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Medicare: A Primer

Jennifer O'Sullivan, Domestic Social Policy Division

August 1, 2008

Abstract. This report provides an overview of Medicare. It begins with a brief program history, and then outlines the key features of Parts A and B, also known as "Original Medicare." That is followed by overviews of Part C and Part D, a discussion of program financing, and a discussion of future program directions.

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CRS Report for Congress

Medicare: A Primer

Updated August 1, 2008

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Prepared for Members and
Committees of Congress

Medicare: A Primer

Summary

Medicare is the nation's health insurance program for persons aged 65 and over and certain disabled persons. In FY2008, the program will cover an estimated 44.6 million persons (37.4 million aged and 7.3 million disabled) at a total cost of \$459.4 billion. Federal costs (after deduction of beneficiary premiums and other offsetting receipts) will total \$389.9 billion. In FY2008, federal Medicare spending will represent approximately 13% of the total federal budget and 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.

Since Medicare was enacted in 1965, it has undergone considerable changes. First, program coverage was expanded to include the disabled and persons with end-stage renal disease (ESRD). Over time, increasing attention was placed on stemming the rapid increase in program spending, which outpaced projections, even in the initial years. This was typically achieved through tightening rules governing payments to providers of services and stemming the annual updates in such payments. The program moved from payments based on "reasonable costs" and "reasonable charges" to payment systems under which a pre-determined payment amount is established for a specified unit of service. At the same time, beneficiaries were given the option to obtain covered services through private managed care arrangements. Most Medicare payment provisions were incorporated into larger budget reconciliation bills designed to control overall federal spending.

In 2003, Congress enacted a major Medicare bill, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This legislation placed increasing emphasis on private sector management of benefits. It also created a new voluntary outpatient prescription drug benefit to be administered by private entities. Further, it introduced the concept of means testing into what had previously been strictly a social insurance program.

Congress continues to register concern about the rapid rise in Medicare spending and the ability of existing funding mechanisms to support the program over the long-term. A combination of factors has contributed to the rapid increase in Medicare costs. These include increases in overall medical costs, advances in health care delivery and medical technology, the aging of the population, and longer life spans. The issues confronting the program are not new; nor are the possible solutions likely to get any easier. For a number of years, various options have been suggested; however, legislative changes have focused on short-term issues. There is no consensus on the long-term approach that should be taken.

This report provides an overview of Medicare. It begins with a brief program history, and then outlines the key features of Parts A and B, also known as "Original Medicare." That is followed by overviews of Part C and Part D, a discussion of program financing, and a brief discussion of future program directions. It will be updated to reflect any legislative changes.

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Medicare: A Primer

Introduction

Medicare is the nation's health insurance program for persons aged 65 and over and certain disabled persons. In FY2008, the program will cover an estimated 44.6 million persons (37.4 million aged and 7.3 million disabled)¹ at a total cost of \$459.4 billion. Federal costs (after deduction of beneficiary premiums and other offsetting receipts) will total \$389.9 billion.² In FY2008, federal Medicare spending will represent approximately 13% of the total federal budget and 3% of GDP.³ 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. 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).

Medicare serves approximately one in seven Americans and virtually all of the population aged 65 and over. In 2006 (the first year of the new drug benefit), Medicare spending accounted for an estimated 57% of federal health spending and 19% of all national health expenditures. Program spending represented 29% of national spending on hospital services, 21% of such spending for physicians and clinical services, and 18% of total drug spending (compared to 2% in 2005). In 2017, program spending is expected to account for 58% of federal spending and 21% of all national health expenditures. Spending in that year is expected to account for 31% of national spending on hospital services, 20% of such spending for physicians and clinical services, and 24% of total drug spending.⁴

The Medicare program is generally viewed as achieving its goal of helping aged and disabled persons meet many of their health care needs. However, the cost of the program and the significant year-to-year increases in such costs are a major concern for the Congress and other observers. The Congressional Budget Office (CBO) projects that program spending will double over the next ten years. The rapid growth rate reflects a number of factors, including overall increases in medical care costs (which typically exceed the rate of inflation in the economy as a whole), advances in health care delivery and medical technology, and longer life expectancies. Additional

¹ Department of Health and Human Services, Budget in Brief, 2009 [<http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf>].

² Congressional Budget Office (CBO), Medicare March 2008 Fact Sheet.

³ CBO, An Analysis of the President's Budgetary Proposals for Fiscal Year 2009 [<http://www.cbo.gov/ftpdocs/89xx/doc8990/03-19-AnalPresBudget.pdf>] and Medicare March 2008 Fact Sheet.

⁴ [<http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf>]

pressures will be placed on the program beginning in 2011, when baby boomers (persons born between 1946 and 1964) begin turning 65, the age when they become Medicare-eligible. For a number of years, Congress has looked at ways to stem the rapid increases in Medicare spending. This effort is likely to intensify in the coming years.

Medicare consists of four distinct parts: Part A (Hospital Insurance, or HI); Part B (Supplementary Medical Insurance, or SMI); Part C (Medicare Advantage, or MA); and Part D (the new prescription drug benefit added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA). The program is administered by the Centers for Medicare and Medicaid Services (CMS).

This report provides an overview of Medicare. It begins with a capsule summary of key program features and major issues. This is followed by a more extensive discussion beginning with a brief program history, and then an outline of the key features of Parts A and B, also known as “Original Medicare.” That is followed by overviews of Part C and Part D, a discussion of program financing, and a brief discussion of future program directions. Concluding sections include an overview of key program facts and a listing of CRS products that provide additional information on topics addressed in this report.

Medicare: A Capsule Summary

KEY FACTS

- Nationwide health insurance program for aged (65 and over) and disabled
- 44.6 million people enrolled in FY2008
- Total outlays in FY2008: \$459.4 billion
- Net outlays (not including beneficiary premiums) in FY2008: \$389.9 billion

PROGRAM STRUCTURE

- “Original Medicare”
 - Parts A and B
- Medicare Advantage - alternative to “Original Medicare”
 - Part C
- Prescription Drug Benefits
 - Part D

“ORIGINAL MEDICARE”

- 80% of beneficiaries get services through Parts A and B
- Part A and Part B - 2 different programs
 - Different eligibility requirements
 - Different benefits
 - Different beneficiary cost-sharing
 - Different financing

ELIGIBILITY

- Part A
 - Almost all aged automatically eligible (they or their spouse paid payroll tax during working career)
 - Disabled who have received cash disability payments for at least two years
 - Persons with end stage renal disease (ESRD, kidney disease)
- Part B
 - Anyone who has Part A and all persons 65 and older
 - Voluntary - almost everyone enrolls

BENEFITS

- Part A
 - Inpatient hospital services
 - Post-hospital skilled nursing facility (SNF) services
 - Home health care (mostly post-hospital)
 - Hospice care
- Part B
 - Physicians services
 - Laboratory services
 - Therapy services
 - Specified preventive services
 - Outpatient hospital services
 - Durable medical equipment
 - Home health care (not covered under Part A)
 - Ambulance Services

BENEFICIARY COST-SHARING

Part A

- Tied to “spell of illness” (starts with hospitalization and ends when out of hospital and SNF for 60 days)
- In each *spell of illness*, beneficiary pays:
 - *Hospital care*:
 - Deductible (\$1,024 in 2008)
 - Days 61-90 - Daily charge (\$256 in 2008)
 - Days 91-150 - Daily charge for lifetime reserve days (\$512 in 2008)
 - Over 150 days - No coverage
 - *Post Hospital SNF Care*
 - Days 1 - 20: No cost-sharing
 - Days 21- 100: Daily coinsurance charge (\$128 in 2008)
 - Over 100 days - No coverage
- Home Health - No cost-sharing
- Hospice care - Nominal cost-sharing

Part B

- Annual Deductible - (\$135 in 2008); and
- Coinsurance - 20% of Medicare’s approved amount
- Exceptions:
 - Some services exempt from deductible and/or coinsurance
 - Mental health services: 50% cost-sharing
 - Hospital outpatient services: fixed amount which varies by service category

PAYMENTS FOR SERVICES

- Payment rules under Part A and Part B differ for each service category and are quite complex
- Generally a pre-determined payment amount is established for a specific unit of service (such as a hospital stay)
- Typically, the law establishes annual update rules; however, they are frequently modified by Congress

PART C: MEDICARE ADVANTAGE (MA)

- 20% of beneficiaries get services through MA
- MA offers coordinated care and certain other private plan options for beneficiaries
- Voluntary for persons enrolled in both Part A and Part B
- MA enrollees get all their services through the plan
- Medicare makes a pre-determined monthly capitation payment to the MA plan for each beneficiary
- Capitation payments do not vary by amount of services used
- Federal government caps its liability (plans at risk for excess costs)

PART D: DRUG BENEFIT

- New in 2006
- Voluntary
- Anyone who has Part A or Part B or enrolled in Part C can enroll
- Administered by private entities: MA plans and prescription drug plans (PDPs)
- Plans must meet minimum standards
- Plans compete to offer benefits in the region
- Beneficiaries select among plans
- Persons with incomes below 150% of poverty have assistance with premium and cost-sharing charges

MEDICARE FINANCING

Part A:

- Financed primarily by payroll taxes paid by *current workers* and their employers:
 - Employees pay 1.45% on all earnings
 - Employers pay 1.45% on all earnings
 - Self-employed pay 2.9% on all earnings
- Revenues credited to Hospital Insurance (HI) trust fund

Part B:

- Financed by a combination of beneficiary premiums and general revenues
 - 25% from monthly premiums (\$96.40 in 2008) paid by *current beneficiaries*
 - 75% from general revenues
 - High income enrollees (in 2008, single beneficiaries with incomes over \$82,000 and couples with incomes over \$164,000) pay a higher premium
- Revenues credited to Supplementary Medical Insurance (SMI) trust fund

Part C:

- No separate financing mechanism
- Payments to MA plans made in appropriate parts from HI and SMI trust funds
- Premiums, if any, vary by plan

Part D:

- Financed by a combination of beneficiary premiums and general revenues
 - Beneficiaries pay different premiums depending on the plan they select
 - On average beneficiary premiums represent 25.5% of costs
 - General revenues finance the remainder
- Revenues credited to separate account in SMI trust fund

FINANCING: KEY POINTS

- Part A financed almost entirely by current workers
- Part B and Part D financed by premiums paid by beneficiaries and general revenues (tax dollars)
- Pending insolvency discussion refers only to Part A (currently estimated to become insolvent in 2019)
- Parts B and D do not become insolvent because of the way they are financed

CURRENT CONCERNS

- Medicare's overall growth rate not sustainable over time
 - Part A trust fund becomes insolvent
 - Parts B and D cost and premium increases will be substantial
- No easy solutions
- Some approaches focus on placing increasing reliance on private sector to deliver and manage benefits
- Other approaches focus on making changes within the current system

MEDICARE TRIGGER

- Enacted in 2003 as part of Medicare Modernization Act (MMA)
 - Intended to force consideration of reforms when there is "excess general revenue spending"
 - The law specifies that "excess spending" is reached when general revenues represent 45% or more of total program outlays
- Requirement for Medicare annual trustees report
 - Report required to specify if projected general revenue spending is expected to exceed 45% of outlays within seven years
 - President submits legislative proposal if finding is made for 2 successive years
 - Legislative proposal must contain recommendations to reduce percentage of total Medicare outlays funded by general revenues
 - Congress required to consider proposal on expedited basis.
 - Proposals to reduce the general revenue percentage can include increases in dedicated funding sources (primarily payroll taxes and premiums) and/or reductions in outlays for any part of the program.
- 2006 report contained finding
- 2007 report contained finding
- President submitted legislative proposal in February 2008
- Proposal would increase Part D premiums for higher income persons; incorporate value-based purchasing; and modify the medical liability system.
- In July 2008, the House approved a resolution specifying that the expedited parliamentary procedures required by MMA would not apply in the House for the remainder of the 110th Congress
- 2008 report also contained finding; submission of a legislative proposal will be required in February 2009

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 only had coverage for inpatient hospital costs. The new program, which became effective July 1, 1966, included coverage for hospital and post-hospital services under Part A and doctors and other medical services under Part B. As was the case for the already existing Social Security program, Part A was to be financed by payroll taxes levied on current workers and their employers; persons had to pay into the system for 40 calendar quarters to become entitled to benefits. However, persons who turned 65 before 1968 were automatically covered, while those who turned 65 between 1967 and 1974 were covered under transitional provisions. Medicare Part B was voluntary; beneficiaries who elected to enroll would pay a monthly premium. Over 90% of the eligible population enrolled. Payments to health care providers under both Part A and Part B were to be 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 was considered a social insurance program, similar to 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 qualified for both programs.

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

During the 1980s and 1990s, a number of laws were enacted which 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 stemming the annual updates in such payments. The program moved from payments based on reasonable costs and reasonable charges to payment systems under which a pre-determined payment amount is established for a specified unit of service. At the same time, beneficiaries were given the option 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 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) that was designed to mitigate the impact of BBA 97 on providers.

In 2003, Congress enacted a major Medicare bill, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). This legislation included the first major benefit expansion since 1965 and placed increasing emphasis on the private sector to deliver and manage benefits. It created a new voluntary outpatient prescription drug benefit to be administered by private entities. It also replaced the existing Medicare+Choice program with a new Medicare Advantage (MA) program; payments to these plans were increased in order to increase the availability of private plan options for beneficiaries. For the first time, MMA introduced the concept of income testing into Medicare. Low-income individuals get additional assistance under the new Part D drug program, while high income persons pay larger Part B premiums beginning in 2007. MMA also modified some provider payment rules and expanded covered preventive services. Finally, the legislation created a specific process for overall program review if general revenue spending exceeds 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) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L.110-275).

Medicare Parts A and B: “Original Medicare”

Approximately 80% of Medicare beneficiaries receive covered services through Part A and Part B. The Part A and B structure, which remains to this day, reflects the political compromises made at the time of enactment in 1965. Together they are known as “Original Medicare.” However, the two programs have different eligibility requirements, benefit structures, payment rules, and financing mechanisms. This section provides an overview of the key features of the two programs. (Medicare financing is discussed later in this report.)

Eligibility

Part A. Most persons age 65 or older are automatically entitled to Part A because they or their spouse paid Medicare payroll taxes for at least 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.) 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 premium. The 2008 monthly premium is \$423 (\$233 for persons with at least 30 quarters of covered employment). 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 the premium.

Part B. Part B is voluntary. All persons entitled to Part A (and persons over 65 not entitled to Part A) may enroll in Part B by paying a monthly premium. The 2008 monthly premium is \$96.40. Beginning in 2007, some higher-income individuals are paying higher premiums. (See the section on Financing, below.)

Persons who voluntarily enroll in Part A (because they are not automatically entitled to Part A) must also enroll in Part B. ESRD beneficiaries are also required to enroll in Part B.

Benefits and Beneficiary Cost-Sharing

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. Coverage 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 (\$1,024 in 2008);
- Days 61-90. Beneficiary pays a *daily* coinsurance charge (\$256 in 2008);
- 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 (\$512 in 2008).
- Days 151 and over. No coverage.

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

Skilled Nursing Facility (SNF) Services. The program covers up to 100 days of post-hospital care for persons needing continued skilled nursing or rehabilitation services on a daily basis. 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 (\$128 in 2008).

Home Health Services. Medicare covers visits by a home health agency when such services are required because an individual is confined to his or her home and needs skilled nursing care on an intermittent basis or physical 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; 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.

Home health services are covered under both 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).

Hospice Care. Hospice services are provided to terminally ill 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 services are for the palliation and management of the illness and include drugs, and medical and support services. 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.

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 (generally a fee schedule or other predetermined amount) for covered services in excess of the annual deductible (\$135 in 2008). 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 (namely to have the patient assign his or her right to payment to the physician). 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.

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.

Covered Part B services include the following:

Physicians Services. Covered 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.

Services of Non-Physician Practitioners. Covered services include those provided by physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical social workers.

Therapy Services. The program covers physical therapy and occupational therapy and speech language pathology services. The program establishes annual limits on covered services. The first is a \$1,810 per beneficiary annual cap (in 2008) for all outpatient physical therapy services and speech language pathology services. The second is a \$1,810 per beneficiary annual cap (in 2008) 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, to be used in 2006, 2007, 2008, and 2009, for services meeting specified criteria for medically necessary services. The limits do not apply to outpatient services provided by hospitals.

Preventive Services. The program covers the following preventive services, at specified screening intervals. The regular Part B deductible and cost-sharing apply, except as otherwise specified.

- “Welcome to Medicare” Physical Exam. The program covers a one-time physical exam within the first six months of enrollment in Part B. Coverage is provided for a physical exam (not including clinical laboratory tests) and referral for preventive and other screening services covered under Part B. Effective January 1, 2009, the exam must be conducted during the first year rather than the first six months of enrollment and the deductible is waived.

- *Vaccines*. The program covers annual flu shots and pneumococcal vaccines (usually needed only once in a lifetime). No deductible or cost-sharing applies for these shots. The program also covers Hepatitis B vaccines for persons at medium to high risk for Hepatitis B.
- *Mammograms*. Annual screening mammograms are covered for asymptomatic women 40 and over. The deductible does not apply.
- *Pap Smears and Pelvic Exams*. Biennial exams are covered. More frequent tests may be covered under certain conditions. The deductible does not apply.
- *Colorectal cancer screening tests*. The following tests are covered for persons 50 and over (except no minimum age for screening colonoscopies):
 - Fecal Occult Blood Test — Once every 12 months;
 - Screening Flexible Sigmoidoscopy — Once every 48 months;
 - Screening Colonoscopy — Once every 10 years, but not within 48 months of a screening sigmoidoscopy; for high risk individuals once every 24 months;
 - Barium Enema — This test can substitute for a flexible sigmoidoscopy or colonoscopy; it is covered every 24 months for high risk individuals and every 48 months for other persons.
 - No cost-sharing applies for fecal occult blood test. The cost-sharing for flexible sigmoidoscopies and colonoscopies performed in hospital outpatient departments is 25%.
- *Prostate Cancer Screening*. The program covers annual screening tests for men aged 50 and over. Tests covered include a digital rectal exam and a prostate specific antigen (PSA) test. There is no deductible or cost-sharing for the PSA test.
- *Cardiovascular Screening*. Tests that check cholesterol and other blood fat (lipid) levels are covered once every five years.
- *Bone Mass Measurement*. The program covers the test once every 24 months for persons at risk for osteoporosis.
- *Diabetes Screening and Self-Management Training*. Screening tests may be covered up to twice a year for at-risk individuals; no deductible or cost-sharing applies. Diabetes self-management educational and training services are covered when furnished in an outpatient setting by a certified provider. The physician must certify the need for services and they must be provided under a comprehensive plan of care.
- *Glaucoma Tests*. They are covered annually for high-risk individuals.
- *Medical Nutrition Therapy (MNT) Services*. MNT services are covered for persons with diabetes or renal disease. The benefit includes an initial assessment of nutrition and lifestyle assessment; nutrition counseling; information regarding managing lifestyle factors that affect diet; and follow-up visits to monitor progress managing diet. Medicare covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that. If the beneficiary's condition, treatment, or diagnosis changes, he or she

may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if continuing treatment is needed into another calendar year.

- *Ultrasound Screening for Abdominal Aortic Aneurysms.* Beginning January 1, 2007, coverage is provided under certain circumstances for persons with a family history or manifested risk factors. The deductible does not apply.
- *Additional Preventive Services.* Effective on or after January 1, 2009, these are services identified by the Secretary, subject to specified conditions.

Clinical Laboratory Tests; Diagnostic X-Ray Tests; Other Diagnostic Tests; and X-Ray, Radium, and Radioisotope Therapy. There is no coinsurance for clinical laboratory services.

Durable Medical Equipment (DME). Coverage is provided for equipment that is durable, prescribed for use in the home, and primarily for medical purposes. It includes such items as: walkers, wheelchairs, hospital beds, and home oxygen equipment. Certain items require the doctor to complete a certificate of medical necessity. A power wheelchair or scooter is only covered if the doctor states that it is required, based on the patient's medical condition. DME must be obtained from a supplier enrolled in Medicare.

Prosthetic Devices. Coverage is provided for prosthetic devices (other than dental) which replace all or part of an internal body organ, braces, and artificial limbs and eyes. Also included are cataract glasses, contact lenses, or intraocular lenses (IOLs) after cataract surgery with an intraocular lens; patient pays any additional costs for insertion of presbyopia-correcting lens or for upgraded frame.

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.

Outpatient Hospital Services and Services in Ambulatory Surgical Centers (ASCs). Coinsurance for outpatient hospital services can range as high as 40% of the payment amount; however, in no case can the amount exceed the inpatient hospital deductible (\$1,024 in 2008). Regular cost-sharing applies for ASC services.

Home Health Services. Home health services not covered under Part A are covered under Part B. (See Part A discussion, above.)

Other Medical and Health Services. Additional covered services include ambulance services, home dialysis equipment and supplies, and services provided in rural health clinics (RHCs) and federally-qualified health centers (FQHCs).

Services for End-Stage Renal Disease Beneficiaries. Individuals with end stage renal disease (i.e., kidney disease) are eligible for all services covered under Parts A and B. In addition, they are covered for dialysis services and, when provided, kidney transplants.

Program Payments

When Medicare was first established, the program generally made payments on the basis of “reasonable costs” and “reasonable charges.” However, program expenditures quickly began to exceed expectations. As a result, Congress sought to rein in expenditures by tightening payment rules. At first, limitations were placed on the definitions of reasonable costs and reasonable charges. Subsequently, the program moved toward payment systems under which a pre-determined payment amount is established for a specified unit of service, such as a hospital discharge or payment classification group. In 1983, the first prospective payment system (PPS) was established for inpatient hospital services, Medicare’s largest spending category. Under the inpatient PPS (IPPS), the payment amounts are intended to represent the average cost for treating a patient for the same condition. Hospitals that are able to keep costs below the fixed payment are able to keep the difference, while those with costs exceeding the fixed payment lose money.

Over time, prospective payment and other pre-determined approaches, such as fee schedules, were established for a number of other service categories. The rules for each payment system are quite complex and differ for each system. Taken together, they are sometimes characterized as “*administered pricing*,” since the price the government sets for the period does not fluctuate by supply or demand. The law generally specifies a formula for calculating an annual update to the payment amount, though Congress frequently amends the statutory requirements.

The following discussion is intended as only a brief overview of Medicare payment systems; for additional information, see CRS Report RL30526, *Medicare Payment Policies* and other CRS reports listed in the Appendix.

Inpatient Hospital Services.

Short-Term General Hospitals. Medicare pays acute care hospitals using a prospectively determined payment for each discharge. A hospital’s payment for its operating costs is the product of two components. The first component is a national standardized amount adjusted by a wage index associated with the area where the hospital is located or where it has been reclassified. The second component is the diagnosis related group (DRG) weight; this reflects the relative hospital resource use associated with the DRG to which the patient is assigned. DRGs are revised periodically, with the most recent update effective October 1, 2007. In that year, CMS began a two-year transition to a payment system that uses severity-adjusted DRGs. The new system has 335 base DRGs, most of which are split into two or

three Medicare severity (MS) DRGs generally based on the presence of a comorbidity or complication. There are 743 MS-DRGs used for payment purposes.

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. Note that physicians' services provided during an inpatient stay are paid under the physician fee schedule (discussed below), not under the IPPS system.

Payments are also made for capital costs. Medicare's capital IPPS is structured similarly to its operating IPPS for short-term general hospitals. A hospital's capital payment is based on a prospectively determined federal payment rate, depends on the DRG to which the patient is assigned, and is adjusted by a hospital's geographic adjustment factor. Qualified hospitals will receive indirect medical education and DSH adjustments to their capital payments as well. The teaching adjustment to capital payments is discontinued over the next two years.

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

Hospitals Receiving Special Consideration Under Medicare's IPPS.

Special payment considerations may apply for hospitals meeting one of the following designations. Generally this results in higher payments than would apply under the IPPS system.

- *Sole Community Hospital (SCH)*. An SCH is a facility located in a geographically isolated area and deemed to be the sole provider of inpatient acute care hospital services in a geographic area based on distance, travel time, severe weather conditions, and/or market share as established by specific criteria.
- *Medicare Dependent Hospital (MDH)*. An MDH is a small rural hospital with a high proportion of patients who are Medicare beneficiaries. It cannot be an SCH and must have 100 or fewer beds.
- *Rural Referral Center (RRC)*. An RRC is a relatively large hospital, generally in a rural area, that provides a broad array of services and treats patients from a wide geographic area, as established by specific criteria.

IPPS Exempt Hospitals and Distinct Part Units. Certain hospitals or distinct hospital units are exempt from IPPS and paid on an alternative basis.

- *Inpatient Rehabilitation Facilities (IRFs)*. An IRF is a freestanding hospital or hospital-based distinct part unit that meets the modified "75% rule" and additional specified conditions. The rule specifies a minimum percentage of the IRF's inpatient population that must have at least one of the qualifying medical conditions. The

compliance threshold to qualify for higher payments as an IRF (historically set at 75%) is set at 60% starting July 1, 2006. In order to be paid as an IRF, 60% of an entity's Medicare patients must have one of the qualifying medical conditions as either a primary or a secondary condition. Medicare payments to an IRF are made under a single PPS which covers both operating and capital costs. Payments will vary according to the case mix group (CMG) to which patients are assigned, based on their impairment level, functional status, comorbidity conditions, and age. Five CMGs are reserved for short-stay patients or those who die in the facility. Facility level adjustments such as the area wage index, rural location, share of low income patients, and teaching status would apply as well. Medicare's IRF-PPS also will provide additional payments for high cost outliers.

- *Long-Term Care Hospitals (LTCHs)*. An LTCH is an acute care general hospital that has a Medicare inpatient average length of stay greater than 25 days. An LTCH is paid on a discharge basis under an MS-DRG-based PPS which includes both operating and capital costs. The LTCH-PPS payment for a Medicare discharge is based on the patient's assignment into one of the covered MS-LTC-DRGs, as well as facility-specific adjustments.
- *Psychiatric Hospitals or Distinct Part Units*. Payments to an inpatient psychiatric facility (IPF) is based on a per diem PPS (IPF-PPS). The system incorporates patient level adjustments for specified DRGs, as well as facility-level adjustments. Payments are higher in the earlier days of a stay.
- *Children's Hospitals and Cancer Hospitals*. These hospitals are paid on a reasonable cost basis, subject to certain limitations and, in certain cases, incentive payments.
- *Critical Access Hospitals (CAHs)*. A CAH is a limited-service facility that is: located more than 35 miles from another hospital (15 miles in certain circumstances); offers 24-hour emergency care; has no more than 25 acute care inpatient beds; and has a 96-hours or less average length of stay. As of January 1, 2006, states can no longer designate entities as necessary providers of care in order to qualify as a CAH. Certain grandfather provisions apply to those previously designated by the states. CAHs are paid on the basis of reasonable costs for inpatient, outpatient, and independent laboratory services; payments equal 101% of reasonable costs. A CAH may elect either a cost-based hospital outpatient service payment or an all-inclusive rate which is equal to a reasonable cost payment for facility services plus 115% of the fee schedule payment for professional (i.e. physicians') services.

Skilled Nursing Facility (SNF) Care. SNF services are paid under a 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. The RUGs system uses patient assessments to assign a beneficiary to one of 53 categories and to determine the

payment for the beneficiary's care. 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. 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 80 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. 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 CPI-U.

Physician Services and Other Services Paid Under the Physician Fee Schedule. A number of Part B services are paid under the physician fee schedule. These include services of physicians, nonphysician practitioners, and therapists. Most services described earlier 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 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 2008 is 0.5% above that for 2007; the conversion factor for 2009 will be 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 payment for those services provided from July 2007-December 2010. The bonus payments are 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.

Clinical Diagnostic Laboratory Services. Clinical lab services are paid on the basis of area-wide fee schedules. There is a ceiling on payment amounts equal to 74% of the median of all fee schedules for the test. Fee schedule amounts are frozen through 2008. For the 2009-2013, the inflation update that would otherwise apply will be reduced by 0.5 percentage points each year

Durable Medical Equipment, Prosthetics and Orthotics (DMEPOS). Except in competitive bidding areas described below, durable medical equipment (DME) is paid on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than \$150 or which are purchased at least 75% of the time); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, fee schedule rates are established locally and are subject to national limits, with floors and ceilings. The floor is equal to 85% of the weighted average of all local payment amounts and the ceiling is equal to 100% of the weighted average of all local payment amounts.

Prosthetics and orthotics are also paid on the basis of a fee schedule in areas that are not competitive bidding areas. Fee schedule rates for prosthetics and orthotics, however, are established regionally and are subject to national limits which have floors and ceilings. The floor is equal to 90% of the weighted average of all regional payment amounts and the ceiling is equal to 120% of the weighted average of all regional payment amounts.

The fee schedules are generally updated annually by the CPI-U (Consumer Price Index), but Congress has often specified the reduction or elimination of updates in certain years.

MMA required the Secretary to establish a competitive bidding program for DMEPOS to replace the fee schedule payments. The program is required to be phased in, starting in 10 of the largest metropolitan statistical areas, expanding to 80 of the largest metropolitan areas, and remaining areas. The Secretary may first phase in items and services with the highest cost and highest volume, or those items and services that the Secretary determines to have the largest savings potential first. The Secretary may exclude certain areas from participation in the program. The program started on July 1, 2008; however, MIPPA terminated the first round of contracts, required the Secretary to rebid the first round in 2009, and delayed subsequent rounds of the program until 2011, in addition to other changes.

The DRA reduced the amount of time certain items of DME can be rented before ownership of the item is transferred to the beneficiary. For items in the capped rental category, such as hospital beds, nebulizers and wheelchairs, the rental period changed from a period not to exceed 15 months, to a maximum of 13 months; ownership of the equipment is then transferred to the beneficiary. For oxygen equipment, the rental period was limited in DRA to a maximum of 36 months. However, MIPPA eliminated the transfer-of-ownership requirement for oxygen equipment. After the 36-month rental period, the supplier retains ownership of the oxygen equipment but allows the beneficiary to continue using it. Medicare will continue to pay for oxygen refills and will pay for maintenance and servicing not covered by the manufacturer's warranty after the 36-month rental period.

Hospital Outpatient Department (HOPD) Services. Under the HOPD-PPS, the unit of payment 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 payment for HOPD services 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 IPPS wage index. Except for new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. The HOPD-PPS also includes pass-through payments for new technologies (specific drugs, biologicals, and devices) and payments for outliers. Starting in 2006, rural 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.

Ambulatory Surgical Center (ASC) Services. Beginning in January 2008, Medicare pays for surgery-related facility services provided in ASCs using a payment system based on the hospital OPSS (HOPD-PPS). The associated physician fees are paid using 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. Integral items and services are packaged with the primary service into an APC. Separate payments are made for corneal tissue acquisition, brachytherapy sources, certain radiology services, many drugs, and certain implantable devices. The ASC system uses the same payment groups (APCs) as the OPSS. The relative weights for most procedures in the ASC payment system is the same as the relative weights in the OPSS. The ASC system uses a conversion factor based on a percentage of the OPSS conversion factor. The percentage of this average dollar figure is set to ensure budget neutrality. By statute, 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. 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. 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). In general, CMS seeks to minimize the financial incentives to shift services from one setting (a physician office or hospital outpatient department) into an ASC.

Part B Covered Drugs and Vaccines. Medicare's payment for Part B covered drugs equals 106% of the average sales price.

Ambulance Services. Ambulance services are paid on the basis of a fee schedule. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The national fee schedule is fully phased in 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 the national and regional fee schedule amounts. The portion of the blend based on national rates is 80% for 2007-2009. In 2010 and subsequently, 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. Geographic adjustments are 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. There is a 25% bonus on the mileage rate for trips of 51 miles and more.

Payments for ground ambulance services originating in rural areas are increased by 3%, and payments for such services originating in other areas are increased by 2% for the period July 1, 2008-December 31, 2009.

End-Stage Renal Disease (ESRD) Dialysis and Transplant Services.

Dialysis services, paid for under Part B, 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," and in applying the geographic index to providers of services, the labor share will be based on the labor share otherwise applied for renal dialysis facilities. 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.

Kidney transplantation services, to the extent they are inpatient hospital services, are subject to the IPPS. However, kidney acquisition costs are paid on a reasonable cost basis.

Medicare Part C: Medicare Advantage (MA)

Approximately 20% of Medicare beneficiaries receive covered services through Part C, rather than through “Original Medicare.” For a number of years, Medicare beneficiaries who are eligible for Medicare Part A and enrolled in Part B have had the option of obtaining covered services through private health plans. Under an agreement with CMS, a plan agrees to provide all services covered under Medicare Parts A and B (except for hospice care) in return for a capitated monthly payment. The same monthly payment is made regardless of how many or how 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, under the fee-for-service payment methodology used under “Original Medicare,” a payment is made to a medical provider for each service (e.g., physician visit) or each unit of service (e.g., a hospital stay) provided.

Background

Medicare’s first risk contract program was created in 1982. Under that program, private entities, mostly health maintenance organizations (HMOs), contracted with Medicare to provide covered services. The BBA, enacted in 1997, replaced the risk contract program with the Medicare+Choice (M+C) program. The M+C program established a new payment formula, which was designed both to reduce overall spending and to reduce the existing variation in payments to plans across the country. Following enactment of BBA 97, managed care plans began leaving the program, citing insufficient Medicare payments; however, other factors also played a role for some plans.

Subsequent legislation addressed some of the issues arising from passage of the BBA. Most recently, Congress made substantial changes to the M+C program with the passage of the MMA in 2003. The act created the Medicare Advantage (MA) program to replace the M+C program and introduced several provisions intended to increase the availability of private plans to Medicare beneficiaries. It provided for immediate payment increases to plans beginning in 2004. Beginning in 2006, it changed the payment structure for local plans and provided for the introduction of regional plans that operate like preferred provider organizations — a popular option in the private health insurance market. The legislation also provided financial

incentives for plans to participate in this new regional option. Additionally, MA enrollees have access to the Part D drug benefit through their MA plan.

Beginning in 2010, the MA program will offer a six-year program (referred to as comparative cost adjustment) designed to test competition between local MA plans and fee-for-service Medicare, in limited areas.

Plan Types

There are several different types of plans that can qualify as MA plans. They include coordinated care plans (which includes health maintenance organizations and preferred provider organizations), private fee-for-service plans, Medical Savings Account plans, and certain other plan types operating under exceptions or demonstration authority. The following are the most common plan types available:

- *Health Maintenance Organizations (HMOs)*. HMO plans offer services to plan members in designated service areas. Beneficiaries are generally required to obtain services from hospitals and doctors that are in the plan's network. Some plans offer a point-of-service option under which an individual may elect to obtain services from a non-network provider; in such cases, the individual pays more for the care. If the plan does not have a point of service option, the individual must pay out-of-pocket, except in emergency cases, for services provided by non-network providers.
- *Local Preferred Provider Organizations (PPOs)*. Persons who enroll in PPOs are generally able to see any doctor or other provider that accepts Medicare. If enrollees use out-of-network (i.e. non-preferred) providers, they will generally pay more, though the amount varies by plan. Local PPOs generally serve individual counties.
- *Regional PPOs (RPPOs)*. Beginning in 2006, regional PPOs are available. Regional PPOs serve one or more of the 26 regions established by the Secretary. Each region consists of either a single state or multi-state area. MA regional plans cover both in- and out-of-network required services and have both a unified Part A and Part B deductible and a limit on out-of-pocket expenses; the limit varies by plan. This is the only group that has a specific limit on out-of-pocket spending in connection with Part A and Part B services.
- *Special Needs Plans (SNPs)*. A SNP may be any plan type (such as an HMO or PPO). However, unlike other plans, a SNP may, in accordance with regulations, restrict enrollment to special needs beneficiaries. Special needs beneficiaries are defined as MA eligible individuals who reside in long-term care facilities, who are eligible for both Medicare and Medicaid, or who meet requirements specified by the Secretary that identify people who would benefit from enrollment in a SNP for specified chronic or disabling conditions. SNPs may restrict enrollment for periods before January 1, 2011. Starting January 1, 2010, all new enrollees to a SNP must

meet the definition of a special needs individual for the respective plan.

- *Private Fee-for-Service (PFFS) Plans.* A PFFS plan is one that (1) reimburses providers on a fee-for-service basis, (2) does not vary rates for a provider based on utilization, and (3) does not restrict the selection of providers who are lawfully authorized to provide services and agree to accept the terms and conditions of payment established by the plan. Starting in 2011, MIPPA require PFFS plans to establish contracted networks of providers in areas where two or more plans with networks (such as HMOs or local PPOs) serve Medicare beneficiaries starting in 2011. PFFS plans sponsored by an employer or union are required to establish contracted provider networks throughout their entire service area starting in 2011.

In general, MA organizations are required to offer at least one plan with Part D drug coverage. MA enrollees can only get Part D coverage through their MA plan. An exception applies for private fee-for-service plans; unlike most other MA plans, they are not required to offer Part D drug coverage, though they may elect to do so. Individuals in PFFS plans not offering drug coverage may purchase drug coverage through a stand-alone Part D drug plan.

Plan Enrollment

Beneficiaries newly eligible for Medicare Part A and enrolled in Part B can join an MA plan. Other persons can generally join an MA plan, or switch from one MA plan to another, only during the annual open enrollment period which occurs from November 15-December 31 each year. 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.

Payments to Plans

Payments to MA plans 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 will equal to its bid plus a rebate equal to 75% of the difference (between the benchmark and the bid). The rebate must be returned to the 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 PFFS

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.

Beginning in 2006, the MA program began to offer MA regional plans. Like local plans, regional plans must submit bids to the Secretary that, in relation to the benchmark, determine the payment the plan receives for each enrollee. The regional program is different from the local program in that the plan bids help determine the benchmarks for each region. The regional 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 will be given a rebate while plans with bids above the benchmark will require an additional enrollee premium.

Additional financial incentives are provided to encourage regional plan participation. During 2006 and 2007, Medicare shared risk with an MA regional plan if its costs fell above or below a statutorily-specified risk corridor. Starting in 2014, a stabilization fund is available to provide incentives for regional plans to enter into or to remain in the MA program. Due to changes in MIPPA, the stabilization fund is financed entirely with a portion of the savings from the regional plan bidding process.

Part D: Outpatient Prescription Drugs

As noted, MMA added a new voluntary outpatient prescription drug benefit, beginning in 2006. Coverage is provided through private prescription drug plans (PDPs) or MA prescription drug (MA-PD) plans. The program relies on these private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies covering the bulk of the risk is provided to encourage participation.

Unlike other Medicare services, the benefits can only be obtained through private plans. Further, while all plans have to meet certain minimum requirements, there are significant differences among them in terms of benefit design, drugs included on plan formularies (i.e. list of covered drugs) and cost-sharing applicable for particular drugs.

Eligibility and Plan Enrollment

Each individual enrolled in Part A or Part B is entitled to obtain qualified prescription drug coverage through enrollment in a prescription drug plan. A beneficiary enrolled in an MA plan providing qualified prescription drug coverage (MA-PD plan) obtains coverage through that plan. In general, MA enrollees can not enroll in a stand-alone prescription drug plan under Part D.

Medicare beneficiaries enrolled in Part A or Part B on or before January 31, 2006, had to enroll by May 15, 2006; those eligible in February 2006 had until May

31, 2006. Those eligible for Medicare beginning March 2006 or later have an initial seven-month enrollment period beginning three months before the month of Medicare eligibility. This initial eligibility period is the same as that applicable for Medicare Part B.

An individual who does not enroll during his or her initial enrollment period is only able to enroll during the annual open enrollment period, which occurs from November 15-December 31 each year. Coverage begins the following January 1. Persons who fail to enroll during their initial enrollment period are subject to a penalty if they decide to enroll in the program at a later date. However, they are not subject to the penalty if they have maintained “creditable” drug coverage through another source. One source of possible creditable coverage is retiree health coverage offered by a former employer or union.

Special rules apply for persons who qualify for the low-income subsidy. These persons are not subject to the delayed enrollment penalty otherwise applicable to persons who miss the enrollment deadline.

Benefits

Qualified Part D plans are required to offer either “standard coverage” or alternative coverage, with actuarially equivalent benefits. In 2008, “standard coverage” has a \$275 deductible, 25% coinsurance for costs between \$276 and \$2,510. From this point, there is no coverage until the beneficiary has out-of-pocket costs of \$4,050 (\$5,726.25 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. A number of plans have reduced or eliminated the deductible. Many plans offer tiered cost-sharing under which lower cost-sharing applies for generic drugs, higher cost-sharing applies for preferred brand name drugs, and even higher cost-sharing applies for non-preferred brand name drugs. Some plans provide some coverage in the doughnut hole; this is generally limited to generic drugs.

Low-Income Provisions

A major focus of the drug benefit is the enhanced coverage provided to low-income individuals who enroll in Part D. Low-income enrollees, including persons (known as “dual eligibles”- those persons enrolled in both Medicare and Medicaid) who previously received drug benefits under Medicaid, have their prescription drug costs paid under the new Part D. Persons with incomes below 150% of poverty have assistance with some portion of their premium and cost-sharing charges. Persons with the lowest incomes have the highest level of benefits.

Drug Payments

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”).

Interaction With Retiree Plans

MMA included significant incentives for employers to continue to offer coverage to their retirees. Specifically, special federal subsidy payments are made to employers or unions offering drug coverage at least actuarially equivalent to “standard coverage.” Subsidy payments are made on behalf of an individual covered under a retiree plan who is eligible to enroll under a PDP or MA-PD plan, but elects not to. In 2008, subsidy payments equal 28% of the retiree’s gross drug costs between \$275 and \$5,600. The federal government is not taking the subsidy in behalf of persons enrolled in TRICARE or the federal employees health benefits (FEHB) program.

Employers or unions may select an alternative option (instead of taking the subsidy) with respect to Part D. They may elect 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. Enhanced coverage may be provided through supplementary or “wrap around” benefits. Alternatively, employers or unions may contract with a PDP or MA-PD to offer the coverage. Finally, they may become a Part D plan sponsor themselves for their retirees.

Medicare 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). Day-to-day program operations, including processing benefits and paying claims, are conducted by private Medicare contractors. Fiscal intermediaries (FIs) perform claims administration functions for Part A services and Part B services performed by Part A providers (such as hospitals and skilled nursing facilities). Carriers perform claims administration functions for other Part B services. Day-to-day program operations for MA plans, MA-PD plans, and PDPs are handled by the plans themselves.

Under contracting reform, mandated by the MMA, the Secretary is authorized to replace FIs and carriers with 19 competitively-selected, Medicare Administrative Contractors (MACs) by 2011. Fifteen A/B MACs will perform claims processing operations for Part A and B Medicare providers. The four regional carriers (DMERCs), which previously handled all durable medical equipment claims in the country, were transitioned to DME MACs. As of December 2007, 1 A/B MAC and the 4 DME MACs were fully operational.

CMS also contracts with private organizations to conduct other administrative functions such as detecting and collecting improper payments, investigating alleged fraud and abuse, and ensuring the quality of care provided to Medicare beneficiaries.

Medicare Financing

Medicare is financed from three principal sources, namely payroll taxes, general revenues, and premiums paid by beneficiaries. Different revenue sources are directed to specific Parts of the program.

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.

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. Each pays a tax of 1.45% on 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) a portion of federal income taxes that individuals pay on their social security benefits; (2) premiums paid by voluntary enrollees who are not automatically entitled to Medicare Part A through their (or their spouse's) work in covered employment; (3) government credits; and 4) interest on federal securities held by the trust fund. Income for Part A is credited to the HI trust fund.

Part B Financing

Medicare Part B is financed through a combination of beneficiary premiums and federal general revenues. Beneficiary premiums equal 25% of estimated program costs for the aged. (The disabled pay the same premium as the aged.) Federal general revenues account for the remaining 75%. Income for Part B is credited to the SMI trust fund.

The 2008 monthly Part B premium is \$96.40. 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 the inception of Medicare, all Part B enrollees paid the same Part B premium, regardless of their income level. For many years, Congress debated whether or not it was appropriate for taxpayers to pay (through general revenue financing) three-quarters of Part B costs for higher income persons, since low income and middle income working persons might be subsidizing higher income elderly persons.

In response, Congress included a provision in MMA that required higher income enrollees to pay higher premiums beginning in 2007. In 2008, individuals whose modified adjusted gross income (AGI) in 2006 exceeded \$82,000 and couples whose modified AGI exceeded \$164,000 are subject to higher premium amounts. In 2008, they pay total premiums ranging from 31.7% to 61.7% of the value of Part B. When fully phased-in in 2009, higher income individuals will pay total premiums ranging from 35% to 80% of the value of Part B.

CMS estimates that 5% of enrollees will pay the higher premiums in 2008. For singles, the higher monthly premium amounts are \$122.20 for beneficiaries with incomes (in 2006) over \$82,000 and less than or equal to \$102,000, \$160.90 for incomes over \$102,000 and less than or equal to \$153,000, \$199.70 for incomes greater than \$153,000 and less than or equal to \$205,000, and \$238.40 for incomes greater than \$205,000. For couples filing joint tax returns, the premium amounts are \$122.20 for beneficiaries with incomes over \$164,000 and less than or equal to \$204,000, \$160.90 for incomes over \$204,000 and less than or equal to \$306,000, \$199.70 for incomes greater than \$306,000 and less than or equal to \$410,000, and \$238.40 for incomes greater than \$410,000.

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. 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.

Beneficiaries pay different premiums depending on the plan they have selected (and whether or not 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.

Medicare Solvency

When people refer to the pending insolvency of Medicare, they are actually referring to the pending insolvency of the HI trust fund. Medicare trustees define insolvency as occurring when trust fund assets at the beginning of the year are insufficient to pay program benefits for the forthcoming year. Because of the way it is financed, the SMI fund (including the Part D account) does not face insolvency although its rapid growth rate is a drain on federal spending. Further, continued premium increases may place a financial burden on some beneficiaries.

The 2008 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. 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.

45% Trigger

The rapid increases in total Medicare costs has long been of concern to Congress and others. The trustees have emphasized the importance of examining the program as a whole, rather than just the HI trust fund. Of particular concern is the fact that over time the economy will be unable to support the increasing reliance on general revenues, which in large measure come from taxes paid by the under-65 population. 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. General revenue financing is defined as: total Medicare outlays minus dedicated financing sources (i.e., HI payroll taxes; income from taxation of Social Security benefits; state transfers for prescription drug benefits; premiums paid under Parts A, B, and D; and any gifts received by the trust funds).

If the trustees determine that general revenue financing will exceed 45% of total financing within seven years, a finding of “excess general revenue funding” is made.” The 2006 report projected that the 45% level would first be exceeded in FY2012; the 2007 report projected that it would first be exceeded in 2013. Both findings were within the required seven-year test period. Both reports therefore, made a determination of “excess general revenue funding.”

MMA requires that if an excess general revenue funding determination is made for two successive years, the President is required to submit a legislative proposal to respond to the warning. The proposal must be submitted, within 15 days of submission of the next President’s Budget (unless during the intervening period legislation is enacted, which eliminates such excess general revenue funding). Since warnings were issued in 2006 and 2007, the proposal was due within 15 days of submission of the President’s FY2009 budget in early 2008.

The President submitted the required proposal in February 2008. It included provisions to increase Part D premiums for higher income persons; incorporate value-based purchasing; and modify the medical liability system. The Congress was required to consider the proposal on an expedited basis, though passage of legislation within a specific time frame was not required. On July 24, 2008, the House of Representatives adopted a resolution which provides that the expedited parliamentary procedures contained in MMA shall not apply in the House during the remainder of the 110th Congress.

The 2008 trustees report also contained a funding warning. Therefore the President will be required to submit a legislative proposal early in 2009.

Additional Insurance Coverage

Medicare provides broad protection against the costs of many, primarily acute care, services. However, the program does not cover all services which 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 policies, 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. (More recent data are not available.)

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.
- *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 by offering subsidies to employers who offer drug coverage, at least as good as that available under Part D. (See discussion, above.)
- *Medigap.* Individual insurance policies which 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. 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.) More recent information is not available.

Medicare Directions

The Medicare program is likely to be the subject of continuing review for a number of years. Both Congress and the Medicare trustees continue to register concern about the rapid rise in Medicare spending and the ability of existing funding mechanisms to support the program over the long-term. Only the Part A fund faces an actual insolvency date. However, few observers believe that the program’s total growth rate is sustainable over time. 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.

A combination of factors have contributed to the rapid increase in Medicare costs. 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. The issues confronting the program are not new, nor are the possible responses likely to get any easier. Solutions involve raising taxes, cutting benefits, raising beneficiaries’ out-of-pocket costs, or some combination of these approaches. Members of Congress, Medicare trustees, and many other observers continue to warn that the problems need to be addressed. At the same time, some Members and beneficiary advocates express concern about the potential impact of any solution on beneficiaries’ out-of-pocket costs or access to needed services.

It seems likely that in the short-term, Congress will focus its attention on specific Medicare issues, for example physician payment updates. It may also

consider Medicare spending reductions as part of legislation (such as budget reconciliation) designed to reduce overall federal spending below specified levels over a specific time period.

At the same time, the Administration, Congress and others may also examine a broad range of policy options designed to achieve more long term reforms. For a number of years, various options have been suggested; however, there is no consensus on the approach that should be taken. One option is placing increasing reliance on the private sector to deliver and manage benefits. This is the approach first used for managed care options under Part C. More recently, the new Part D drug benefit gave increased flexibility to private entities. Within federally-established parameters, individual entities design their benefit packages and determine payment amounts. The intention is to encourage competition by allowing beneficiaries to select coverage that best meets their needs. Proponents claim that this will result in lower overall costs as well as enable the federal government to distance itself from the business of establishing detailed payment rules for each service category.

Some Members and other observers oppose the efforts to change the basic structure of Medicare. They contend that a single nationwide benefit structure, administered by the federal government, has served beneficiaries well and should be retained. They contend that any necessary savings for Part A and B services can be achieved within the context of the existing program and suggest that increased MA payments have actually increased overall program costs. Additionally, some persons also suggest that savings could be achieved under Part D if the federal government were allowed to enter into price negotiations with drug manufacturers.

At one time, it was thought that the MMA provision relating to an excess general revenue funding determination might have an impact on the Medicare discussion this year. For the second straight year, the Medicare trustees report had contained an excess general revenue funding determination under which general revenues are expected to be greater than 45% of outlays within the next seven years. (See "Financing" section, above.) As a result, the President was required to submit a legislative proposal responding to the warning. The President submitted the proposal in February 2008. MMA had required expedited congressional action. However, on July 24, 2008, the House of Representatives adopted a resolution which provides that the expedited parliamentary procedures contained in MMA shall not apply in the House during the remainder of the 110th Congress.

The 2008 trustees report also contained a funding warning. Therefore, under the MMA provisions, the President will be required to submit a legislative proposal early in 2009.

It should be noted that the MMA provision defines general revenues as total outlays minus dedicated revenues (primarily payroll taxes and premiums). Under this calculation, increases in dedicated revenues and/or reductions in outlays in any part of Medicare will lower general revenues and can be used to meet the trigger requirements. It should be noted that lowering Part A spending lowers both overall Medicare spending and "excess general revenue spending." However, if no other changes were made, spending under Parts B and D (and associated general revenue financing) would represent a larger proportion of total spending.

On the other hand, legislation directed at general revenue financing under Parts B and D will not address the pending insolvency of Part A which is funded primarily by payroll taxes. It is therefore expected that Congress will need to examine a variety of options in the coming years.

Key Medicare Statistics

Tables 1-3 show CBO estimates from the March 2008 Medicare Fact Sheet which contains information on the various components of program spending. CBO March baseline numbers are the numbers Congress uses when it considers legislation. Slightly different estimates are provided by the Medicare trustees.

Table 1. Medicare Outlays, Selected Years
(\$ in billions)

	FY2008	FY2009	FY2013	FY2018
Total Outlays	\$459.4	\$491.5	\$642.0	\$894.6
Offsetting Receipts (premiums and amounts paid by states)	69.4	72.2	90.3	128.0
Net Outlays	389.9	419.3	551.7	766.6

Source: Congressional Budget Office (CBO), Fact Sheet for CBO's March 2008 Baseline: Medicare.

Note: Totals may not add due to rounding.

Table 2. Distribution of Total Outlays
(\$ in billions)

	FY2008		FY2009	
	Amount	Percent	Amount	Percent
Benefits	\$452.5	98.5	\$484.7	98.6
Part A	225.3	49.0	240.3	48.9
Part B	181.9	39.6	190.2	38.7
Part D	45.5	9.9	54.3	11.0
Administration	7.0	1.5	6.9	1.4
Total	459.4	100.0	491.5	100.0

Source: Congressional Budget Office (CBO), Fact Sheet for CBO's March 2008 Baseline: Medicare.

Notes: Spending for Part C is made in appropriate parts from the Part A and B trust funds and is recorded under benefits totals for Part A or Part B. Totals may not add due to rounding.

Table 3. Medicare Benefit Payments, by Category
(\$ in billions)

	FY2008	FY2009
Total	\$452.5	\$484.7
Part A, only	166.2	171.3
Hospital Inpatient Care	132.2	135.9
Skilled Nursing Facilities	22.9	23.5
Hospice	11.1	11.9
Part B, only	122.1	120.7
Physician Fee Schedule	56.4	52.6
Other Professional and Outpatient Ancillary	28.9	30.0
Other Facility Services	16.6	16.6
Hospital Outpatient	20.2	21.5
Parts A and B	110.5	130.1
Group Plans	94.1	112.8
Home Health Agencies	16.4	17.3
Part D	45.4	54.3
Payment to Prescription Drug Plans	25.1	32.2
Payments to Union/Employer-sponsored	3.2	3.3
Low-Income Subsidy Payments	17.1	18.8
Recoveries^a	8.3	8.2

Source: Congressional Budget Office (CBO), Fact Sheet for CBO's March 2008 Baseline: Medicare.

Note: Totals may not add due to rounding.

a. Amounts paid to providers and later recovered

Table 4. Projected Growth in Medicare Population
(in millions)

	FY2008 (est)	FY2013 (est.)	FY2018 (est.)
Total (Part A enrollment)	44.0	49.4	57.2

Source: Congressional Budget Office (CBO), Fact Sheet for CBO's March 2008 Baseline: Medicare.

Table 5. Characteristics of Medicare Population, 2002
(by percent)

Race	100	Age	100
White (not Hispanic or Latino)	78.2	Aged	84.8
Black (not Hispanic or Latino)	9.6	65-74	43.8
Hispanic or Latino	7.5	75-84	29.8
Other	4.7	85 and over	11.2
Sex	100	Disabled	15.2
Male	44.1	Under 45	3.8
Female	55.9	45-64	11.4

Source: Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States 2007*, November 2007, p. 411.

[<http://www.cdc.gov/nchs/data/hus/hus07.pdf>]

Note: Totals may not add due to rounding.

**Table 6. Percentage of Persons Age 65 and Over
Characterized as Poor or Near Poor, 2005**

	Poor^a	Near Poor^a
All Races and Origins	10.1	26.7
Hispanic or Latino	19.9	34.7
Black or African American, only	23.3	34.5
Asian only	12.8	20.1
White only, not Hispanic or Latino	7.9	25.4

Source: Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States 2007*, November 2007, p. 97. [<http://www.cdc.gov/nchs/data/hs/hs07.pdf>].

Note: Includes some aged persons not enrolled in Medicare; does not include the disabled.

- a. Poor is defined as family income less than 100% of the poverty level and near poor is defined as family income between 100% and 199% of the poverty level. Assets are not considered.

Appendix: Other CRS Products

Recent Legislation

- CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*, by Hinda Chaikind, Jennifer O’Sullivan, Sibyl Tilson, Paulette Morgan, Holly Stockdale, Jim Hahn, Gretchen A. Jacobson, Richard Rimkunas, Evelyne Baumrucker, April Grady, Jean Hearne, Elicia J. Herz, Julie Stone, Gene Falk, and Emile Stoltfus
- CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*, by Hinda Chaikind, Jim Hahn, Jean Hearne, Elicia J. Herz, Gretchen A. Jacobson, Paulette C. Morgan, Chris L. Peterson, Holly Stockdale, Jennifer O’Sullivan, Julie Stone, and Sibyl Tilson
- CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children’s Health Insurance Program (SCHIP) Provisions*, by Evelyne P. Baumrucker, Hinda Chaikind, April Grady, Jim Hahn, Jean Hearne, Elicia J. Herz, Bob Lyke, Paulette C. Morgan, Jennifer O’Sullivan, Richard Rimkunas, Julie Stone, Sibyl Tilson, and Karen Tritz
- CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)*, by Jennifer O’Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette C. Morgan
- CRS Report RL32005, *Medicare Fee-for-Service Modifications and Medicaid Provisions of H.R. 1 as Enacted*, (MMA provisions) by Sibyl Tilson, Jennifer Boulanger, Jean Hearne, Steve Redhead, Evelyne Baumrucker, Julie Stone, Bernadette Fernandez, and Karen Tritz

In General

- CRS Report RL30526, *Medicare Payment Policies*, by Sibyl Tilson, Hinda Chaikind, Jennifer O’Sullivan, Julie Stone and Paulette C. Morgan
- CRS Report RL34359, *Medicare: FY2009 Budget Issues*, by Hinda Chaikind, Jim Hahn, Gretchen A. Jacobson, Paulette C. Morgan, Jennifer O’Sullivan, Holly Stockdale, Julie Stone, and Sibyl Tilson
- CRS Report RL33713, *Pay-for-Performance in Health Care*, by Jim Hahn
- CRS Report RL33587, *Medicare Secondary Payer — Coordination of Benefits*, by Hinda Chaikind
- CRS Report RL31223, *Medicare: Supplementary “Medigap” Coverage*, by Jennifer O’Sullivan
- CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*, by Holly Stockdale

Financing

- CRS Report RS20173, *Medicare: Financing the Part A Hospital Insurance Program*, by Jennifer O’Sullivan
- CRS Report RS20946, *Medicare: History of Part A Trust Fund Insolvency Projections*, by Jennifer O’Sullivan
- CRS Report RL32582, *Medicare: Part B Premiums*, by Jennifer O’Sullivan
- CRS Report RS21731, *Medicare: Part B Premium Penalty*, by Jennifer O’Sullivan
- CRS Report RS22796, *Medicare Trigger*, by Hinda Chaikind and Christopher M. Davis
- CRS Report RL34407, *The President’s Proposed Legislative Response to the Medicare Funding Warning*, by Hinda Chaikind, Jim Hahn, Jennifer O’Sullivan, and Henry Cohen

Part A Issues

- CRS Report RS22399, *Recent Developments in Medicare Affecting Long-Term Care Hospitals*, by Sibyl Tilson
- CRS Report RL32640, *Medicare Payment Issues Affecting Inpatient Rehabilitation Facilities (IRFs)*, by Sibyl Tilson
- CRS Report RL33921, *Medicare’s Skilled Nursing Facility Payment*, by Julie Stone
- CRS Report RS22195, *Social Security Disability Insurance (SSDI) and Medicare: The 24-Month Waiting Period for SSDI Beneficiaries Under Age 65*, by Scott Szymendera

Part B Issues

- CRS Report RL31199, *Medicare: Payments to Physicians*, by Jennifer O’Sullivan
- CRS Report RL31419, *Medicare: Payments for Covered Part B Prescription Drugs*, by Jennifer O’Sullivan
- CRS Report RS22769, *Medicare Clinical Laboratories Competitive Bidding Demonstration*, by Barbara English

Medicare Advantage

- CRS Report RL34151, *Private Fee for Service (PFFS) Plans: How They Differ from Other Medicare Advantage Plans*, by Paulette C. Morgan, Hinda Chaikind, and Holly Stockdale
- CRS Report RL32618, *Medicare Advantage Payments*, by Hinda Chaikind and Paulette C. Morgan

Part D Prescription Drug Program

- CRS Report RL34280, *Medicare Part D Prescription Drug Benefit: A Primer*, by Jennifer O’Sullivan
- CRS Report RL33782, *Federal Drug Price Negotiation: Implications for Medicare Part D*, by Jim Hahn

- CRS Report RL33802, *Pharmaceutical Costs: A Comparison of Department of Veterans Affairs (VA), Medicaid, and Medicare Policies*, by Gretchen A. Jacobson, Sidath Viranga Panangala, and Jean Hearne

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Julie Stone	Skilled Nursing Facilities Home Health Services Hospice Care	7-1386
Sibyl Tilson	Inpatient Hospital Services Outpatient Hospital Services Ambulatory Surgical Center Services Inpatient Rehabilitation Facilities Rural Issues	7-7368