

# Chapter 4: Medicare

**M**edicare is a federal program that, according to the program's trustees, helped 42.5 million Americans with their medical bills in 2005 – including bills for hospital care, physician care and care by certain other health care professionals.<sup>1</sup> Medicare services are available to all those 65 years or older who are U.S. citizens or legal residents living in the U.S. for five years in a row.<sup>2</sup> Also eligible are individuals younger than 65 with certain conditions or permanent disabilities, described below.<sup>3</sup>

Like Social Security, Medicare depends on today's workers paying the costs of today's beneficiaries. Employers and employees each pay a Medicare tax of 1.45 percent of the employee's income for beneficiaries' hospital care.

But Medicare doesn't cover all of beneficiaries' medical expenses. In fact, it pays for only two-thirds of the cost of the services it does cover, and it provides no coverage at all for items such as dental care, eyeglasses and hearing aids.<sup>4</sup> It also doesn't cover long-term care, as will be discussed later (and in Chapter 6 on Medicaid).

Most beneficiaries are in Medicare's "original" or "traditional" fee-for-service program. But a growing number (almost 15 percent in 2006) are enrolled in Medicare managed

care plans, under the Medicare Advantage program.<sup>5</sup>

## WHO'S COVERED BY MEDICARE?

As mentioned, anyone age 65 or older is eligible for Medicare, if the person is a U.S. citizen or a legal non-citizen residing in the U.S. for five continuous years at the time they apply for the program. As of 2005, 35.8 million Medicare beneficiaries fit this description.<sup>6</sup>

The program also covered 6.7 million people under age 65 with disabling conditions.<sup>7</sup> Most people who qualify for cash benefits under Social Security Disability Insurance can obtain Medicare-covered services after a two-year wait.<sup>8</sup> Individuals with end stage renal disease or amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease) have shorter waiting periods, or none.<sup>9</sup>

## WHAT DO THE DIFFERENT PARTS OF MEDICARE COVER?

The law that governs Medicare divides it into four parts, covering different types of health care and with different sources of funding. (For an easy way to distinguish the parts, see the table, "What Medicare Covers – And Doesn't Cover.")

*Part A:* Covers hospital care; skilled nursing facility care for up

## KEY FACTS

- Medicare is a federal government program that covers 35.8 million Americans age 65 and older.<sup>a</sup>
- It also covers 6.7 million people with disabling illnesses.<sup>b</sup>
- By the year 2030, when the youngest of the baby boomers will have turned 65, the rolls of Medicare beneficiaries will have swelled to 78 million – almost double the 2005 enrollment.<sup>c</sup>
- Annual Medicare expenditures by the federal government are expected to grow by almost 45 percent between 2006 and 2011, from \$338 billion to \$489 billion.<sup>d</sup>
- There were 3.9 workers for every Medicare beneficiary in 2004. By 2030, however, there will be only 2.4 workers paying taxes to cover each Medicare beneficiary for Medicare Part A, which covers most hospital care.<sup>e</sup>

**For story ideas on Medicare, see page 56. A list of experts and websites also begins on page 56.**

to 100 days following a hospitalization; and some care from home health providers, hospices and rehabilitation facilities. Providers are paid a fixed fee for each episode of care covered by Medicare Part A.

*Part B:* Covers physician care; physician procedures and treatments on an outpatient basis delivered in hospital outpatient departments, ambulatory surgical centers, and other non-hospital facilities; most home health care services; other professional services; and durable medical equipment such as wheelchairs. Providers are paid a fee for each service covered by Medicare Part B.

*Part C:* Also known as Medicare Advantage, delivers care through private entities in which beneficiaries enroll voluntarily. Medicare Advantage plans cover all of the benefits provided under Parts A, B, and D (the Medicare prescription drug benefit), and sometimes additional benefits not otherwise covered. (See the “Medicare Advantage” section below.)

*Part D:* Medicare’s prescription drug benefit, which began January 1, 2006. This benefit is covered in detail in Chapter 5 of this sourcebook.

Here are some of the services that Medicare does not cover (although some are covered by Medicare supplemental, or Medigap, policies which many beneficiaries purchase separately).<sup>10</sup>

- Acupuncture
- Dental care
- Care outside the United States
- Most chiropractic services
- Cosmetic surgery
- Custodial care (unless skilled nursing care is provided)
- Eyeglasses (except after cataract surgery)
- Hearing aids (except certain implants for extreme hearing loss)
- Long-term care
- Personal care services
- Private duty nursing

## MEDICARE ADVANTAGE

As part of the Medicare Modernization Act of 2003 (MMA), Medicare is seeking to expand coverage under its managed care plans so that such plans are available to nearly every senior nationwide. The

MMA aimed to provide drug coverage exclusively through private plans, with some exceptions, and one of the ways seniors were to receive their drug coverage was by enrolling for all-inclusive coverage in the health maintenance organizations, preferred provider organizations and other private plan options authorized by Medicare.

The Congressional Budget Office (CBO) projects that managed care enrollment will expand to 17.5 percent of beneficiaries in 2016, from 14.7 percent in 2006.<sup>11</sup> The percentage could go even higher if the Medicare prescription drug benefit turns out to be more popular than the CBO expects.

Medicare Advantage plans are paid a fixed monthly amount for each beneficiary enrolled. Many see this as a cost-containment strategy. However, managed care’s record in controlling Medicare costs has been a point of contention. According to several official estimates, Medicare for years enrolled beneficiaries who, if they had continued receiving care on a fee-for-service basis, would have cost the program less than the monthly fees the federal government paid to HMOs to cover the health care needs of those beneficiaries.<sup>12</sup>

Furthermore, after the Balanced Budget Act of 1997 (BBA), HMOs expanded enrollment quickly, only to later withdraw from many markets – some because payment rates did not grow as quickly as the HMOs anticipated, others because they didn’t achieve the desired market share.

Payment increases contained in MMA have enticed plans back into the program. According to the Medicare Payment Advisory Commission, to enroll beneficiaries in managed care plans in 2006, Medicare on average paid 11 percent more than it would have paid to providers for treating those same beneficiaries on a fee-for-service basis.<sup>13</sup>

The 2003 law guaranteed that no plan would be paid less than 100 percent of average fee-for-service costs.

Five million beneficiaries had enrolled in Medicare Advantage plans in 2005<sup>14</sup>, up from a post-BBA low of 4.66 million in 2003, but still well off the peak of 6.23 million in 2000.<sup>15</sup> Whether or not plans remain in the program may, as in the past, depend on whether they continue to view the business as a

## What Medicare Covers - And Doesn't Cover

(Adapted with permission from the Medicare Rights Center. For updates, go to [www.medicarerights.org](http://www.medicarerights.org))

### Under Medicare Part A - In 2007 You Pay:

Monthly Premium	Nothing (if you or your spouse have worked for 10 years or more), \$226 (if you or your spouse worked between 7.5 and 10 years), \$410 (if you or your spouse worked less than 7.5 years)
Inpatient Hospital	\$992 deductible per benefit period; No coinsurance for days 1-60, \$248 daily coinsurance for days 61-90, \$496 daily coinsurance for 60 lifetime reserve days
Skilled Nursing Facility	No deductible for each benefit period, No coinsurance for days 1-20, \$124 daily coinsurance 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 2007 You Pay:

Monthly Premium	\$93.50
Annual Deductible	\$131
Doctor and other medical services	20% <sup>1</sup>
Outpatient mental health services	50%
Outpatient hospital care	Coinsurance or Copayment <sup>2</sup>
Home health care, Clinical diagnostic lab services	Nothing
Other diagnostic tests and x-rays; Diabetes self-mgmt supplies (glucose monitors, lancets, test strips); Durable medical equipment (e.g., wheelchairs); Physical therapy services <sup>3</sup> ; Ambulance services; Chiropractor services, Blood (after first three pints per year)	20%

### Under Medicare Part D - In 2007 You Pay:

Monthly Premium	Varies by plan. Average national premium is \$27.35.
Annual Deductible	Varies by plan. Cannot be more than \$265.
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 \$2,400), you may have to pay 100% of the cost of your drugs until coverage begins again (coverage gap). In all plans, after you have spent \$3,850 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 pay 5%, or \$2.15 for generics and \$5.35 for brand-name drugs (whichever is higher) of the cost of each drug (catastrophic coverage).
Coinsurance/ Copayments - If you have extra help	If you have Medicaid and your income is below 100% of the Federal Poverty Level (\$9,800 a year in 2006 for individuals and \$13,200 a year for couples): \$1 for generics and \$3.10 for brand-name drugs. After your total drug costs reach \$5,451.25, you will get catastrophic coverage and pay \$0 for each drug for the rest of the calendar year. If you have Full Extra Help: \$2.15 for generics and \$5.35 for brand-name drugs. After your total drug costs reach \$5,451.25, 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. After your total drug costs reach \$5,451.25, you will get catastrophic coverage and pay \$2.15 for generics and \$5.35 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):

Acupuncture, Dental care, Care outside of the United States, Most chiropractic services, Cosmetic surgery, Custodial care (unless skilled nursing care is provided), Eyeglasses (except after cataract surgery), Hearing aids (except certain implants for extreme hearing loss), Long-term care, Personal care services, Private duty nursing

<sup>1</sup> 20% of the Medicare-approved amount for providers who don't charge patients more than that. If your doctor does charge more, federal law allows him or her to charge up to 15% above Medicare's approved amount. Some state laws offer more protection. <sup>2</sup> Based on diagnosis. <sup>3</sup> Starting January 1, 2006, Medicare is limiting how much it will pay for outpatient physical therapy (PT), speech-language pathology (SLP) and occupational therapy (OT). After the limit has been reached, you will pay the full cost of the services until January 1st of the following year.

profitable one. In 2007, Medicare Advantage plans are expected to receive about a 1.1 percent increase in payments.<sup>16</sup> (For more details from the Centers for Medicare and Medicaid Services, see a fact sheet at [www.cms.hhs.gov/MedicareAdvtgSpecRateStats](http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats) under “Ratebooks and Supporting Data.”)

Another provision in the MMA affecting managed care plans is a pilot program beginning in 2010 in which managed care plans will compete with the fee-for-service program.<sup>17</sup> Such regional demonstration projects for competitive bidding have proven controversial in the past, with plans and providers in the selected regions protesting and preventing them from being implemented.<sup>18</sup>

A different pilot project will allow Medicare Advantage participants to enroll in consumer-directed health plans starting in 2007.<sup>19</sup> (See Chapter 2 on Private Health Coverage for information on how such plans work.)

## HOW IS MEDICARE FINANCED?

Health care services covered by Medicare Part A are paid from the federal government’s Hospital Insurance (HI) Trust Fund. The HI trust fund is mainly financed by a 2.9 percent tax on employee income – 1.45 percent from employees and 1.45 percent from employers. (Individuals paying the self-employment tax pay the entire 2.9 percent.) Other sources of HI trust fund revenues – 14 percent of the total – include interest on trust fund investments, premiums collected from individuals not subject to payroll taxes, and income taxes on some Social Security cash benefits.<sup>20</sup>

Most beneficiaries pay no monthly premium for Part A coverage, although they do have to pay a deductible for each hospitalization and some coinsurance. (See table, “What Medicare Covers – And Doesn’t Cover.”) These beneficiaries include people age 65 or older who are receiving Social Security or Railroad Retirements benefits, or are eligible for such benefits. People 65 or older who don’t fit this description can also get Medicare Part A coverage by paying a monthly premium.

Beneficiaries under age 65 pay no premiums for Part A coverage if they have received Social Security or Railroad Retirement Board disability payments for at least 24 months, or if they have end-stage renal disease.

Services covered by Medicare Part B are paid from the Supplementary Medical Insurance (SMI) Trust Fund. This is financed from beneficiary premiums and the federal government’s general fund, which is largely derived from income tax revenue. Anyone age 65 or older, or otherwise eligible for Medicare, is eligible for Part B services.

Beneficiary premiums for Part B are \$88.50 a month in 2006, rising to a minimum of \$93.50 in 2007.<sup>21</sup> (See box, “2007 Medicare Premiums and Deductibles.”) When Medicare was implemented in 1966, 50 percent of Part B funding came from beneficiary premiums. Six years later, Congress limited the increase in the premium to the rate of increase in Social Security cash benefits, causing the share of total Part B costs covered by premiums to fall.

Beginning in 1984, Congress mandated that the monthly premium for Medicare Part B must be sufficient to cover 25 percent of the program’s costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent from general revenues.<sup>22,23</sup>

Medicare Advantage plans receive reimbursement from both the HI and SMI trust funds because such plans cover services falling under both the Part A and Part B umbrellas.

## FUTURE MEDICARE ENROLLMENT AND FINANCING

The 2006 Medicare Trustees Report projects that Medicare’s cost per beneficiary will rise 47 percent for the hospital component of Medicare (Part A) between 2006 and 2015. Per beneficiary costs are expected to rise 42 percent for Medicare’s physician component (Part B), and a whopping 92 percent for the Medicare prescription drug benefit (Part D). (See chart, “Projected Federal Costs Per Medicare Beneficiary, Selected Years.”)

Despite these looming cost increases, the Hospital Insurance (HI) trust fund is healthy for the near term. Trust fund assets are expected to increase from \$286 billion to \$311 billion between the end of 2005 and the end of 2009.<sup>24</sup> Changes to the program in the late 1990s, including adjustments to the fees paid to hospitals, doctors and other providers, helped to

## 2007 Medicare Premiums and Deductibles

<b>Part A Premium</b>	<b>\$410 (paid by about 1 percent of beneficiaries)</b>
<b>Part A Deductible</b>	<b>\$982</b>
<b>Part B Standard Premium</b>	<b>\$93.50</b>
<b>Part B Deductible</b>	<b>\$131</b>

The standard premium for Medicare Part B coverage will be \$93.50 per month beginning in January 2007. This 5.6 percent increase is the smallest percent increase since 2001.

In 2007, for the first time, higher income retirees will pay more for their Medicare Part B premiums than those with lower incomes. The change will affect the 4 percent of Medicare Part B enrolled individuals with an annual income of more than \$80,000, or married couples whose income exceeds \$160,000. Premiums for these enrollees will be \$106, \$124.70, \$143.40 or \$162.10, depending on how much the enrollee's income exceeds the trigger amount. Premiums will be determined according to the income listed on beneficiaries' tax returns, and will be deducted from Social Security checks, as at present.

This sliding scale phases in over three years. As a result, those in the highest-income group are expected to eventually pay a premium more than three times as high as the standard premium. Implementing higher fees for higher income beneficiaries is projected to save Medicare \$7.7 billion over five years, and almost \$21 billion over 10 years.

Sources: Centers for Medicare and Medicaid Services (2006). ([www.cms.hhs.gov/apps/media/press/release.asp?Counter=1958](http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1958)) and Kathy M. Kristof (2006). "Medicare Part B Fees Head for a Sliding Scale." Los Angeles Times, Sept. 17 ([www.latimes.com](http://www.latimes.com))

secure this financing.

But in 2010, the year before the first baby boomers reach age 65, expenses for the HI trust fund are expected to exceed income by \$1.8 billion.<sup>25</sup> This shortfall will reach \$42.2 billion by 2015 if no changes are made to the program,<sup>26</sup> and the trust fund will be exhausted in 2018, federal actuaries project.<sup>27</sup>

The Medicare trustees in May 2006 posed some drastic ways to secure Medicare's future financing:

"The [Part A trust fund] could be brought into actuarial balance over the next 75 years by an immediate 121 percent increase in program income, or an immediate 51 percent reduction in program outlays (or some combination of the two). As with Social Security, however, adjustments of a far greater magnitude would be necessary to the extent changes are delayed or phased in gradually...."<sup>28</sup>

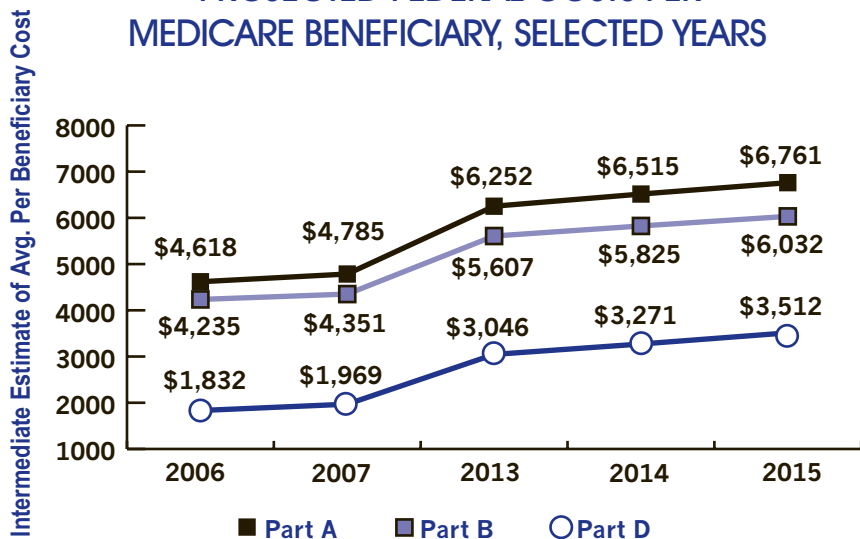
In contrast to their warning about the Part A trust fund, the Medicare trustees aren't as worried about Part B or Part D. "Both (are) projected to remain

adequately financed into the indefinite future (since current law automatically sets financing each year to meet next year's expected costs," the trustees wrote in 2006.<sup>29</sup>

A provision in the Medicare Modernization Act may spur the White House and Congress to either reduce the growth in Medicare spending or generate more revenue for the program. The act requires the Medicare trustees to issue an official Medicare funding warning if the difference between total Medicare expenditures and "dedicated funding sources" (such as premiums and payroll taxes) is greater than 45 percent of total outlays during two consecutive years of a seven-year period looking forward (from 2006 to 2012 currently).

The 2006 Medicare Trustees Report projects that this 45 percent trigger point will occur in 2012, if Medicare benefits and funding continue on their present course. If the 2007 Trustees Report projects that the 45 percent trigger will be reached in 2013 as well, the act would then require "a Presidential proposal to respond to the warning and expedited

### PROJECTED FEDERAL COSTS PER MEDICARE BENEFICIARY, SELECTED YEARS



Source: Centers for Medicare and Medicaid Services (2006).  
 "2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." May 1, p. 160.  
 ([www.cms.hhs.gov/apps/media/press/release.asp?Counter=1958](http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1958))

### BENEFICIARY OUT-OF-POCKET EXPENSES

As mentioned, Medicare leaves most beneficiaries paying considerable out-of-pocket amounts for their care. (For some of these, see the table, "What Medicare Covers – And Doesn't Cover.")

The average cost per Medicare beneficiary for Medicare-covered services was estimated in one study at \$9,236 (in 2004 dollars). Of this amount, the government pays 67 percent (\$6,170) and beneficiaries pay 33 percent (\$3,066).<sup>35</sup> (See chart, "Who Pays for Medicare-Covered Services?")

Congressional consideration of such a proposal."<sup>30</sup> Congress is required to consider such a White House proposal, but isn't required to vote on it.

Even without an official Medicare warning, as a major component of federal spending, Medicare is frequently targeted by lawmakers trying to reduce federal deficits – such as when they sought to reduce five-year Medicare spending by \$112 billion in 1997 under the Balanced Budget Act.

The federal deficit for FY 2006 is estimated at \$300 to \$350 billion,<sup>31</sup> and in early 2006, expectations were that federal spending would not go into the black until 2012. Over that time, more than \$3 trillion is expected to be added to the federal government's debt<sup>32</sup>, which in September 2006 stood at \$8.5 trillion.<sup>33</sup>

All this is not to say, however, that hospitals and doctors' offices will suddenly be treating an overwhelming number of Medicare beneficiaries. A recent analysis suggests that the aging of the population will contribute only about three-fourths of one percent per person per year to the growth of hospital use.<sup>34</sup> The change will be gradual, but significant.

And since some health care services are not covered by Medicare, beneficiaries' out-of-pocket medical spending can be even higher. One study found that Medicare beneficiaries not in nursing homes or other institutions spent 22 percent of their income on health care in 2003.<sup>36</sup> This doesn't take into account spending changes related to the Medicare prescription drug benefit, which went into effect on January 1, 2006.

This cost-sharing has a significant impact on Medicare beneficiaries. For low-income seniors, the burden is especially severe. Two additional programs run by Medicaid help low-income seniors bear those costs:

- The Qualified Medicare Beneficiary (QMB, pronounced "QUIM-bee") program pays premiums, deductibles and coinsurance for Part A and Part B for those below the federal poverty level, which is \$13,200 for a household of two in 2006.
- The Specified Low Income Beneficiary Program (SLMB, pronounced "SLIM-bee") pays Part B premiums for Medicare beneficiaries between 100 and 120 percent of the poverty level.

## QUALITY AND EFFECTIVENESS

While working on ways to reduce costs, Medicare policymakers have also been developing new ways to improve the quality of care delivered to beneficiaries. (For more information on such methods, see Chapter 9, “Quality”.) One recent development in this area is “pay for performance” (P4P) – initiatives that induce providers to report quality data, and eventually reimburse them based on how they compare to quality standards or to their peers.

The federal government’s involvement in quality improvement efforts is expected to have a far-ranging ripple effect throughout the health care system. Considering the government’s purchasing power, providers can’t afford to ignore federal quality guidelines that influence payments.

Several provisions in the MMA and previous laws call for quality improvement or reporting of data on quality.<sup>37,38,39,40</sup> Also authorized under MMA are clinical effectiveness studies on health care treatments that are frequently used by Medicare beneficiaries. The federal Agency for Healthcare Research and Quality is conducting that research.<sup>41,42</sup>

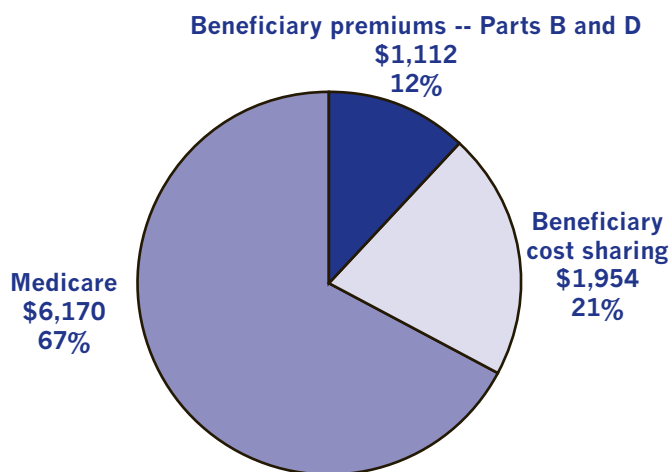
## CURRENT POLICY DEBATES AND PROPOSALS

### Costs

Anticipating the coming tidal wave of Medicare recipients, planners are vigorously looking for ways to control the cost of the program. This can be done by reducing provider payments, reducing benefits or tightening eligibility.

In the “reducing benefits” category is a proposal to make Medicare a “premium support” system – that is, the government would no longer run an insurance program but would instead subsidize what seniors pay to enroll in private insurance plans. Advocates say such a system would allow seniors more choice. They could enroll in health plans with more generous benefits if they wanted to pay extra, or they could seek out the cheapest plan and receive a rebate.

### WHO PAYS FOR MEDICARE-COVERED SERVICES? (2004) (AVG PER-BENEFICIARY SPENDING BY SOURCE)



Source: Davis, Karen et al. (2005). “Medicare Extra: A Comprehensive Benefit Option For Medicare Beneficiaries.” *Health Affairs*, Oct. 4. ([www.healthaffairs.org](http://www.healthaffairs.org))

Advocates also say the concept could help bring costs under control and enhance health care quality by spurring competition. Opponents claim such a system would undercut the principle of Medicare as an equal entitlement to all who are eligible.

Similarly, a popular concept among those who support free-market solutions to the Medicare financing question is the health savings account (HSA), which would allow seniors to enroll in a high-deductible Medicare Advantage health plan, and allow Medicare to pay into a specially designated, interest-earning savings account from which a senior can draw money tax-free to pay for day-to-day medical expenses. Proponents say beneficiaries will spend Medicare’s money more carefully if it is kept in an account that they own. (For more on HSAs, see Chapter 2, “Private Coverage”.)

Another cost-saving proposal is raising the eligibility age for Medicare from 65 to 67, as the federal government has done for Social Security, depending on when beneficiaries were born. Seniors’ advocates say the savings gained would be modest and a large number of seniors aged 65 and 66 would become, or remain, uninsured.<sup>43</sup>

*Market-based approaches*

As noted, the Medicare Modernization Act calls for a demonstration project in 2010 that will test Medicare managed care against traditional Medicare fee-for-service in a real world marketplace – six metropolitan areas, yet to be named. The traditional Medicare program will bid for beneficiaries' business, competing against managed care plans.

Beneficiaries in the demonstration areas will get a voucher to use in buying their coverage. If a plan charges more than the voucher amount, the beneficiary will have to pay the difference. Policymakers from all political leanings will be watching this demonstration carefully.

If judged successful, the demonstration could spur the federal government to step back somewhat from its hands-on operation of the Medicare program and turn over more of the operational details to managed care plans. Consumer advocates worry that this would fundamentally change the compact that Medicare has had with beneficiaries.<sup>44</sup>

**EARLY RETIREES**

As retiree health coverage becomes rarer, early retirees between the ages of 55 and 64 face a dilemma: How to pay for their health care needs before Medicare kicks in? Private insurance is available to only the healthiest older adults, as private insurers often charge prohibitive premiums or deny coverage to those with preexisting conditions (over half of adults 55 to 64), says the Medicare Rights Center. Without a public insurance option, 1.5 million adults ages 55 to 64 with chronic conditions go uninsured, the center states.<sup>45</sup>

**STORY IDEAS**

- What are hospitals in your area doing to try to maximize their Medicare payments? Talk with your local hospital's chief financial officer to find out. Ask about payments for "outliers" – very high-cost cases – and the adjustment for urban vs. rural wage scales.
- What is the status of Medicare managed care in your area? If plans withdrew during the late 1990s or early in this decade, are seniors reluctant to join again? Are plans beginning to come back into the market?
- Are local companies taking advantage of federal subsidies to continue their retiree health plans?
- What about retirees without health coverage from their former employers but who are too young to get Medicare? How do they pay for their health care needs?
- Are physicians adjusting their practices because of flat Medicare payment rates over the last few years? How?
- How do hospitals in your area score on Medicare performance measures as published on the Medicare Hospital Compare web site? What are they doing to improve their scores?
- Are hospitals in your area involved in any Medicare pay-for-performance initiatives? How are they faring?
- In some areas, specialty hospitals compete aggressively with general hospitals for the most profitable patients. Is this true in your area, and if so, what is the impact on local health care for seniors?

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