Medicare

David Ganz, MD, PhD
VA Greater Los Angeles Healthcare System
UCLA MPGMG
October 4, 2007
Overview

• The American health care system(s)
• Structure of Medicare
• General Q&A
Our Health Care System(s)

• Publicly funded
  – Medicare (federal only)
    • Age 65 and older
    • Permanent kidney failure needing dialysis/transplant
    • Certain types of disability (including Lou Gehrig’s disease)
  – Medicaid (federal/state)
    • Low-income
    • Eligibility rules vary by state
Our Health Care System(s)

• Publicly funded (continued)
  – SCHIP (federal/state)
    • Covers children
  – Department of Veterans Affairs (federal)
    • Priority to Veterans with low income or “service-connected” injury
  – Tricare (federal, for military employees)
  – County and city systems
Our Health Care System(s)

• Private insurance (usually employer-based)
  – Indemnity (Fee-for-service)
  – PPO (Preferred-provider organization)
    • PPO as insurance product
  – HMO (Health maintenance organization)
    • Group/staff model HMO (e.g. Kaiser-Permanente)
    • HMO as insurance product
Origins of Medicare

- Previous attempts at enacting universal health insurance had failed
- Insurance for elders considered politically more feasible than universal insurance
- Medicare seen as extension of Social Security
- Medicare explicitly structured to be similar to private insurance plans of its time

Ball RM. Health Affairs 1995;14:62
Structure of Medicare

• Federal program enacted in 1965 under the Johnson administration
• From the outset, divided into two benefits:
  – Part A: hospital care, skilled nursing facility stays (up to 100 days), hospice, some home health, funded by payroll tax, no premium
  – Part B: MD visits and outpatient services, funded by general revenue and beneficiary premiums ($93.50/month in 2007 but higher for high-income individuals)

Patashnik E et al. J Health Politics Policy Law 2001;26:7
Medicare Managed Care (Part C)

- Has been available as alternative to traditional Medicare Parts A+B since program inception
- Typical scenario:
  - Beneficiary pays Medicare Part B premium
  - In return for restrictions on access to care, managed care organization (MCO) provides more generous package of benefits to beneficiary
  - Medicare pays a certain amount to MCO per enrolled beneficiary per month, adjusted for patient complexity
  - MCO at financial risk
Medicare Advantage

• 2003 legislation created new private options for Medicare beneficiaries:
  – FFS
  – PPO
• Commercial plans get paid fixed amount per member per month (adjusted for complexity)
• But physicians typically paid on a fee-for-service basis…more later
Medicare Enrollees

• Prior to Medicare, only half of those 65 and older had health insurance--now about 97%
• Rapid growth of enrollees over time
  – 19 million in 1966
  – 40 million in 2001
  – estimated 77 million in 2030
• Vast majority are in traditional fee-for-service Medicare

Major Medicare Milestones

• 1972: Coverage expanded to include individuals with end-stage renal disease and those with long-term disabilities
• 1983: Prospective payment system for inpatient services established (Traditional Medicare only)
• 1986: Hospice benefit made permanent
• 2003: Medicare Modernization Act provides prescription drug benefit effective 2006

http://www.cms.hhs.gov/about/history/mcaremil.asp
http://www.hospice-america.org/history.html
Fee-for-Service vs. Managed Care

- Physician bills fee-for-service Medicare for each service provided (each patient visit, each joint injection, etc.)
- versus…
- Physician contracts with, or is employed by, managed care organization to provide needed care to patients
- New commercial PPO/FFS plans feel like traditional FFS Medicare (to some extent) but are administered by private plans
Medicare FFS

• Fee-for-service (FFS) as it relates to physicians:
  – Physician sees patient
  – Physician submits claim to regional carrier
  – Carrier determines if claim is eligible for reimbursement
  – Medicare pays 80% of allowable fee for the service
  – Beneficiary responsible for remaining 20%
  – For mental health, beneficiary has 50% copay

• Private FFS/PPO plans will have their own arrangements
Medicare Part A covers…

• Acute hospitalizations ($992 deductible, 2007)
• Up to 100 days of post-hospital care in a skilled nursing facility (SNF)
  – First 20 days, no co-pay; thereafter, $124/day (2007)
  – Does not include custodial care
• Hospice care
• Ambulance to hospital or SNF if medically necessary
• Home health care (covered by Part B if beneficiary doesn’t have Part A)

Medicare Part B covers...

- Durable medical equipment (e.g., wheelchair)
- Physician office visits
- Non-physician services
  - Social workers, psychologists, physician assistants, nurse practitioners

Medicare Part B covers…

• Cancer chemotherapy, drugs given in MD offices, and limited other drugs
• Lab tests and imaging studies
• Typical preventive services (colon cancer screening, etc.)
  – “Welcome to Medicare” physical exam: must be within 6 months of getting Part B)

Medicare A & B do not cover…

- Eyeglasses
- Dental work
- Hearing aids
- Transportation to outpatient services
- Long-term nursing home care

Medicaid and Long-Term Care

• If a Medicare beneficiary needs long-term care, she
  – Pays privately, spending down her assets
  – Becomes eligible for Medicaid once assets reach a critical threshold

• Medicaid is primary payer for long-term care
Supplements/Alternatives to Medicare

• Employer coverage for retirees
• Medicare-Medicaid (dually-eligible population)
  – PACE (Program for All-Inclusive Care of the Elderly)
• Medicare with private Medigap policy
  – Medigap prescription coverage being phased out
Medicare Part D (Prescription Drugs)

• Options for Medicare beneficiaries:
  – Medicare FFS with voluntary stand-alone prescription drug plan (PDP)
    • Additional premium ~$27/month for PDP (2007)
  – Medicare managed care including prescriptions
  – Stay in employer-sponsored health plan, which Medicare will subsidize
  – VA (If you’re a Veteran)

Medicare Drug Benefit

- Plans must cover at least two drugs within each therapeutic class
- Tiered copayments allowed
- Beneficiaries with low income (<15K/yr) and modest assets (<11.5 K) have no monthly premium, no annual deductible, and minimal copayments

Benefit Design for Part D

• First $250 – beneficiary pays 100%
• Next $2000 ($250-$2250)
  – Beneficiary pays 25%, Medicare pays 75%
• Next $2850 ($2250-$5100)
  – Beneficiary pays 100% (“doughnut hole”)
• Additional expenditure above $5100
  – Beneficiary pays 5%, Medicare pays 95% (“catastrophic coverage”)

Medicare and You

• How does Medicare affect physicians?
  – Documentation requirements for billing (in traditional Medicare)
    • Potential audit to check for overbilling
  – Care has to be “medically necessary,” and not all procedures are approved
  – Medicare fee schedule
  – Medicare Part D formularies
For Additional Information

- www.medicare.gov
Acknowledgements

• Brandon Koretz, M.D.
• Sue Charette, M.D.