



Medicare Primer

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Summary

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

Generally, individuals are eligible for Medicare if they or their spouse worked for at least 40 quarters in Medicare-covered employment, are 65 years old, and are a citizen or permanent resident of the United States. Individuals may also qualify for coverage if they are a younger person with a permanent disability, have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant), or have amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease). In addition, individuals with one or more specified lung diseases or types of cancer who lived for six months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009, are also deemed entitled to benefits under Part A and eligible to enroll in Part B.

In FY2012, the program will cover approximately 50 million persons (41 million aged and 9 million disabled) at a total cost of about \$576 billion, accounting for approximately 3.7% of GDP. Medicare is an entitlement program, which means that it is required to pay for covered services provided to eligible persons so long as specific criteria are met.

Since 1965, the Medicare program has undergone considerable change. During the 111th Congress, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) and the Health Care and Education Affordability Reconciliation Act of 2010 (the Reconciliation Act, or HCERA; P.L. 111-152) were signed into law. They made numerous changes to the Medicare program that modify provider reimbursements, provide incentives to increase the quality and efficiency of care, and enhance certain Medicare benefits.

However, in the absence of congressional action, the Medicare program will be unsustainable in the long run. The Hospital Insurance (Part A) trust fund has been estimated to become insolvent in 2024. And although the Supplementary Medical Insurance (Parts B and D) trust fund is financed in large part through federal general revenues and cannot become insolvent, Medicare spending growth will put increasing strains on Congress's competing priorities.

The 112th Congress may continue to debate the recent changes to Medicare and may also consider additional legislative action ranging from technical corrections to broader structural changes. Additionally, Congress may consider legislative action to address the 2013-2021 automatic Medicare spending reductions under the Budget Control Act of 2011 (BCA; P.L. 112-25).

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Introduction

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

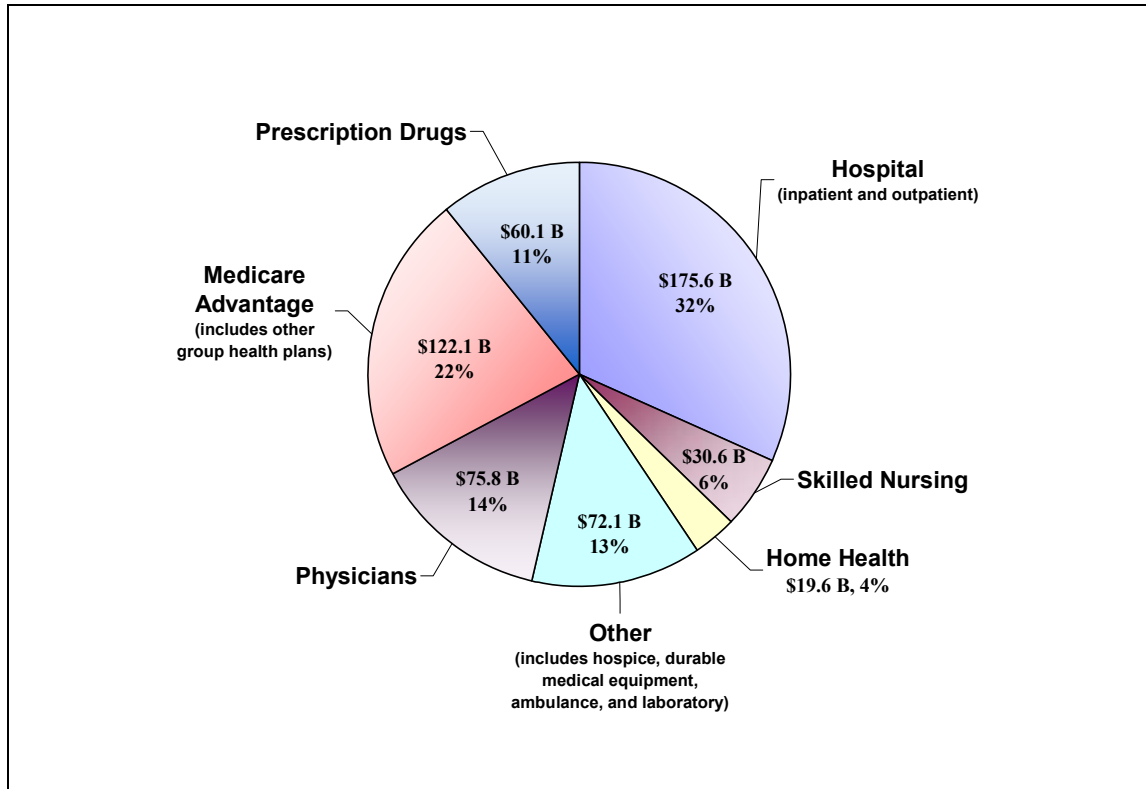
- Part A (Hospital Insurance, or HI) covers inpatient hospital services, skilled nursing care, and home health and hospice care. The HI trust fund is mainly funded by a dedicated payroll tax of 2.9% of earnings, shared equally between employers and workers.
- Part B (Supplementary Medical Insurance,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

Medicare serves approximately one in six Americans and virtually all of the population aged 65 and over. In 2012, the program will cover an estimated 50 million persons (41 million aged and 9 million disabled). The Congressional Budget Office (CBO) estimates that total Medicare spending in 2012 will be about \$575.7 billion, accounting for approximately 3.7% of GDP. In 2012, spending on benefits will be approximately \$555.9 billion. Almost a third of Medicare benefit spending is for hospital services (see **Figure 1**). CBO also estimates that federal Medicare spending (after deduction of beneficiary premiums and other offsetting receipts) will be about \$491.9 billion in 2012, accounting for about 13.6% of total federal spending. Medicare is an entitlement program, which means that it is required to pay for all covered services provided to eligible persons, so long as specific criteria are met. Spending under the program (except for a portion of administrative costs) is considered mandatory spending and is not subject to the appropriations process.

Medicare is expected to continue to be a high-priority issue in the second session of the 112th Congress. The program has a significant impact on the lives of millions of Americans and on the economy in general through its coverage of important health care benefits for the aged and disabled, the payment of premiums and other cost-sharing by those beneficiaries, and its payments to providers who supply those health care services. Projections of future Medicare expenditures and funding indicate that the program will place increasing financial demands on the federal budget and on beneficiaries over time. In response to these concerns, Congress may consider a range of Medicare reform options, from making changes within the current structure, including modifying provider payments and revising existing oversight and regulatory mechanisms, to redesigning the entire program.

The Committees of jurisdiction for the entitlement (or benefits) portion of Medicare are the Senate Committee on Finance, the House Committee on Ways and Means, and the House Committee on Energy and Commerce. The House and Senate Committees on Appropriations have jurisdiction over the discretionary spending used to administer and oversee the program.

Figure I. Projected Medicare Benefit Spending, by Category, FY2012
 (\$555.9 billion)



Source: Figure by CRS based on data from the Congressional Budget Office, March 2012 Medicare Baseline.

Note: The \$555.9 billion for benefit payments does not include administration costs or recoveries.

Medicare History

Medicare was enacted in 1965 (P.L. 89-97) in response to the concern that only about half of the nation’s seniors had health insurance, and most of those had coverage only for inpatient hospital costs. The new program, which became effective July 1, 1966, included Part A coverage for hospital and post-hospital services and Part B coverage for doctors and other medical services. As is the case for the Social Security program, Part A is financed by payroll taxes levied on current workers and their employers; persons must pay into the system for 40 calendar quarters to become entitled to premium-free benefits. Medicare Part B is voluntary, with a monthly premium required of beneficiaries who choose to enroll. Payments to health care providers under both Part A and Part B were originally based on the most common form of payment at the time, namely

“reasonable costs” for hospital and other institutional services or “usual, customary and reasonable charges” (UCR)¹ for physicians and other medical services.

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

In the ensuing years, Medicare has undergone considerable change. P.L. 92-603, enacted in 1972, expanded program coverage to certain individuals under 65 (the disabled and persons with end-stage renal disease (ESRD)),² and introduced managed care into Medicare by allowing private insurance entities to provide Medicare benefits in exchange for a monthly capitated payment. This law also began to place limitations on the definitions of reasonable costs and charges in order to gain some control over program spending which, even initially, exceeded original projections.

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

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

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

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173),³ which included a major benefit expansion and placed increasing

¹ Also known as “customary, prevailing and reasonable charges,” this method based physician payments on charges commonly used by physicians in a local community. The payment for a service was the lowest of (1) the physician’s billed charge for the service, (2) the physician’s customary charge for the service, or (3) the prevailing charge for that service in the community.

² ESRD is a stage of kidney impairment that appears to be irreversible and permanent, requiring a regular course of dialysis treatments or a kidney transplantation to maintain life.

³ For more information, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and (continued...)*

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

During the 109th Congress, two laws were enacted that incorporated minor modifications to Medicare's payment rules. These were the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432). In the 110th Congress, additional changes were incorporated in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)⁴ and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275).⁵

In the 111th Congress, comprehensive health reform legislation was enacted that, among other things, made statutory changes to the Medicare program. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148), enacted on March 23, 2010, included numerous provisions affecting Medicare payments, payment rules, covered benefits, and the delivery of care. The Health Care and Education Affordability Reconciliation Act of 2010 (the Reconciliation Act, or HCERA; P.L. 111-152), enacted on March 30, 2010, made changes to a number of Medicare-related provisions in the ACA and added several new provisions.⁶ Included in the ACA, as amended, are provisions that (1) constrain Medicare's annual payment increases for certain providers; (2) change payment rates in the Medicare Advantage program so that they more closely resemble those in fee-for-service; (3) reduce payments to hospitals that serve a large number of low-income patients; (4) create an Independent Payment Advisory Board that will make recommendations to adjust Medicare payment rates; (5) phase out the Part D prescription drug benefit "doughnut hole"; (6) increase resources and enhance activities to prevent fraud and abuse; and (7) provide incentives to increase the quality and efficiency of care, such as creating value-based purchasing programs for certain types of providers, allowing accountable care organizations (ACOs) that meet certain quality and efficiency standards to share in the savings,⁷ creating a voluntary pilot program that bundles payments for physician, hospital, and post-acute care services, and adjusting payments to hospitals for readmissions related to certain potentially preventable conditions.

During the first session of the 112th Congress, on August 2, 2011, the Budget Control Act of 2011 (BCA; P.L. 112-25) was enacted. It provided for increases in the debt limit and established

(...continued)

Modernization Act of 2003.

⁴ For more information, see CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*.

⁵ For more information, see CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*.

⁶ For more information, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

⁷ Groups of providers and suppliers who work together to manage and coordinate care for Medicare fee-for-service beneficiaries. See CRS Report R41474, *Accountable Care Organizations and the Medicare Shared Savings Program*.

procedures designed to reduce the federal budget deficit, including the creation of a Joint Select Committee on Deficit Reduction.⁸ The failure of the Joint Committee to propose budget reduction legislation by its mandated deadline triggered automatic spending reductions (“sequestration”) in years 2013 through 2021. Unless Congress takes action to prevent these cuts, most Medicare program expenditures will be subject to reductions of up to 2% in each of those years.⁹ Under sequestration, Medicare’s benefit structure would generally remain unchanged; however, most Medicare plans and providers would see a reduction in their Medicare payments. Spending for certain Medicare payments are exempt from sequestration and would therefore not be reduced. These exemptions include (1) Part D low-income subsidies, (2) the Part D catastrophic subsidy, and (3) Qualified Individual (QI) premiums. Some Medicare administrative and operational expenditures could be subject to reductions higher than 2%.¹⁰ CBO estimates that Medicare spending reductions will total approximately \$123 billion over nine years.¹¹

Eligibility and Enrollment

Most persons aged 65 or older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems. Persons under age 65 who receive cash disability benefits from Social Security or the Railroad Retirement systems for at least 24 months are also entitled to Part A. (Since there is a five-month waiting period for cash payments, the Medicare waiting period is effectively 29 months.)¹² The 24-month waiting period is waived for persons with amyotrophic lateral sclerosis (ALS, “Lou Gehrig’s disease”). Individuals of any age with ESRD who receive dialysis on a regular basis or a kidney transplant are eligible for Medicare. Medicare coverage for individuals with ESRD usually starts the first day of the fourth month of dialysis treatments. In addition, individuals with one or more specified lung diseases or types of cancer who lived for six months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009, are also deemed entitled to benefits under Part A and eligible to enroll in Part B.

Persons over age 65 who are not automatically entitled to Part A may obtain coverage by paying a monthly premium (\$451 in 2012) or, for persons with at least 30 quarters of covered employment, a reduced monthly premium (\$248 in 2012). In addition, disabled persons who lose their cash benefits solely because of higher earnings, and subsequently lose their extended Medicare coverage, may continue their Medicare enrollment by paying a premium, subject to limitations.

⁸ For a comprehensive discussion of the BCA, see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan.

⁹ Section 256(d) of the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA, P.L. 99-177) contains special rules for the Medicare program in case of a sequestration. While BBEDCA ordinarily limits reduction of certain Medicare spending to 4% under a sequestration order, the BCA limits the size of this reduction to 2%. See CRS Report R42050, *Budget “Sequestration” and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar for additional detail.

¹⁰ OMB will determine which parts of the Medicare program fall under the 2% cap and which could be subject to higher caps.

¹¹ Congressional Budget Office, *Estimated Impact of Automatic Budget Enforcement Procedures Specified in the Budget Control Act*, September 12, 2011, <http://www.cbo.gov/ftpdocs/124xx/doc12414/09-12-BudgetControlAct.pdf>.

¹² For more information, see CRS Report RS22195, *Social Security Disability Insurance (SSDI) and Medicare: The 24-Month Waiting Period for SSDI Beneficiaries Under Age 65*.

Generally, enrollment in Medicare Part B is voluntary. All persons entitled to Part A (and persons over 65 not entitled to premium-free Part A) may enroll in Part B by paying a monthly premium. For most Part B enrollees, the 2012 monthly premium is \$99.90.¹³ (See the “Part B” section, below.) While enrollment in Part B is voluntary for most individuals, in most cases, those who voluntarily enroll in Part A must also enroll in Part B. Additionally, ESRD beneficiaries and Medicare Advantage enrollees (discussed below) must also enroll in Part B.

Together, Parts A and B of Medicare comprise “original Medicare,” which covers benefits on a fee-for-service (FFS) basis. Beneficiaries have another option for coverage through private plans, called the Medicare Advantage (MA or Part C) program. When beneficiaries first become eligible for Medicare, they may choose either original Medicare or they may enroll in a private MA plan. Each fall, there is an annual open enrollment period during which time Medicare beneficiaries may choose a different MA plan, or leave or join the MA program.¹⁴ Beneficiaries are to receive information about their options to help them make informed decisions.¹⁵ In 2012, the annual open enrollment period will be from October 15 to December 7 for plan choices starting the following January. Starting in 2012, MA plans with a 5-star quality rating will be allowed to enroll Medicare beneficiaries who are either in traditional Medicare or in an MA plan with a lower quality rating at any time.

Finally, each individual enrolled in either Part A or Part B is also entitled to obtain qualified prescription drug coverage through enrollment in a Part D prescription drug plan. Similar to Part B, enrollment in Part D is voluntary and the beneficiary pays a monthly premium. Beginning in 2011, some higher-income enrollees pay higher premiums, similar to enrollees in Part B. Generally, beneficiaries enrolled in an MA plan providing qualified prescription drug coverage (MA-PD plan) must obtain their prescription drug coverage through that plan.¹⁶

¹³ In 2012, all Part B enrollees, except for those subject to high income or late enrollment adjustments, pay the same premium amount of \$99.90 per month. In 2011, because there was no Social Security cost-of-living adjustment (COLA) due to the economic slowdown, a statutory hold-harmless provision prohibited established Medicare beneficiaries from Part B premium increases. The hold harmless protects an individual’s Social Security benefit from a decrease as a result of a Part B premium increase. However, the provision did not apply to certain categories of beneficiaries, and some beneficiaries paid higher Part B premiums in 2011. See CRS Report R40561, *Interactions Between the Social Security COLA and Medicare Part B Premiums*.

¹⁴ Starting in 2011, MA enrollees are only permitted to drop out of their MA plans and return to original Medicare during the first 45-day period of each calendar year. Though they are no longer allowed to switch to another MA plan as they were able to do previously, MA enrollees who use the 45-day period to disenroll from their MA plan may enroll in a stand-alone Part D prescription drug plan (PDP), or may elect to enroll in other non-Medicare Advantage private plan options, such as a Medicare Cost plan or a demonstration plan. MA enrollees will still be able to switch plans during special enrollment periods, such as when an MA enrollee moves outside his or her plan’s service area or if an enrollee’s MA plan is terminated.

¹⁵ In addition to the yearly Medicare & You Handbook, <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>, which is mailed to beneficiaries’ homes, beneficiaries can consult <http://www.Medicare.gov> to find information such as the items and services covered under Medicare, cost sharing requirements, finding a participating medical provider or private health plan, and nursing home quality scores.

¹⁶ If a Medicare beneficiary enrolls in a Private Fee-for-Service (PFFS) plan that does not provide drug coverage, he or she may enroll in a stand-alone Prescription Drug Plan (PDP). However, enrollees in other types of MA plans who want Part D prescription drug coverage must choose a Medicare Advantage Prescription Drug (MA-PD) plan, which is an MA plan that provides all Medicare required parts A, B, and D benefits. If a Medicare beneficiary enrolls in a local HMO or regional PPO that does not offer drug coverage, he or she does not have the option to enroll in a stand-alone PDP plan.

In general, individuals who do not enroll in Part B or Part D during an initial enrollment period (when they first become eligible for Medicare) must pay a permanent penalty of increased monthly premiums if they choose to enroll at a later date. Individuals who do not enroll in Part B during their initial enrollment period may enroll only during the annual open enrollment period, which occurs from January 1–March 31 each year. Coverage begins the following July 1. However, the law waives the Part B late enrollment penalty for current workers who have primary coverage through their own or a spouse’s employer-sponsored plan. These individuals have a special enrollment period once their employment ends; as long as they enroll in Part B during this time, they will not be subject to penalty.

Individuals who do not enroll in Part D during their initial enrollment period may enroll during the annual open enrollment period, which corresponds with the Part C annual enrollment period—from October 15 to December 7, with coverage effective the following January. Individuals are not subject to the Part D penalty if they have maintained “creditable” drug coverage through another source, such as retiree health coverage offered by a former employer or union. However, once employees retire or have no access to “creditable” Part D coverage, a penalty will apply unless they sign up for coverage during a special enrollment period. Finally, for persons who qualify for the low-income subsidy for Part D, the delayed-enrollment penalty does not apply.

Benefits and Payments

Medicare Parts A, B, and D each cover different services, with Part C providing a private plan alternative for Medicare services, except hospice. The Parts A-D covered services are described below, along with a description of Medicare’s payments.

Part A

Part A provides coverage for inpatient hospital services, post-hospital skilled nursing facility (SNF) services, home health services, and hospice care, subject to certain conditions and limitations. Approximately 17% of Part A enrollees use Part A services during a year.

Inpatient Hospital Services

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

- Days 1-60. Beneficiary pays a deductible (\$1,156 in 2012).
- Days 61-90. Beneficiary pays a *daily* coinsurance charge (\$289 in 2012).

- Days 91-150. After 90 days, the beneficiary may draw on one or more of 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.) For lifetime reserve days, the beneficiary pays a daily coinsurance charge (\$578 in 2012); otherwise the beneficiary pays all costs.
- Days 151 and over. Beneficiary pays for all costs for these days.

Inpatient mental health care in a psychiatric facility is limited to 190 days during a patient's lifetime. Cost sharing is structured similarly to that for stays in a general hospital (above).

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

Additional payments are made to hospitals for cases with extraordinary costs (outliers), indirect costs incurred by teaching hospitals for graduate medical education, and disproportionate share hospital (DSH) payments to those hospitals serving a certain volume of low-income patients. Additional payments may also be made for qualified new technologies that have been approved for special add-on payments. In FY2012, certain low volume hospitals will receive an add-on payment for each Medicare discharge, an amount that ranges from 25% for hospitals with less than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. Prospective payments are also made for inpatient capital costs.

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

Additional payments or special treatment may apply for hospitals meeting one of the following designations: (1) sole community hospitals (SCHs), (2) Medicare dependent hospitals, and (3) rural referral centers. Certain hospitals or distinct hospital units are exempt from IPPS and paid on an alternative basis,¹⁷ including (1) inpatient rehabilitation facilities, (2) long-term care hospitals, (3) psychiatric facilities including hospitals and distinct part units, (4) children's hospitals and cancer hospitals, and (5) critical access hospitals.

Skilled Nursing Facility (SNF) Services

Medicare covers up to 100 days of post-hospital care for persons needing skilled nursing or rehabilitation services on a daily basis.¹⁸ The SNF stay must be preceded by an inpatient hospital stay of at least three days, and the transfer to the SNF typically must occur within 30 days of the

¹⁷ Hospitals in the state of Maryland are exempt from the IPPS and are paid under a state-specific payment system.

¹⁸ For additional information on skilled nursing facility benefits, see CRS Report R42401, *Medicare's Skilled Nursing Facility Primer: Benefit Basics and Issues*, by Scott R. Talaga.

hospital discharge. There is no beneficiary cost-sharing for the first 20 days of a Medicare-covered SNF stay. For days 21 to 100 beneficiaries are subject to daily coinsurance charges (\$144.50 in 2012). The 100-day limit begins again with a new spell of illness.

SNF services are paid under a prospective payment system (PPS), which is based on a per diem urban or rural base payment rate, adjusted for case mix (average severity of illness) 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) classification system, which uses patient assessments to assign a beneficiary to one of 66 groups that reflect the beneficiary's expected use of services. Patient assessments are done at various times during a patient's stay and the RUG category a beneficiary is placed in can change with changes in the beneficiary's condition. Extra payments are not made for extraordinarily costly cases ("outliers").

Home Health Services

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

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

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

Hospice Care

The Medicare hospice benefit covers services designed to provide palliative care and management of a terminal illness; the benefit includes drugs and medical and support services. These services are provided to 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. Starting January 1, 2011, a hospice physician or nurse practitioner must have a face-to-face encounter with the individual to determine continued eligibility prior to the 180th day recertification, and for each subsequent recertification. Hospice care is provided in lieu of most other Medicare services related to the curative treatment of the terminal illness. Beneficiaries electing hospice care from a hospice program may receive curative services for illnesses or injuries unrelated to their terminal illness and they may disenroll from the hospice at any time. Nominal cost-sharing is required for drugs and respite care.

Payment for hospice care is based on one of four prospectively determined rates (which correspond to four different levels of care) for each day a beneficiary is under the care of the hospice. The four rate categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. Payment rates are adjusted to reflect differences in area wage levels, using the hospital wage index.¹⁹ Payments to a hospice are subject to an aggregate cap that limits the average per beneficiary cost to a cap that is adjusted annually by changes to the medical care expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

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

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

Part B

Medicare Part B covers physicians' services, outpatient hospital services, durable medical equipment, and other medical services. Initially, over 98% of the eligible population voluntarily enrolled in Part B, but in recent years, the percentage has fallen to about 93%.²⁰ Over 70% of Part B enrollees use Part B services during a year. The program generally pays 80% of the approved amount (most commonly, a fee schedule or other predetermined amount) for covered services in excess of the annual deductible (\$140 in 2012). The beneficiary is liable for the remaining 20%.

Most providers and practitioners are subject to limits on amounts they can bill beneficiaries for covered services. For example, physicians and some other practitioners may choose whether or not to accept "assignment" on a claim. When a physician accepts assignment, the physician can only bill the beneficiary the 20% coinsurance plus any unmet deductible. When a physician agrees to accept assignment on all Medicare claims in a given year, the physician is referred to as a "participating physician." There are several advantages to being a participating provider,

¹⁹ By October 1, 2013, the Secretary will be required to implement budget neutral revisions to the methodology for determining hospice payments for routine home care and other services. These revisions could include adjustments to the per diem payments reflecting differences in resources used during the course of an entire episode of hospice care.

²⁰ For details, see the Annual Reports of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, <http://www.cms.hhs.gov/reportstrustfunds/>.

including higher reimbursement under the Medicare fee schedule, a lower beneficiary copayment, and automatic forwarding of Medigap claims.

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. Alternatively, physicians may choose not to accept any Medicare payment and enter into private contracts with their patients.

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; for these services, applicable providers may bill beneficiaries for amounts above Medicare’s recognized payment level and may do so without limit.²¹

Physicians and Non-physician Practitioner Services

Medicare Part B covers medically necessary doctors’ services, outpatient care, home health services, some preventive care, and some other medical services. Certain limitations apply for services provided by chiropractors and podiatrists. Beneficiary cost-sharing is typically 20% of the approved amount, although preventive care services require no coinsurance from the beneficiary and outpatient mental health services are currently in the third of a five-year phase-in that will reduce beneficiary responsibility from 50% to 20% by 2014.²² Covered non-physician practitioner services include, but are not limited to, those provided by physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical social workers.

A number of Part B services are paid under the physician fee schedule. These include services of physicians, non-physician practitioners, and therapists. Most services described below 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 is based on the Medicare Economic Index (MEI, which measures changes in the prices of the inputs required to provide physician services) subject to an adjustment to match spending under the sustainable growth rate (SGR) system, which establishes a target for total cumulative 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 each year since 2002. However, Congress has acted several times to avert reductions, thereby overriding the statutory formula for the 2003-2012 period. The update to the conversion factor was 0% (compared to 2009 payment levels) for January through May 2010 and 2.2% for

²¹ Certain durable medical equipment suppliers in competitive bidding areas are required to accept assignment.

²² This “mental health parity” was introduced in MIPPA (P.L. 110-275). Beneficiaries are responsible for a 40% copayment for outpatient mental health services in 2012.

June 2010 through December 2011.²³ The fee schedule payments will be maintained at this level through 2012.²⁴

In addition to the fee schedule reimbursements, physicians who report on selected quality measures for services for which quality measures are established will receive bonus payments for those services provided beginning in July 2007. The bonus payments were 1.5% during the second half of 2007 and for 2008, 2.0% for 2009 and 2010, 1.0% for 2011, and 0.5% in 2012. The bonus remains at 0.5% in 2013 and 2014 for those who successfully report the measures. Subsequently, those providers who fail to successfully report the measures will be subject to a 1.5% penalty in 2015 and a 2% penalty in 2016 and future years. Additional bonus payments will be made for 2009-2013 for Medicare professionals providing covered services who are successful electronic prescribers and in 2011-2014 for those who meet the requirements of a Maintenance of Certification Program (MOCP).²⁵

Therapy Services

Medicare therapy services include physical therapy, occupational therapy, and speech language pathology services. The program establishes annual limits (therapy caps) on covered services. The first is a \$1,880 per beneficiary annual cap in 2012 for all outpatient physical therapy services and speech language pathology services. The second is a \$1,880 per beneficiary annual cap in 2012 for all outpatient occupational therapy services. The limits, which are updated annually, apply to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The Secretary is required to implement an exceptions process, effective from 2006 through 2011, for services meeting specified criteria for medically necessary services. The limits do not apply to outpatient services provided by hospitals.

Preventive Services

The original Medicare statutes prohibited payment for covered items and services that are “not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,” which effectively excluded preventive and screening services.²⁶ In recent years, Congress has added and expanded Medicare coverage for a number of such services through legislation, including MMA, MIPPA, and ACA. Under current law, if a preventive service is recommended for use by the U.S. Preventive Services Task Force (USPSTF, an independent evidence-review panel)²⁷ and Medicare covers the service, all cost-sharing must be waived. Also, the HHS Secretary may add coverage of a USPSTF-recommended service that is not already covered. Coverage for preventive and screening services currently includes, among other services: (1) a “welcome to Medicare” physical exam during the first year of enrollment in

²³ For details, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn and Janemarie Mulvey.

²⁴ The Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78) included an override of the statutory SGR update for January and February 2012, and the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) maintained the payment freeze through the end of 2012.

²⁵ For details, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

²⁶ Social Security Act section 1862(a)(1)(A); 42 U.S.C. 1395y(a)(1)(A).

²⁷ U.S. Preventive Services Task Force, <http://www.uspreventiveservicestaskforce.org/>.

Part B and an annual visit and prevention plan thereafter; (2) flu vaccine (annual), pneumococcal vaccine, and hepatitis B vaccine (for persons at high risk); (3) screening tests for breast, cervical, prostate, and colorectal cancers; (4) screening for other conditions such as depression, heart disease, glaucoma, and osteoporosis; and (5) intensive behavioral therapy for heart disease and for obesity.²⁸ These services are covered under the Medicare Part B fee schedule.

Clinical Lab and other Diagnostic Tests

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

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

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

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

Except in competitive bidding areas (described below), Medicare pays for most DMEPOS based on fee schedules. Medicare pays 80% of the lower of the supplier's charge for the item or the fee schedule amount. The beneficiary is responsible for the remaining 20%. In general, fee schedule amounts are updated each year by a (1) measure of price inflation, and (2) a measure of economy-wide productivity, which may result in lower fee schedule amounts from one year to the next. In addition, Congress has specified a reduction or elimination in the price inflation updates in recent years.

Numerous studies and investigations have shown that Medicare pays more for certain items of DME and PO than some other health insurers and some retail outlets.²⁹ Such overpayments may

²⁸ A complete list of covered services, intervals, and limitations is available at CMS, overview of Medicare prevention, <http://www.cms.gov/PrevntionGenInfo/>.

²⁹ See General Accounting Office (GAO) report, "Medicare Payments for Oxygen," May 15, 1997, GAO-97-120R; HHS Office of the Inspector General report, "Medicare Home Oxygen Equipment: Cost and Servicing," September (continued...)

be due partly to the fee schedule mechanism of payment. MMA required the Secretary to establish a Competitive Acquisition Program for certain DMEPOS in specified areas. Instead of paying for medical equipment based on a fee schedule established by law, payment for items in competitive bidding areas is based on the supplier bids. MIPPA delayed the program and required the first round of the program to be re-bid, in addition to other changes. The re-bid took place in 2009 and the program started in nine metropolitan areas in January 2011.³⁰ The second round will expand the program to 91 additional areas. Bidding for round 2 began in January 2012, with payments based on those bids starting in July 2013.

Part B Drugs and Biologics³¹

Certain specified outpatient prescription drugs and biologics are covered under Medicare Part B. (However, most outpatient prescription drugs are covered under Part D, discussed below.) Covered Part B drugs and biologics include drugs furnished incident to physicians' services, immunosuppressive drugs following a Medicare-covered organ transplant, erythropoietin for treatment of anemia for persons with ESRD, oral anti-cancer drugs (provided they have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if furnished incident to physicians services), and drugs needed for the effective use of DME. Generally, Medicare's reimbursement for Part B covered drugs equals 106% of the drug manufacturer's reported average sales price. Health care providers also receive a separate payment for administering Medicare Part B drugs. Medicare pays 80% of the amount paid to providers, while the beneficiaries are responsible for the remaining 20%.

Hospital Outpatient Department Services

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

Under the OPPS, the unit of payment for acute care hospitals is the individual service or procedure as assigned to an ambulatory payment classification (APC). To the extent possible, integral services and items (excluding physician 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."

(...continued)

2006, OEI-09-04-00420.

³⁰ For more information, see CRS Report R41211, *Medicare Durable Medical Equipment: The Competitive Bidding Program*, by Paulette C. Morgan.

³¹ Biologics are generally derived from living organisms rather than inorganic chemical compounds.

Medicare's hospital outpatient payment is calculated by multiplying the relative weight associated with an APC by a conversion factor. For most APCs, 60% of the conversion factor is geographically adjusted by the wage index used for the inpatient prospective payment system. Except for new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. The OPPS also includes pass-through payments for new technologies (specific drugs, biologicals, and devices) and payments for outliers.³²

Ambulatory Surgical Center Services

Medicare covers surgical and medical services performed in an ambulatory surgical center (ASC) that are (1) commonly performed on an inpatient basis but may be safely performed in an ASC; (2) not of a type that are commonly performed or that may be safely performed in physicians' offices; (3) limited to procedures requiring a dedicated operating room or suite and generally requiring a post-operative recovery room or short term (not overnight) convalescent room; and (4) not otherwise excluded from Medicare coverage.

Beginning in January 2008, Medicare pays for surgery-related facility services provided in ASCs using a payment system based on the OPPS. (Associated physician fees are paid for separately under the physician fee schedule.) Each of the 3,300 procedures approved for payment in an ASC is classified into an ambulatory payment classification (APC) group on the basis of clinical and cost similarity. The ASC system uses the same payment groups (APCs) as the OPPS, and for most procedures, the same relative weights used in the OPPS also apply. The ASC system uses a conversion factor based on a percentage of the OPPS conversion factor. The percentage of this average dollar figure is set to ensure budget neutrality, so that total payments under the new ASC payment system should equal total payments under the old ASC payment system. A different payment method is used to set ASC payment for new, office-based procedures, separately payable drugs, and device-intensive procedures.³³ This policy also applies to separately payable radiology services. Separately payable drugs in an ASC are paid the same amount as if provided in a hospital outpatient department. Different rules apply for device intensive procedures (where a device that is packaged into an APC accounts for more than half of its total payments). Separate payments are made for corneal tissue acquisition, brachytherapy sources, certain radiology services, many drugs, and certain implantable devices.

Ambulance

Medicare Part B covers ambulance services to or from a hospital, critical access hospital, or a skilled nursing facility when other modes of transportation could endanger the Medicare beneficiary's health. Ambulance services must be provided by qualified suppliers, and are paid for on the basis of a fee schedule. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. There is a national fee schedule for air ambulance services. For ground ambulance services, payments through 2009 were equal to the greater of the national fee schedule or a blend of 80% national and 20% regional fee schedule

³² Additionally, starting in 2006, rural sole community hospitals (SCHs) receive an additional 7.1% in Medicare payments. Special payment protections apply to cancer hospitals, children's hospitals, small rural hospitals (that are not SCHs) with 100 or fewer beds, and SCHs.

³³ 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.

amounts. Beginning in 2010, the payments in all areas are based on the national fee schedule amount.

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

Rural Health Clinics and Federally Qualified Health Centers

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

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

Part B Services for End-Stage Renal Disease

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

In effect since January 1, 2011, the new ESRD prospective payment system (PPS) makes no payment distinction as to the site where renal dialysis services are provided. With the implementation of the ESRD PPS, Medicare dialysis payments are bundled (phased in over four years, 2011 through 2014) using a single payment for Medicare renal dialysis services that includes (1) items and services included in the former payment system’s base 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. The new system is case-mix adjusted based on factors such as patient weight, body mass index, comorbidities, length of time on dialysis, age, race, ethnicity, and other appropriate factors as determined by the Secretary of Health and Human Services. Dialysis facilities that fail to meet the performance standards of three ESRD-related quality measures receive reduced payments.

Part C, Medicare Advantage

Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person amount to provide all Medicare covered benefits (except hospice) to beneficiaries who enroll in their plan. Medicare beneficiaries who are eligible for Part A, enrolled in Part B, and do not have ESRD are eligible to enroll in an MA plan if one is available in their area. Some MA plans may choose their service area (local MA plans), while others agree to serve one or more regions defined by the Secretary (regional MA plans). As of December 2011, nearly all Medicare beneficiaries had access to an MA plan and approximately 25% of beneficiaries were enrolled in one. Private plans may use different

techniques to influence the medical care used by enrollees. Some plans, such as health maintenance organizations (HMOs), may require enrollees to receive care from a restricted network of medical providers; enrollees may be required to see a primary care physician who will coordinate their care and refer them to specialists as necessary. Other types of private plans, such as private fee-for-service (PFFS) plans, may look more like original Medicare, with fewer restrictions on the providers an enrollee can see and minimal coordination of care.

In general, MA plans offer additional benefits or require smaller co-payments or deductibles than original Medicare. Sometimes beneficiaries pay for these additional benefits through a higher monthly premium, but sometimes they are financed through plan savings. The extent of extra benefits and reduced cost-sharing varies by plan type and geography. However, Medicare Advantage plans are seen by some beneficiaries as an attractive alternative to more expensive supplemental insurance policies found in the private market.

By contract with CMS, a plan agrees to provide all required services covered in return for a capitated monthly payment adjusted for the demographics and health history of actually enrolled beneficiaries. The same monthly payment is made regardless of how many or few services a beneficiary actually uses. The plan is at-risk if costs, in the aggregate, exceed program payments; conversely, the plan can retain savings if aggregate costs are less than payments. 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 will pay for providing those services in the plan's service area (a benchmark). If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate. Starting in 2012, the size of the rebate will be dependent on plan quality and will range from 50% to 70% of the difference between the bid and the benchmark. The rebate must be returned to enrollees in the form of either additional benefits, reduced cost-sharing, reduced Part B or Part D premiums, or some combination of these options. 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.

The MA benchmarks are determined through statutorily specified formulas that have changed over time. Since BBA 97, formulas have increased the benchmark amounts, in part, to encourage plan participation in all areas of the country. As a result, however, the benchmark amounts (and plan payments) in some areas are higher than the average cost of original FFS Medicare. Most recently, ACA changed the way benchmarks are to be calculated by tying them closer to (or below) spending in FFS Medicare, and adjusting them based on plan quality. At the time of passage, the Congressional Budget Office expected the ACA changes to result in reduced MA enrollment and plan subsidies for extra benefits, though the impact was expected to vary by market. Subsequently, the Secretary announced an MA plan quality demonstration to test whether different structures of bonus payments lead to greater quality improvements. The demonstration increases the size of the quality-adjusted benchmarks above levels authorized in the ACA, and expands the number of plans eligible to receive a quality-adjusted benchmarks. The demonstration may mitigate some of the reductions in enrollment and extra plan benefits that had been expected with the passage of the ACA.

In 2006, the MA program began to offer MA regional plans. Regional MA plans must agree to serve one or more regions designated by the Secretary. There are 26 MA regions consisting of states or groups of states. Regional plan benchmarks include two components: (1) a statutorily determined amount (comparable to benchmarks described above) and (2) a weighted average of plan bids. Thus, a portion of the benchmark is competitively determined. Similar to local plans,

plans with bids below the benchmark are given a rebate, while plans with bids above the benchmark require an additional enrollee premium.

In general, MA eligible individuals may enroll in any MA plan that serves their area. However, some MA plans may restrict their enrollment to beneficiaries who meet additional criteria. For example, employer-sponsored MA plans are generally only available to the retirees of the company sponsoring the plan. In addition, Medicare Special Needs Plans (SNPs) are a type of coordinated care MA plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs individuals. Special needs individuals are any MA eligible individuals who are either institutionalized as defined by the Secretary, eligible for both Medicare and Medicaid, or have a severe or disabling chronic condition and would benefit from enrollment in a specialized MA plan.

Part D

Medicare Part D provides coverage of outpatient prescription drugs to Medicare beneficiaries who choose to enroll in this optional benefit.³⁴ (As previously discussed, Part B provides limited coverage of some outpatient prescription drugs.) In 2011, about 60% of eligible Medicare beneficiaries enrolled in Part D. Prescription drug coverage is provided through private prescription drug plans (PDPs), which offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA-PDs), which offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Part C. Plans must meet certain minimum requirements; however, there are significant variations among them in benefit design, including differences in premiums, drugs included on plan formularies, and cost-sharing for particular drugs.

Qualified Part D prescription drug plans are required to offer either “standard coverage” or alternative coverage that has actuarially equivalent benefits. In 2012, “standard coverage” has a \$320 deductible and a 25% coinsurance for costs between \$320 and \$2,930. From this point, there is minimal coverage until the beneficiary has out-of-pocket costs of \$4,700 (about \$6,657.50 in total spending); this coverage gap has been labeled the “doughnut hole.”³⁵ Once the beneficiary reaches the catastrophic limit, the program pays all costs except for nominal cost-sharing. In 2010, Medicare sent a tax free, one-time \$250 rebate check to each Part D enrollee who reached the doughnut hole. Starting in 2011, the coverage gap will be gradually reduced each year until it is eliminated in 2020.³⁶ In 2012, a 50% discount is provided by drug manufacturers for brand-name drugs and Medicare pays for 14% of the cost of generic drugs dispensed during the coverage gap. By 2020, through a combination of manufacturer discounts and increased Medicare coverage, Part D enrollees will be responsible for 25% of the costs in the coverage gap (the same as during the initial coverage period). Most plans offer actuarially equivalent benefits rather than the standard package, including alternatives such as reducing or eliminating the deductible, or using tiered cost-sharing with lower cost-sharing for generic drugs.

³⁴ The Part D program was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), and began in 2006.

³⁵ The actual level of total covered Part D spending before reaching the catastrophic threshold will depend on whether the individual qualifies for the low-income subsidy and the portion of brand name and generic drugs purchased during the coverage gap.

³⁶ For additional information, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

Medicare's payments to plans are determined through a competitive bidding process, and enrollee premiums are tied to plan bids. Plans are paid a risk-adjusted monthly per capita amount based on their bids during a given plan year. Part D plan sponsors determine payments for drugs and are expected to negotiate prices. The federal government is prohibited from interfering in the price negotiations between drug manufacturers, pharmacies, and plans (the so-called "non-interference clause").

Part D also provides enhanced coverage for low-income enrolled individuals, such as persons who previously received drug benefits under Medicaid (known as "dual eligibles"—enrollees in both Medicare and Medicaid). Additionally, certain persons who do not qualify for Medicaid, but whose incomes are below 150% of poverty, may also receive assistance for some portion of their premium and cost-sharing charges.

MMA included significant incentives for employers to continue to offer coverage to their retirees by providing a 28% federal subsidy. In 2012, the maximum potential subsidy per covered retiree is \$1,730.40 for employers or unions offering drug coverage that is at least actuarially equivalent (called "creditable" coverage), to standard coverage.³⁷ Employers or unions may select an alternative option (instead of taking the subsidy) with respect to Part D, such as electing to pay a portion of the Part D premiums. They may also elect to provide enhanced coverage, though this has some financial consequences for the employer or union. Alternatively, employers or unions may contract with a PDP or MA-PD to offer the coverage or become a Part D plan sponsor themselves for their retirees.

Administration

At the federal level, Medicare is administered by CMS within the Department of Health and Human Services (HHS). CMS contracts with private entities to administer much of the program's day-to-day activities. Functions such as paying providers (processing reimbursement claims), enrolling providers and suppliers in Medicare, educating providers about billing requirements, and processing appeals are performed by Medicare Administrative Contractors (MACs). MMA required the Secretary to implement FFS contracting reform by 2011. CMS completed Round I of Parts A and B FFS contractor reform by awarding contracts to 15 A/B MACs to process Part A and B claims and four DME MACs to process DME supplier claims. CMS plans to further consolidate A/B MACs to 10 contracts during a second round of contract awards, which began in July 2010.³⁸

Under authority provided in the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), CMS contracts with private organizations to protect Medicare trust funds from making improper payments and from fraud and abuse.³⁹ In addition, to reducing improper

³⁷ The ACA changed how these subsidies are treated for tax purposes. Employers currently can exclude the retiree drug subsidies from their gross income, as well as claim a business deduction for retiree prescription drug expenses. Beginning in 2013, the allowed deduction for retiree prescription drug coverage will be reduced by the amount of the federal drug subsidy received. For additional information, see CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey.

³⁸ For more information, see http://www.cms.gov/MedicareContractingReform/02_Spotlight.asp#TopOfPage.

³⁹ For more information on Medicare contractors and Medicare fraud and abuse, see CRS Report RL34217, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*, by Cliff Binder.

Medicare payments, CMS contracts with other private entities, called Recovery Audit Contractors (RACs). In MMA, Congress authorized a three-year demonstration to test RACs, but has since expanded RACs nationwide and applied them to all parts of Medicare. RACs are responsible for reducing Medicare's improper payment rates by identifying underpayments and overpayments made to providers, recovering overpayments, and working with providers to prevent future improper payments. RACs are paid a contingency fee based on a percentage of the overpayments they recover from Medicare providers and suppliers. In FY2010, the Medicare RAC program identified approximately \$92 million in FFS claims corrections, of which \$75 million was overpayments and \$17 million was underpayments. In FY2011, the Medicare RAC program identified \$939 million in FFS corrections, \$797 million in overpayments and \$142 million in underpayments.⁴⁰

In addition to Medicare program integrity enhancements in ACA, Section 4241 of the Small Business and Jobs Act of 2010 (SBJA, P.L. 111-240) appropriated \$100 million for CMS to initiate predictive modeling and other analytics technologies ("predictive analytics technologies").⁴¹ Predictive analytics technologies have been compared to technologies used in private sector financial services industries, such as banking, insurance, and credit cards, to reduce fraudulent billing. By combining data and information from multiple sources, including Medicare FFS claims history (aberrant billing patterns), enrollment information, background checks, and other public and private information (links to questionable affiliations), complaints, predictive analytics technologies could help to determine if claims were legitimate before they were paid.

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

In January 2011, CMS established a Center for Medicare and Medicaid Innovation (CMI).⁴² The purpose of CMI is to test and evaluate innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care furnished under these programs. In selecting the models, the Secretary is required to give preference to those that improve the coordination, quality, and efficiency of health care services.

⁴⁰ The Centers for Medicare & Medicaid Services, FY2011 Fee-for-Service Recovery Audit Program, November 23, 2011, https://www.cms.gov/Recovery-Audit-Program/02_Recent_Updates.asp#TopOfPage.

⁴¹ Section 4241, "Use of Predictive Modeling and other Analytic Technologies to Identify and Prevent Waste, Fraud, and Abuse in the Medicare Fee-for-Service Program," of the Small Business and Jobs Act of 2010 (P.L. 111-240) authorized a one-time \$100 million appropriation from the Medicare Trust Funds. The predictive modeling funding is available until expended. If certain interim objectives are not met by the predictive modeling program, the Secretary may impose moratoriums on further expansion, until refinements or improvements are made.

⁴² For more information, see <http://innovations.cms.gov/>.

Financing

Medicare's financial operations are accounted for through two trust funds, the Hospital Insurance (HI) trust fund for Part A and the Supplementary Medical Insurance (SMI) trust fund for Part B, which are maintained by the Department of the Treasury. The HI and SMI trust funds are overseen by a board of trustees that makes annual reports to Congress. HI is primarily funded by payroll taxes, while SMI is funded through general revenue transfers and premiums.⁴³

The trust funds are simply accounting mechanisms; 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.

ACA established a new 15-member Independent Payment Advisory Board that will, beginning in 2014, make recommendations to reduce Medicare spending in years when Medicare costs are projected to exceed a target growth rate.⁴⁴ The board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The board is prohibited from making proposals that ration care, raise taxes, increase Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

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 the employee's earnings; the self-employed pay 2.9%. Beginning in 2013, some higher-income employees will pay higher payroll taxes. Unlike Social Security, there is no upper limit on earnings subject to the tax. Other sources of income include (1) interest on federal securities held by the trust fund, (2) a portion of federal income taxes that individuals pay on their social security benefits, (3) premiums paid by voluntary enrollees who are not automatically entitled to Medicare Part A, (4) transfers from states, and (5) other revenues. Income for Part A is credited to the HI trust fund. Part A expenditures for CY2012 are estimated to reach approximately \$270 billion.⁴⁵ About \$208 billion of this amount is expected to be funded by payroll taxes and \$34 billion by interest income and other sources; approximately \$29 billion will need to be drawn out of accumulated assets in the HI trust fund to make up the difference between expected income and expenditures.

In 2008, Part A expenditures began to exceed payroll tax income; and, in 2009, the Medicare trustees estimated that the HI trust fund would become insolvent (i.e., have \$0 in accumulated assets) by 2017. In 2010, subsequent to the enactment of health reform legislation, the Medicare Trustees estimated that changes made by ACA to reduce program spending and increase Part A

⁴³ For more information on Medicare financing, see CRS Report R41436, *Medicare Financing*, by Patricia A. Davis.

⁴⁴ For more information, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

⁴⁵ 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table III.B4, p. 60, <http://www.cms.hhs.gov/reportstrustfunds/>. Note, the Medicare trustees generally report expenditures on a calendar year basis, while CBO reports on a fiscal year basis.

revenues would extend the solvency of the HI trust fund for another 12 years, until 2029. Due mainly to a slower than expected economic recovery, the 2011 Medicare trustees report moved up the insolvency date by five years, to 2024. The 2012 report continues to project a 2024 insolvency date.⁴⁶

Part B Financing

Medicare Part B is financed mostly from federal general revenues, with beneficiary premiums set at 25% of estimated program costs for the aged. (The disabled pay the same premium as the aged.) Income for Part B is credited to the SMI trust fund. Total spending for Part B is estimated to reach about \$247 billion in CY2012, with general revenues financing approximately \$166 billion of that amount.⁴⁷

The 2012 monthly premium is \$99.90 for most Medicare beneficiaries who voluntarily enroll in Part B.⁴⁸ Individuals receiving Social Security benefits have their Part B premium payments automatically deducted from their Social Security benefit checks. An individual's Social Security check cannot go down from one year to the next as a result of the annual Part B premium increase (except in the case of higher-income individuals subject to income-related premiums).

Since 2007, higher-income enrollees pay higher premiums. In 2012, individuals whose modified adjusted gross income (AGI) exceeds \$85,000 and each member of a couple filing jointly whose modified AGI exceeds \$170,000 are subject to higher premium amounts. These higher-income premiums range from 35% to 80% of the value of Part B, affecting about 4% of Medicare Part B enrollees in 2012.⁴⁹ As a result of ACA, the income thresholds have been frozen at the 2010 level through 2019, which means that more people may be subject to the high-income premium over time.

Part C Financing

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

⁴⁶ For additional information on HI solvency estimates, see CRS Report RS20946, *Medicare: History of Insolvency Projections*, by Patricia A. Davis.

⁴⁷ 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table III.C4, p. 98, <http://www.cms.hhs.gov/reportstrustfunds/>.

⁴⁸ In 2010 and 2011, most Part B enrollees paid a monthly premium of \$96.40. However, in 2010, new enrollees paid \$110.50 per month and paid the same amount in 2011 due to the hold harmless provision. In 2011, new enrollees paid \$115.40 per month. Those who didn't have Part B premiums deducted from a Social Security check (such as Federal Civil Service retirees, and those who have their premiums paid by Medicaid on their behalf) also paid \$115.40 per month. For more information, see CRS Report R40561, *Interactions Between the Social Security COLA and Medicare Part B Premiums*, by Jim Hahn and Alison M. Shelton.

⁴⁹ The higher monthly premium amounts for 2012 are based on 2010 income levels and are (1) \$139.90—for single beneficiaries with income \$85,001-\$107,000 or for each member of a couple filing jointly with income \$170,001-\$214,000; (2) \$199.80—for single beneficiaries with income \$107,001-\$160,000 or for each member of a couple filing jointly with income \$214,001-\$320,000; (3) \$259.70—for single beneficiaries with incomes \$160,001-\$214,000 and each member of a couple filing jointly with income \$320,001-\$428,000; and (4) \$319.70—for single beneficiaries with incomes greater than \$214,000 and each member of a couple filing jointly income above \$428,000. ACA freezes these income thresholds through 2019 at 2010 levels, so potentially, as beneficiary income increases, more people may qualify for the higher income premium.

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. In CY2012, total spending for Part D is estimated to reach approximately \$69 billion, with about \$51 billion of that amount paid for by general revenues.⁵⁰

In 2012, the base beneficiary premium is \$31.08.⁵¹ However, beneficiaries pay different premiums depending on the plan they have selected and whether they are entitled to low-income premium subsidies. Additionally, beginning in 2011, higher income Part D enrollees pay higher premiums. (The income thresholds are the same as for Part B, as described above.) On average, beneficiary premiums are set at 25.5% of expected total Part D costs for basic coverage.

Additional Insurance Coverage

While Medicare provides broad protection against the costs of many, primarily acute care, services, the program does not cover all services that may be used by its aged and disabled beneficiaries. For example, 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 Medicare Advantage plans).

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, reduced cost sharing, or reduced Part B or D premiums. All MA plans have a catastrophic cap.⁵²
- Employer Coverage. Coverage may be provided through a current or former employer. In recent years, a number of employers have cut back on the scope of retiree coverage. Some have dropped such coverage entirely, particularly for future retirees. As noted earlier, the MMA attempted to stem this trend, at least for prescription drug coverage, by offering subsidies to employers who offer drug coverage, at least as good as that available under Part D.
- Medigap. Individual insurance policies that supplement fee-for-service Medicare are referred to as Medigap policies. Beneficiaries with Medigap insurance typically have coverage for a portion of Medicare’s deductibles and coinsurance;

⁵⁰ 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table III.D3, p. 122, <http://www.cms.hhs.gov/reportstrustfunds/>.

⁵¹ There is no “hold harmless” provision under Part D similar to that under Part B. Part D premium increases are not affected by Social Security cost-of-living adjustments.

⁵² Starting in 2011, all MA plans are required to include a maximum out-of-pocket (OOP) limit determined by CMS. Prior to 2011, only MA regional plans were required to include a catastrophic cap on OOP spending.

they may also have coverage for some items and services not covered by Medicare. Individuals select from a set of standardized plans, though not all plans are offered in all states.

- **Medicaid.** Certain low-income Medicare beneficiaries also may be eligible for full or partial benefits under their state's Medicaid program.⁵³ Individuals eligible for both Medicare and Medicaid are referred to as dual eligibles. The lowest-income dual eligibles qualify for full Medicaid benefits, so that the majority of their health care expenses are paid by either Medicare or Medicaid; Medicare pays first, with Medicaid picking up most of the remaining costs. In addition to full-benefit dual eligibles, state Medicaid programs pay Medicare premiums and some cost-sharing for other partial dual eligibles, who have higher income than full-benefit dual eligibles but are still considered to have low income.⁵⁴
- **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 2008, close to 90% of beneficiaries had some form of additional coverage. (Some persons may have had more than one type of additional coverage.)

Medicare Issues

Although recent health legislation helped to improve the financial outlook for Medicare, projected expenditures are still expected to outpace GDP growth and to consume an increasing portion of the federal budget. As such, the 112th Congress may continue to focus on Medicare spending as it considers ways to address the nation's growing deficit and debt. For example, the 112th Congress may consider the sustainability of reductions to providers' annual payment increases made by recent statutory changes, the potential impact of new delivery models to slow growth rates in medical expenditures and/or to improve quality, and the development of a viable long-term replacement for the current method of updating physician payments according to the sustainable growth rate (SGR) formula.

Some of the key policy issues and questions the second session of the 112th Congress may face include the following:

- A combination of factors have contributed to the rapid growth in Medicare spending. These include increases in overall medical costs driven by new and increasing use of technology and increases in the intensity and volume of

⁵³ See CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz for additional information.

⁵⁴ In addition to individuals eligible for full Medicaid benefits, other low-income Medicare beneficiaries are entitled to limited benefits under the Medicare Savings Program (MSP). MSP includes three benefit categories each with different benefit levels: (1) Qualified Medicare Beneficiaries (QMBs), (2) Specified Low-Income Beneficiaries (SLMB), and (3) Qualified Individuals (QIs). For QMBs, state Medicaid programs pay Medicare Part B premiums and Medicare cost-sharing (deductibles and co-payments) when beneficiaries' incomes are under 100% of the federal poverty level (FPL). For SLMBs, state Medicaid programs pay Part B premiums when beneficiaries' incomes are between 100% and 120% of the FPL. For QIs, Medicaid pays premiums when beneficiaries' incomes are between 120% and 135% of poverty. To be eligible for MSP, Medicare beneficiaries must also meet Medicaid's other eligibility requirements (e.g., meet citizenship or legal residency requirements).

- services provided per beneficiary. While the percentage of the population over 65 and the life expectancy of the elderly has increased, these demographic effects have a secondary impact on spending compared to the increase in services per beneficiary. How will changes made in recent health care reform legislation affect the growth in Medicare expenditures and the long-term solvency of the Medicare Hospital Insurance (Part A) trust fund and the pressure on Part B premiums to rise? What will be the potential impact on the program if the BCA automatic spending reductions were to go into effect as required in 2013-2021? Will existing financing mechanisms be sufficient to support program spending over the long term? If not, what options are available to strengthen the program's financing and to ensure long-term sustainability?
- Under ACA, certain providers, such as hospitals, skilled nursing facilities (SNFs), and home health agencies (HHAs), face permanent reductions in the annual updates to their Medicare payment rates. Can, and if so, how will these providers modify service to become more efficient? Will Medicare payment reductions for these providers lead to higher prices to other payers or can increased efficiencies result in reduced costs to other payers as well? How will these reductions affect the availability of these services to Medicare beneficiaries? How may providers be affected by reduced payments under BCA sequestration requirements?
 - Medicare payments to physicians and other providers continue to grow at rates that require ever-larger future reductions in the reimbursement rates under current law by the sustainable growth rate (SGR) system. Congress's continued reliance on short-term fixes to forestall reductions in the Medicare fee schedule prolongs the search for a long-term solution or replacement to the update formula. At the same time, each override becomes more costly. Additionally, uncertainty regarding the stability of Medicare's physician payments and the potential for future reductions has accelerated concern that Medicare beneficiaries will be increasingly unable to access providers should program participation fall as a result. Further, what will the impact be on Medicare beneficiary access to care due to increased demand for health care services as a result of ACA's Medicaid expansions and the expected growth in the number of insured in the private sector?
 - A number of Medicare reimbursement policies affecting hospitals, skilled nursing facilities, ambulance services, and clinical laboratories are set to expire in 2012. These include such things as hospital inpatient Section 508 wage reclassifications, an extension of the exceptions process for outpatient therapy caps, hospital outpatient hold-harmless payments, and ambulance service add-on payments.⁵⁵ These policies have generally been extended each year over the past several years; the cost of extending these policies again through 2012 is expected to cost about \$2.5 billion.⁵⁶ Congress will need to address whether these policies

⁵⁵ For additional information, see CRS Report RL30526, *Medicare Payment Policies*, coordinated by Paulette C. Morgan.

⁵⁶ Congressional Budget Office, Letter to the Honorable Dave Camp, December 9, 2011, *Estimate on H.R. 3630, the Middle Class Tax Relief and Job Creation Act of 2011, as introduced on December 9, 2011*, Table 2, <http://www.cbo.gov/ftpdocs/126xx/doc12609/hr3630.pdf>. Note: while the proposed legislation would have extended most of the provisions from January 2012 through December 2012, the CBO score reflects fiscal year estimates (continued...)

- should be continued in both the short and long-term, and if so, it will need to determine how these extensions will be paid for.
- In 2012, almost all beneficiaries have the option to receive their Medicare covered benefits under the original Medicare program, or through a private health plan under the Medicare Advantage (MA) program (also known as Medicare Part C). Prior to ACA, payments to MA plans exceeded the cost of original Medicare in many locations due to statutory payment rules designed to encourage plan availability. In recent years the number and type of plan choices have been high, however, the greater cost of these plans has been called into question. Starting in 2012, ACA changes how the maximum possible payments to MA plans are calculated, first by tying maximum payments closer to or below the level of spending in original Medicare and second, by adjusting payments based on plan quality. This may result in payment reductions for many MA plans. How will changes in MA payments affect plan availability and the types of supplemental benefits and reduced cost-sharing that some plans offer? Will the payment changes encourage higher plan quality or greater efficiency in the management and delivery of health care? Will a greater emphasis on plan quality encourage enrollees to switch to higher quality MA plans?
 - Since 2011, pharmaceutical manufacturers have been required to provide a 50% discount on brand name drugs for enrollees in the coverage gap (often referred to as the “doughnut hole”) in order to participate in the Medicare outpatient prescription drug (Part D) program. Additionally, the coverage gap is being gradually phased out and will be completely closed in 2020. How will the phase-out of the doughnut hole affect beneficiaries’ out-of-pocket costs and their ability to access needed prescriptions? How many manufacturers will continue to provide 50% discounts for brand name drugs in the coverage gap? Will Medicare cover drugs that are medically necessary but whose manufacturers did not enter into an agreement to provide the discount? What will be the impact of the gap closure on total Medicare Part D expenditures and beneficiary premiums? What impact will the growing number of brand name drugs going off patent have on future Medicare Part D program and enrollee expenditures?
 - Medicare cost-sharing is generally higher than it is under private employer-sponsored insurance plans. For example, under fee-for-service Medicare there is no limit on out-of-pocket expenditures and there are significant co-payments for some services. Consequently, many beneficiaries pay additional premiums for insurance to supplement Medicare (e.g., Medigap). How will the level of beneficiary out-of-pocket expenses be affected by efforts to control Medicare spending? What is the impact of high out-of-pocket costs and gaps in Medicare coverage on beneficiaries’ health and access to care?
 - Medicare has been tasked by ACA with developing, expanding, or implementing a range of programs, demonstrations, and pilot programs related to accountable care organizations (ACO), bundled payments for care provided to a patient across various settings, reduced payments because of hospital readmissions and hospital acquired conditions, payments for care coordination, and value-based purchasing

(...continued)

(October through September); therefore the CBO estimate shows increased costs in both FY2012 and FY2013.

- which can lead to lower medical costs and/or improved quality of care. How can these programs be designed to ensure that a sufficient number of providers will participate? How long will it take before results from these initiatives can be assessed? What elements are key to successful implementation (for example, adequate number of participating primary care providers, advanced and integrated information systems, changes to antitrust and antifraud legislation, and adequate financial incentives)? Can these models be successfully implemented for Medicare and also positively impact the private market for health care?
- In establishing the Center for Medicare and Medicaid Innovation as well as the Federal Coordinated Health Care Office under ACA, Congress provided options that can be used to experiment with new service delivery and payment options for beneficiaries of both Medicare and Medicaid. Will these changes help to maintain and improve quality of care while decreasing medical care costs to both the Medicaid and Medicare programs for dual eligible beneficiaries? What new approaches or authority might be necessary to ensure that acute and long-term care services are integrated, while maintaining or improving quality of care for dual eligible beneficiaries?
 - Program integrity provisions in ACA increased resources, added new requirements, enhanced activities to prevent fraud and abuse, and increased uniformity in program integrity activities among Medicare, Medicaid, and CHIP. The Small Business and Jobs Act of 2010 (SBJA) provided additional appropriations to CMS for the development of predictive analytics technologies that could help to prevent fraudulent claims from being paid. Will these changes be sufficient to deter potentially fraudulent providers from entering the program, while at the same time not being so burdensome as to discourage legitimate providers from participating in Medicare? Will CMS, its contractors, and oversight agencies be better able to prevent improper payments in the first place and reduce the reliance on the “pay-and-chase” approach? How much savings will be realized from these new authorities and activities; and how can this savings best be measured? Will additional authorities or new approaches be needed? Are program integrity resources appropriately allocated to all program areas, including Medicare Part C and D?

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