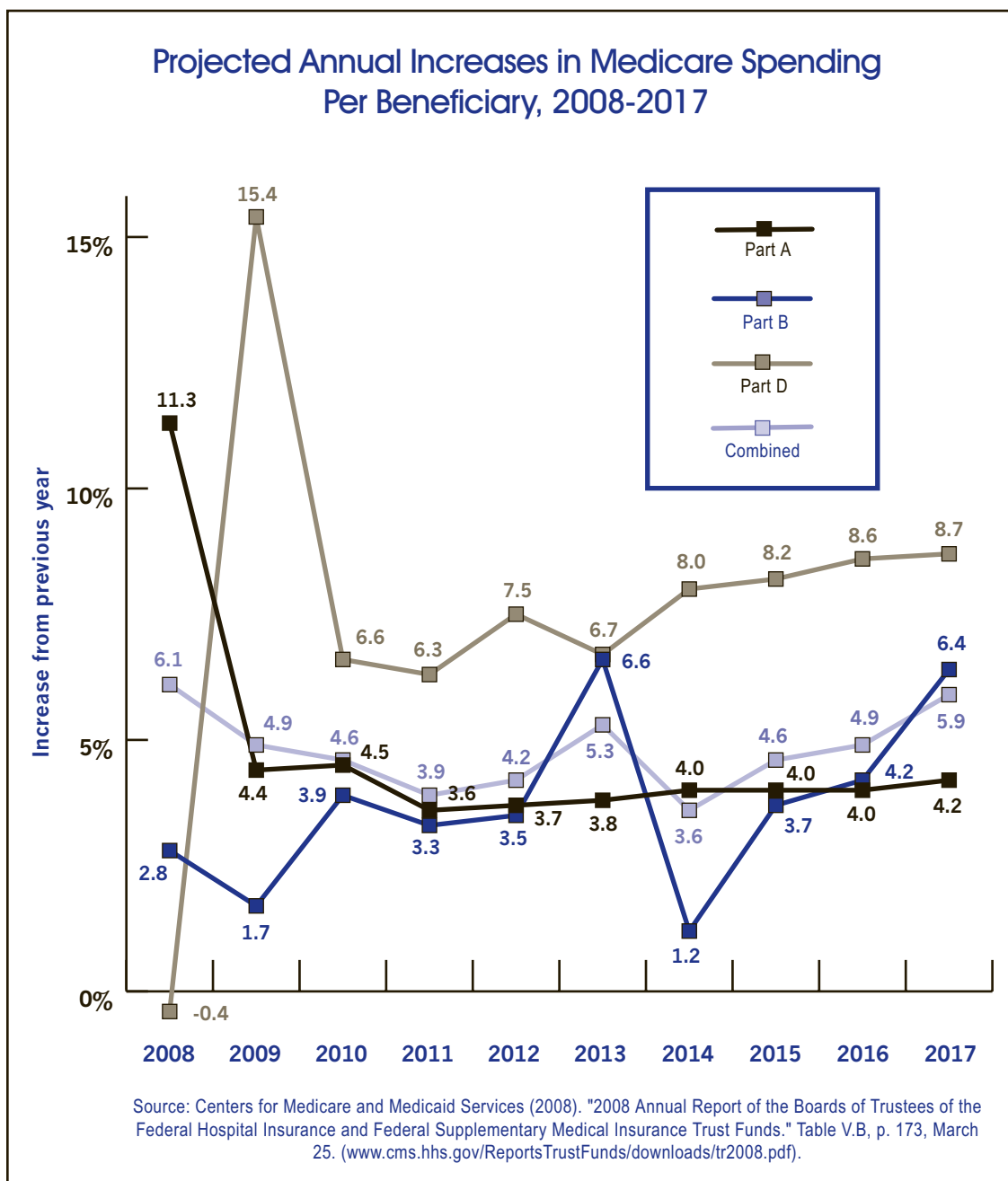
Part B, known as Supplementary Medical Insurance (or SMI), covers physician services, outpatient care and home health care after 100 visits. It is funded partly by premiums, which accounted for 24.8 percent of the Part B income in 2007.³ The rest comes from general revenue. The monthly premium for most beneficiaries is \$96.40 in 2009. Some with higher incomes pay higher, income-related premiums; some with low incomes and assets pay no premiums. Most face a Part B deductible of \$135 in 2009. In 2009, premiums for the wealthiest beneficiaries will cover 80 percent of their Part B costs.⁴

Part C replaces the benefits from parts A, B and D by enrollment in a private plan called a Medicare Advantage (or MA) plan, which includes at least the benefits associated with traditional Medicare. In 2008, around 10 million beneficiaries were enrolled in MA plans.⁵ (See the glossary for more on MA.)

Part D is the outpatient prescription drug benefit which took effect in 2006. The benefit is provided by free-standing private drug plans (except for those beneficiaries who are enrolled in Medicare Advantage plans with a prescription benefit). It is funded by general revenue, contributions from the states and premium payments from beneficiaries (an amount that made up 7.9 percent of Part D income in 2007).⁶ Each plan sets its own premium; the national average in 2009 is \$30.36 per month. The deductible cannot be more than \$295.

There are also some important benefits that Medicare does not cover. These include custodial long-term care, dental services and most vision and hearing services.

For a detailed description of what Medicare covers and how it is financed, go to the website for the Medicare Rights Center (www.medicarerights.org)



and the official U.S. government website for people with Medicare (www.medicare.gov).

Assuring adequate funding for both Social Security and Medicare faces the problem that, with the aging of the population, there will be fewer workers supporting each retiree. (See chart, "Historical and Projected Number of Medicare Beneficiaries and Number of Workers Per Beneficiary.")

But Medicare has an added problem. Spending on health care has historically grown around 2.5 percentage points faster than the rest of the economy in real (that is, adjusted for inflation) per capita terms

- something economists call the "excess spend" in health care. This excess spend will drive up future Medicare expenditures more than will the aging of the population.⁷

This phenomenon is especially evident in spending for the Medicare prescription drug program (Part D). The Medicare trustees estimate that Part D spending will increase by 15 percent in 2009 and will see an annual growth rate substantially exceeding the other parts of Medicare each year through 2017.⁸ (See chart, "Projected Annual Increases in Medicare Spending Per Beneficiary, 2008 - 2017.")

But policymakers are most immediately worried about funding for Part A. According to the latest Medicare trustees' report, the Part A trust fund will be exhausted in 2019 unless revenues increase, benefits are cut, or a combination of both. In early 2009, the Centers for Medicare and Medicaid Services reported that the economic crisis could cause the fund to be depleted even earlier, by 2016.⁹ (See chart, "Hospital Insurance (Part A) Trust Fund Balance, 2003 - 2019.")

LIKELY POLICY DEBATES

Several issues are likely to be debated on Capitol Hill during 2009-2010. These include:

Appropriate payment rates for Medicare Advantage
Several authoritative sources have estimated that Medicare Advantage plans receive higher payments than would be spent on the same individuals if they had remained in traditional Medicare.¹⁰ Future payments were reduced in July 2008 legislation that financed a temporary "fix" for physician payments. It is highly likely that the remaining disparity will be eliminated over several years.

What to do with the sustainable growth rate (SGR) that limits spending on Part B, and more broadly, how to reform physician payment

In July 2008, physician fees under Medicare were scheduled to be reduced by about 10 percent because spending on Part B of Medicare once again exceeded the SGR. (See text box, "Medicare's Sustainable Growth Rate Formula.") Congress adopted a temporary "fix" to provide a 1 percent increase in payments. But that runs out in January 2010, after which fees are scheduled for a 20 percent reduction.¹¹ That large a reduction seems unthinkable. But Congress has very little time to decide whether and how to change the SGR and how to change physician reimbursement so that physicians who provide efficiently produced high quality services are appropriately rewarded.

Whether to remove the prohibition that prevents the HHS Secretary from "negotiating" drug prices and, if the prohibition is removed, how the secretary should make use of the new authority

The 2003 Medicare Modernization Act prohibits the secretary of Health and Human Services from negotiating drug prices for Medicare (as the Veterans Administration does for its health facilities).¹² This

Medicare's Sustainable Growth Rate Formula

The Medicare program has tried several methods to determine how much to pay physicians. The latest method, starting in 1998, is called the Sustainable Growth Rate (SGR).

The SGR formula aims to control spending by physician services provided under Part B. It sets an overall target amount of spending (both annual spending and cumulative spending). The target amount covers payments for physician services and also for items such as lab tests and imaging services that are provided in connection with physician services. For details, go to a helpful issue brief from the Congressional Budget Office at www.cbo.gov/ftpdocs/75xx/doc7542/09-07-SGR-brief.pdf.

Payment rates are supposed to be adjusted annually - upward if spending is below the target figure, downward if spending is more than the target. In real life, however, Congress can (and does) step in to reduce any payment cut the formula yields. This happened most recently in the summer of 2008, when Congress voted to rescind a pending 10.6 percent cut.

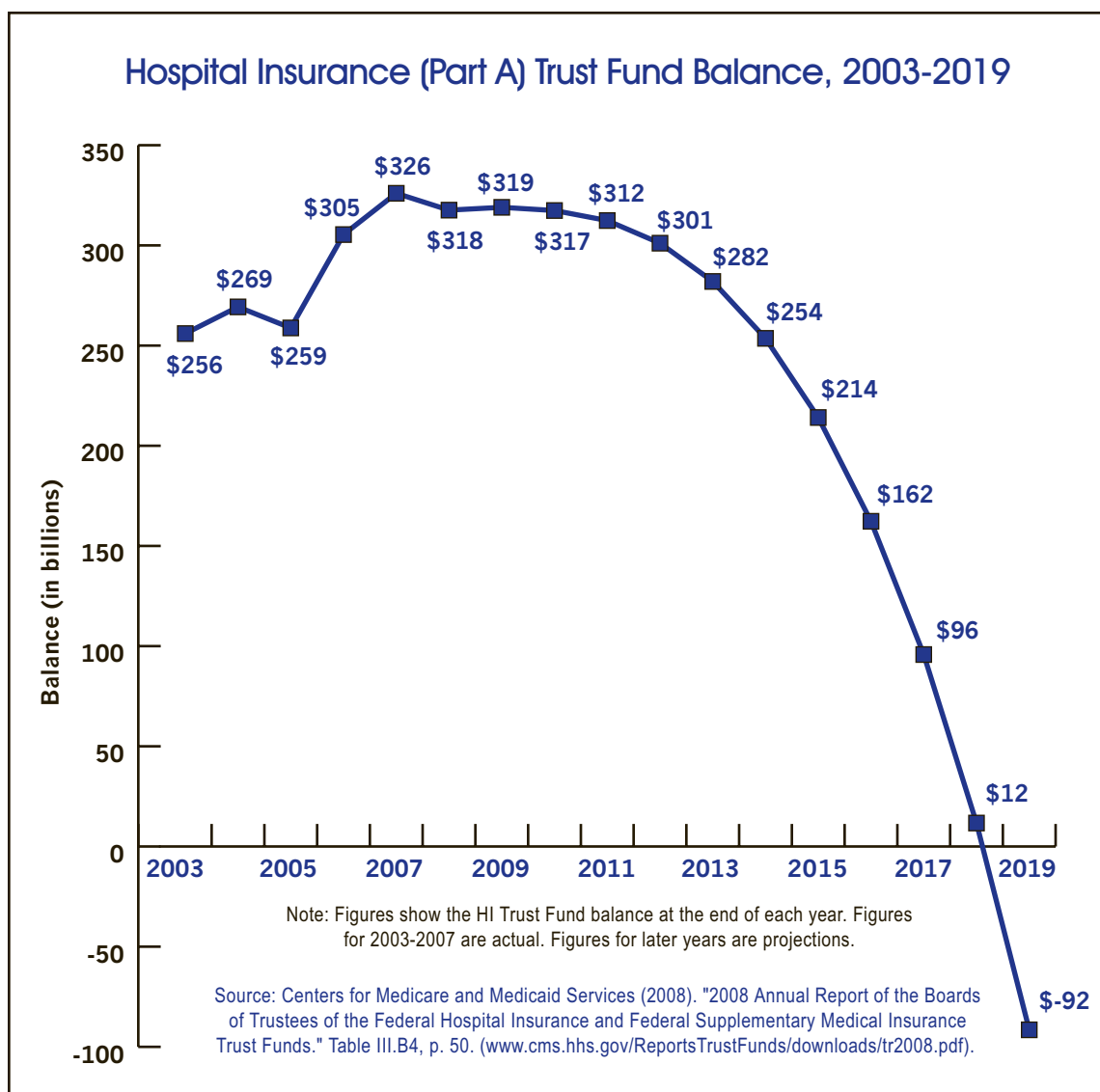
(Editor's Note: Dr. Wilensky, administrator of the Medicare program under the first President Bush, and the original author of this chapter, told Robert Pear of the New York Times in July 2008, "The physician payment mechanism is hands down the most broken part of Medicare. We desperately need a new way to reimburse doctors").

¹ Pear, Robert (2008). "Long-Term Fix Is Elusive In Medicare Payments." New York Times, July 13. (www.nytimes.com).

prohibition is likely to be repealed by the new Congress. But if this happens, it is unclear how a new authority to negotiate prices would be exercised, given that most Medicare beneficiaries get their outpatient prescription drugs through free-standing private plans rather than directly through traditional Medicare. One possibility is that the secretary would use the authority to cap prices for very high cost single-source drugs, such as some of the anti-cancer drugs.

Whether to change the design of Part D so that it is administered directly by CMS like the rest of traditional Medicare

As noted, Part D is provided by free-standing private drug plans. Some advocates of traditional Medicare would prefer that it be administered directly by the government. In this case, government-set drug prices



would also be likely (as described above), since payments to providers are set for the rest of traditional Medicare.

TIPS FOR REPORTERS

- Some people confuse Medicare with Medicaid. Medicare is the federal program for people over 65 and certain people with permanent and severe disabilities. Medicaid is a federal/state program for certain low-income people.
- A small number of people are on both Medicare and Medicaid. They are called "dual eligibles" and spend a disproportionately large share of Medicare money. For more, see www.cms.gov/DualEligible.
- "End of life" care is always controversial. From

27 to 31 percent of Medicare dollars are spent during the last 12 months of a person's life.¹³ This share has been relatively constant for several decades.¹⁴

- Re-importation of drugs from other countries is a popular idea, but assuring safety in the supply chain is hard. Think of China and Heparin.
- Medicare physician fees have been held at about the same level over most of the decade, but spending on Part B of Medicare has been increasing at 10 to 12 percent per year. This reflects changes in the volume and mix of services that have been provided and is a good reminder that setting prices is not the same as controlling expenditures.

- Medicare covers primarily acute care events, although it does provide 100 days of nursing home care following a hospitalization. Most nursing home care is paid for either by Medicaid or directly by individuals, not by Medicare.
- Medicare covers only about two-thirds of the costs for the services it covers and no coverage at all for some items, like dental care, eyeglasses or hearing aids.¹⁵ It provides minimal long-term care.

STORY IDEAS

- The economic stimulus bill signed into law in February 2009 includes incentives for physicians and hospitals to adopt electronic health records and use them "meaningfully." How quickly are physicians and hospitals in your area responding to these incentives? What problems are they running into as they make the transition from paper records? Do patients have any concerns about the privacy of their medical information being maintained?
- Open period for beneficiaries to change their outpatient prescription drug plans is Nov. 15 to Dec. 30 of each year. How many seniors actually change plans? Ask them why they changed plans.
- Concern was raised initially about confusion over Part D plan options and what would happen over time. Now that the program has been running for awhile, how do seniors feel about Part D?
- Have seniors changed the amount of generic drugs they use as a result of their Part D plans? If so, was it their choice because of the incentives in the program or did the plan require it?
- Physician access is always an issue - particularly when physician fees are being held almost constant and under threat of reduction. Are seniors in your area having trouble getting appointments with physicians? With new physicians that they haven't previously seen? With primary care physicians? With specialists? Any indication this is actually occurring, as opposed to predictions that it will occur?
- Do seniors regard physicians as being responsive to their needs and concerns? Do their clinicians talk with them about ways to stay healthy and improve their quality of life?
- We hear a lot about problems with nursing homes. Do seniors in your area know that Medicare provides only limited coverage for long-term care? Have they thought about how they would pay for long-term care services?
- Have seniors made efforts to designate who would be in charge of their health care decisions in case they become incapacitated? Do they know about advance directives and living wills indicating what kind of end-of-life care they want? Do they have one? Does someone else know about it?
- What are seniors doing to improve their own health? Are they exercising regularly - including walking on a regular basis? Are there problems in their home or neighborhood that make it difficult for them to stay healthy?

EXPERTS AND WEBSITES

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Websites

AARP
www.aarp.org

AdvaMed
www.advamed.org/

Aetna
www.aetna.com

Alliance for Health Reform
www.allhealth.org

Alliance of Community Health Plans
www.achp.org

American Enterprise Institute
www.aei.org

American Hospital Association
www.aha.org

American Institutes for Research
www.air.org

America's Health Insurance Plans
www.ahip.org

Blue Cross Blue Shield Association
www.bcbs.com

Brookings Institution
www.brookings.edu

Center for Medicare Advocacy
www.medicareadvocacy.org

Center for Medicare and Medicaid Services, CMS
www.cms.hhs.gov

Center for Studying Health System Change
www.hschange.org

Center on an Aging Society, Georgetown University
<http://ihcrp.georgetown.edu/agingsociety/>

Center on Budget and Policy Priorities
www.cbpp.org

Commonwealth Fund, The
www.commonwealthfund.org

Consumers Union
www.consumersunion.org

Families USA
www.familiesusa.org

Federation of American Hospitals
www.fah.org

Generic Pharmaceutical Association
www.gphaonline.org

Government Accountability Office
www.gao.gov

Health Affairs
www.healthaffairs.org

Health Policy R & D
www.hprd.net

Heller School for Social Policy and Management,
Brandeis University
www.heller.brandeis.edu

Heritage Foundation
www.heritage.org

Issues Research, Inc.
www.issuesresearch.com

Jennings Policy Strategies
www.jenningsps.com

Johns Hopkins University School of Public Health
www.jhsph.edu

Kaiser Family Foundation
www.kff.org

Kaiser Foundation Health Plan Inc.
www.kaiserpermanente.org

Kennedy School of Government, Harvard
University
www.ksg.harvard.edu/

Mathematica Policy Research
www.mathematica-mpr.com

Medicare Payment Advisory Commission
www.medpac.gov

Medicare Rights Center
www.medicarerights.org

Medicare.gov - U.S. Government Site for People
with Medicare
www.medicare.gov

National Academy of Social Insurance
www.nasi.org

National Association of Chain Drug Stores
www.nacds.org

National Association of Public Hospitals
www.naph.org

National Council on Aging
www.ncoa.org

National Women's Law Center
www.nwlc.org

Open CRS
www.opencrs.com

Robert Wood Johnson Foundation
www.rwjf.org

UnitedHealth Group
www.unitedhealthgroup.com

Urban Institute
www.urban.org

Wellpoint Health Networks, Inc.
www.wellpoint.com

ENDNOTES

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- ¹ For details, go to this page at the Medicare Rights Center website - (http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=14). You will also find useful information at the eligibility page of the federal government's website for Medicare - (www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment#TabTop) - or to the similar page at the website of the Medicare Rights Center - (www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=14). For an interactive tool to gauge Medicare eligibility, go to (www.medicare.gov/MedicareEligibility/home.asp?version=default&browser=IE%7C7%7CWInXP&language=English).
- ² For details, go to this page at the Medicare Rights Center website - (www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=15).
- ³ Centers for Medicare and Medicaid Services (2008). "2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." Table II.B1, March 25, p.5. (www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf).
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