HEALTH POLICY

An Overview of Medicare for Clinicians

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BACKGROUND: Medicare is estimated to cover 14% of the population of the USA (Henry J Kais Fam Found 2017), over fifty million people. Despite covering a smaller percentage of the population than employer-sponsored insurance and Medicaid, Medicare is the most common payer for inpatient encounters. The Healthcare Cost and Utilization Project estimated that in 2015, Medicare was the primary payer for 39.4% of hospitalizations (HCUP 2019). While in daily practice it may be practical to assume that patients eligible for Medicare are financially insulated from the costs of care, the reality is that no care exists in a vacuum. Medicare is a complex program that mitigates but does not completely eliminate costs to patients.

OBJECTIVE: This review aims to shed light for providers on the basics of Medicare, and how beneficiaries are impacted financially by their care to better understand some of the social barriers our patients face in seeking care.

KEY WORDS: Medicare; health insurance; health policy.

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HISTORY OF PASSAGE OF MEDICARE

Medicine was evolving rapidly in the second half of the nineteenth century. With the introduction of various discoveries such as anesthesia and antiseptic surgery, hospital care was changing. Rather than long-term care of the chronically unwell, hospitals came to utilize ever advancing therapies to treat patients.[1,2] With this increasing complexity of care came a parallel increase in costs. This rise in costs was reflected in the work of a group formed in 1927 called the Committee on the Cost of Medical Care (CCMC).[3] In its final report in 1933, the committee made several recommendations to address the evolving landscape of healthcare costs. One of the most controversial of these recommendations was summarized in a reflection written by the CCMC's Director of Study, I.S Falk, 25 years after the committee's dissolution. His description of this majority recommendation was that "medical costs should be placed on a group payment basis through insurance, taxation, or both."[4]

This notion of public health insurance had previously been advocated by Theodore Roosevelt in his run for a third term as a progressive, but never came to fruition after his loss to Woodrow Wilson.[2] Two decades later, around the time the CCMC completed its final report, the idea reemerged as a possible component of Social Security in Franklin Roosevelt's New Deal.[5] The resistance to national health insurance was fierce, however, with lobbying groups including the American Medical Association strongly opposed out of concern that group payment would compromise physician autonomy. The CCMC's majority recommendations cited above were accompanied by a minority report written by dissenters within the committee. They broke with the majority by arguing against group payment methods, and opposition groups seized onto this minority recommendation. Roosevelt dropped comprehensive national health insurance out of fear of risking passage of the remainder of his New Deal reforms.[1,2,5]

Harry S. Truman took up the mantle of healthcare reform and advocated for it vigorously as a part of his "Fair Deal." Various bills were introduced around the idea of national health insurance, but they never garnered the necessary support. Success did not come until later, when the proponents of public insurance recognized that they needed to narrow their focus to covering the elderly. This was felt to be more socially acceptable, as described by Marmor, "the aged could be presumed to be both needy and deserving because, through no fault of their own, they had lower earning capacity and higher medical expenses."[6] With this change in paradigm of the proposed plans, the protracted political debate continued, spanning multiple administrations. Studies estimated that prior to enactment of Medicare, almost half of all seniors did not have health insurance.[7]

It was not until the summer of 1965 that Lyndon B. Johnson signed Title XVIII and XIX of the Social Security Act into law, known as Medicare and Medicaid. At the signing, he said, "because the need for this action is plain, and it is so clear indeed that we marvel not simply at the passage of this bill, but what we marvel at is that it took so many years to pass it."[8] Shortly after enactment, 19 million seniors enrolled;[7] the first of whom was President Truman. Since that time, that number has increased to roughly 42 million.[9]

LATER ADDITIONS TO THE PROGRAM

At implementation, Medicare was only composed of Parts A and B. In 1972, it was expanded to include dialysis patients and those on disability.[7] In 1983, in an attempt to curb rising costs, Medicare switched its inpatient coverage from fee-for-

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service to a prospective payment system using Diagnosis-Related Groups (DRGs),[10] whereby each diagnosis is assigned a predetermined cost of treatment. In 1997, Medicare Part C was formalized, giving enrollees the option of enrolling in Medicare-approved private plans. In 2003, Part D was enacted, providing coverage for prescription drugs. Each of these is discussed further below.

THE PARTS OF MEDICARE

Medicare is a federally funded program, administered by The Centers for Medicare and Medicaid Services (CMS), a branch of the U.S. Department of Health & Human Services (HHS). Currently, Medicare comprises four parts, A, B, C, and D. In general terms, Part A covers inpatient services and Part B covers outpatient services. All eligible seniors are automatically enrolled in part A and most are enrolled in part B. Part D is optional and helps cover prescription drug costs. Lastly, Part C allows for enrollees to opt for a Medicare-approved private plan that offers all the benefits of Part A, Part B, and in many cases Part D.[11]

Medicare: Part A—Inpatient Services

Part A—What Does it Cover?. Medicare Part A (Hospital Insurance) covers inpatient hospitalizations and related services. This includes hospital days, post-discharge skilled nursing facility (SNF) days, home health services, and hospice services.[7]

Part A—How Is it Funded?. Part A is funded through the Hospital Insurance (HI) fund. This trust fund is financed mostly by a mandatory payroll tax. This payroll tax totals 2.9% of a worker's income; the cost of which is split between employer and employee. People with higher incomes pay up to 3.8%.[11]

Part A—What Does it Cost Patients?. Most patients covered under Part A are eligible for it without a premium if either they or their spouse has paid into the fund through a payroll tax for a period of 10 years prior to retirement. Those that do not meet this requirement can pay a premium for Part A (Medicare maintains an online eligibility and premium calculator).[12] Although for most enrollees there is no monthly premium, patients are still responsible for cost-sharing of the services Part A provides.

Medicare Part A covers the costs of its services over what is called a benefit period. At the start of each benefit period, a patient is allotted a set number of covered inpatient days, SNF days, and home health visits to last them until the end of the benefit period. Patients consume these allotted covered days as the benefit period goes on. Once a new benefit period starts, these allotted days are replenished.

Benefit periods are not defined as a fixed unit of time. The first benefit period starts the first time a patient is hospitalized on Medicare. They stay in that same benefit period indefinitely, until they go for 60 consecutive days without being admitted to a hospital or a SNF. Once this happens, a new benefit period starts and their allotted covered inpatient and SNF days are replenished.[11]

Before any hospital or SNF days are covered, however, each benefit period starts with a deductible which was $1340 in 2018. Part A does not cover inpatient care until this amount is spent by the patient out of pocket. After a patient spends their deductible for a benefit period, they are allotted their set number of covered inpatient days. Once the fully covered days in a benefit period are used, patients are allotted a number of partially covered inpatient days. Any more inpatient days beyond that within that same benefit period are paid for fully by the patient (unless they have reserve days, see below). Benefit periods are illustrated in Figure 1. For skilled nursing facilities, patients similarly have a set number of fully covered days, as well as a number of partially covered days in a benefit period, before they must cover full expenses out of pocket. It should be noted that SNF days are only covered if they follow 2 inpatient midnights. After a patient is discharged home, if they go 60 consecutive days without being readmitted or going back to a SNF, the benefit period ends, a new one begins, and all available covered days are replenished. Alternatively, if a patient is frequently readmitted, and so remains in the same benefit period, they will ultimately consume all their available covered days. Every Medicare patient gets 60 lifetime reserve days to use in that instance. These are not replenished with new benefit periods. Each reserve day involves cost-sharing. One reserve day costs the patient an amount set to equal half of whatever the deductible is set to that year ($670 per reserve day in 2018).[11]

Part A—Prospective Payment System. Medicare Part A's reimbursement structure underwent a significant change in the early 1980s. Prior to 1983, Medicare Part A reimbursed hospitals after discharge based on the cost of treatment. In the face of rising costs, legislation was passed in 1983 to change Medicare reimbursement from a retrospective to a prospective payment system.[10] In the new system, admissions for each type of medical problem were allocated a predetermined amount for reimbursement. A pneumonia admission was allotted X dollars and a hip fracture admission was allotted Y dollars. Hospitals that spent less than the predetermined amount got to keep the rest. Hospitals that spent more absorbed the extra cost. The hope was to incentivize efficient care.[10] Overall, it seems to have led to an acceleration in decrease in length of stay, particularly in the first few years after implementation.[13]

Part A—Diagnosis-Related Groups. Medicare determines the cost for admissions of certain diagnoses using a system of Diagnosis-Related Groups (DRGs). In general terms, the DRG system assigns a different value or weight to admissions of different types.[14]

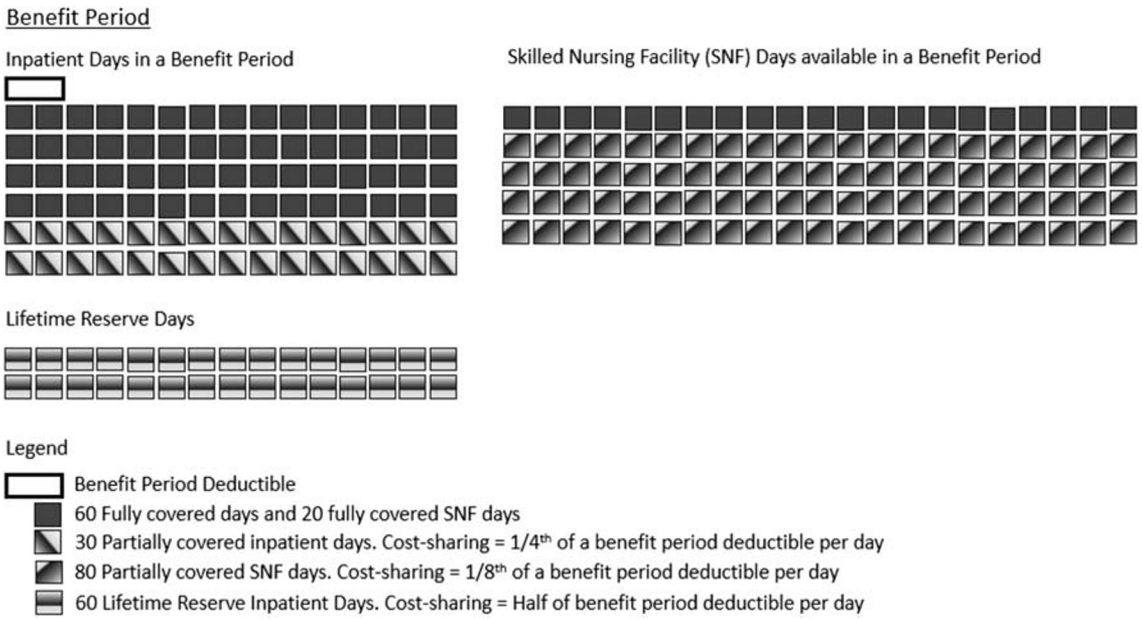

Fig. 1 Number of covered days available in a benefit period. Partially filled boxes designate days that are partially covered by cost-sharing incurred by the patient. All days are restored at the start of a new benefit period, except for lifetime reserve days; lifetime reserve days are not renewed between benefit periods.

There are hundreds of DRGs, each meant to reflect the average cost of an admission for a specific medical problem. CMS publishes its list of DRGs yearly[15(p. 201)]. For example, in the fiscal year 2017, an admission for "Heart Transplant with major complications or comorbidities" was assigned a DRG weight of 27.1. An "Acute Myocardial Infarction, Discharged Alive without comorbidities or complications" had a DRG weight of 0.75.

When patients are discharged, their documentation is sent to coders who extract ICD codes from the chart. With assistance from an algorithm, the set of ICD codes is used to determine what DRG classification best applies to the admission. This DRG weighting factor is multiplied by a monetary amount that varies according to regional prices, regional wages, involvement of trainees in the care, and amount of indigent care provided by the institution. The result is used to determine hospital reimbursement, which can vary significantly between institutions. The Office of the Inspector General provides an example calculation.[14]

Medicare: Part B—Outpatient Services

Part B—What Does it Cover?. Medicare Part B (Supplemental Medical Insurance) covers outpatient costs. These include physician services, outpatient testing and imaging, home health services not associated with admissions, outpatient therapy, radiation therapy, dialysis, and a small subset of drugs not covered under Part D,[11] such as biologics and some classes of immunosuppression.

Part B—How Is it Funded?. Part B is funded through the Supplemental Medical Insurance (SMI) fund. This fund contains two separate accounts: one that finances Part B and one that finances Part D. Unlike Part A, Medicare Part B enrollees pay a monthly premium that covers a quarter of the expenditures of the program. The remainder of expenditures are covered by United States Treasury funds that are allocated each year, based on anticipated outlays and revenue from premiums.

Part B—What Does it Cost Patients?. In 2018, the monthly premium was $134 per month. This number is income-adjusted for individual enrollees. For patients who make less than $85,000, there is no adjustment. Those who make more are required to pay an increased premium, up to $428.60 for those making more than $160,000 in 2018.[11]

In addition to the premium, patients have to pay an annual deductible ($183 in 2018) before services are covered. They are then responsible for a 20% co-insurance payment on most remaining services.[11,16]

Medicare: Part B—Physician Reimbursement

Reimbursement for physicians is dependent on whether they are "participating physicians," meaning those that agree at the start of the year to render services at the Medicare-approved rate as payment in full. In most cases, this payment is determined by a fee schedule. For these physicians, reimbursement includes the annual deductible and co-insurance paid by patients. Non-participating physicians may charge higher than Medicare rates up to a regulated limit.[11]

Medicare: Part D—Drug Prescriptions

Part D—What Does it Cover?. Part D was the most recent addition to Medicare, enacted in 2003 after a prolonged political debate and implemented in 2006, with the goal of

covering prescription drug costs. CMS contracts with private insurance companies, called Part D sponsors, to provide patients with Part D prescription drug plans.[17] As of 2016, 71% of Medicare beneficiaries were enrolled in Part D. Three sponsors (UnitedHealth, Humana, and CVS Health) accounted for 53% of Part D enrollment.[18]

Part D—How Is it Funded?. Part D is also funded through the SMI Fund (although from a different account than Part B). Similar to Part B, Part D enrollees pay a premium, and only about a quarter of Part D's expenditures are covered by premiums. The remaining 75% of funding comes from general treasury revenue.[11]

Part D—What Does it Cost Patients?. Enrollees pay for Part D in two ways. First is the monthly premium. Second is cost-sharing in the form of both an annual deductible and contributions to a percentage of drug costs. The Part D monthly premium is set to cover approximately a quarter of the costs of providing coverage.[11] This number changes each year as costs of covering prescriptions change. In 2018, the base premium was approximately $35. This base premium varies slightly by enrollee sponsor and patient income (ranging from $20 to $80), but the average is close to the base amount.[19]

In addition to the premium, patients also have an annual deductible ($405 in 2018).[11,20] At the start of each year, drug costs are born fully by the patient up to that amount. Once past the deductible, the costs of prescription drugs are split 25–75 between the patient and the sponsor, respectively. Once a certain threshold of total drug costs is reached, patients enter the coverage gap, colloquially referred to as the "donut hole." Until 2010, patients in the coverage gap were responsible for 100% of drug costs until their out-of-pocket payments reached a second cost threshold, called catastrophic coverage. Once patients reach the catastrophic coverage threshold, they were then only responsible for 5% of any further drug costs. Part D covered the rest. In short, until 2010, the patients paid a deductible, then split costs 25–75 until the first threshold. Once the first threshold was reached, they paid 100% of costs until the second threshold was reached; after which, they split costs 5–95. This whole cycle resets at the start of the year, which is why out-of-pocket drug costs can vary throughout the year, depending on which phase of cost-sharing a patient is in[21].

Since 2010, legislation has been written to incrementally cover an increasing percentage of costs in the gap, or to "close the donut hole." In 2018, patients were only responsible for 35% of brand-name drugs and 44% of generics. By 2020, the When the gap is completely closed, after the initial deductible, patients are responsible for 25% of their drug costs and remain in this 25–75 split all the way up to the catastrophic coverage threshold at which point they transition directly to the 5–95 split.

In 2018, the initial deductible was $405, the threshold for entry into the coverage gap was $3750 total drug costs, and the threshold for entry into the catastrophic coverage phase was $5000 out-of-pocket for the year.[11,20]

Medicare: Part C—Medicare Advantage

Medicare Part C, or Medicare Advantage, consists of Medicare-approved private plans that provide all the benefits of Parts A, B, and often D.[11] Part C is financed by both the HI and SMI funds. Private plans submit bids to Medicare based on their estimated costs per enrollee and are reimbursed based on a formula that establishes benchmark amounts for each area. Enrollees pay a premium that goes towards covering the difference between the proposed bid and Medicare's calculated reimbursement. Medicare Advantage plans have become increasingly prevalent. Since the early 2000s, the percentage of Medicare enrollees in Part C has tripled, with approximately a third of all Medicare enrollees in 2017 opting for a Part C plan.[22] Despite this, the concept of introducing private elements to Medicare has remained controversial among lawmakers and the public, between proponents of increasing privatization and opponents who favor movement towards more comprehensive national insurance.[23]

"Medigap" Insurance

Medigap Insurance refers to insurance that enrollees can purchase privately for a premium, which helps defray some of Medicare's out-of-pocket cost-sharing expenses, such as deductibles, co-pays, and co-insurance that come with use of Parts A, B, and D. Roughly 20% of all Medicare beneficiaries have a Medigap plan.[24]

CONCLUSION

The history of Medicare has involved many protracted political battles. At enactment, it significantly increased the proportion of the elderly population that is insured and has since continued to evolve to balance coverage with cost-sharing. As the program has expanded, it has become increasingly complex with various components that cover different aspects of care and impact both beneficiaries and providers differently. Although it may be practical to think of insured patients as being financially insulated from the increasing costs of our system, the reality is that while Medicare significantly mitigates costs, it does not fully protect patients from them. Patients may have deductibles for Parts A, B and D, premiums for Part B and D, and cost-sharing for all three. While providers cannot know the details of coverage for every patient, a stronger foundation of understanding of the general components of one of our largest insurers is sure to improve our ability to empathize with the many challenges our patients face in navigating our healthcare system as they seek care.

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