“Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called “End-Stage Renal Disease”)

— Center for Medicare and Medicaid Services

Why Medicare?
Proposed Medicare

• President Johnson, congressional majorities

• Benefits similar to popular FEHBP plan
AMA Alternative

• Eldercare
• “Kerr-Mills on steroids”
• More benefits than Medicare
• Limited to elderly welfare population
Medicare’s Origins

• Preceded by Social Security
• July 1, 1965 — Medicare signed into law
• July 1, 1966 — Implemented
Medicare Legislative Milestones

- 1965 — Title XVIII (65+)
- 1972 — Long-term disabilities and End Stage Renal Disease (ESRD)
- 1980 — Home health, Medigap Federal oversight
- 1983 — Prospective Payment System (PPS)
- 1988-9 — Catastrophic
- 1992 — Resource Based-Relative Value Scale (RB-RVS)
- 1997 — Sustainable Growth Rate (SGR)
- 2003 — Part D Outpatient Prescription Drugs
- 2010 — Health Care Reform
Medicare’s Share of Federal Outlays, 2010–2021

22.9% to 28.1%
Medicare

• Fee-for-Service (FFS) or Traditional
  • Part A, Hospital Insurance (HI)
  • Part B, Supplementary Medical Insurance (SMI)
  • Part D, Outpatient Prescription Drug

• Private Health Plans/Managed Care
  • Part C, Medicare Advantage (MA)
Medicare Eligibility

- Aged (65+)
- Railroad Retirement benefits
- Disabled, receiving cash assistance (after 24 months)
- End Stage Renal Disease (dialysis)
Medicare Enrollment, 1966-2010

Number in millions:

<table>
<thead>
<tr>
<th>Year</th>
<th>Nonelderly Disabled</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966</td>
<td>2.2</td>
<td>19.1</td>
</tr>
<tr>
<td>1970</td>
<td>3.0</td>
<td>20.5</td>
</tr>
<tr>
<td>1975</td>
<td>2.9</td>
<td>22.8</td>
</tr>
<tr>
<td>1980</td>
<td>3.3</td>
<td>25.5</td>
</tr>
<tr>
<td>1985</td>
<td>31.1</td>
<td>28.2</td>
</tr>
<tr>
<td>1990</td>
<td>34.2</td>
<td>31.0</td>
</tr>
<tr>
<td>1995</td>
<td>37.6</td>
<td>33.2</td>
</tr>
<tr>
<td>2000</td>
<td>39.6</td>
<td>34.3</td>
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<tr>
<td>2005</td>
<td>42.5</td>
<td>35.8</td>
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<tr>
<td>2006</td>
<td>43.3</td>
<td>36.3</td>
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<tr>
<td>2007</td>
<td>44.0</td>
<td>37.0</td>
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<tr>
<td>2008</td>
<td>45.4</td>
<td>37.9</td>
</tr>
<tr>
<td>2009</td>
<td>46.1</td>
<td>38.5</td>
</tr>
<tr>
<td>2010</td>
<td>47.0</td>
<td>39.0</td>
</tr>
</tbody>
</table>

NOTES: Numbers may not sum to total due to rounding. People with disabilities under age 65 were not eligible for Medicare prior to 1972.
SOURCE: Centers for Medicare & Medicaid Services, Medicare Enrollment: Hospital Insurance and/or Supplemental Medical Insurance Programs for Total, Fee-for-Service and Managed Care Enrollees as of July 1, 2008: Selected Calendar Years 1966-2008; 2009-2010, HHS Budget in Brief, FY2011.
Eligible individuals
(U.S. citizens/legal residents)

- Entitled to Part A (payroll taxes for 40 quarters)
- May enroll in:
  - Part B (late enrollment penalty)
  - Part C: Medicare Advantage (MA) Plan
  - Part D: Prescription drug plan (PDP)
Sources of Supplemental Coverage Among Medicare Beneficiaries, 2008

Total Medicare Beneficiaries, 2008 = 41.8 Million

NOTES: Supplemental coverage was assigned in the following order: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Medigap, 5) Other public/private coverage, 6) No supplemental coverage. Individuals with more than one source of coverage were assigned to the category that appears highest in the ordering. RDS is retiree drug subsidy.

Medicare Administration

Social Security Administration

Medicare

Health Care Financing Administration

CMS

Centers for Medicare & Medicaid Services

Medicaid

Social and Rehabilitation Service (SRS)
Dual Eligibles
(Medicare and Medicaid)

- **Full Duals**
  - Eligible for all Medicaid benefits (gaps in Medicare coverage, LTC)
  - Medicaid generally pays Medicare cost sharing

- **Partial Duals** (Medicare Savings Duals)
  - Not eligible for full Medicaid benefits
  - Only Medicaid assistance with Medicare cost-sharing and/or premium
Medicaid Benefits for Full Duals

- Medicaid pays Medicare cost-sharing (Medicare pays first)
- Services not covered by Medicare
  - Nursing home care
  - Dental care
  - Transportation to providers
  - Routine eye care
- “Wrap around coverage” can vary from state to state since states can choose which optional benefits to provide under Medicaid
# Benefits for Medicare Savings Duals

<table>
<thead>
<tr>
<th></th>
<th>Premium</th>
<th>Cost-sharing</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qualified Medicare Beneficiaries</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>&lt; 100% FPL</td>
</tr>
<tr>
<td><strong>Specified Low-Income Medicare Beneficiaries</strong></td>
<td>Part B</td>
<td>No</td>
<td>&lt; 120% FPL, limited resources</td>
</tr>
<tr>
<td><strong>Qualified Working Disabled Individuals</strong></td>
<td>Part B</td>
<td>No</td>
<td>&lt;135% FPL</td>
</tr>
<tr>
<td></td>
<td>Part A</td>
<td>No</td>
<td>&lt; 200% FPL (insuff. work)</td>
</tr>
</tbody>
</table>
Part A Benefits

- **Inpatient hospital care** (150 days/spell of illness)
  - 1st day deductible: $1,132
  - $283 per day for days 61-90 of stay
  - $566/day for life-time reserve days (60 days)
- **Skilled nursing care** (level of care criteria)
  - requires 3-day prior hospital stay
  - $141.50/day for days 21-100 (maximum of 100 days/benefit period)
- **Home health care** (level of care & homebound)
  - no co-insurance
- **Hospice care** (no coverage for curative services)
  - terminal illness w/6 months prognosis
  - no co-insurance

*No catastrophic out-of-pocket spending limit*
Part B Benefits (voluntary)

Annual $162 deductible & 20% co-insurance (except Home health/Lab.)

- Outpatient hospital services
- Physicians’ services
- Ambulatory surgery services
- Home health services
- Drugs and biologics
- Therapy services
- Durable medical equipment/prosthetics/orthotics
- Laboratory and x-ray services
- Preventive services

*No catastrophic out-of-pocket spending limit*
Part B Premiums, 2011

• Standard premium = $115.40

• For high income beneficiaries
  (incomes over $85,000/individual, $170,000/couple)
  $161.50 to $369.10
Part D: Outpatient Rx

- Voluntary
- Low-income subsidies
- Private plans
  - Free standing drug plans (PDPs) or
  - Combined with a MA plan (MA-PD)
Prescription Drug Coverage Among Medicare Beneficiaries, 2010

- Stand-Alone Prescription Drug Plan (PDP): 17.7 million (38%)
- Medicare Advantage Drug Plan: 9.9 million (21%)
- Retiree Drug Coverage: 8.3 million (18%)
- Other Drug Coverage: 5.9 million (13%)
- No Drug Coverage: 4.7 million (10%)

Total in Part D Plans: 27.7 Million (60%)

Total Number of Medicare Beneficiaries = 46.5 Million

NOTES: Numbers do not sum to 100 percent due to rounding. 1 Includes Veterans Affairs, retiree coverage without ODS, Indian Health Service, state pharmacy assistance programs, employer plans for active workers, Medigap, multiple sources, and other sources. 2 Includes Retiree Drug Subsidy (RDS) and FEHBP and TRICARE retiree coverage.

SOURCE: Centers for Medicare & Medicaid Services, 2010 Enrollment Information (as of February 16, 2010).
Standard Part D Benefit, 2011

Source: MedPAC.
Part D Low Income Subsidy

- Help with premiums, deductibles, and cost sharing
- Qualification based on income and assets
- Beneficiary enrolls in a Medicare drug plan

- Duals deemed eligible for assistance
  - Automatically assigned to qualifying plans if beneficiary does not choose
# LIS Eligibility and Benefits in Part D, 2010

<table>
<thead>
<tr>
<th>Beneficiary Category</th>
<th>Income</th>
<th>Asset limit (indiv/couple)</th>
<th>Covered costs and services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual eligibles, QMB, SLMB, QI</td>
<td>Deemed eligible</td>
<td>Deemed eligible</td>
<td>No premium or deductible, $1.10-$2.50 (generic), $3.30-$6.30 (brand), no copays after drug spending reaches $6,440</td>
</tr>
<tr>
<td>Full subsidy</td>
<td>&lt;135% of poverty</td>
<td>$8,100/ $12,914</td>
<td>No premium or deductible, $2.50 (generic), $6.30 (brand), no copays after drug spending reaches $6,440</td>
</tr>
<tr>
<td>Limited subsidy</td>
<td>&lt;150% of poverty</td>
<td>$12,510/ $25,010</td>
<td>Sliding scale, $63 deductible, 15% coinsurance until drug spending reaches $6,440, then $2.50 (generic), $6.30 (brand)</td>
</tr>
</tbody>
</table>
Medicare Part C

• Voluntary enrollment in private health plans (Medicare Advantage)

• All benefits under Part A and B
• May offer lower cost-sharing and premiums
• May offer additional benefits
• Plans may be local (county) or regional (groups of states)
MA and PDP Regions

Note: An MA region is one color. A difference in shading indicates that there are multiple PDP regions nested within the MA region. No change indicates that the MA and PDP regions are the same. For example, Wisconsin and Illinois are in one MA region; they are each a separate PDP region. Each territory is its own PDP region.
Weighted Average Monthly Premium for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2009-2010

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$36</td>
<td>$48</td>
</tr>
<tr>
<td>HMO</td>
<td>$31</td>
<td>$38</td>
</tr>
<tr>
<td>Local PPO</td>
<td>$61</td>
<td>$83</td>
</tr>
<tr>
<td>PFFS</td>
<td>$28</td>
<td>$44</td>
</tr>
<tr>
<td>Regional PPO</td>
<td>$37</td>
<td>$65</td>
</tr>
</tbody>
</table>

% change in premiums:
- Total: 32%
- HMO: 22%
- Local PPO: 37%
- PFFS: 55%
- Regional PPO: 78%

NOTES: Excludes SNPs, demonstrations, NCSPs, PACE plans, employer-sponsored (i.e., group) plans, plans for special populations (e.g., Mannonbols) and plans that do not offer Part D benefits. The total includes cost plans, which are not shown separately. Weighted average monthly premiums are based on MA-PD plans available in 2009 and 2010, weighted for the respective year of enrollment.

Enrollment by Part
Out-of-pocket Costs

• Part A inpatient daily deductible (hospital, SNF)
• Part A lifetime reserve days (hospital)
• Part B premium
• Part B deductible & coinsurance
• Part D premium
• Part D deductible/initial benefit limit (“donut hole”)
• Note: No catastrophic out-of-pocket limit
• Non-covered services (e.g., vision or dental)
Sources of Payment for Medicare Fee-for-Service Beneficiaries’ Health Care Spending, 2006

*Includes Medical, Long-Term Care, and Premium Expenses*

- Medicare: 48%
- Medicaid: 8%
- Private Insurance: 14%
- Premiums: 10%
- Services: 15%
- Out-of-Pocket: 25%
- Other/Uncollected: 4%

Average Total Medical and Long-Term Care Expenses per Medicare Fee-for-Service Beneficiary, 2006: $17,231

NOTES: Excludes Medicare Advantage enrollees. Includes institutionalized and non-institutionalized beneficiaries. Numbers may not sum to 100 percent due to rounding.

Chart 6-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2006

Note: FFS (fee-for-service). Analysis includes FFS beneficiaries not living in institutions such as nursing homes. Out-of-pocket spending is on Medicare cost sharing and noncovered services.

Medicare Financing

• Part A
  • Payroll Taxes
  • Interest
  • Tax on Social Security benefits

• Part B
  • Premiums
  • General Revenue

• Part D
  • General Revenues
  • Premiums
  • Payments from states
Medicare Trust Funds

• Hospital Insurance (HI) Trust Fund pays for Part A and a share of Part C

• Supplementary Medical Insurance (SMI) Trust Fund pays for Parts B, D, and a share of Part C
Years of HI Trust Fund Solvency

Source: Medicare Trustees Reports, multiple years.
Workers per HI Beneficiary

Source: Medicare Trustees Reports
Medicare Benefit Payments by Major Service Categories, FY2009

Source: CMS OACT
Structural Elements of Medicare FFS Payment Systems

• Define the products and services to identify the basic unit for payment
• Develop classification system
• Set relative values
• Set a national base payment rate
Structural Elements

• Make adjustments
  • Local market conditions (input prices vary the cost of providing care)
• Teaching
• Non-physicians
• Update payment rates
# FFS Payment Systems

<table>
<thead>
<tr>
<th>Provider/service</th>
<th>Payment unit</th>
<th>Patient/service classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital</td>
<td>Per discharge</td>
<td>Medicare severity-diagnosis-related groups (MS-DRG)</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>Per service</td>
<td>Ambulatory payment classifications (APC)</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>Per diem</td>
<td>Resource utilization groups (RUG)</td>
</tr>
<tr>
<td>Home health agency</td>
<td>Per 60 day episode</td>
<td>Home health resource groups (HHRG)</td>
</tr>
<tr>
<td>Physician</td>
<td>Per service</td>
<td>Healthcare common procedure coding System (HCPC)</td>
</tr>
</tbody>
</table>
Physician Payment

Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare payments only. The physician fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are reduced when specified nonphysician practitioners bill Medicare separately, but not when services are provided “incident to” a physician.
Inpatient Hospital Payment

Note: MS-DRG (Medicare severity diagnosis related group), LOS (length of stay), IPPS (inpatient prospective payment system). Capital payments are determined by a similar system.

* Transfer policy for cases discharged to postacute care settings applies for cases in 273 selected MS-DRGs.

** Additional payment made for certain rural hospitals.
Medicare MA Plan Payments

• Payment is per beneficiary, per month
• Plan’s “bid” and Medicare’s “benchmark” determine:
  • Medicare’s base payments to the plan
  • Beneficiaries’ plan premium
  • Extent of extra benefits
• Payments adjusted for beneficiary health status
• Bonus for quality rating (starting in 2012)
Part D Plan Payments

- Payment is per beneficiary, per month
- Plan’s “bid” and Medicare’s “benchmark” determine:
  - Medicare’s base payments to the plan
  - Beneficiaries’ plan premium
- Adjusted for beneficiary health status
- Protections against risk for plans
  - Individual reinsurance
  - Risk corridors
Part D Plan Payments

Note: Rx HCC (prescription drug hierarchical condition category). The Rx HCC is the model that estimates the enrollee risk adjuster.
* Figure 3 outlines the process for calculating enrollee premiums.
** Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.
Physician Issues

• Physician fee schedule and the sustainable growth rate (SGR)

• Physician participation
Medicare Physician Participation and Fee Schedule Update

- Actual Update
- Formula Update
- % MD Participation

Graph showing the comparison of Actual Update and Formula Update with % MD Participation from 2005 to 2010.
Percent of Physicians and Other Practitioners Participating in Medicare Part B, by State, 2009

National Average, 2009 = 96%

NOTES: Other practitioners include Limited License Practitioners and Non-Physician Practitioners.
Medicare Proposals

- Increase age of eligibility
- No cap on Medicare payroll
- Individual Medicare accounts
- Premium support/Defined contribution/Vouchers
- More beneficiary cost-sharing
Life Expectancy at 65 has increased...
...and is projected to continue.
Medicare Benefits to Taxes Over Lifetime

Two-earner couple: one earning a high wage ($68,900 in 2010) and one earning an average wage ($43,100 in 2010)

<table>
<thead>
<tr>
<th>Turn 65 in ...</th>
<th>Lifetime Benefits</th>
<th>Lifetime Taxes</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>$35,000</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>$132,000</td>
<td>$16,400</td>
<td>8.05</td>
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<tr>
<td>2010</td>
<td>$343,000</td>
<td>$140,000</td>
<td>2.45</td>
</tr>
<tr>
<td>2030</td>
<td>$530,000</td>
<td>$171,000</td>
<td>3.10</td>
</tr>
</tbody>
</table>

Source: Steuerle and Rennane, Jan. 2011.
PPACA & Medicare

• CMS Innovation Center
• Independent Payment Advisory Board
• Payment reductions (productivity adjustment)
• Reforms: Bundled payments, ACOs, Value-based purchasing, etc.
• Future NHPF briefings!!