UNDERSTANDING MEDICARE

2011

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Medicare was created by the Social Security Act of 1965. It is a federal program providing health insurance to more than 47 million people, including 39 million elderly and 8 million disabled,[1] of which about 993,000 are Missourians.[2] As our population ages, total enrollment is expected to rise to more than 63 million by 2020, and 80 million by 2030.[3] Unlike Medicaid, states do not help fund or administer Medicare; it is an entirely federal program.

This report explains how health insurance under Medicare works, including: (1) benefits; (2) eligibility; (3) cost-sharing; (4) provider reimbursement; and (5) financing and expenditures. Enacted in 2010, the Patient Protection and Affordable Care Act (commonly referred to as the ACA)[4] makes a number of reforms to Medicare intended to reduce costs and improve the quality of care. These include:

- Eliminating cost-sharing for preventive services;
- Eliminating the "donut hole" in Part D prescription drug coverage;
- Adding a comprehensive checkup and personalized prevention plan to Part B benefits; and
- Paying hospitals and physicians based, in part, on the quality of care they provide.

Changes to Medicare specific to the ACA are discussed throughout.

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Benefits

There are four parts to Medicare:

- Part A covers inpatient hospital stays,
- Part B covers physician services,
- Part C is Medicare Advantage, and
- Part D covers prescription drugs.

Parts A and B comprise "traditional fee-for-service" Medicare, in which the government pays providers directly for the care they provide. In contrast, Medicare Advantage is a voluntary program in which the federal government pays private companies to administer benefits under Parts A and B. Private companies also administer Part D benefits.

Part A – Hospital Insurance
Part A covers inpatient hospital care, including such costs as laboratory tests, X-rays, operating and recovery rooms, and inpatient prescription drugs. Medicare will only cover 90 inpatient days in a benefit period, which starts when a person enters the hospital, and continues until no inpatient hospital or skilled nursing care has been provided for at least 60 consecutive days.

Enrollees also have an additional lifetime reserve of 60 days that can be used to cover days 91 and up in a given benefit period.

Part A also covers medically necessary stays in skilled nursing facilities (i.e., nursing homes) if they occur within 30 days of a hospitalization of at least 3 days; the first 100 visits by a home health agency following a 3-day hospital stay or skilled nursing facility stay; and hospice care. Medicaid, not Medicare, pays for most nursing home stays.

Part B – Supplemental Medical Insurance

Part B is a voluntary program paying for the services of individual providers, including, but not limited to: physicians, surgeons, psychologists, social workers, and nurse practitioners. Part B also covers many other goods and services, including: emergency room services, durable medical equipment (DME) for home use, outpatient laboratory tests and X-rays, physical and occupational therapy, radiation therapy, and ambulance services. In 2011, the ACA added a free annual comprehensive wellness visit and personalized prevention plan to covered Part B benefits.

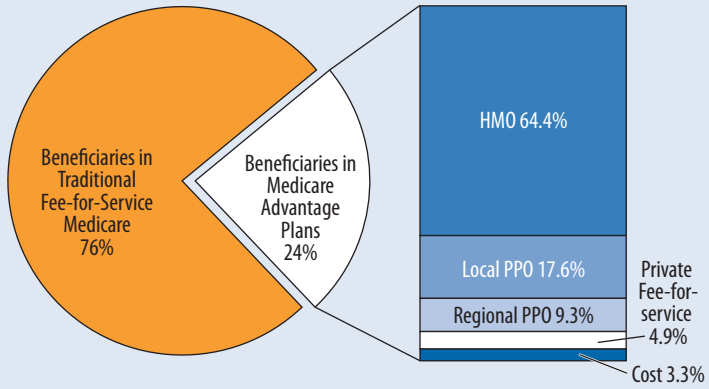
Part C – Medicare Advantage

While Medicare enrollees have had the option to enroll in private plans since the 1970s, enrollment in Medicare Advantage was relatively low until recently.[5] Since 2005, participation has more than doubled to 12.1 million people (24% of all Medicare beneficiaries).[6] The percentage enrolled in each state varies, from about 1 percent in Alaska, to more than 40 percent in Hawaii.[7] Missouri is close to average, with about 20 percent of its Medicare recipients enrolled in Medicare Advantage plans.

Figure 1

Medicare Benefit Payments By Type of Service, 2011

Total Medicare beneficiaries in Medicare Advantage, 2011 = 12.1 million



NOTE: HMO is health maintenance organization. PPO is preferred provider organization. Cost is a type of HMO plan available only in certain parts of the country. Percentages may not add to 100 due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, "Monthly Contract and Enrollment Summary Report," March 2011, available at https://www.cms.gov/MCRAdvPartDEnrolData/MCESR/list.asp#TopOfPage.

Private Medicare Advantage plans must provide at least those services covered by Parts A and B, and may provide additional benefits, such as vision and hearing coverage or reduced cost sharing (such as covering Part B premiums). Medicare Advantage plans vary greatly. Most have restricted provider networks of some kind, such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) (see Figure 1). This means the plan will only pay for goods and services received through the plan's approved providers. In contrast, there are some Medicare Advantage plans similar to traditional fee-for-service Medicare; they allow members to go to any provider willing to accept the plan's payment. Since 2007, all Medicare enrollees have had access to at least one type of Medicare Advantage plan,[8] and in 2010, Medicare enrollees could choose from an average of 33 different Medicare Advantage plans.[9]

Part D Prescription Drug Coverage
Prescription drug coverage was added to Medicare in 2003 by the Medicare Prescription Drug, Improvement, and Modernization Act.[10] All Part D benefits for those who choose to enroll are administered through private companies, either a stand-alone drug plan or a Medicare Advantage plan (about 80% of Medicare Advantage plans provide Part D benefits). As of March 2011, there were 29.1 million people enrolled in Part D, with 18.6 million in stand-alone plans and 10.5 million in Medicare Advantage plans.[11] In Missouri, 620,000 people are enrolled in Part D, with 425,500 in stand-alone plans and 194,500 in Medicare Advantage plans.[12] The medications covered may vary significantly between plans, as companies can create lists of covered and non-covered drugs ("drug formularies"), and have other rules to determine coverage and cost-sharing amounts for any particular drug.

Eligibility

Part A
Three groups are entitled to Part A benefits:[13]

- Those age 65 and over who are eligible for Social Security or Railroad Retirement benefits.
- Those under age 65 who have been entitled to Social Security or Railroad Retirement benefits because of a disability for at least 24 months.[14] The waiting period is waived for those with Amyotrophic Lateral Sclerosis, also known as ALS or Lou Gehrig's Disease.
- Those with end stage renal disease if they are (or if they are the spouse or dependent child of someone who is) receiving Social Security benefits; considered "fully insured" by Social Security; or entitled to Medicare.

Those 65 and over and some disabled individuals not entitled to Part A benefits can still enroll in Part A by voluntarily paying a monthly premium of $450 in 2011, reduced to $248 for those who have at least 30 quarters of Medicare-covered employment, or who are married to such a person.[15]

Part B
A person can enroll in Part B if entitled to Part A or age 65 or over.[16]

Part C
A person can enroll in Part C if entitled to Part A and enrolled in Part B.[17]

Part D
A person can enroll in Part D if entitled to Part A or enrolled in Part B.[18]

What is Meant by "Cost Sharing"?

Cost sharing comes in four basic forms.

- A premium is a fixed amount of money a person must pay to have health insurance in a benefit period. In Medicare, for example, a person must pay a premium each month to stay enrolled in Parts B and D.
- A deductible is a fixed amount of money a person must pay toward his or her health care costs before insurance pays anything.
- Co-insurance is a percentage of a person's health care costs he or she must pay, usually after any deductible is paid.
- A copay is a fixed amount of money a person must pay each time he or she uses a particular service, such as a doctor's visit or hospital stay.

What is the Federal Poverty Level?

The federal poverty level is an amount of income, based on family size and composition, below which a family would be unable to meet its basic needs. In 2010, the FPL for a family of two with at least one person over age 65 is $13,180 a year.[23]

Cost Sharing

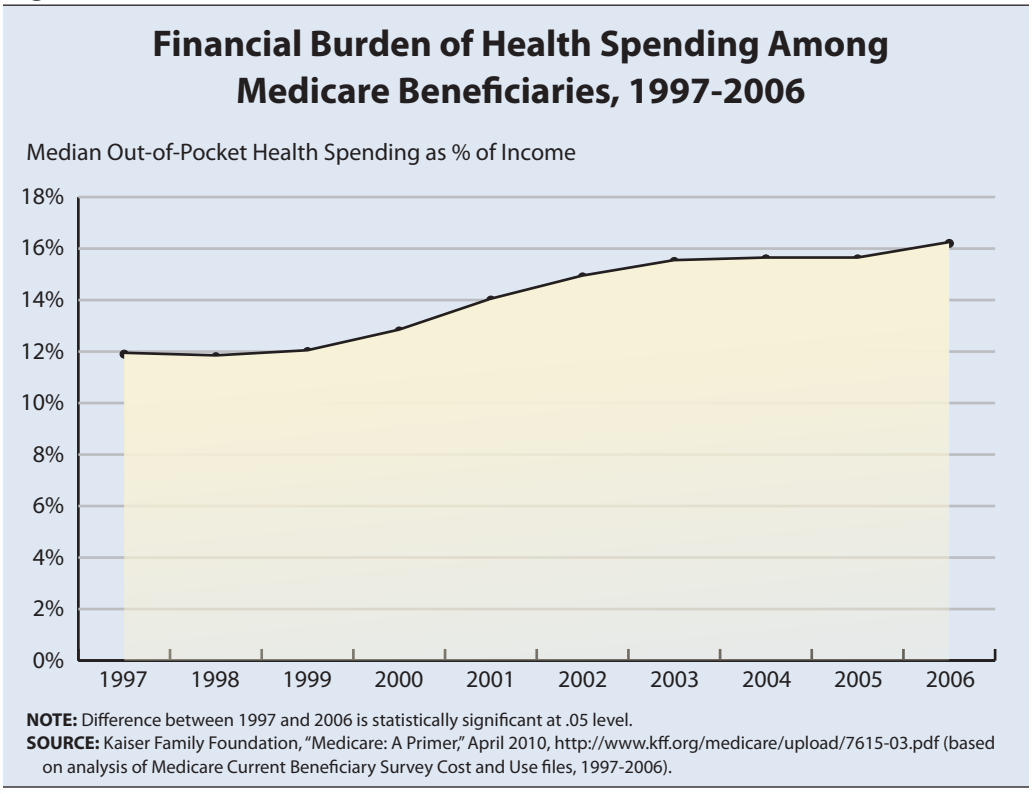
Health care is not free for Medicare enrollees, who may have to pay out-of-pocket costs to receive covered services.

In 2009, those in traditional fee-for-service Medicare had to pay an average of $1,492 out-of-pocket for covered services; Missourians paid an average of $1,564.[19] These figures grow substantially if all Medicare enrollees and all out-of-pocket payments are included, not just those payments necessary to satisfy Medicare's cost-sharing requirements (e.g., payments for non-covered nursing home stays and premiums for private health insurance). Factoring in all money spent on health care, the average enrollee paid $4,241 out-of-pocket in 2006, and the median enrollee spent more than 16 percent of income on health care (see Figure 2).[20]

Medicare enrollees may have difficulty paying for and accessing health care due to cost-sharing requirements. A 2007 survey found that 15 percent of elderly and 48 percent of disabled Medicare enrollees had problems paying off medical bills.[21] Similarly, 20 percent of elderly and 53 percent of disabled recipients had gone without care in the past year because of costs. Medicare enrollees are also typically poorer and sicker than the general population. For example:[22]

- Nearly half have incomes below 200 percent of the federal poverty level (see box on left),
- 44 percent have three or more chronic health conditions,
- 29 percent rate themselves in fair or poor health, and
- 29 percent have cognitive impairments.

Figure 2



NOTE: Difference between 1997 and 2006 is statistically significant at .05 level.
SOURCE: Kaiser Family Foundation, "Medicare: A Primer," April 2010, http://www.kff.org/medicare/upload/7615-03.pdf (based on analysis of Medicare Current Beneficiary Survey Cost and Use files, 1997-2006).

Part A

For fee-for-service enrollees in 2011, there is a deductible of $1,132 for inpatient hospital stays, a copay of $283 for days 61 through 90, and a copay of $566 for lifetime reserve days.[24] For skilled nursing facility stays, there is a copay of $141.50 for days 21 through 100.[25] There is no copay or deductible for home health visits. Hospice care also has no deductible, but does include small copays for drugs (up to $5) and coinsurance for inpatient respite care (5%). In 2009, those enrolled in fee-for-service Medicare paid a total of $14.9 billion in cost-sharing to receive covered Part A services, an average of $428 per enrollee.[26]

Part B

In 2009, fee-for-service Part B enrollees had to pay a total of $37.7 billion for covered services, an average of $1,188 per enrollee.[27] For 2011, there is a deductible of $162.[28] After the deductible is met, enrollees must pay coinsurance for most goods and services, usually set at 20 percent (coinsurance alone accounted for 63.8% of all Medicare cost-sharing liability in Parts A and B in 2009).[29] Enrollees also must pay a monthly premium between $115.40 and $369.10, depending on their income.[30] Further, a Part B enrollee who visits a non-participating provider may be subject to balance billing (see box on right).

As of 2011, the ACA eliminated all cost-sharing for certain preventive services with a Grade A or B recommendation from the U.S. Preventive Services Task Force.[31]

Part C

Medicare Advantage enrollees pay premiums if their plans charge more than the maximum Medicare pays a plan in their county (called county benchmarks). The enrollee pays the difference through premiums. If a plan charges less than what Medicare pays, there are no premiums and the plan gets to keep 75 percent of the difference, called a rebate, to provide extra benefits (most plans reduce cost-sharing). Medicare keeps the other 25 percent of the difference. Medicare Advantage enrollees may also pay a separate Part B or Part D premium. In 2009, 52 percent of Medicare Advantage enrollees paid no premium to enroll in Medicare Advantage. In 2012, the ACA will tie a plan's rebate to its quality rating between 1 and 5 stars: plans with fewer than 3.5 stars get a 50 percent rebate; those with 3.5 or 4 stars get a 65 percent rebate; and those with 4.5 or 5 stars get a 70 percent rebate.[32]

The ACA also prohibits Medicare Advantage plans from having higher cost-sharing requirements for some benefits, compared to traditional fee-for-service Medicare.

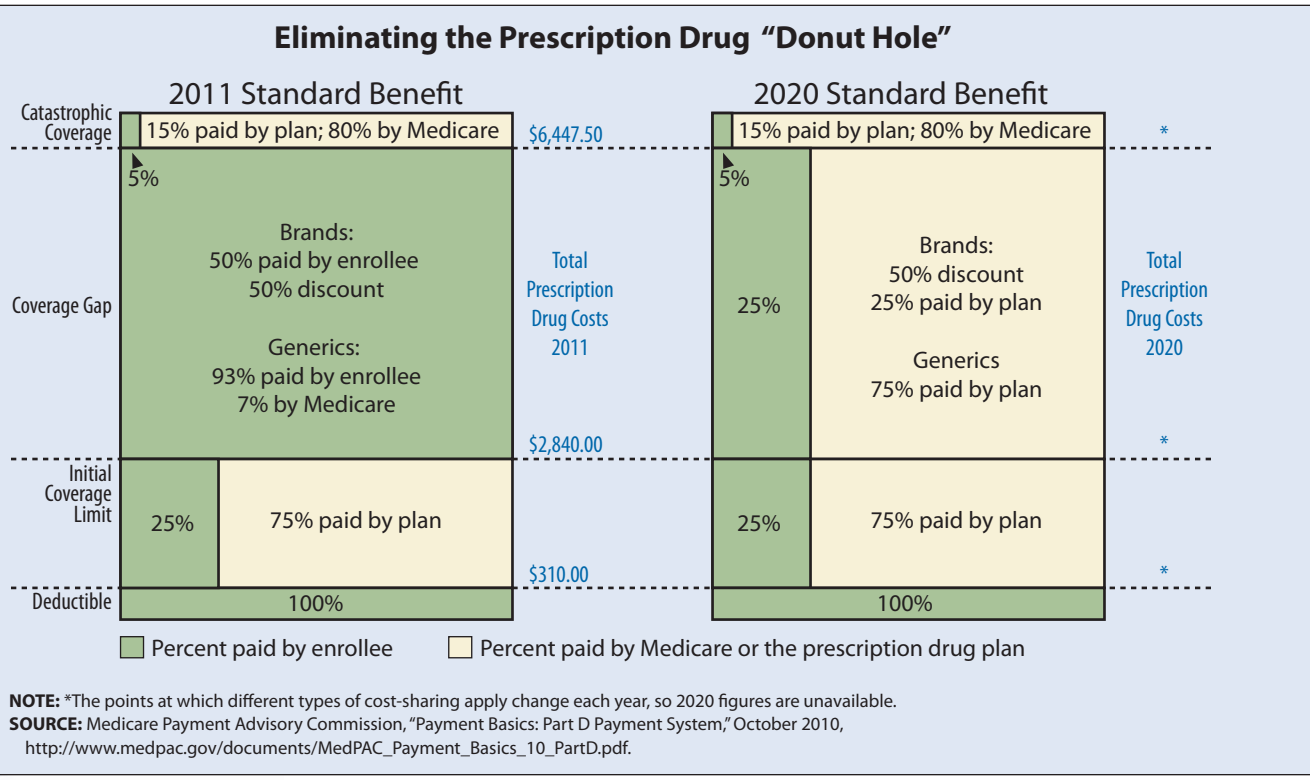
Part D

Prescription drug plans may have the same cost sharing as a standard benefit created by the government, or they may design their own plans so long as they are actuarially equivalent to or better than the standard benefit. The standard benefit has been controversial because of the "donut hole," a gap in coverage where the enrollee must pay thousands of dollars

Balance Billing

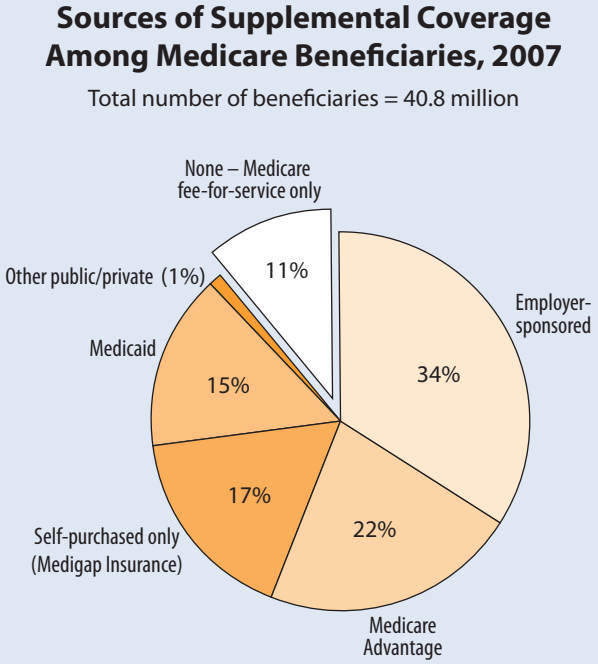
Participating providers agree to charge no more than the price Medicare sets for a service. Non-participating providers, however, may charge more than the price Medicare sets and then bill the enrollee for the difference, a practice called balance billing. Medicare enrollees can choose to see only participating providers.

Figure 3



NOTE: *The points at which different types of cost-sharing apply change each year, so 2020 figures are unavailable.
SOURCE: Medicare Payment Advisory Commission, "Payment Basics: Part D Payment System," October 2010, http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_PartD.pdf.

Figure 4



NOTE: Percents rounded to the nearest whole number.
SOURCE: Kaiser Family Foundation, "Medicare: A Primer," April 2010, http://www.kff.org/medicare/upload/7615-03.pdf (based on analysis of the CMS 2007 Medicare Current Beneficiary Survey Access to Care file).

out-of-pocket before coverage kicks back in. The donut hole was reached by 31 percent of all Part D enrollees in 2008, a third of whom had no help paying for these costs.[33] Enrollees used to be responsible for 100 percent of costs in the gap, but the ACA changed that. In 2010, the ACA gave any prescription drug plan enrollee with spending in the coverage gap a $250 rebate.[34] Discounts for brand name and generic drugs are now being gradually phased in so that, by 2020, the enrollee will be responsible for just 25 percent of the costs of brand name and generic drugs while in the gap (see Figure 3).[35] Closing the donut hole is expected to cost the government $42.6 billion through 2019.[36]

Cost sharing varies greatly from the standard benefit design. In 2011, the average monthly premium for all Part D plans was $32.34.[37] The premiums in Missouri vary from $11.70 to $113.30, but the majority are between $16 and $35.[38] Also, more than 72 percent of all Missouri plans have no deductible, and a quarter provide extra benefits in the coverage gap, such as discounts on generics or brand name medications.[39] Plans that charge no deductible usually charge copays for each prescription instead.

Supplemental Coverage – Medigap

Enrollees may pay cost sharing with personal funds, or they may have a private health insurance plan that pays some or all of these costs (see Figure 4). Private plans include employer-sponsored insurance if an enrollee is still working, employer-sponsored retiree health plans, or Medigap (optional insurance that covers costs not paid by Medicare). There are ten types of Medigap plans companies can offer, called Plans A, B, C, D, F, G, K, L, M, and N (plans E, H, I, and J are no longer offered).[40] They all provide certain benefits, such as covering hospital copays under Medicare Part A and coinsurance under Medicare Part B. Other benefits are covered by only some of the plans, such as the Part A and Part B deductibles and costs due to balance billing. While the benefits for each plan are set in advance by the federal government, the prices can vary, based on a person's age when issued the policy; a person's current age (so the price can go up as the person ages); or regardless of age, so everyone who has the policy is charged the same amount, called community rating. In 2008, 17 percent of all Medicare beneficiaries had a Medigap plan.[41]

Provider Reimbursement

The following describes how providers are paid in traditional fee-for-service Medicare. As described above, the government does not directly pay providers who care for Medicare Advantage enrollees. Instead, the government pays the private plans, and the plans contract with providers and hospitals to provide care.

Part A

Medicare pays hospitals and facilities a one-time, set amount of money for each admission. The amount of the payment depends on the patient's primary diagnosis upon entering the hospital, which places him or her in a particular diagnosis-related group (DRG). Each group reflects what it reasonably should cost to provide care for a typical patient with that diagnosis. The amount is adjusted based on other factors, such as the geographic location of the hospital, but not based on the actual cost of providing care to the patient. Thus, if care costs less than what Medicare pays, the hospital makes money; if care costs more, the hospital loses money. Additionally, some hospitals receive payments from Medicare through the Disproportionate Share Hospital Program (DSH), which provides extra financial assistance to hospitals caring for large percentages of low-income patients.[42]

The ACA made several changes to hospital reimbursement. Starting in 2013, hospitals will be eligible for bonus payments by providing high-quality care, based on factors such as outcomes for patients admitted with heart failure or pneumonia, and hospital-acquired infection rates.[43] Additionally, payments under the DSH program will be reduced by 75 percent beginning in 2014, saving $22.1 billion by 2019.[44] In 2012, payments to hospitals will be reduced for certain preventable readmissions. Similarly, in 2015, the 25 percent of hospitals with the highest rates of hospital-acquired infections will have their Medicare payments for these conditions reduced by 1 percent.[45]

Physician Fees and the SGR

Physician payments are supposed to be adjusted each year based on a sustainable growth rate (SGR) formula, which tries to ensure physician payments do not grow faster than the gross domestic product (GDP). The GDP is the value of all goods and services produced in a country in a period of time, usually a year. The SGR led to payments for physicians being increased each year between 1997 and 2001, but reduced by 4.8 percent in 2002.[49] Each year since, the SGR has called for a reduction, and each year Congress has acted to prevent the reduction. In 2011, a 24.9 percent reduction was delayed.[50] The reduction for 2012 is estimated to be 29.5 percent.[51]

Controlling Costs in Medicare Advantage

On average, payments to Medicare Advantage plans are 14 percent more than what it would cost to cover an enrollee in traditional fee-for-service Medicare.[54] This money pays for plan profits, overhead, and additional benefits for enrollees (every $1.00 in extra benefits costs the government about $1.30 in subsidies). The ACA addresses the higher costs by lowering payments to Medicare Advantage plans and aligning them with fee-for-service costs. Also, beginning in 2014, Medicare Advantage plans must have medical-loss ratios of at least 85 percent, meaning plans have to spend at least 85 percent of their Medicare dollars on enrollees' health services.

Medicare will also experiment with bundled payments in a national pilot program starting in 2013.[46] Currently, providers are paid separately from hospitals, but the pilot program will pay hospitals and providers with a single payment to cover all health care provided during an episode of care, which begins three days before a hospital admission and ends 30 days after discharge.

Part B

Medicare also pays physicians a set amount for each service they provide, according to the Medicare Physician Fee Schedule.[47] The amount of the fee is based on where the procedure falls on a resource-based relative value scale (RBRVS). The RBRVS sets a price based on the work expense of a procedure (i.e., the time and intensity of the physician's work), the practice expense (i.e., the general costs of maintaining a practice, such as office rent and workers' wages), and the malpractice expense (i.e., malpractice costs associated with maintaining a practice).[48] As with hospitals, the fee is adjusted based on the provider's geographic location, but not the actual costs to the physician.

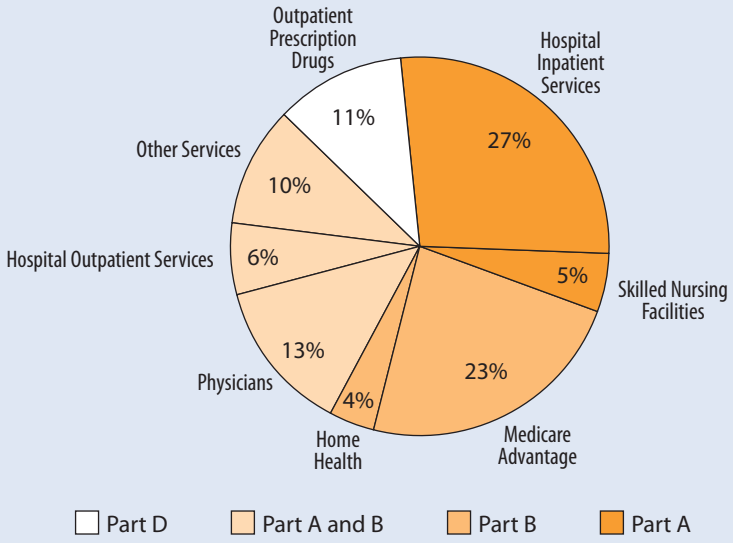
The ACA made several changes to physician reimbursement. First, emphasizing preventive services and rural health care, it immediately increased payments by 10 percent to primary care providers, as well as general surgeons practicing in health professional shortage areas. The law also created a Center for Medicare and Medicaid Innovation, which will create and test changes to payment or service-delivery models in order to reduce costs and improve care. Further, the ACA requires the fee schedule to reflect the quality of care provided, not just costs. This is done through a value-based payment modifier, which will be based on quality measures developed by the Department of Health and Human Services and phased in over two years beginning in 2015.[52]

Financing and Expenditures

The federal government pays for Medicare Part A using the Hospital Insurance Trust Fund, which is primarily funded by a dedicated income tax of 2.9 percent for the self-employed and 1.45 percent each for employers and their employees. Beginning in 2013, the ACA adds an additional tax of 0.9 percent for individuals earning more than $200,000 ($250,000 for joint filers), and a tax of 3.8 percent on unearned income for individuals with incomes over $200,000 ($250,000 for joint filers).[53] Medicare Part B is paid for using the Supplemental Medical Insurance Trust Fund, which is funded by enrollee premiums (25%) and general tax revenues (75%). Medicare Part D is financed through general tax revenues (about 77% in 2010), enrollee premiums (11%), and state payments on behalf of dual-eligibles, those enrolled in both Medicare and Medicaid (12%). Medicare Part C is not financed separately; it is funded by Parts A, B, and D, as appropriate.

The ACA will help the federal government pay for Medicare in the coming decades. In 2010, Medicare cost $523 billion, or about 12.9 percent of all federal expenditures and 3.6 percent of the country's GDP.[55] Before the

Figure 5



NOTE: Perecents rounded to the nearest whole number.
SOURCE: Kaiser Family Foundation, "Medicare Chartbook," figure 8.7, 2010, http://facts.kff.org/chartbooks/medicare chartbook, fourth edition, 2010.pdf (based on Congressional Budget Office, Medicare baseline, August 2010).

ACA, Medicare costs were predicted to rise to 11.2 percent of GDP by 2080.[56] With the cost reductions in the ACA, Medicare spending is now predicted to rise to only 6.2 percent of GDP by 2085.[57] Similarly, before the ACA, Part A's Hospital Insurance Trust Fund would have become insolvent by 2017, but after the ACA it will remain solvent until 2024.[58] Once the Trust Fund becomes insolvent, the only source of funding for Medicare Part A would be each year's tax revenues, which would not be sufficient. New funding or benefit reductions would have to occur. The burdens on Parts B and D are also expected to increase substantially in the long term, but both are less likely to become insolvent.

The ACA tries to reduce Medicare expenditures in several ways. First, the law creates a 15-member Independent Payment Advisory Board (IPAB), whose proposals to reduce Medicare spending would automatically go into effect unless Congress enacted an equally cost-reducing alternative. The first proposal from IPAB is due in 2014. Second, the ACA reduces annual updates in payments to hospitals, nursing facilities, home health agencies, and other non-physician providers, which are expected to save $156.6 billion through 2019.[59] Third, the ACA contains several provisions designed to control costs in Medicare Advantage and reduce waste, fraud, and abuse in Medicare (see box on right). Overall, the health care reform law is expected to reduce Medicare expenditures by $424 billion between 2010 and 2019.[60]

Waste, Fraud, and Abuse in Medicare

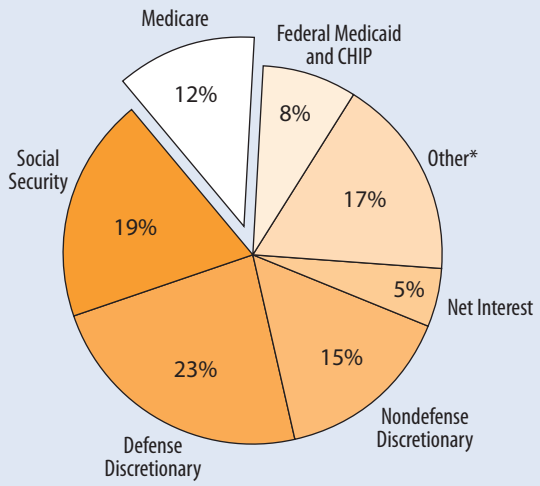
Waste, fraud, and abuse lead to improper payments and overpayments in Medicare, costing $34.3 billion annually in fee-for-service Medicare, and as much as $60 billion overall.[61] The ACA addresses this problem in many ways, including:

- Increased penalties for health care crimes under the Federal Sentencing Guidelines;
- Part D prescription drug plans and Medicare Advantage plans are required to have anti-fraud policies;
- When prescribing durable medical equipment or home health services, providers must have face-to-face encounters with their patients;
- Enrollees can be penalized for knowingly participating in health care fraud;
- Before providing imaging services (e.g., MRIs), a physician must inform a patient in writing that the services can be obtained elsewhere, and provide a list of other area suppliers, in order to prevent unneccesary self-referrals; and
- Part D plans must use uniform drug dispensing techniques to reduce waste in long-term care facilities.

Figure 6

Medicare Spending as a Share of Total Federal Spending in 2010

2010 total federal outlays = $3.6 trillion



NOTE: Amount for Medicare includes offsetting premium receipts. *Other category includes disaster costs and negative outlays for Troubled Asset Relief Program.

SOURCE: Kaiser Family Foundation, "Medicare: A Primer," April 2010, http://www.kff.org/medicare/upload/7615-03.pdf (based on Office of Management and Budget, FY2011 Budget, Summary Tables, February 2010).

Summary

Medicare is the largest health insurance program in the United States, covering a large and growing group of elderly and disabled Americans who might otherwise not have any health coverage. Medicare helps pay for essential services such as inpatient hospital stays, physician services, and prescription drugs. The Affordable Care Act tries to address some of Medicare's shortcomings by closing coverage gaps, improving the quality of care, reducing costs, and extending the financial security of Medicare Part A by almost a decade.

Online Resources

Medicare's official website – https://www.medicare.gov/default.aspx

"Medicare & You" Handbook – http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf

Apply to enroll in Medicare – https://www.ssa.gov/retireonline

Supplemental Medigap plans available in your area – http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx

Medicare Advantage and prescription drug plans available in your area – https://www.medicare.gov/find-a-plan/questions/home.aspx

Information and statistics from the Centers for Medicare & Medicaid Services – http://www.cms.gov/home/medicare.asp

Information and statistics from the Kaiser Family Foundation – http://www.kff.org/medicare/index.cfm

Endnotes

1 Board of Trustees, Federal Hospital Insurance and Federal Supplimentary Insurance Trust Funds, "2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplimentary Medical Insurance Trust Funds," page 9, 2011, http://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf.

2 Kaiser Family Foundation, "Missouri: Medicare Enrollment," as of May 2010, http://www.statehealthfacts.org/profileind.jsp?cat=6&sub=74&rgn=27&cat=6.

3 Board of Trustees, Federal Hospital Insurance & Federal Supplementary Medical Insurance Trust Funds, "2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Funds," page 56, 2010, https://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf.

4 The 2010 health care reform law is actually two laws: the Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, 124 Stat. 119, and the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. 111-152, 124 Stat. 1029. For a summary of most or all of the provisions that impact Medicare, see Congressional Research Service, "Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline," June 2010, https://www.aamc.org/download/133858/data/crstimeline.pdf.pdf.

5 Centers for Medicare & Medicaid Services, "Table 12.1: Health Maintenance Organization (HMO) and Cost Contract Enrollment Growth: Selected Calendar Years 1990-2009," available at https://www.cms.gov/MedicareMedicaidStatSupp/09_2010.asp#TopOfPage.

6 Medicare Advantage enrollment is 12.1 million as of March 2011. Centers for Medicare & Medicaid Services, "Monthly Contract and Enrollment Summary Report," March 2011, available at https://www.cms.gov/MCRAdvPartDEnrolData/MCESR/list.asp#TopOfPage. However, the most recent period for which both Medicare Advantage enrollment and total Medicare enrollment are available is July 2009. At that time, there were 11.1 million people enrolled in Medicare Advantage and 46.6 million in Medicare. Centers for Medicare & Medicaid Services, "Monthly Contract and Enrollment Summary Report," July 2009, available at https://www.cms.gov/MCRAdvPartDEnrolData/MCESR/list.asp?listpage=3; Centers for Medicare & Medicaid Services, "Medicare Enrollment: National Trends: 1966-2009: Medicare Aged and Disabled Enrollees by Type of Coverage," 2009, https://www.cms.gov/MedicareEnRpts/Downloads/HISMI2009.pdf.

7 Centers for Medicare & Medicaid Services, "Table 12.8: Medicare Advantage and Other Private Health Plans Penetration, (Percent of Medicare Beneficiaries Enrolled), by Geographic Area: December 2009," available at https://www.cms.gov/MedicareMedicaidStatSupp/09_2010.asp#TopOfPage.

8 Centers for Medicare & Medicaid Services, "Table 12.2: Percent of Medicare Population with Access to at Least One Risk/Medicare+Choice (M+C)/Medicare Advantage (MA) CCP (1993-2009), Private Fee-for-Service (PFFS) (2000-2009), or M+C/MA Plan of Either Type (2000-2009)," available at https://www.cms.gov/MedicareMedicaidStatSupp/09_2010.asp#TopOfPage.

9 Kaiser Family Foundation, "Medicare Advantage 2010 Data Spotlight," November 2009, http://www.kff.org/medicare/upload/8007.pdf.

10 Pub. L. 108-173, 117 Stat. 2066.

11 Centers for Medicare & Medicaid Services, "Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report: Monthly Summary Report," March 2011, available at https://www.cms.gov/MCRAdvPartDEnrolData/MCESR/list.asp#TopOfPage.

12 These data are from December 2009. Centers for Medicare & Medicaid Services, "Table 14.1: Medicare Part D: Type of Plan or Retiree Drug Subsidy for Part D Enrollees, by Area of Residence," December 2009, available at https://www.cms.gov/MedicareMedicaidStatSupp/09_2010.asp#TopOfPage.

13 42 U.S.C. §§ 226 (Part A), 226A (Part A for those with End Stage Renal Disease).

14 Specifically, a person must be entitled to Social Security Disability Insurance benefits, Social Security Child's Insurance benefits because of a disability, Social Security Widow's or Widower's Insurance benefits because of a disability, or Railroad Retirement disability benefits.

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Understanding Medicare is prepared by Jeff Herman, Health Policy Fellow at the Missouri Foundation for Health (MFH).

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1000 St. Louis Union Station, Suite 400
St. Louis, Missouri 63103
Toll-free 800 . 655 . 5560
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