
# Medicare Primer

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# Summary

Medicare is the nation's federal insurance program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65. Medicare, which consists of four parts (A-D), covers hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, and hospice care, among other services.

Generally, individuals are eligible for Medicare if they or their spouse worked for at least 40 quarters in Medicare-covered employment, are 65 years old, and are a citizen or permanent resident of the United States. Individuals may also qualify for coverage if they are a younger person with a permanent disability, have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant), or have amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease).

In FY2009, the program will cover an estimated 45 million persons (38 million aged and 7 million disabled) at an estimated total cost of about $492 billion, accounting for over 3% of GDP. Medicare is an entitlement program, which means that it is required to pay for services provided to eligible persons, so long as specific criteria are met.

The 111th Congress is likely to continue the work of previous Congresses in addressing the rapid rise in Medicare spending, its growing share of GDP, and the inability of Medicare's current funding mechanisms to sustain the program over the long term. A combination of factors have contributed to the rapid increase in Medicare spending, including increases in overall medical costs, advances in health care delivery and medical technology, the aging of the population, and longer life spans. In addition, both the shrinking employment base and the impact of the economic downturn on Medicare revenues further exacerbate the issues facing Medicare. The issues confronting the program are not new; nor are the possible solutions likely to get any easier. For a number of years, various reform options have been suggested; however, legislative changes have focused mainly on short-term solutions. Achieving consensus is more difficult for both long-term solutions and Medicare's position within the broader context of health reform.

This report provides an overview of Medicare and will be updated to reflect any legislative changes.

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# Introduction

Medicare is the nation's federal insurance program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65. Medicare consists of four distinct parts:

- Part A (Hospital Insurance, or HI) covers inpatient hospital services, skilled nursing care, and home health and hospice care. The HI trust fund is mainly funded by a dedicated payroll tax of 2.9% of earnings, shared equally between employers and workers.
- Part B (Supplementary Medical Insurance, or SMI) covers physician services, outpatient services, and home health and preventive services. The SMI trust fund is funded through beneficiary premiums (set at 25% of estimated program costs for the aged) and general revenues (the remaining amount, approximately 75%).
- Part C (Medicare Advantage, or MA) is a private plan option for beneficiaries that covers all Part A and B services, except hospice. Individuals choosing to enroll in Part C must also enroll in Part B. Part C is funded through the HI and SMI trust funds.
- Part D covers prescription drug benefits. Funding is included in the SMI trust fund and is financed through beneficiary premiums (about 25.5%) and general revenues (about 74.5%).

Medicare serves approximately one in seven Americans and virtually all of the population aged 65 and over. In 2009, the program will cover an estimated 45 million persons (38 million aged and 7 million disabled). The Congressional Budget Office (CBO) estimates that total Medicare spending in 2009 will be about $492 billion, accounting for over 3% of GDP. CBO also estimates that federal Medicare spending (after deduction of beneficiary premiums and other offsetting receipts) will be about $419 billion in 2009, accounting for over 14% of total federal spending. Medicare is an entitlement program, which means that it is required to pay for all covered services provided to eligible persons, so long as specific criteria are met. Spending under the program (except for a portion of administrative costs) is considered mandatory spending (not discretionary spending, which is subject to the appropriations process).

The 111th Congress is likely to continue the work of previous Congresses in addressing the issues confronting Medicare. The Committees of Jurisdiction for the entitlement (or benefits) portion of Medicare are the Senate Committee on Finance, the House Committee on Ways and Means, and the House Committee on Energy and Commerce. The House and Senate Committees on Appropriations have jurisdiction over the discretionary spending used to administer and oversee the program.

# Medicare History

Medicare was enacted in 1965 (P.L. 89-97) in response to the concern that only about half of the nation's seniors had health insurance, and most of those had coverage only for inpatient hospital

costs. The new program, which became effective July 1, 1966, included Part A coverage for hospital and post-hospital services and Part B coverage for doctors and other medical services. As is the case for the Social Security program, Part A is financed by payroll taxes levied on current workers and their employers; persons must pay into the system for 40 calendar quarters to become entitled to premium-free benefits. Medicare Part B is voluntary, with a required monthly premium. Initially, over 90% of the eligible population enrolled. Payments to health care providers under both Part A and Part B were originally based on the most common form of payment at the time, namely "reasonable costs" for hospital and other institutional services or "reasonable charges" for physicians and other medical services.

Medicare is considered a social insurance program and is the second largest such federal program, after Social Security. The 1965 law also established Medicaid, the federal/state health insurance program for the poor; this was an expansion of previous welfare-based assistance programs. Some low-income individuals qualify for both Medicare and Medicaid.

In the ensuing 40 years, Medicare has undergone considerable changes. P.L. 92-603, enacted in 1972, expanded program coverage to individuals under 65 including the disabled and persons with end-stage renal disease (ESRD), and introduced managed care into Medicare. This law also began to place limitations on the definitions of reasonable costs and charges in order to gain some control over program spending which, even initially, exceeded original projections.

During the 1980s and 1990s, a number of laws were enacted that included provisions designed to further stem the rapid increase in program spending and to postpone the bankruptcy of the Medicare Part A trust fund. This was typically achieved through tightening rules governing payments to providers of services and limiting the annual updates in such payments. The program moved from payments based on reasonable costs and reasonable charges to payment systems under which a predetermined payment amount was established for a specified unit of service. At the same time, beneficiaries were given expanded options to obtain covered services through private managed care arrangements, typically health maintenance organizations. Most Medicare payment provisions were incorporated into larger budget reconciliation bills designed to control overall federal spending.

This effort culminated in the enactment of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). This law slowed the rate of growth in payments to providers and established new payment systems for certain categories of providers. It also established the Medicare+Choice program, which expanded private plan options for beneficiaries and changed the way most of these plans were paid. BBA 97 further expanded preventive services covered by the program.

Subsequently, Congress became concerned that the BBA 97 cuts in payments to providers were somewhat larger than originally anticipated. Therefore, legislation was enacted in both 1999 (Balanced Budget Refinement Act of 1999, BBRA, P.L. 106-113) and 2000 (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, BIPA, P.L. 106-554) designed to mitigate the impact of BBA 97 on providers.

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173),[1] which included a major benefit expansion and placed increasing

[1] For more information, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*.

emphasis on the private sector to deliver and manage benefits. The MMA included provisions that (1) created a new voluntary outpatient prescription drug benefit to be administered by private entities; (2) replaced the Medicare+Choice program with the Medicare Advantage (MA) program and raised payments to plans in order to increase their availability for beneficiaries; (3) introduced the concept of income testing into Medicare, with higher-income persons paying larger Part B premiums beginning in 2007; (4) modified some provider payment rules; (5) expanded covered preventive services; and (6) created a specific process for overall program review if general revenue spending exceeded a specified threshold.

During the 109th Congress, two laws were enacted that incorporated minor modifications to Medicare's payment rules. These were the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432). In the 110th Congress, additional changes were incorporated in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)[2] and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275).[3]

# Eligibility and Enrollment

Most persons aged 65 or older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems. Persons under age 65 who receive cash disability benefits from Social Security or the Railroad Retirement systems for at least 24 months are also entitled to Part A. (Since there is a five-month waiting period for cash payments, the Medicare waiting period is effectively 29 months.)[4] The 24-month waiting period is waived for persons with amyotrophic lateral sclerosis (ALS, "Lou Gehrig's disease"). The disabled population also includes persons under age 65 with end stage renal disease (ESRD); coverage for these individuals generally begins in the fourth month of dialysis treatments or the month of a kidney transplant.

Persons over age 65 who are not automatically entitled to Part A may obtain coverage by paying a monthly premium ($443 in 2009) or, for persons with at least 30 quarters of covered employment, a reduced monthly premium ($244 in 2009). In addition, disabled persons who lose their cash benefits solely because of higher earnings, and subsequently lose their extended Medicare coverage, may continue their Medicare enrollment by paying a premium, subject to limitations.

Generally, enrollment in Medicare Part B is voluntary. All persons entitled to Part A (and persons over 65 not entitled to premium-free Part A) may enroll in Part B by paying a monthly premium. The 2009 monthly premium is $96.40. Beginning in 2007, some higher-income individuals pay higher premiums. (See the "Part B" section, below.) While enrollment in Part B is voluntary for most individuals, those who voluntarily enroll in Part A must also enroll in Part B. Additionally,

[2] For more information, see CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*.

[3] For more information, see CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*.

[4] For more information, see CRS Report RS22195, *Social Security Disability Insurance (SSDI) and Medicare: The 24-Month Waiting Period for SSDI Beneficiaries Under Age 65*.

ESRD beneficiaries and Medicare Advantage enrollees (discussed below) must also enroll in Part B.

Together, Parts A and B of Medicare comprise "Original Medicare," which covers benefits on a fee-for-service basis. Beneficiaries have another option for coverage through private plans, called the Medicare Advantage (MA or Part C) program. When beneficiaries first become eligible for Medicare, they may chose either Original Medicare or they may enroll in a private MA plan. Each year, there is an annual open enrollment period from November 15-December 31, during which time Medicare beneficiaries may chose a different MA plan, or leave or join the MA program.[5]

Finally, each individual enrolled in either Part A or Part B is also entitled to obtain qualified prescription drug coverage through enrollment in a Part D prescription drug plan. Similar to Part B, enrollment in Part D is voluntary and the beneficiary pays a monthly premium. Generally, beneficiaries enrolled in an MA plan providing qualified prescription drug coverage (MA-PD plan) must obtain their prescription drug coverage through that plan.[6]

Generally, individuals who do not enroll in Part B during an initial enrollment period (when they first become eligible for Medicare) must pay a permanent penalty of increased Part B monthly premiums if they choose to enroll at a later date. Individuals who do not enroll in either Part B or D during their initial enrollment period may enroll only during the annual open enrollment period, which occurs from November 15-December 31 each year. Coverage begins the following January 1. However, the law waives the Part B late enrollment penalty for current workers who have primary coverage through their own or a spouse's employer-sponsored plan. These individuals have a special enrollment period once their employer coverage ends, and as long as they enroll in Part B during this time they will not be subject to penalty. Additionally, individuals are not subject to the Part D penalty if they have maintained "creditable" drug coverage through another source, such as retiree health coverage offered by a former employer or union. However, once employees retire or have no access to "creditable" Part D coverage, a penalty will apply unless they sign up for coverage during a special enrollment period. Finally, for persons who qualify for the low-income subsidy for Part D, the delayed enrollment penalty does not apply.

# Benefits and Payments

Medicare Parts A, B, and D each cover different services, with Part C providing a private plan alternative for Medicare services, except hospice. The Parts A-D covered services are described below, along with a description of Medicare's payments. This report provides an overview of the payment mechanisms for the various Medicare services. For a detailed description of the payment

[5] In addition, MA enrollees can generally change enrollment or drop out of their MA plans and return to Original Medicare during the first three months of each calendar year, or, for new enrollees, the first three months in which they are eligible to be enrolled in an MA plan. In certain cases, such as when an MA enrollee moves, he or she may switch plans at that time.

[6] If a Medicare beneficiary enrolls in a Private Fee-for-Service (PFFS) plan that does not provide drug coverage, he or she may enroll in a stand-alone Prescription Drug Plan (PDP). However, enrollees in other types of MA plans who want Part D prescription drug coverage must choose a Medicare Advantage Prescription Drug (MA-PD) plan, which is an MA plan that provides all Medicare required parts A, B, and D benefits. If a Medicare beneficiary enrolls in a local HMO or regional PPO that does not offer drug coverage, he or she does not have the option to enroll in a stand-alone PDP plan.

mechanism for each of the Medicare services, refer to CRS Report RL30526, *Medicare Payment Policies*.

# Part A

Part A provides coverage for inpatient hospital services, post-hospital skilled nursing facility (SNF) services, post-hospital home health services, and hospice care, subject to certain conditions and limitations. Approximately 20% of Part A enrollees use Part A services during a year.

## Inpatient Hospital Services

Medicare inpatient hospital services include (1) bed and board; (2) nursing services; (3) use of hospital facilities; (4) drugs, biologicals, supplies, appliances, and equipment; and (5) diagnostic and therapeutic items and services. (Physicians' services provided during an inpatient stay are paid under the physician fee schedule and discussed below in the "Physicians and Non-physician Practitioner Services" section.) Coverage for inpatient services is linked to an individual's benefit period or "spell of illness" (defined as beginning on the day a patient enters a hospital and ending when he or she has not been in a hospital or SNF for 60 days). An individual admitted to a hospital more than 60 days after the last discharge from a hospital or SNF begins a new benefit period. Coverage in each benefit period is subject to the following conditions:

- Days 1-60. Beneficiary pays a deductible ($1,068 in 2009).
- Days 61-90. Beneficiary pays a daily coinsurance charge ($267 in 2009).
- Days 91-150. After 90 days, beneficiary may draw on one or more 60 lifetime reserve days, provided they have not been previously used. (Each of the 60 lifetime reserve days can be used only once during an individual's lifetime.) Beneficiary pays daily coinsurance charge ($534 in 2009).
- Days 151 and over. No coverage.

Inpatient mental health care in a psychiatric facility is limited to 190 days during a patient's lifetime.

Medicare makes payments to most acute care hospitals under the inpatient prospective payment (IPPS) system, using a prospectively determined amount for each discharge. A hospital's payment for its operating costs is the product of two components: (1) a discharge payment amount adjusted by a wage index for the area where the hospital is located or where it has been reclassified, and (2) the weight associated with the Medicare severity-diagnosis related group (MS-DRG) to which the patient is assigned. This weight reflects the relative costliness of the average patient in that MS-DRG, which is revised periodically, with the most recent update effective October 1, 2009.

Additional payments are made for cases with extraordinary costs (outliers), indirect costs incurred by teaching hospitals for graduate medical education, and disproportionate share (DSH) costs for hospitals serving a disproportionate share of low-income patients. Additional payments may also be made for qualified new technologies that have been approved for special add-on payments. Payments are also made for capital costs, which are structured similarly to the operating cost IPPS for short-term general hospitals.

Medicare also makes payments outside the IPPS system for direct costs associated with graduate medical education for hospital residents, subject to certain limits. Medicare reimburses hospitals for 70% of the allowable costs associated with beneficiaries' unpaid deductible and copayment amounts.

Special payments, which are generally higher than the IPPS payments, may apply for hospitals meeting one of the following designations: (1) Sole Community Hospitals, (2) Medicare Dependent Hospitals, and (3) Rural Referral Centers. Certain hospitals or distinct hospital units are exempt from IPPS and paid on an alternative basis,[7] including (1) Inpatient Rehabilitation Facilities,[8] (2) Long-Term Care Hospitals,[9] (3) Psychiatric Hospitals or Distinct Part Units, (4) Children's Hospitals and Cancer Hospitals, and (5) Critical Access Hospitals.

## Skilled Nursing Facility (SNF) Services

Medicare covers up to 100 days of post-hospital care for persons needing skilled nursing or rehabilitation services on a daily basis.[10] The SNF stay must be preceded by a hospital stay of at least three days, and the transfer to the SNF must occur within 30 days of the hospital discharge. There is no beneficiary cost-sharing for the first 20 days. Days 21-100 are subject to daily coinsurance charges ($133.50 in 2009). The 100-days limit begins again with a new spell of illness.

SNF services are paid under a prospective payment system (PPS), which is based on a per diem urban or rural base payment rate, adjusted for case mix and area wages. The per diem rate generally covers all services, including room and board, provided to the patient that day. The case-mix adjustment is made using the resource utilization groups (RUGs) system, which uses patient assessments to assign a beneficiary to one of 53 categories that reflect the beneficiary's expected use of services. Patient assessments are done at various times during a patient's stay and the RUG category a beneficiary is placed in can change with changes in the beneficiary's condition. Extra payments are not made for extraordinarily costly cases ("outliers").

## Home Health Services

Medicare covers visits by a participating home health agency for beneficiaries who (1) are confined to home, (2) need skilled nursing care on an intermittent basis, or (3) need physical or occupational therapy or speech language therapy. After establishing such eligibility, the continuing need for occupational therapy services may extend the eligibility period. Covered services include part-time or intermittent nursing care, physical or occupational therapy or speech language pathology services, medical social services, home health aide services, and medical supplies and durable medical equipment. The services must be provided under a plan of care established by a physician, and the plan must be reviewed by the physician at least every 60 days.

[7] Hospitals in the state of Maryland are exempt from the IPPS and are paid under a state-specific payment system.

[8] For more information, see CRS Report RL32640, *Medicare Payment Issues Affecting Inpatient Rehabilitation Facilities (IRFs)*.

[9] For more information, see CRS Report RS22399, *Recent Developments in Medicare Affecting Long-Term Care Hospitals*.

[10] For more information, see CRS Report RL33921, *Medicare's Skilled Nursing Facility Payments.*

Home health services are covered under both Medicare Parts A and B. Part A covers up to 100 visits following a stay in a hospital or SNF. Part A also covers all home health services for persons not enrolled in Part B. All other home health services are covered under Part B. There is no beneficiary cost-sharing for home health services (though some other Part B services provided in connection with the visit, such as durable medical equipment, are subject to cost-sharing charges).

Home health services are paid under a home health PPS, based on 60-day episodes of care; a patient may have an unlimited number of episodes. Under the PPS, a nationwide base payment amount is adjusted by differences in wages (using the hospital wage index). This amount is then adjusted for case mix using the applicable Home Health Resource Group (HHRG) to which the beneficiary has been assigned. The HHRG applicable to a beneficiary is determined following an assessment of the patient's condition and care needs using the Outcome and Assessment Information Set (OASIS); there are 153 HHRGs. Further payment adjustments may be made for outlier visits (for extremely costly patients), a significant change in a beneficiary's condition, a partial episode which occurs because a beneficiary transfers from one agency to another, or a low utilization adjustment for beneficiaries receiving four or fewer visits.

## Hospice Care

The Medicare hospice benefit covers services designed to provide palliative care and management of a terminal illness; the benefit includes drugs and medical and support services. These services are provided Medicare beneficiaries with a life expectancy of six months or less for two 90-day periods, followed by an unlimited number of 60-day periods. The individual's attending physician and the hospice physician must certify the need for the first benefit period, but only the hospice physician needs to recertify for subsequent periods. Hospice care is provided in lieu of most other Medicare services related to the curative treatment of the terminal illness. Beneficiaries electing hospice care from a hospice program may receive curative services for illnesses or injuries unrelated to their terminal illness and they may disenroll from the hospice at any time. Nominal cost-sharing is required for drugs and respite care.

Payment for hospice care is based on one of four prospectively determined rates (which correspond to four different levels of care) for each day a beneficiary is under the care of the hospice. The four rate categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. Payment rates are adjusted to reflect differences in area wage levels, using the hospital wage index. Payments to a hospice are subject to an aggregate cap that limits the average per beneficiary cost to a cap that is adjusted annually by changes to the medical care expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

## Part A Services for End-Stage Renal Disease (ESRD)

Individuals with ESRD (i.e., kidney disease) are eligible for all services covered under Parts A and B. Kidney transplantation services, to the extent they are inpatient hospital services, are subject to the inpatient hospital PPS. However, kidney acquisition costs are paid on a reasonable cost basis. (See "Part B Services for End-Stage Renal Disease" for an explanation of dialysis benefits and payments, as well as other Part B ESRD services.)

# Part B

Medicare Part B covers physicians' services, outpatient hospital services, durable medical equipment, and other medical services. Over 80% of Part B enrollees use Part B services during a year. The program generally pays 80% of the approved amount (most commonly, a fee schedule or other predetermined amount) for covered services in excess of the annual deductible ($135 in 2009). The beneficiary is liable for the remaining 20%.

Most providers and practitioners are subject to limits on amounts they can bill beneficiaries for covered services. For example, physicians and some other practitioners may choose whether or not to accept "assignment" on a claim. When a physician accepts assignment, the physician can only bill the beneficiary the 20% coinsurance plus any unmet deductible. When a physician agrees to accept assignment on all Medicare claims in a given year, the physician is referred to as a "participating physician." Physicians who do not agree to accept assignment on all Medicare claims in a given year are referred to as nonparticipating physicians. Nonparticipating physicians may or may not accept assignment for a given service. If they do not, they may charge beneficiaries more than the fee schedule amount on nonassigned claims; however, these "balance billing" charges are subject to certain limits. Additionally, other providers may choose not to accept any Medicare payment and enter into a private contract with their patient.

For some providers, such as nurse practitioners and physician assistants, assignment is mandatory; these providers can only bill the beneficiary the 20% coinsurance and any unmet deductible. For other Part B services, such as durable medical equipment, assignment is optional; providers may bill beneficiaries for amounts above Medicare's recognized payment level and may do so without limit.

## Physicians and Non-physician Practitioner Services

Covered physician services include surgery, consultation, and home, office, and institutional visits. Certain limitations apply for services provided by chiropractors and podiatrists. Beneficiary cost-sharing for outpatient mental health treatment services equals 50% (rather than the usual 20%) of the approved amount. Covered non-physician practitioner services include, but are not limited to, those provided by physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical social workers.

A number of Part B services are paid under the physician fee schedule.[11] These include services of physicians, non-physician practitioners, and therapists. Most services described below as preventive services (except for laboratory tests paid under the laboratory fee schedule) and diagnostic tests are paid under the physician fee schedule. There are over 7,000 service codes under the fee schedule.

The fee schedule assigns relative values to each service code. These relative values reflect physician work (based on time, skill, and intensity involved), practice expenses, and malpractice expenses. The relative values are adjusted for geographic variations in the costs of practicing medicine. These geographically adjusted relative values are converted into a dollar payment amount by a national conversion factor. The conversion factor is updated each year by a formula

[11] For more information, see CRS Report RL31199, *Medicare: Payments to Physicians*.

specified in law. The update percentage equals the Medicare Economic Index (MEI, which measures inflation) subject to an adjustment to match spending under the cumulative sustainable growth rate (SGR) system, which establishes a target for total expenditures since 1996. If total expenditures exceed the target, the update for a future year is reduced. Application of the SGR formula would have led to negative updates since 2002. However, Congress has acted several times to avert reductions, thereby overriding the statutory formula for the 2003-2009 period. The conversion factor for 2009 is 1.1% above that for 2008. Unless Congress takes additional action, application of the SGR formula is expected to result in a sizeable reduction in the conversion factor in 2010 and continue to lead to annual reductions for the foreseeable future.

Additionally, physicians who report on selected quality measures for services for which quality measures are established will receive bonus payments for those services provided from July 2007-December 2010. The bonus payments were 1.5% during the second half of 2007 and 2008 and 2.0% for 2009 and 2010. Additional bonus payments will be made for 2009-2013 for Medicare professionals providing covered services who are successful electronic prescribers.

## Therapy Services

Medicare therapy services include physical therapy, occupational therapy, and speech language pathology services. The program establishes annual limits on covered services. The first is a $1,840 per beneficiary annual cap in 2009 for all outpatient physical therapy services and speech language pathology services. The second is a $1,840 per beneficiary annual cap in 2009 for all outpatient occupational therapy services. The limits, which are updated annually, apply to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The Secretary is required to implement an exceptions process, effective from 2006 through 2009, for services meeting specified criteria for medically necessary services. The limits do not apply to outpatient services provided by hospitals.

## Preventive Services

The original Medicare statutes prohibited payment for covered items and services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member," which effectively excluded preventive and screening services. In recent years, Congress has added and expanded Medicare coverage for a number of such services through legislation, including MMA and MIPPA. Coverage for some preventive and screening services currently include the following: (1) a welcome to Medicare physical exam during the first year of enrollment in Part B; (2) annual flu shots, pneumococcal vaccines (usually needed only once in a lifetime), and Hepatitis B vaccines; (3) annual screening mammograms for asymptomatic women 40 and over; (4) pap smears and pelvic exams; (5) colorectal cancer screening tests; (Fecal Occult Blood Test, Screening Flexible Sigmoidoscopy, screening colonoscopy, and Barium Enema); (6) prostate Cancer Screening; (7) cardiovascular screening; (8) bone mass measurement; (9) diabetes screening and self-management training; (10) glaucoma tests; (11) medical nutrition therapy (MNT) services; (12) ultrasound screening for abdominal aortic aneurysms; and (13) others as specified by the Secretary of Health and Human Services. These services are paid for under the Medicare Part B fee schedule, although in some cases the deductible and/or cost-sharing is waived.

## Clinical Lab and other Diagnostic Tests

Part B covers clinical laboratory tests. Neither copayment nor deductible applies to services paid under the Medicare clinical laboratory fee schedule. There is no coinsurance for clinical laboratory services. Clinical lab services are paid on the basis of area-wide fee schedules.[12] There is a ceiling on payment amounts equal to 74% of the median of all fee schedules for the test. In general, annual increases in clinical lab fees are based on the percentage change in the CPI-U. However, Congress has modified the update in recent years, by (1) freezing the fee schedule amounts through 2008 and (2) reducing the update that would otherwise apply by 0.5 percentage points each year, for 2009-2013.

Part B also covers diagnostic x-ray tests and other diagnostic tests, as well as x-ray, radium, and radioisotope therapy. Generally, these services are paid for under the physician fee schedule.

## Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Medicare covers a wide variety of equipment and devices under the heading of durable medical equipment (DME), and prosthetics, orthotics (PO) if they are medically necessary and are prescribed by a physician. DME is defined as equipment that (1) can withstand repeated use, (2) is used primarily to serve a medical purpose, (3) is not generally useful in the absence of an illness or injury, and (4) is appropriate for use in the home. DME includes such items as hospital beds and wheelchairs, blood glucose monitors, and oxygen and oxygen equipment. It also includes related supplies, such as drugs and biologics that are necessary for the effective use of the product. PO is defined as items that replace all or part of a body organ, such as colostomy bags and pacemakers, as well as leg, arm, back, and neck braces and artificial legs, arms, and eyes. Medicare also covers some items or supplies (S), such as disposable surgical dressings that do not meet the definitions of DME or PO.

Except in competitive bidding areas (described below), Medicare pays for most DMEPOS based on fee schedules. Medicare pays 80% of the lower of the item's actual charge or the fee schedule amount. The beneficiary is responsible for the remaining 20%. In general, fee schedule amounts are updated each year by a measure of price inflation, but Congress has specified a reduction or elimination in updates in recent years.

Numerous studies and investigations have shown that Medicare payments for certain items of DME and PO are higher than those made by other health insurers and some retail outlets.[13] Such overpayments may be due partly to the fee schedule mechanism of payment. MMA required the Secretary to establish a Competitive Acquisition Program for certain DMEPOS in specified areas. Instead of paying for medical equipment based on a fee schedule established by law, payment for items would be determined based on the supplier bids. The bids would determine how much suppliers were "willing to accept" to furnish different items. MIPPA delayed the program and required the first round of the program to be re-bid in 2009, in addition to other changes.

[12] For more information, see CRS Report RS22769, *Medicare Clinical Laboratories Competitive Bidding Demonstration*.

[13] See General Accounting Office (GAO) report, "Medicare Payments for Oxygen", May 15, 1997, GAO-97-120R; HHS Office of the Inspector General report, "Medicare Home Oxygen Equipment: Cost and Servicing, September 2006," EOI-09-04-00420.

## Part B Drugs

Certain specified outpatient prescription drugs are covered under Medicare Part B. (However, most outpatient prescription drugs are covered under Part D, discussed below.) Covered Part B drugs include drugs furnished incident to physicians' services, immunosuppressive drugs following a Medicare-covered organ transplant, erythropoietin for treatment of anemia for persons with ESRD; oral anti-cancer drugs (provided they have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if furnished incident to physicians services); and drugs needed for the effective use of DME. Generally, Medicare's payment for Part B covered drugs equals 106% of the average sales price.[14]

## Hospital Outpatient Department Services

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of the patient. A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services, rather than supplies alone, from a hospital or Critical Access Hospital. Generally, payments under the hospital outpatient prospective payment system (OPPS) cover the operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. These payments cover services such as the use of an operating suite, treatment, procedure or recovery room; use of an observations bed as well as anesthesia; certain drugs or pharmaceuticals; incidental services; and other necessary or implantable supplies or services. Payments for services such as those provided by physicians and other professionals as well as therapy and clinical diagnostic laboratory services, among others, are separate.

Under the OPPS, the unit of payment for acute care hospitals is the individual service or procedure as assigned to an ambulatory payment classification (APC). To the extent possible, integral services and items (excluding physicians services paid under the physician fee schedule) are bundled within each APC. Specified new technologies are assigned to new technology APCs until clinical and cost data are available to permit assignment into a clinical APC. Medicare's hospital outpatient payment is calculated by multiplying the relative weight associated with an APC by a conversion factor. For most APCs, 60% of the conversion factor is geographically adjusted by the wage index used for the inpatient prospective payment system. Except for new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. The OPPS also includes pass-through payments for new technologies (specific drugs, biologicals, and devices) and payments for outliers.[15]

## Ambulatory Surgical Center Services

Medicare covers surgical and medical services performed in a Ambulatory Surgical Center (ASC) that are (1) commonly performed on an inpatient basis but may be safely performed in an ASC; (2) not of a type that are commonly performed or that may be safely performed in physicians'

[14] For more information, see CRS Report RL31419, *Medicare: Payments for Covered Part B Prescription Drugs*.

[15] Additionally, starting in 2006, rural Sole Community Hospitals (SCHs) receive an additional 7.1% in Medicare payments. Special provisions apply for cancer hospitals, children's hospitals, small rural hospitals (that are not SCHs) with 100 or fewer beds, and SCHs with not more than 100 beds.

offices; (3) limited to procedures requiring a dedicated operating room or suite and generally requiring a post-operative recovery room or short term (not overnight) convalescent room; and (4) not otherwise excluded from Medicare coverage.

Beginning in January 2008, Medicare pays for surgery-related facility services provided in ASCs using a payment system based on the OPPS. (Associated physician fees are paid for separately under the physician fee schedule.) Each of the 3,300 procedures approved for payment in an ASC is classified into an ambulatory payment classification (APC) group on the basis of clinical and cost similarity. The ASC system uses the same payment groups (APCs) as the OPPS, and for most procedures, the same relative weights used in the OPPS also apply. The ASC system uses a conversion factor based on a percentage of the OPPS conversion factor. The percentage of this average dollar figure is set to ensure budget neutrality, so that total payments under the new ASC payment system should equal total payments under the old ASC payment system. A different payment method is used to set ASC payment for new, office based procedures, separately payable drugs, and device-intensive procedures.[16] This policy also applies to separately payable radiology services. Separately payable drugs in an ASC are paid the same amount as if provided in a hospital outpatient department. Different rules apply for device intensive procedures (where a device that is packaged into an APC accounts for more than half of its total payments). Separate payments are made for corneal tissue acquisition, brachytherapy sources, certain radiology services, many drugs, and certain implantable devices.

## Ambulance

Medicare Part B covers ambulance services provided by qualified suppliers, paid for on the basis of a fee schedule. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. There is a national fee schedule for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the national fee schedule or a blend of 80% national and 20% regional fee schedule amounts. Beginning in 2010, the payments in all areas will be based on the national fee schedule amount.

The payment for a service equals a base rate for the level of service plus payment for mileage, with geographic adjustments made to a portion of the base rate. Additionally, the base rate is increased for air ambulance trips originating in rural areas and mileage payments are increased for all trips originating in rural areas.

## Rural Health Clinics and Federally Qualified Health Centers

Medicare covers Part B services in rural health clinics (RHCs) and federally qualified health centers (FQHCs) [17] provided by (1) physicians and specified non-physician practitioners; (2) visiting nurses for homebound patients in home health shortage areas; (3) registered dieticians or nutritional professionals for diabetes training and medical nutrition therapy; and (4) others, as well as otherwise covered drugs.

[16] New, office-based procedures are services that are performed in physician offices at least 50% of the time. Payment is set at the lower of the ASC rate or the practice expense portion of the physician fee schedule payment rate.

[17] For more information, see CRS Report RL32046, *Federal Health Centers Program.*

RHCs and FQHCs are paid based on an "all-inclusive" rate per beneficiary visit subject to a per visit upper limit, adjusted annually for inflation.

### Part B Services for End-Stage Renal Disease

Individuals with ESRD are eligible for all Part B Services. Part B also covers their dialysis services, drugs, and biologicals, including erythropoiesis stimulating agents (ESAs) for the treatment of ESRD, diagnostic laboratory tests, and other items and services furnished to individuals for the treatment of ESRD.

Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two methods for payment. Under Method I, facilities are paid a prospectively set amount, known as the composite rate, for each dialysis session. Patients electing home dialysis may choose to be paid under either Method I or under Method II, as a series of separately billable services.

Under Method I, the composite rate is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and for area wage differences. Beginning January 1, 2009, the payment rate for dialysis services will be "site neutral," as adjustments will no longer be made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs.

Beginning January 1, 2011, Medicare dialysis payments will be bundled (phased-in over four years) using a single payment for Medicare renal dialysis services that includes (1) items and services included in the composite rate as of December 31, 2010; (2) erythropoiesis stimulating agents (ESAs) for the treatment of ESRD; (3) other drugs and biologicals for which payment was made separately (before bundling); and (4) diagnostic laboratory tests and other items and services furnished to individuals for the treatment of ESRD.

Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equipment, supplies, and support services. Payment to these suppliers, known as Method II, is made on the basis of reasonable charges, limited to 100% of the median hospital composite rate, except for patients on continuous cycling peritoneal dialysis, when the limit is 130% of the median hospital composite rate. The composite rate is case-mixed adjusted.

## Part C

Medicare beneficiaries who are eligible for Part A and enrolled in Part B can obtain all Medicare covered services (except hospice) through private health plans. Approximately 20% of beneficiaries receive covered services through Part C, rather than through Original Medicare. Under an agreement with CMS, a plan agrees to provide all required services covered in return for a capitated monthly payment. The same monthly payment is made regardless of how many or few services a beneficiary actually uses. The plan is at-risk if costs, in the aggregate, exceed program payments; conversely, the plan can retain savings if costs are less than payments. In contrast, the fee-for-service payment methodology used in Original Medicare makes payments to a medical provider for each service (e.g., physician visit) or each unit of service (e.g., a hospital stay) provided.

Payments to MA plans[18] are based on a comparison of each plan's estimated cost of providing Medicare covered services (a bid) relative to the maximum amount the federal government is willing to pay for providing those services in the plan's service area (a benchmark). If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate equal to 75% of the difference (between the benchmark and the bid). The rebate must be returned to enrollees in the form of either additional benefits; reduced cost sharing; a reduction in the monthly Part B premium, prescription drug premium, or supplemental premium (for services beyond required Medicare benefits); or some combination of these options. The remaining 25% of the difference between the bid and the benchmark is retained by the federal government. If a plan's bid is equal to or above the benchmark, its payment will be the benchmark amount and each enrollee in that plan will pay an additional premium, equal to the amount by which the bid exceeds the benchmark.

Each year, plans wishing to participate in the MA program must submit new bids. The Secretary has the authority to negotiate the bid amounts, except for Private Fee-For-Service (PFFS)[19] plans. Benchmark amounts are increased each year by the greater of either 2% or growth in overall Medicare. In years specified by the Secretary, a benchmark for an area can be set at per capita spending in Original Medicare if that amount is greater than the benchmark the area would otherwise receive.

In 2006, the MA program began to offer MA regional plans. Regional plan benchmarks include two components: (1) a statutorily determined amount (comparable to benchmarks described above) and (2) a weighted average of plan bids. Thus, a portion of the benchmark is competitively determined. Similar to local plans, plans with bids below the benchmark are given a rebate, while plans with bids above the benchmark require an additional enrollee premium.

Beginning in 2010, the Secretary will establish a six-year program for the application of comparative cost adjustment (CCA) in a limited number of CCA areas. The program is designed to test direct competition among local MA plans, as well as competition between local MA plans and Original Medicare. The benchmark for MA local plans in a CCA area will be calculated using a formula that weights projected spending in Original Medicare and plan bids. For Medicare beneficiaries in Original Medicare, Part B premiums in CCA areas will be adjusted either up or down, depending on whether the Original Medicare amount is more or less than the CCA area benchmark. If the Original Medicare amount is greater than the benchmark, beneficiaries in Original Medicare will pay a higher Part B premium than beneficiaries with Original Medicare in non-CCA areas. If the Original Medicare amount is less than the benchmark, the Part B premium for Original Medicare beneficiaries will be reduced by 75% of the difference. These increases and decreases are subject to certain limits. Beneficiaries in Original Medicare with incomes below 150% of poverty, who qualify for low-income subsidies under the Medicare prescription drug program, will not have their Part B premium increased.

## Part D

Part D of Medicare covers outpatient prescription drugs. (As previously discussed, Part B provides limited coverage of prescription drugs.) Qualified Part D prescription drug plans are

[18] For more information, see CRS Report R40374, *Medicare Advantage.*

[19] For more information on PFFS plans, see CRS Report RL34151, *Private Fee for Service (PFFS) Plans: How They Differ from Other Medicare Advantage Plans*.

required to offer either "standard coverage" or alternative coverage, with actuarially equivalent benefits. In 2009, "standard coverage" has a $295 deductible, 25% coinsurance for costs between $296 and $2,700. From this point, there is no coverage until the beneficiary has out-of-pocket costs of $4,350 ($6,153.75 in total spending); this coverage gap has been labeled the "doughnut hole." Once the beneficiary reaches the catastrophic limit, the program pays all costs except for nominal cost-sharing. Most plans offer actuarially equivalent benefits rather than the standard package, including alternatives such as reducing or eliminating the deductible, using tiered cost-sharing with lower cost-sharing for generic drugs, or coverage in the doughnut hole.

Plans determine payments for drugs and are expected to negotiate prices. The federal government is prohibited from interfering in the price negotiations between drug manufacturers, pharmacies, and plans (the so-called "non-interference clause").

Part D also provides enhanced coverage for low-income enrolled individuals, such as persons (known as "dual eligibles"—enrollees in both Medicare and Medicaid) who previously received drug benefits under Medicaid. Additionally, persons with incomes below 150% of poverty receive assistance for some portion of their premium and cost-sharing charges.

MMA included significant incentives for employers to continue to offer coverage to their retirees by providing a 28% federal subsidy. In 2009, the maximum potential subsidy per covered retiree is $1,597.40 for employers or unions offering drug coverage that is at least actuarially equivalent (called "creditable" coverage), to standard coverage. Employers or unions may select an alternative option (instead of taking the subsidy) with respect to Part D such as electing to pay a portion of the Part D premiums. They may also elect to provide enhanced coverage, though this has some financial consequences for the employer or union. Alternatively, employers or unions may contract with a PDP or MA-PD to offer the coverage or become a Part D plan sponsor themselves for their retirees.

# Administration

At the federal level, Medicare is administered by the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). Medicare statute delegates much of the day-to-day administration of the program to private contractors. Functions such as paying providers, enrolling physicians in the Medicare program, educating providers about Medicare billing requirements, and processing appeals are performed by Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), and Carriers. Generally, MACs perform these functions for Parts A and B providers, FIs for Part A providers, and Carriers for Part B providers. In 2003, the MMA mandated that the Secretary implement fee-for-service contracting reform and replace FIs and Carriers with MACs by 2011. CMS has contracted with 15 A/B MACs to process Parts A and B claims and 4 DME MACs to process claims for DME suppliers. Unlike the current claims administration contracts, MAC contracts are competitively selected and re-competed every five years.

Medicare also contracts with private organizations to protect the Medicare trust funds from making improper payments and fraud and abuse.[20] The Health Insurance Portability and

[20] For more information on Medicare contractors and Medicare fraud and abuse, see CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse.*

Accountability Act (HIPAA, P.L. 104-191) of 1996 gave the Secretary the authority to contract with specialized private entities to combat health care fraud.

To reduce improper payments in fee-for-service Medicare, CMS contracts with a different private entity called a Recovery Audit Contractor, or RAC. In response to congressional concern that improper payments were increasing in Medicare, Congress authorized the creation of RACs as a three-year demonstration program in the MMA. In December 2006, Congress passed TRHCA, which made the program permanent and required its expansion nationwide by 2010. Improper payments, which largely result from billing mistakes or inadvertent claims processing errors, were estimated to amount to approximately $10.4 billion in 2008. RACs are responsible for reducing the rate of Medicare improper payments by identifying under- and overpayments made to providers, recovering overpayments, and working with providers to prevent future improper payments.

Medicare's quality assurance activities are handled by State Survey Agencies and Quality Improvement Organizations (QIOs), which operate in all 50 states, the District of Columbia, and two territories. State survey agencies are responsible for inspecting Medicare provider facilities (i.e., nursing homes, home health agencies, and hospitals) to ensure their compliance with federal safety and quality standards referred to as Conditions of Participation (CoPs). QIOs monitor the quality of care delivered to Medicare beneficiaries and educate providers on the latest quality improvement techniques.

# Financing

Medicare's financial operations are accounted for through two trust funds, the Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) trust fund, which are maintained by the Department of the Treasury. The HI and SMI trust funds are overseen by a board of trustees that makes annual reports to Congress. HI is primarily funded by payroll taxes, while SMI is funded through general revenue transfers and premiums.

The trust funds are an accounting mechanism; there is no actual transfer of money into and out of a fund. Income to the trust funds is credited to the fund in the form of interest-bearing government securities. Expenditures for services and administrative costs are recorded against the fund. The securities represent obligations that the government has issued to itself. As long as the trust fund has a balance, the Treasury Department is authorized to make payments for it from the U.S. Treasury.

## Part A Financing

The primary source of funding for Part A is payroll taxes paid by employees and employers.[21] Each pays a tax of 1.45% on the employee's earnings; the self-employed pay 2.9%. Unlike Social Security, there is no upper limit on earnings subject to the tax. Other sources of income include (1) interest on federal securities held by the trust fund, (2) a portion of federal income taxes that individuals pay on their social security benefits, (3) premiums paid by voluntary enrollees who

[21] For more information on the Part A financing, see CRS Report RS20173, *Medicare: Financing the Part A Hospital Insurance Program* and CRS Report RS20946, *Medicare: History of Part A Trust Fund Insolvency Projections*.

are not automatically entitled to Medicare Part A, (4) transfers from states, and (5) other revenues. Income for Part A is credited to the HI trust fund.

## Part B Financing

Medicare Part B is financed mostly from federal general revenues, with beneficiaries paying premiums equal to 25% of estimated program costs for the aged.[22] (The disabled pay the same premium as the aged.) Income for Part B is credited to the SMI trust fund.

The 2009 monthly Part B premium is $96.40.[23] Individuals receiving Social Security benefits have their Part B premium payments automatically deducted from their Social Security benefit checks. An individual's Social Security check cannot go down from one year to the next as a result of the annual Part B premium increase (except in the case of higher income individuals subject to income-related premiums).

Since 2007, higher income enrollees pay higher premiums. For 2009, individuals whose modified adjusted gross income (AGI) in 2007 exceeded $85,000 and each member of a couple filing jointly whose modified AGI exceeded $170,000 is subject to higher premium amounts. In 2009, higher-income premiums range from 35% to 80% of the value of Part B, affecting about 5% of enrollees.[24]

## Part C Financing

Payments for spending under the Medicare Advantage program are made in appropriate parts from the HI and SMI trust funds. There is no separate trust fund for Part C.

## Part D Financing

Medicare Part D is financed through a combination of beneficiary premiums and federal general revenues. In addition, certain transfers are made from the states.[25] These transfers, referred to as "clawback payments," represent a portion of the amounts states could otherwise have been expected to pay for drugs under Medicaid if drug coverage for the dual eligible population had not been transferred to Part D. Part D revenues are credited to a separate Part D account within the SMI trust fund.

[22] According to the 2008 Trustees report, the Part B premiums which are set to cover about 25% of program costs for the aged, currently cover about 22% of costs of Part B.

[23] For more information see, CRS Report R40082, *Medicare: Part B Premiums.*

[24] The higher monthly premium amounts for 2009 are based on 2007 income levels and are (1) $134.90—for single beneficiaries with income $85,001-$107,000 or for each member of a couple filing jointly with income $170,001-$214,000; (2) $192.70—for single beneficiaries with income $107,001-$160,000 or for each member of a couple filing jointly with income $214,001-$320,000; (3) $250.50—for single beneficiaries with incomes $160,001-$213,000 and each member of a couple filing jointly with income $320,000-$426,000; and (4) $308.30—for single beneficiaries with incomes greater than $213,000 and each member of a couple filing jointly income above $426,000.

[25] For more information, see CRS Report RL34280, *Medicare Part D Prescription Drug Benefit: A Primer*; CRS Report RL33782, *Federal Drug Price Negotiation: Implications for Medicare Part D*; and CRS Report RL33802, *Pharmaceutical Costs: A Comparison of Department of Veterans Affairs (VA), Medicaid, and Medicare Policies.*

Beneficiaries pay different premiums depending on the plan they have selected (and whether they are entitled to low-income premium subsidies). On average, beneficiary premiums account for 25.5% of expected total Part D costs for basic coverage. Part D premium payments may be automatically deducted from Social Security benefit checks, paid directly to the PDP sponsor or MA-PD organization, or made through an electronic funds transfer.

# Additional Insurance Coverage

While Medicare provides broad protection against the costs of many, primarily acute care, services, the program does not cover all services that may be used by its aged and disabled beneficiaries. Medicare does not cover eyeglasses, hearing aids, dentures, or most long-term care services. Further, unlike most private insurance polices, it does not include an annual "catastrophic" cap on out-of-pocket spending on cost-sharing charges for services covered under Parts A and B (except for persons enrolled in regional PPOs under MMA). Prior to implementation of the drug benefit in 2006, the program generally covered only about one-half of beneficiaries' total health care expenses.

Most Medicare beneficiaries have some coverage in addition to Medicare. The following are the main sources of additional coverage for Medicare enrollees.

- Medicare Advantage. Many MA plans offer services in addition to those covered under Original Medicare and may also have a catastrophic cap.
- Employer Coverage. Coverage may be provided through a current or former employer. In recent years, a number of employers have cut back on the scope of retiree coverage. Some have dropped such coverage entirely, particularly for future retirees. As noted earlier, the MMA attempted to stem this trend, at least for prescription drug coverage, by offering subsidies to employers who offer drug coverage, at least as good as that available under Part D.
- Medigap.[26] Individual insurance policies that supplement Medicare are referred to as Medigap policies. Beneficiaries with Medigap insurance typically have coverage for a portion of Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select one of the standardized plans, though not all plans are offered in all states.
- Medicaid. Certain low-income Medicare beneficiaries may also be eligible for full or partial benefits under their state's Medicaid program. Persons eligible for the full range of benefits (known as the "full dual eligibles") generally have the majority of their health care expenses met through a combination of coverage under the two programs; Medicare pays first, with Medicaid picking up most of the remaining costs.[27]

[26] For more information, see CRS Report RL31223, *Medicare: Supplementary "Medigap" Coverage*.

[27] Certain other individuals are entitled to more limited protection under one of three Medicaid Savings programs. The Qualified Medicare Beneficiary (QMB) program pays Medicare Part B premiums and Medicare cost-sharing charges for persons under 100% of poverty. The Specified Low-Income Medicare Beneficiary (SLMB) program pays Part B premium charges for those between 100% and 120% of poverty, while the Qualified Individual (QI) program pays such premiums for those between 120% and 135% of poverty.

- Other Public Sources. Individuals may have additional coverage through the Department of Veterans Affairs, or TRICARE for military retirees eligible for Medicare (and enrolled in Part B).

In the years prior to implementation of the drug benefit, close to 90% of beneficiaries had some form of additional coverage. (Some persons may have had more than one type of such coverage.)

# Medicare Issues

The 111th Congress is likely to continue the work of previous Congresses in addressing the issues facing the Medicare program, including the continued rise in Medicare spending and the inability of existing funding mechanisms to support the program over the long term. Within this framework, payment changes affecting physicians, practitioners, suppliers, and providers are likely to spark discussion and warrant attention. Congress confronts a delicate balancing act in weighing financing issues against the need to provide appropriate, high-quality medical care for Medicare beneficiaries. Efforts to reform or modify the Medicare program are further complicated by a variety of factors because of both the nature of the program and its relationship with the health care system.

- Considerable geographic variation in the amount of services and the payment for health care is longstanding and well-documented. Some of the payment variation is intentionally designed to reflect geographic variations in wages; however, differences in local practice patterns combined with the payment variations have resulted in substantial differences in per capita payments across geographic areas. By statute, Medicare is prohibited from interfering in the practice of medicine or in the manner in which medical services are provided.
- While Medicare provides coverage for the aged and disabled, it does not guarantee access to care. Beneficiaries under traditional FFS Medicare must seek care from available and accessible providers. However, the decision to participate in Medicare (and the extent of such participation) is at the discretion of the provider or individual practitioner. The longstanding issue with Medicare's physician payments and the potential for future reductions have accelerated concern that Medicare beneficiaries will be increasingly unable to find Medicare providers. Patient advocates are concerned that certain groups (racial minorities, lower-income individuals, and beneficiaries in rural areas) may face greater obstacles in accessing necessary health services.
- MMA addressed a significant gap within Medicare by creating an outpatient prescription drug benefit. However, the perceived deficiencies and accomplishments in the design of this benefit have been widely discussed. The Part D drug benefit is administered by private entities; most beneficiaries face a significant "donut hole" in coverage before getting catastrophic coverage. Addressing an extensive restructuring of the outpatient prescription drug benefit is complicated, in part, by large associated costs. Negotiated pricing and increased oversight could bring an increased federal role, opposed by those who support the reliance of Part D on the private sector.
- While Medicare is generally not subject to income tests, since 2007, Medicare has required higher income beneficiaries to pay higher Part B premiums. (Certain lower-income Medicare beneficiaries may receive help with their cost-sharing

and premiums.) Further changes to the entitlement nature of the program that differentiates premiums and/or cost-sharing could increase program revenues, but these changes may have adverse effects, providing incentives for the wealthiest and healthiest individuals with other insurance options to drop out of the voluntary aspects. If the healthiest individuals did not participate in Medicare Part B, this could potentially change the risk pool, raising additional concerns about adverse selection.

## Solvency and Trigger

The term "Medicare insolvency" refers to the pending insolvency of only the HI trust fund, defined by the Medicare trustees as occurring when trust fund assets at the beginning of the year are insufficient to pay program benefits for the forthcoming year. The 2008 Medicare Trustees Report projects that under intermediate assumptions, the HI trust fund will become insolvent in 2019. The report further states that beginning in 2004, tax income (from payroll taxes and from the taxation of Social Security benefits) began to fall below expenditures. Projected expenditures exceed total income each year beginning in 2008 (except for 2009). If income falls short of expenditures, costs are met by drawing on HI fund assets through transfers from the general fund of the Treasury until the fund is depleted.

However, looking only at the HI trust fund provides a limited view of the problems facing the Medicare program. Because most Part B and D spending of the SMI fund is financed by general revenues transfers, it does not face insolvency. Its rapid growth rate is, however, a drain on federal spending. In response, MMA required the annual trustees report to include an expanded analysis of Medicare expenditures and revenues. Specifically, each year the trustees must determine whether general revenue financing will exceed 45% of total Medicare outlays within the next seven years.[28] Such warnings occurred for both 2008 and 2009. However, issues with the trigger formula have raised questions about its usefulness for addressing program spending. Congress may chose to revisit this measure or work on other measures for analyzing the issues facing the Medicare program in its entirety. Most recently, on January 6, 2009, the House approved a rules package (H.Res. 5) that nullifies the trigger provision in the House for two years (the duration of the 111th Congress).

## Medicare Spending

A combination of factors have contributed to the rapid increase in Medicare spending. These include increases in overall medical costs, advances in health care delivery and medical technology, increases in the percentage of the population over 65, and longer life spans. The trend is expected to accelerate in 2011, when the baby boom generation (persons born between 1946 and 1964) begin to turn 65 and become eligible for Medicare.

Medicare growth, if unchecked, will continue to consume a larger share of the GDP each year. The 2008 trustees report noted that total program expenditures, which represented 3.1% of GDP in 2006, were expected to climb to 7.0% by 2035 and rise to 10.7% by 2080. It further noted that the level of program expenditures is expected to exceed that for Social Security in 2028 and be 85% more than the cost of that program by 2082. Given limited federal resources and an aging

[28] For more information, see CRS Report RS22796, *Medicare Trigger*.

population, the discussion may expand to exactly where Medicare fits into the nation's priorities for spending.

## Options

In the face of ballooning costs, particular attention has been placed on stemming the rapid growth in program spending. Generally, attempts have been made to restrict provider payments, through curtailing payment updates and the development of new, prospectively determined payment methods. Most recently, however, significant changes have been introduced that may alter Medicare's foundation as an entitlement program, reshape its benefit structure, increase its reliance on private entities to provide benefits, and allow competition in local areas to determine Medicare beneficiaries out-of-pocket payments.

In the short term, Congress may choose to focus its attention on specific Medicare issues, such as physician payment updates. Past Congresses have worked to offset the costs of modifying physician payments with other program savings. The debate over whether Medicare Advantage payments should be reduced is also likely to continue; despite its popularity as a private option for Medicare, MedPAC has indicated it is more costly to provide services through MA than through Original Medicare. Congress may also consider other Medicare spending reductions, such as limiting growth in other provider payments. Other possible options may also involve raising taxes or raising beneficiaries' out-of-pocket costs.

Additional policy options to address cost, quality, and access issues have been discussed by Congress and health policy analysts, including (1) utilizing value-based purchasing—the concept of linking higher quality and more value for each dollar spent by Medicare; (2) adopting MedPAC's recommendation to reduce Indirect Medical Education funding for teaching hospitals and use the funds to create a hospital incentive pool; (3) continuing expansion of Health Information Technology (building on provisions included in P.L. 111-5 , the American Recovery and Reinvestment Act of 2009); (4) improving quality and expand the Physician Quality Reporting Initiative; (5) decreasing regional variation in volume; (6) encouraging care delivered in and coordinated through patient-centered medical homes with appropriate payments; (7) increasing payments for services provided by primary care physicians; (8) modifying Part B drugs payments in the SGR target calculation; (9) implementing DME and lab competitive bidding; and (10) reexamining the budget-neutrality adjustment factor to the hospice wage index. Suggested Part D reforms might include provisions such as minimum rebates, beneficiary protections, expanding coverage for low-income beneficiaries, negotiation with plan sponsors and/or drug manufacturers, oversight, and comparative effectiveness. CBO has also developed a set of budget options for reducing Medicare expenditures, including reducing annual updates for hospitals, physicians, skilled nursing care, and others.[29]

None of the changes are easy, and strong cases can be made for either reducing or expanding Medicare spending and revenues. These are difficult questions and for beneficiaries and taxpayers, the solutions are likely to produce winners and losers. The issues confronting the program are not new, nor are the possible responses likely to get any easier.

[29] See CBO Budget Options Volume I, Health Care, December 2008.

Many members of Congress, Medicare trustees, and other observers continue to warn that the problems need to be addressed, and that the longer one waits, the more drastic the changes will need to be. These changes will likely be balanced by concerns about the potential impact of any solution on beneficiaries' out-of-pocket costs or access to needed services.

Congress may also choose to examine these and other options within the broader context of health reform, looking at ways to both expand Medicare to a larger population, such as early retirees, or using Medicare as a vehicle to provide access to the uninsured. For example, Medicare could be expanded to provide immediate coverage for the disabled population and to cover those who lack viable health insurance options, particularly the near elderly without insurance. Depending on the policymaker's health care reform agenda, a Medicare-like program may be seen as a health care insurance option for even a broader population. Any discussion of proposed changes to Medicare (or, more generally, health care reform) occurs in the context of strong ideological differences about the appropriate role of public and private sector entities to provide health care services as well as the use of market forces and competition to establish payments within the Medicare program.

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