



# Medicare and Medicaid

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## EXECUTIVE SUMMARY

While similar, Medicare and Medicaid are not the same. In basic terms, Medicare is a purely federal program designed to provide health benefits to seniors. Medicaid is a program primarily run through state governments, but funding is a partnership between federal and state governments to provide health benefits to the poor. In 2012, Medicare is expected to cover approximately 50 million people and the Congressional Budget Office (CBO) estimates total Medicare spending will be about \$575.5 billion. Republicans are opposed to the policy decisions made by Democrats regarding Medicaid and Medicare – particularly in their government takeover of health care. This law cuts \$500 billion from Medicare to pay for its new entitlement programs to provide government-run health care to American citizens. And further, it contains an unprecedented expansion of Medicaid which many states have said they will have a very hard time complying with without breaking the bank, so to speak.

Established in 1965, Medicare is the second largest federal social insurance program after Social Security. Since it is an entitlement program, Medicare is required to pay for all covered services provided to eligible persons so long as specific criteria are met. Almost one-third of Medicare benefit spending is for hospital services. Medicare is funded primarily from three sources: general revenue, payroll tax contributions and beneficiary premiums. Two statutorily separate trust funds comprise Medicare: the Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) trust fund. The HI trust fund covers Medicare Part A and the SMI trust fund covers Medicare Parts B and D. According to the 2012 Medicare Trustees report, just like last year's report, the HI trust fund is expected to be exhausted in 2024. Expenditures from the HI trust fund have exceeded income each year since 2008.

Despite its federal/state cost-sharing, Medicaid, also enacted in 1965, is the third largest entitlement spending item in the federal budget behind Social Security and Medicare. For state budgets, it is either the largest or second largest spending item after education. In FY 2011, a total of 69.4 million people were estimated to be enrolled in Medicaid at some time during the year. One-half of these beneficiaries were children and 17.8 million were adults in families with dependent children. There were also 10.7 million disabled individuals and 5.7 million seniors enrolled in Medicaid in FY 2011. Compared to both Medicare and employer-sponsored health care plans, Medicaid offers the broadest array of medical care and related services available in the United States today.

Unlike Medicare and Social Security, federal funding for Medicaid comes entirely from general revenues, rather than a dedicated account or trust fund within the U.S. Treasury. Federal spending levels are largely determined by the states, which generally receive open-ended funding as long as they operate their programs in compliance with federal law. Therefore, it represents a growing portion of the federal budget, having increased from two percent of federal outlays in FY 1975 to an estimated seven percent in FY 2008. According to CBO's March 2012 baseline report, Medicaid outlays are projected to rise an average annual rate of 9.0 percent during the 2012 to 2022 period due to both demographic changes and an increase in enrollment beginning in 2014 as a result of significant program changes under the Democrats' health care overhaul law. That enrollment increase is estimated to be roughly 17 million individuals by 2021.

The bottom line is that the government is running out of money. Medicare is facing an unprecedented fiscal challenge and Medicaid's breathtakingly rapid increase in cost and growth makes it a significant current and future burden on the government's finances. Current projections regarding Medicare's solvency are perhaps more uncertain than ever before because of difficulties in predicting a path for the current economy, uncertainties about the effects of health reform and indecision about the long-term treatment of physician payments in the Medicare program. Increases in the prices paid per service, increases in the volume and

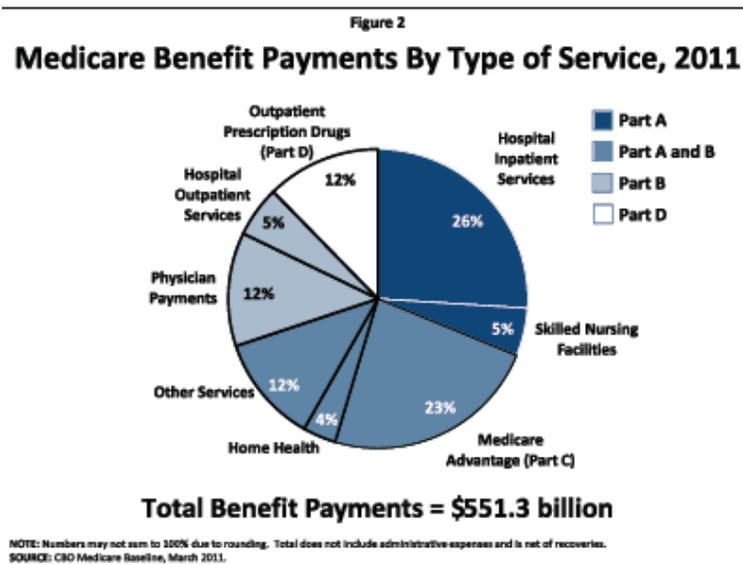
complexity of services provided per beneficiary and growing program enrollment and an aging population living longer are all factors that increase health care costs, including those paid for by Medicare, Medicaid and private health insurance. Medicaid has become too costly and complex for states to effectively manage and is also confounded by the same demographic problems facing Medicare and Social Security.

Those that hold all of the above concerns regarding both Medicaid and Medicare believe that fundamental reform is needed in order to ensure their long-term fiscal sustainability while continuing to provide quality care to promote the best possible health for all beneficiaries. There are no easy answers, but it is also important to ensure that, whatever reforms are enacted, do not affect the benefit system of current Medicare and Medicaid beneficiaries.

## MEDICARE BASICS

Medicare is a federal insurance program that pays for covered health care services of qualified beneficiaries and acts as a federal entitlement program to provide health insurance to those age 65 and older. It has also been expanded over the years to include permanently disabled individuals under 65. Medicare, expanded beyond the original program, today 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 percent of earnings, shared equally between employers and workers.
- **Part B (Supplementary Medical Insurance, or SMI):** This covers physician services, outpatient services and some home health and preventive services. Participants pay monthly premiums and copays for Part B coverage. The SMI trust fund is funded through beneficiary premiums (set at 25 percent of estimated program costs for the aged) and general revenues (the remaining amount, approximately 75 percent).  
**Note:** Some participants also purchase Medigap or Medicare Supplement Insurance from private insurance companies to fill coverage gaps of Parts A and B. Medigap policies are discussed later in this chapter.
- **Part C (Medicare Advantage, or MA):** Formerly known as Medicare + Choice, now known as Medicare Advantage, it is a private plan option for beneficiaries that covers all Part A and B services, except hospice. Like an HMO or PPO, Medicare Advantage is run by private companies approved by the federal government, provides Part A and B coverage and may include additional coverage for certain services as well as coverage for prescription drugs at an additional cost. There is no need for a Medigap policy. 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:** This is the Medicare Prescription Drug Benefit. It is optional prescription drug coverage provided by private insurance companies approved by and under contract with Medicare. Funding is included in the SMI trust fund and is financed through beneficiary premiums (about 25.5 percent) and general revenues (about 74.5 percent).



Medicare serves approximately one in seven Americans and virtually all of the population aged 65 and over. In 2012, the program is estimated to cover approximately 50 million people (41 million aged and nine million disabled). According to the Congressional Budget Office (CBO), total Medicare spending (mandatory plus discretionary) in 2012 will be about \$575.7 billion. This breaks down to \$569.4 billion of mandatory spending and \$6.3 billion of discretionary spending. Almost one-third of Medicare benefit spending is for hospital inpatient services.

## THE HISTORY OF MEDICARE

Medicare is considered to be a social insurance program and is the second largest such federal program after Social Security. The 1965 law that established Medicare also established Medicaid, the federal/state health insurance program for the poor (more about Medicaid later). Some low-income individuals actually qualify for both Medicare and Medicaid. In the ensuing years, Medicare has undergone considerable change.

**Editor's Note:** The following comprehensive timeline is based on "Medicare: A Timeline of Key Developments," by the Henry J. Kaiser Family Foundation which can be found [here](#).

### 1965 to 1969

**1965:** In January 1965, President Lyndon B. Johnson, in his first legislative message to the 89th Congress, detailed a program including hospital insurance for the aged under Social Security and health care for needy children.

By July 1965, the Congress had passed what became known as "the Mills Bill," H.R. 6675, a package of health benefits and Social Security improvements. President Johnson signed H.R. 6675 into law (P.L. 89-97) on July 30, 1965, in Independence, Mo., with former President Harry S. Truman at his side. President Truman, during his administration, had advocated for such a program. This law established Medicare for the elderly and Medicaid for the indigent. President Truman became the first American to enroll in Medicare.



**1966:** 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. All people age 65 and older were automatically covered under Part A and coverage began for seniors who signed up for the voluntary Part B coverage. At its inception in 1966, the Medicare Part A deductible was \$40 per year and the Medicare Part B premium was \$3 per month. More than 19 million individuals age 65 and older were enrolled in Medicare at its beginning.

### 1970 to 1979

**1970:** By 1970, the total Medicare population had risen to 20.4 million beneficiaries. The Medicare Part A deductible was now \$52 per year and the Medicare Part B premium was \$5 per month.

**1972:** On Oct. 30, 1972, President Nixon signed the Social Security Amendments of 1972 (P.L. 92-603), the first major adjustment to Medicare after its enactment. Among other things, this law extended Medicare to individuals under age 65 with long-term disabilities (who were receiving Social Security Disability Insurance, or SSDI, payments for at least two years) and to those with end-stage renal disease (ESRD).

**1973:** By the end of 1973, nearly two million people under age 65 with long-term disabilities or ESRD were added to the Medicare rolls. The Amendments also established professional standards review organizations

(PSROs) to review patient care, encouraged the use of health maintenance organizations (HMOs) and gave Medicare the authority to conduct demonstration programs. Additionally, Medicare was also expanded to include some chiropractic services, speech therapy and physical therapy.

**1975:** By 1975, the Medicare Part A deductible rose to \$92 per year, the Medicare Part B premium to \$6.70 per month and the total Medicare population to 24.9 million.

**1977:** The Health Care Financing Administration (HCFA), today known as the Centers for Medicare and Medicaid Services (CMS), was created in 1977 by then-Secretary Joe Califano of the Department of Health, Education and Welfare, today known as the Department of Health and Human Services (HHS), to administer both the Medicare and Medicaid programs.

### **1980 to 1989**

**1980:** By 1980, there were 28.4 million Medicare beneficiaries, Medicare Part A's deductible was now \$180 per year and the Medicare Part B premium was \$8.70 a month.

The Omnibus Reconciliation Act of 1980 expanded home health services by eliminating the limit on the number of visits, the prior hospitalization requirement and the deductible for any Part B benefits. It also required a list to be developed of surgical procedures that could be done on an outpatient basis in an ambulatory surgical center and would be reimbursed on a prospective payment system. It also brought Medicare supplemental insurance, also called "Medigap," under federal oversight and established a voluntary certification program for Medigap policies (more on Medigap later).

**1981:** The Omnibus Budget Reconciliation Act of 1981 included provisions to slow the growth in Medicare spending, including a change that resulted in an increase in the inpatient hospital deductible.

**1982:** Additionally, the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982 increased the Part B premium to cover 25 percent of program costs as part of more polices designed to slow the growth of Medicare spending. Hospice services for the terminally ill were added to Medicare's covered benefits, a risk-based prospective payment system for HMO's was established and the HCFA's PSROs were replaced with Peer Review Organizations (PROs) in order to expand its quality oversight efforts. TEFRA also imposed a ceiling on the amount Medicare would pay for a hospital discharge and required HHS to submit a plan for prospective payments to hospitals and nursing homes. And finally, TEFRA required federal employees to begin paying the HI payroll tax.

**1983:** The Social Security amendments of 1983 established an inpatient hospital prospective payment system (PPS) for Medicare. The PPS is based on diagnosis-related groups, or DRGs – a pre-determined payment for treating a specific condition. PPS was adopted to replace cost-based payments.

**1984:** The Deficit Reduction Act of 1984 (DEFRA) froze physician fees, established the Participating Physicians' Program and established fee schedules for laboratory services, all of which were intended to slow the growth of Medicare's spending and constrain the federal deficit.

**1985:** By 1985, there were 31.1 million Medicare participants, Medicare Part A's deductible was \$400 per year and Medicare Part B's premium was \$15.50 per month.

The Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, made Medicare coverage mandatory for newly hired state and local government employees and established the Emergency Medical Treatment and Labor Act (EMTALA) which required Medicare hospitals operating active emergency rooms to provide appropriate medical screenings and stabilizing treatments.

To again slow the growth of Medicare spending, the Emergency Extension Act of 1985 froze PPS payment rates for inpatient hospital care and continued the DEFRA-enacted physician payment freezes.

**1986:** The 1986 Omnibus Budget Reconciliation Act (OBRA) revised several payment procedures for various Medicare services to attempt to slow the growth in Medicare spending.

**1987:** In response to well-documented quality problems facing seniors in nursing homes, the 1987 OBRA imposed quality standards for Medicare- and Medicaid-certified nursing homes. OBRA 1987 also modified payments to providers under Medicare as part of the deficit reduction legislation.

The Medicare and Medicaid Patient and Program Protection Act of 1987 was enacted to improve antifraud efforts and strengthen beneficiary protection programs.

And, once again, in an attempt to slow Medicare spending, the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 froze Medicare payment rates.

**1988:** In 1988, the largest expansion of Medicare since its inception was enacted by way of the Medicare Catastrophic Coverage Act. It included an outpatient prescription drug benefit and a cap on beneficiaries' out-of-pocket expenses and expanded hospital and skilled nursing facility benefits. Medicaid began coverage of Medicare premiums and cost-sharing for Medicare beneficiaries with incomes below 100 percent of the federal poverty level, known as Qualified Medicare Beneficiaries (QMB).

Additionally, the U.S. Bipartisan Commission on Comprehensive Health Care, or the "Pepper" Commission after the late Congressman Claude Pepper (D-Fla.), was established to assess the feasibility of a long-term care benefit under Medicare.

**1989:** These outpatient drug benefits and the out-of-pocket limit did not last very long and were repealed in 1989. The QMB benefits were retained. The OBRA of 1989 replaced charge-based payments with the Resource-Based Relative Value Scale (RBRVS) for physicians and limits were placed on physician balanced billing. Also, physicians were prohibited from referring Medicare patients to clinical laboratories in which they have a financial interest. And, of course, OBRA 1989 included a number of other provisions designed to slow the growth in Medicare spending.

### **1990 to 1999**

**1990:** In 1990, the Medicare Part A deductible was \$592 per year, the Medicare Part B premium was \$28.60 a month and there were 34.3 million Medicare beneficiaries.

The 1990 OBRA established the Specified Low-Income Medicare Beneficiary (SLMB) eligibility group requiring state Medicaid programs to cover premiums for beneficiaries with incomes between 100 percent and 120 percent of the federal poverty level. Medicare was also expanded to cover screening mammography and partial hospitalization services in community mental health centers. Federal standards were established

for Medigap policies, including standardized benefit packages and minimum loss ratios, replacing the voluntary certification system.

**1993:** The 1993 OBRA modified payments to Medicare providers (as part of overall deficit reduction legislation) and lifted the cap on wages subject to the HI payroll tax. States also started to cover Medicare Part B premiums for SLMBs.

**1996:** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Medicare Integrity Program, which dedicated funds for program integrity activities.

**1997:** The Balanced Budget Act (BBA) of 1997 included a broad range of changes in provider payments to slow the growth of Medicare spending as part of the legislation to balance the federal budget. It also established the Medicare + Choice program, now known as Medicare Part C or Medicare Advantage. It also created five new Medicare prospective payment systems: inpatient rehabilitation hospital or unit services; skilled nursing facility services; home health services; hospital outpatient services and outpatient rehabilitation services. Additional assistance was also provided with Medicare Part B premiums for beneficiaries with incomes between 120 percent and 135 percent of poverty through a first-come first-serve block grant program administered by state Medicaid programs and partial premium assistance for those with incomes between 135 percent and 175 percent of poverty. The BBA of 1997 also created the National Advisory Commission on the Future of Medicare and the Medicare Payment Advisory Commission.

**1998:** The website, <http://www.medicare.gov>, was launched in 1998 to provide updated information to the public about Medicare.

**1999:** The first annual *Medicare & You* handbook was mailed to all Medicare households in 1999. This handbook is still available today and candidates may find it helpful in understanding all there is to know about Medicare. The 2012 *Medicare & You* handbook is available [here](#).

The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work.

The Balanced Budget Refinement Act of 1999 (BBRA) increased payments for some Medicare providers and reduced or froze payment rates for other Medicare services. BBRA also increased payments to Medicare + Choice (now known as Medicare Part C, or Medicare Advantage) plans.

Also in 1999, the National Advisory Commission on the Future of Medicare (created by the BBA of 1997) completed its work on Medicare reform, but lacked sufficient votes to report out a formal recommendation.

## **2000 to 2009**

**2000:** In 2000, the Medicare Part A deductible was \$776 per year and the Medicare Part B premium was \$54.50 per month. Also, Medicare had 39.7 million beneficiaries.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 further increased Medicare payments to providers and Medicare + Choice plans, reduced certain Medicare beneficiary copayments and added covered preventive services. BIPA also enabled people with amyotrophic

later sclerosis (ALS or Lou Gehrig's disease) to enroll in Medicare upon diagnosis instead of having to satisfy the 24-month waiting period.

**2001:** By 2001, the Part A deductible had risen to \$792 per year and the Standard Part B premium was \$50.00 per month. Medicare + Choice enrollment was 5.6 million, total Medicare beneficiaries numbered 40.1 million and total Medicare spending was \$217 billion in 2001.

Then-Secretary Tommy Thompson of HHS renamed the HCFA the Centers for Medicare and Medicaid Services (CMS) in 2001.

**2002:** The Part A deductible was \$812 per year, the Standard Part B premium was \$54.00 a month, Medicare + Choice enrollment was 5 million, total Medicare beneficiaries numbered 40.5 million and total Medicare spending was \$230 billion in 2002.

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, along with other public health measures, temporarily moved deadlines for submitting Medicare + Choice plan information. The law stated that in 2005, people enrolled in Medicare + Choice plans would only be able to make and change elections to a Medicare + Choice on a more limited basis, which was later changed by the Medicare Modernization Act of 2003.

**2003:** The Part A deductible was \$876 per year, the Standard Part B premium was \$66.60 per month, Medicare + Choice enrollment was 4.7 million, total Medicare beneficiaries numbered 41.9 million and total Medicare spending was \$295 billion in 2003.

The Consolidated Appropriations Resolution (CAR) of 2003 increased payments for some hospitals, updated the physician fee schedule and extended payment of the Part B premium for beneficiaries with incomes between 120 percent and 135 percent of poverty. Those with incomes between 135 percent and 175 percent of poverty no longer received assistance from Medicaid in paying their Part B premiums.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was passed by the House and the Senate in November 2003 and was signed into law (P.L. 108-173) on Dec. 8, 2003, by President Bush providing a new outpatient prescription drug benefit under Medicare beginning in 2006 (Medicare Part D). In the interim, it created a temporary prescription drug discount card and transitional assistance program. The MMA also established a new income-related Part B premium for beneficiaries with higher incomes (starting in 2007), indexed the Part B deductible, created regional PPOs under the Medicare Advantage program (previously called Medicare + Choice) along with financial and other incentives for private health plans to contract with Medicare. The MMA also established a new way of assessing Medicare's financial status by looking at general revenues as a share of total Medicare spending.

**2004:** By 2004, the Part A deductible had risen to \$876 per year, the Standard Part B premium was \$66.60 per month, Medicare Advantage enrollment was 4.7 million, total Medicare beneficiaries numbered 41.9 million and total Medicare spending was \$295 billion.

The temporary Medicare-approved Drug Discount Card Program began along with a transitional assistance program to provide a \$600 annual credit to low-income Medicare beneficiaries without prescription drug coverage in 2004 and 2005.

**2005:** The Part A deductible had risen to \$912 per year, the Standard Part B premium was \$78.20 per month, Medicare Advantage enrollment was 5.1 million, total Medicare beneficiaries was 42.6 million and total Medicare spending was \$325 billion.

Medicare began covering a “Welcome to Medicare” physical, along with other preventive services such as cardiovascular screening blood tests and diabetes screening tests. Medicare began education and outreach activities to implement the 2006 prescription drug benefit.

Nov. 15, 2005 through May 15, 2006, was the first open enrollment period for the new Part D drug benefit, in which Medicare beneficiaries could enroll in a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MAPD).

**2006:** In 2006, the Part A deductible was \$952 per year, the Standard Part B premium was \$88.50 per month, the average Part D premium was \$32.30 per month, Medicare Advantage enrollment was 6.5 million, Part D enrollment was 22.5 million (as of June 11, 2006), total Medicare beneficiaries numbered 43.4 million and total Medicare spending was \$374 billion.

In January 2006, the Medicare Drug Benefit went into effect and Medicare beneficiaries began receiving subsidized prescription drug coverage through Part D plans.

As required by law, the Medicare Trustees calculated for the first time that general revenues would exceed 45 percent of total Medicare outlays within a seven-year period.

**2007:** The Part A deductible was \$992 per year, the Standard Part B premium was \$93.50 per month, the average Part D premium was \$27.35 per month, Medicare Advantage enrollment was 7.9 million, Part D enrollment was 23.9 million, total Medicare beneficiaries numbered 44.1 million and total Medicare spending was \$426 billion in 2007.

Beginning in 2007, Medicare beneficiaries with higher incomes (more than \$80,000/individual; \$160,000/couple) began paying a higher monthly Part B premium based on their modified adjusted gross income (MAGI), ranging from \$105.80 to \$161.40 per month, depending on their income.

For the second consecutive year, the Medicare Board of Trustees calculated that general revenue would exceed 45 percent of Medicare funding within the succeeding seven years, triggering a “Medicare funding warning.”

In December 2007, the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173) was signed into law. It prevented a 10.1 percent reduction in Medicare physician payments that was scheduled for 2008 and gave physicians a 0.5 percent increase through June 30, 2008.

**2008:** By 2008, the Part A deductible had risen to \$1,024 per year, Part B premiums were \$96.40 per month, the average Part D premium was \$27.93 per month, Medicare Advantage enrollment was 9.4 million, Part D enrollment was 25.4 million, total Medicare beneficiaries numbered 44.8 million and total Medicare spending was \$444 billion. Medicare beneficiaries with incomes exceeding \$82,000/individual and \$164,000/couple paid income-related Part B premiums of up to \$238.40.

In July 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was signed into law (P.L. 110-175). This law prevented a reduction in physician fees through the end of 2008 and increased

fees by 1.1 percent through 2009. The cost of the postponement of physician fee cuts was offset by cutting bonus payments to Medicare Advantage plans. MIPPA also provided benefit improvements; it reduced coinsurance for mental health visits, eliminated the deductible for the “Welcome to Medicare” exam and increased allowable resources for low-income beneficiaries applying for the Medicare Savings Programs (MSP) and modified the definition of excludable assets in determining Low-Income Subsidy (LIS) program eligibility. The law also prohibited the deeming of providers for Private Fee-for-Service plans in certain counties.

In response to the “Medicare funding warning” issued in 2007, President Bush submitted proposals to Congress to reduce the share of general revenues as a share of total spending, as required by law. For the third consecutive year in 2008, the Medicare Trustees issued the same “Medicare funding warning” as they had the previous two years.

## **HOW DOES MEDICARE WORK?**

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, which is the discretionary spending amount) is considered mandatory spending and is not subject to the appropriations process. According to the Congressional Budget Office (CBO) March 2012 baseline, total Medicare spending (mandatory plus discretionary) in 2012 will be about \$575.7 billion. This breaks down to \$569.4 billion of mandatory spending and \$6.3 billion of discretionary spending. Almost one-third of Medicare benefit spending is for hospital services. CBO also estimates that federal Medicare spending (after deduction of beneficiary premiums and other offsetting receipts) will be about \$491.9 billion in 2012.

### **Medicare Financing**

Medicare is funded primarily from three sources: general revenue (42 percent), payroll tax contributions (37 percent) and beneficiary premiums (13 percent). Medicare has two trust funds: the Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) trust fund. The HI trust fund covers Medicare Part A services and the SMI trust fund covers Medicare Parts B and D. The two trust funds are statutorily separate, with all HI and SMI benefit expenditures paid out of their respective trust funds. The primary source of funding for the HI trust fund is the payroll tax on covered earnings of current workers. Employers and employees each pay 1.45 percent of wages and, unlike the Social Security tax, there is no annual maximum limit on taxable earnings.

***Editor's Note:** For more information on payroll taxes, please refer to the Tax Policy chapter of the 2012 NRCC Issues Book.*

Other sources of revenue for the HI trust fund include interest paid on U.S. Treasury securities held in the HI trust fund, a portion of the federal income taxes that individuals pay on their Social Security benefits and premiums paid by those who would otherwise not qualify for Medicare Part A.

The SMI trust fund has different revenue sources. There are no payroll taxes collected for this and enrollment in Medicare Parts B and D is voluntary. Individuals enrolled in Parts B and D must pay premiums, which cover about 25 percent of program costs. The other 75 percent of revenues for the SMI trust fund comes mostly from general revenues transfers. Other sources of revenue include interest paid on U.S. Treasury securities held in the fund and Part D state transfers for Medicare beneficiaries who are also eligible for Medicaid (dual-eligibles).

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.

### **Medicare Part A**

Medicare Part A covers inpatient hospital care (care that requires at least one overnight stay in a hospital). Post-acute care can also be provided upon discharge from a hospital in long-term care hospitals, inpatient rehabilitation facilities and skilled nursing facilities. Part A also provides hospice care and a home health care

benefit for care that is needed in conjunction with a hospital stay (other home care services are provided under Part B).

Beneficiaries generally do not pay a monthly premium for Part A coverage if they or their spouse paid Medicare taxes while working. For the rare few who do pay a Part A premium, the premium can be very high.

### **Part A Coverage Includes:**

#### **➤ Inpatient Acute Care Hospitals**

- Medicare beneficiaries are eligible to receive basic inpatient care at any one of the 3,500 facilities that contract with Medicare. Medicare's inpatient hospital benefit covers beneficiaries for 90 days of care per episode of illness, with a 60-day lifetime reserve. Beneficiaries pay a deductible and no coinsurance for the first 60 days of each benefit period. A benefit period begins the day someone enters the hospital or skilled nursing facility (SNF) and ends when they have not received any inpatient hospital care or skilled care in a SNF for 60 consecutive days in a row. Beneficiaries pay a per day charge for days 61–90 of each benefit period and a higher charge per “lifetime reserve day.” Beneficiaries are responsible for all costs after their 60 lifetime reserve days have been used.

#### **➤ Long-term Care Hospitals (LTCHs)**

- Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital care for relatively extended periods of time. Some are admitted to LTCHs, which must have an average Medicare length of stay greater than 25 days. LTCHs are paid predetermined per-discharge rates based primarily on the patient's diagnoses and market area wages.

#### **➤ Inpatient Rehabilitation Facilities (IRFs)**

- IRFs serve patients needing intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Relatively few beneficiaries use intensive rehabilitation therapy because they generally must be able to tolerate and benefit from 3 hours of therapy per day to be eligible for treatment in an IRF. IRFs are paid predetermined per-discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive statuses, and age) and market area wages.

#### **➤ Skilled Nursing Facilities (SNFs)**

- Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities. SNFs are the most commonly used post-acute care setting. Medicare pays SNFs a predetermined daily rate based that is expected to cover operating and capital costs. Beneficiaries do not owe anything for the first 20 days of skilled nursing care in each benefit period. They must pay a per-day charge for days 21–100 and all costs for each day after day 100 in a benefit period.

➤ **Home Health Agencies (HHAs)**

- Beneficiaries who are generally restricted to their homes and need skilled care (from a nurse or physical or speech therapist) on a part-time or intermittent basis are eligible to receive certain medical services at home. Home health agency personnel can provide skilled nursing care; physical, occupational, and speech therapy; medical social work; and home health aide services. Home health agencies are paid a pre-determined daily rate for each 60-day episode of care, based on patients' conditions and service use, and then adjusted to reflect the level of market input prices in the geographical area where services are delivered. Beneficiaries are not required to make any copayments for home health services.

➤ **Hospice**

- The hospice benefit is designed for patients with a terminal diagnosis who have decided to forgo curative treatment. The benefit covers an array of services, such as: skilled nursing services; drugs and biologicals for pain control and symptom management; physical, occupational, and speech therapy; counseling services; home health aide and homemaker services; short-term inpatient care; inpatient respite care; and other services necessary for the palliation and management of the terminal illness.
- Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit. Medicare makes a daily payment, regardless of the amount of services provided on a given day and on days when no services are provided. Payments are made according to a fee schedule that has four base payment amounts for the four different categories of care: routine home care, continuous home care, inpatient respite care, and general inpatient care.
- Beneficiaries do not pay for hospice care. They are responsible for small copayments of up to \$5 for prescription medicines. If they require inpatient respite care, they must pay five percent of the Medicare-approved amount for that care.

Income for Part A is credited to the HI trust fund. Part A's primary source of funding is payroll taxes paid by employees and employers. 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 interest on federal securities held by the HI trust fund, a portion of federal income taxes individuals pay on their Social Security benefits, premiums paid by voluntary enrollees who are not automatically entitled to Medicare Part A and transfers from states.

According to the [2012 Medicare Trustees report](#), just like last year's report, the HI trust fund is expected to be exhausted in 2024. Part A expenditures for 2011 totaled \$256.7 billion. Expenditures from the HI trust fund have exceeded income each year since 2008, with the fund deficit amounting to \$27.7 billion in 2011. In 2012, total income to the HI trust fund is expected to again fall short of estimated expenditures by almost \$29 billion. Expenditures for the HI trust fund are expected to total \$270.4 billion in 2012.

## **Medicare Part B**

Part B helps cover medically-necessary services like doctors' services, outpatient care, home health services, durable medical equipment and other medical services. Part B also covers some preventive services. More than 80 percent of Part B enrollees use Part B services during a year.

### **Part B Coverage Includes:**

#### **➤ Physicians Services**

- Covered services include surgery, consultation, and home, office, and institutional visits. Certain limitations apply for services provided by chiropractors and podiatrists.

#### **➤ Services of Non-Physician Practitioners**

- Covered services include those provided by physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical social workers. The providers are also reimbursed through the SGR.

#### **➤ Outpatient Hospital Services**

- Medicare beneficiaries receive a wide range of services where their hospital treatment did not require an overnight stay, ranging from simple injections to complex procedures that require anesthesia. Spending for these services has grown rapidly, largely because of changes in technology and medical practice that have led to new services and encouraged shifts in care from inpatient to ambulatory care settings. Medicare pays for outpatient care using a formula that predicts the cost of an average patient receiving a specific treatment in that geographic area. Hospitals can also receive additional payments for extraordinarily high-cost services and pass-through payments. These payment rates are updated annually.

#### **➤ Therapy Services**

- Part B covers outpatient physical and occupational therapy and speech language pathology services, subject to an annual spending limit per beneficiary. The spending limits, which are updated annually, apply to services provided by independent therapists and outpatient rehabilitation facilities.

#### **➤ Preventive Services**

- Part B covers the following preventive services (at specified screening intervals): a “Welcome to Medicare” physical upon enrollment into Medicare; certain vaccines; mammograms, pap smears and pelvic exams; colorectal cancer screenings; prostate cancer screening; cardiovascular screening; bone mass measurement; diabetes screening; medical nutrition therapy; and ultrasound screening for abdominal aortic aneurysms.

### ➤ **Clinical Laboratory Tests**

- Medicare is the largest single purchaser of clinical lab services. Clinical lab services are tests on specimens taken from the human body (such as blood and urine) and are used to diagnose health status. Medicare Part B covers medically necessary diagnostic and monitoring lab services ordered by a physician. There is no coinsurance for clinical laboratory services.

### ➤ **Imaging**

- Technological advances in imaging have opened a range of diagnostic and treatment opportunities that are nothing less than transformative. At the same time, imaging spending has increased significantly. From 2000 through 2006, Medicare spending for physician imaging services doubled from about \$7 billion to about \$14 billion – an average annual increase of 13 percent, compared to an 8 percent increase in spending for all Medicare physician-billed services over the same time period.

### ➤ **Durable Medical Equipment (DME)**

- Coverage is provided for equipment that can be used more than once, prescribed for use in the home, and primarily for medical purposes. It includes such items as: walkers, wheelchairs, hospital beds, and home oxygen equipment. Certain items require the doctor to complete a certificate of medical necessity. A power wheelchair or scooter is only covered if the doctor states that it is required, based on the patient's medical condition. DME must be obtained from a Medicare-approved supplier. Regular Part B cost sharing applies.

Given that Medicare reimbursements often far exceed the actual cost of the equipment, the Medicare Modernization Act (MMA) of 2003 required the Secretary of HHS to begin a program of competitive acquisition for DME, prosthetics and orthotics. Competitive acquisition was to begin in 10 metropolitan statistical areas (MSAs) in 2007, expanding to 80 MSAs in 2008, and additional areas in 2009. The Secretary was authorized to phase-in competitive bidding among the highest cost and highest volume items and services or for those that have the largest savings potential. The first round of bids were submitted on Sept. 25, 2007, and the program began on July 1, 2008. However, under incredible pressure from seniors' interest groups and DME trade associations, legislation in 2008 stopped the program, terminated all contracts with suppliers and required the Secretary to rebid the first round in 2009. Further expansion of the program was delayed by two years until 2011. If ever fully implemented, the program is projected to save Medicare about \$1 billion annually.

### ➤ **Outpatient Drugs**

- Certain specified outpatient prescription drugs are covered under Medicare Part B (however, most outpatient prescription drugs are covered under Part D). Covered Part B drugs include: drugs administered by a physician, immunosuppressive drugs following a Medicare-covered organ transplant, erythropoietin for treatment of anemia for persons with end-stage renal disease, and oral anti-cancer drugs.

### ➤ **Ambulatory Surgical Centers (ASCs)**

- ASCs are also known as outpatient surgery centers or same day surgery centers. An ASC is a health care facility that specializes in providing surgery, including certain pain management and diagnostic services (e.g., colonoscopy) in an outpatient setting. In simple terms, ASC-qualified procedures can be considered procedures that are more intensive than those done in the average doctor's office but not so intensive as to require a hospital stay. The most common Medicare-paid procedures are cataract removal and lens replacement, colonoscopy, and other eye procedures.

### ➤ **End-Stage Renal Disease**

- Individuals with end-stage renal disease (ESRD) – irreversible loss of kidney function – require either dialysis or kidney transplantation to survive. Since 1972 Medicare benefits have been extended to individuals with ESRD, and today nearly 90 percent of all people with ESRD in the U.S. are covered by Medicare.

Part B is financed through a combination of beneficiary premiums and federal general revenues, which are deposited into the SMI trust fund. Beneficiaries pay the Part B premium each month, which generally equals 25 percent of estimated annual Part B costs. Most people will pay the standard premium amount. If a beneficiary's modified adjusted gross income (MAGI) is above a certain amount, however, they may pay more. Federal general revenues subsidize the remaining 75 percent. Part B generally pays 80 percent of the approved amount for the cost of a procedure, and the beneficiary is responsible for paying the remaining 20 percent after paying an annual deductible. Additional subsidies are provided to low-income individuals. Beneficiaries who choose not to enroll in Part B and do not maintain "creditable coverage" are subject to a late-enrollment penalty (assessed to the premiums) if they enroll later.

Total spending for Part B was \$225.3 billion in 2011, according to the 2012 Medicare Trustees Report, and are expected to be \$246.9 billion in 2012. The 2012 monthly premium is \$99.90 for most Medicare beneficiaries who voluntarily enroll in Part B. Individuals receiving Social Security benefits have their Part B premium payments automatically deducted from their Social Security benefit checks. Since 2007, higher-income enrollees pay higher premiums. In 2012, individuals whose MAGI exceeds \$85,000 and each member of a couple filing jointly whose MAGI exceeds \$170,000 are subject to higher premium amounts. These higher-income premiums range from 35 percent to 80 percent of the value of Part B, affecting about four percent of Medicare Part B enrollees in 2012. As a result of the Democrats' health care overhaul law, 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.

### **Medigap (Medicare Supplement Insurance) Policies**

Medicare pays for many, but not all, health care services and supplies. Individual insurance policies that supplement fee-for-service Medicare are referred to as Medigap policies. A Medigap policy, sold by private insurance companies, can help pay some of the health care costs ("gaps") that Medicare does not cover, like copayments, coinsurance and deductibles. Some Medigap policies also offer coverage for services that Medicare does not cover, like medical care when beneficiaries travel outside the United States. Medicare does not pay any of the costs for a Medigap policy. Every Medigap policy must follow federal and state laws designed to protect beneficiaries and it must be clearly defined as "Medicare Supplement Insurance."

## **Medicare Advantage Plans (Part C)**

A Medicare Advantage plan (like an HMO or PPO) is another health coverage choice available as part of Medicare. Medicare Advantage plans, sometimes called “Part C” or “MA plans,” are offered by private companies approved by Medicare.

Medicare Advantage plans provide all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage including coverage for emergency and urgent care. Medicare Advantage plans must cover all of the services that original Medicare covers except hospice care. Original Medicare covers hospice care regardless. Medicare Advantage plans are not considered supplemental coverage.

Medicare Advantage plans may offer extra coverage, such as vision, hearing, dental and/or health and wellness programs. Most include Medicare prescription drug coverage. Medicare pays a fixed amount for beneficiaries’ care every month to the companies offering Medicare Advantage plans. These companies must follow rules set by Medicare. However, each Medicare Advantage plan can charge different out-of-pocket costs and have different rules providing services.

As part of the recently enacted health care reform law, House Democrats have moved to drastically cut payments to Medicare private health plans, known as Medicare Advantage. Enrollment in MA plans has more than doubled in recent years, largely because payment reforms enacted in 2003 have allowed plans to serve beneficiaries in more areas (while roughly half of seniors had access to an MA plan in 2003, today every senior has access to one). The Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare policy, found that Medicare pays, on average, 14 percent more for beneficiaries who are enrolled in MA than for those who are enrolled in traditional Medicare. The Congressional Budget Office (CBO) estimates that reducing MA rates to traditional Medicare levels would save \$157 billion. Given its popularity, Democrats see the MA program as a threat to the government-run program. While there may be financial savings in reforming MA payments, such reforms need to be carefully considered because payment cuts could harm patient access to these plans, many of which offer additional benefits not available to those enrolled in traditional fee-for-service Medicare.

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.

The Henry J. Kaiser Family Foundation website provides a fact sheet on Medicare Advantage (which is updated periodically) that candidates may find useful and is available [here](#).

Below, please find the current Medicare Advantage statistics for your state. For updated numbers in the future, please visit the Henry J. Kaiser Family Foundation website, <http://www.statehealthfacts.org>.

\*Penetration: the number of enrollees in Medicare Advantage divided by the number of Medicare beneficiaries

State	Total MA Enrollment	MA Plan Penetration*
Alabama	174202	20.77%
Alaska	120	0.62%

Arizona	342978	37.12%
Arkansas	75645	14.65%
California	1734900	36.33%
Colorado	206116	33.94%
Connecticut	108766	19.23%
Delaware	5149	3.64%
District of Columbia	7567	9.73%
Florida	1072453	31.95%
Georgia	269574	21.93%
Guam	0	0.19%
Hawaii	88986	42.62%
Idaho	63070	28.68%
Illinois	163256	9.28%
Indiana	172124	17.37%
Iowa	64749	12.94%
Kansas	45560	11.45%
Kentucky	121501	16.94%
Louisiana	164979	24.14%
Maine	35414	13.51%
Maryland	61840	7.99%
Massachusetts	185692	17.79%
Michigan	389983	23.66%
Minnesota	349715	44.45%
Mississippi	46676	9.66%
Missouri	213298	21.67%
Montana	24349	14.91%
Nebraska	28771	11.48%
Nevada	109757	30.92%
New Hampshire	12593	5.98%
New Jersey	169125	12.87%
New Mexico	81106	26.20%
New York	918606	30.93%
North Carolina	262974	17.83%
North Dakota	9472	9.48%
Ohio	640245	33.86%
Oklahoma	89678	15.19%
Oregon	254056	41.22%
Pennsylvania	865200	38.32%
Puerto Rico	453808	68.19%
Rhode Island	63553	34.93%
South Carolina	123989	16.15%

South Dakota	11663	9.42%
Tennessee	265842	25.29%
Texas	600193	20.12%
United States	11541872	25.60%
Utah	88115	34.56%
Vermont	5407	5.31%
Virgin Islands	0	0.78%
Virginia	155941	14.20%
Washington	247229	25.51%
West Virginia	73222	22.36%
Wisconsin	273527	30.15%
Wyoming	3360	5.80%

### **Medicare Prescription Drug Coverage (Part D)**

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established a voluntary prescription drug benefit under a new Medicare Part D. The new benefit was effective as of Jan. 1, 2006. Prescription drug coverage is provided through private prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. While participation is voluntary, in order to get Medicare drug coverage, beneficiaries must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered.

Companies compete against each other for enrollees. Plans compete based on monthly premiums, copays, deductibles and covered drugs that are required to be at least as good as a standard benefit defined in the original law. By 2008, nearly 90 percent of Medicare beneficiaries had prescription drug coverage, including more than 25 million who were enrolled in Medicare Advantage and Part D. In 2011, the average Medicare beneficiary had a choice of 33 stand-alone PDPs.

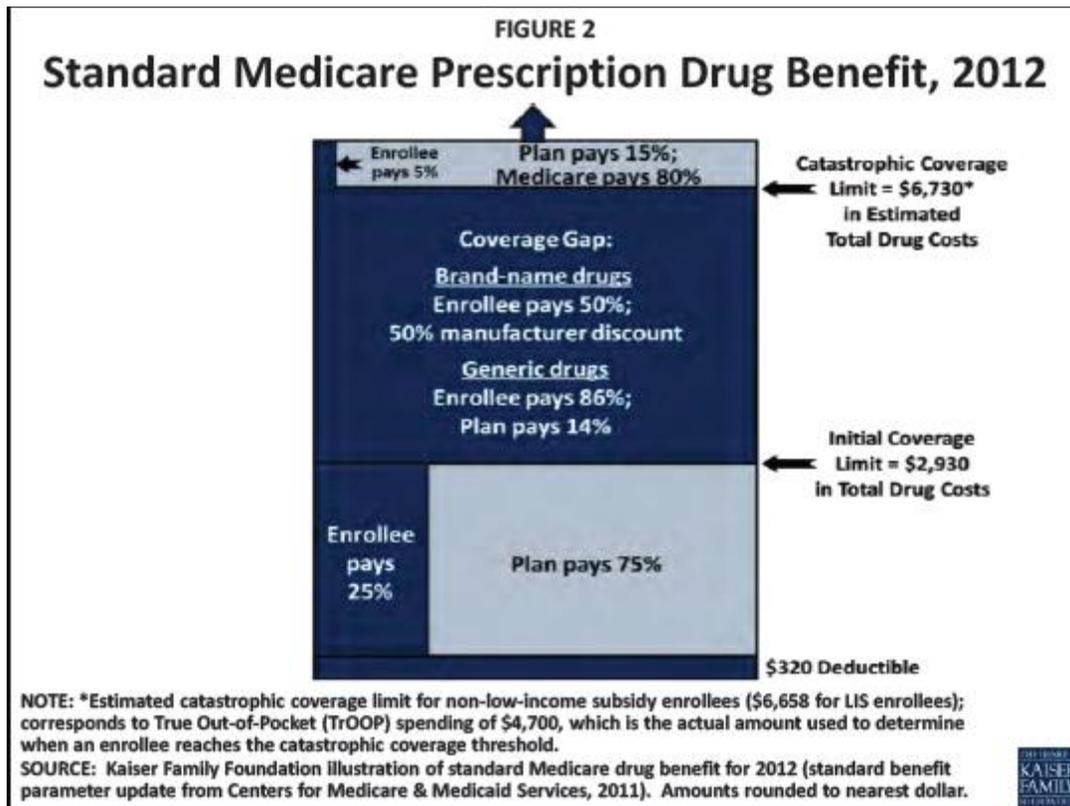
Medicare Part D is financed through a combination of beneficiary premiums and federal general revenues. In addition, certain transfers are made from the states. These transfers, referred to as “clawback payments,” represent a portion of the amounts states could otherwise have been expected to pay for 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 2011, total spending for Part D was \$67.1 billion and is estimated to reach approximately \$68.8 billion.

**Part D Premiums and Payment Structure:** In 2012, the base beneficiary premium is \$31.08. The average monthly PDP premium in 2012 is \$39.40. The standard benefit includes a deductible, coverage for 75 percent of allowable drug expenses up to a benefit limit, then a catastrophic limit on true out-of-pocket spending and coverage for 95 percent of allowable drug expenses above this catastrophic limit. Beneficiaries do not receive a subsidy for drug spending within a “coverage gap” under a standard benefit design. This spending range is often referred to as the “doughnut hole.” Low-income beneficiaries receive additional subsidies, resulting in no monthly premiums and copays as low as \$1 per prescription. Low-income beneficiaries are not subject to the doughnut hole. This payment structure is charged below:

**Medicare Part D Benefit Parameters for Defined Standard Benefit  
2006 through 2012 Comparison**

<b>Part D Standard Benefit Design Parameters:</b>	<b>2011</b>	<b>2012</b>
<b>Deductible</b> - (after the Deductible is met, Beneficiary pays 25% of covered costs up to total prescription costs meeting the Initial Coverage Limit.	\$310	\$320
<b>Initial Coverage Limit</b> - Coverage Gap (Donut Hole) begins at this point. (The Beneficiary pays 100% of their prescription costs up to the Out-of-Pocket Threshold)	\$2,840	\$2,930
<b>Total Covered Part D Drug Out-of-Pocket Spending including the Coverage Gap</b> - Catastrophic Coverage starts after this point.	\$6,447.50 plus a <a href="#">50%</a> <a href="#">brand</a> <a href="#">discount</a>	\$6,657.50 plus a <a href="#">50%</a> <a href="#">brand</a> <a href="#">discount</a>
<b>Out-of-Pocket Threshold</b> - This is the Total Out-of-Pocket Costs including the Donut Hole. 2012 Example: \$320 (Deductible) +(((\$2930-\$320)*25%) (Initial Coverage) +(((\$6657.5-\$2930)*100%) (Cov. Gap) = \$4,700 (Maximum Out-Of-Pocket Cost prior to Catastrophic Coverage - excluding plan premium)	\$4,550   \$ 310.00 \$ 632.50  <u>\$3607.50</u>  \$4550.00	\$4,700   \$ 320.00 \$ 652.50  <u>\$3727.50</u>  \$4700.00

Here is a graphical representation:



### The “Doughnut Hole”

The concept of the “doughnut hole” or “coverage gap” in Part D has become a political hot button with seniors. However, as usual in Washington, this has become a rhetorical argument rather than a factual one. While it is not recommended for candidates to defend the “doughnut hole” due to the political sensitivity of the issues, it is important to understand a few things about this concept.

**Put in place as a cost-sharing mechanism between the federal government and those seniors with extremely high-cost drug needs, the “doughnut hole” only fully applies under the standard benefit plan of Medicare Part D defined in the original legislation.**

Companies offering Part D plans must offer at least one standard Part D plan. However, these companies can, and most often do, offer alternative plan structures. Many offer enhanced plans that provide additional benefits such as offering some form of coverage within the doughnut hole. Many plans choose to subsidize the cost of generic drugs in the doughnut hole and some plans even extend the subsidies to branded drugs. These plans generally come with different pricing structures than the standard plan. For example, a plan could offer a deductible lower than \$310 and use predictable copayments (\$15 for generics; \$25 for branded) instead of coinsurance. Most beneficiaries have chosen an enhanced plan of one sort or another. **In fact, only five percent of enrollees have chosen a standard benefit plan.**

**Fewer than 15 percent of non-low-income beneficiaries actually hit the “doughnut hole,”** either because their costs never reach the prescribed threshold or they had purchased a type of plan that prevented a loss of coverage in the gap.

However, beneficiaries that find themselves in the doughnut hole continue to receive the negotiated, discounted drug prices which are often significantly cheaper than the retail prices they would pay if they did not have Part D drug coverage.

**Essentially, seniors could choose not to have a prescription drug plan with a “doughnut hole” or “coverage gap.”** Seniors that find themselves in a plan with such a gap can change their coverage to a plan that provides coverage during the gap during the annual open enrollment period in the fall of each year.

***Editor’s Note:** The Medicare Part D open enrollment period from Nov. 15 to Dec. 31 each year is the annual opportunity for seniors to compare plans make coverage changes to their prescription drug benefit. Coverage begins on Jan. 1 of the following year and beneficiaries must stay enrolled in the chosen plan for the full calendar year.*

**Part D Competition Lowers Costs:** The ability of the Part D drug plans to control program costs stands in stark contrast to the dramatic cost increases in the traditional Medicare program where competition and market-driven reform is noticeably absent. Compared to its initial estimate in 2003, the net ten year cost of the Medicare drug benefit is nearly \$250 billion (almost 40 percent) lower than originally estimated. Additionally, a PricewaterhouseCooper study released in 2009 found that Part D plans are extracting 29 percent discounts from drug companies. Part D saved seniors an average of \$1,200 off their drug costs.

The Henry J. Kaiser Family Foundation website provides a fact sheet on the Medicare Prescription Drug Benefit (which is updated periodically) that candidates may find useful and is available [here](#).

### **The Sustainable Growth Rate (SGR) – Doctor Payments Under Medicare**

Physician payment rates are set under the fee schedule payment system and based on the relative costs of providing a service. The fee schedule is updated annually according to the Sustainable Growth Rate (SGR) formula, which is intended to control spending in Medicare. The SGR can actually result in either an increase or decrease in reimbursement payments. In fact, in the first few years of the SGR payment method, physicians saw modest increases in their reimbursements from Medicare.

Early on, however, the SGR was due to provide a negative increase, or cut, in reimbursements to physicians. Yielding to incredible political pressure from doctor’s groups, Congress stepped in to prevent the cut for that year. Doing so, however, resulted in increasing SGR imposed cuts in following years. Each year, the pressure for Congress to prevent the cuts increases. Congress has overridden the formula the last seven years, but it has only resulted in the small cuts accumulating. The payment formula was slated to cut reimbursement rates by an estimated 27.4 percent in 2012. But, the final Social Security payroll tax holiday law provided a “doc fix” through the end of 2012.

***Editor’s Note:** For more information about the Social Security payroll tax holiday legislation, please refer to both the Social Security and Tax Policy chapters in the 2012 NRCC Issues Book.*

Most members on both sides of the aisle consider the formula “flawed” for a variety of reasons. First, there is an argument that cost savings in Medicare should not be borne solely by our physicians. Secondly, largely

because of low reimbursement rates, physicians are choosing to accept less and less Medicare beneficiaries, simply because they cannot afford to provide seniors care with a payment rate that is less than their costs in most cases. The SGR exacerbates this physician shortage causing doctors to either drop Medicare beneficiaries from their practice, or never see them altogether because they simply cannot afford to provide the care at the current or reduced rates.

Republicans believe that we need an equitable payment formula for physicians' services in Medicare that fairly pays doctors for their work, but that also keeps costs in check through the elimination of unnecessary duplication, waste, fraud and abuse of the payment system.

## **MEDICARE'S LONG-TERM FINANCING PROBLEMS**

By law, the Medicare Board of Trustees is required to report annually to Congress on the financial and actuarial status of the funds. According to its [2012 report](#), the Board of Trustees estimates that by 2024, HI revenues and assets will no longer be sufficient to fully cover Part A costs and the fund will be exhausted. Solvency of the HI trust fund is the measure of Medicare's financial health that typically receives the most attention. Because of the way it is financed, the SMI fund cannot face insolvency, however, the Trustees project that SMI expenditures will continue to grow rapidly, and thus place increasing strains on the federal budget.

Since its enactment in 1965, spending on Medicare has grown steadily as measured in absolute dollars, as a share of the federal budget and as a share of the gross domestic product (GDP), and these trends are expected to continue. In FY 2010, Medicare's \$524 billion in total expenditures represented 15 percent of all federal spending, exceeded only by Social Security benefits and defense spending, which each accounted for 20 percent. By 2020, Medicare is projected to reach 17 percent of budget outlays and four percent of the GDP.

Between 1985 and 2009, growth in Medicare spending averaged almost nine percent annually, compared with five percent growth in both the GDP and medical care inflation during those years. The addition of the Part D prescription drug program in 2006 contributed to the rate of growth. Excluding Part D, average annual Medicare growth in total spending was just under eight percent overall and six percent per enrollee. Current projections regarding Medicare's solvency are perhaps more uncertain than ever before because of difficulties in predicting a path for the current economy, uncertainties about the effects of health reform and indecision about the long-term treatment of physician payments in the Medicare program. The Medicare Trustees have identified several factors that increase health care costs, including those paid for by Medicare, Medicaid and private health insurance. Specifically, these are increases in the prices paid per service and increases in the volume and complexity of services provided per beneficiary. Medicare costs are also affected by growing program enrollment and an aging population, along with other factors unique to the Medicare program.

Growing program enrollment and an aging population, often discussed as a "driver" of Medicare spending, is, as in the case of Social Security's current unsustainable path, the accelerating growth in program enrollment that will occur with the retirement of the post-World War II "baby boom" generation, who began to turn 65 in 2011. Between 1995 and 2009, as the cohort of those born during the Great Depression and World War II became eligible for Medicare, Medicare enrollment growth grew by an average of 623,000 beneficiaries annually. Looking to the future, net Medicare enrollment growth is expected to average more than 1.6 million beneficiaries annually between 2010 and 2030, and the program will reach a total of 80 million enrollees in 2030 – double the number of enrollees in 2000.

Like Social Security, Medicare's pay-as-you-go financing system drawn from workers payroll taxes is fundamentally unsustainable. An aging population living longer is a great thing for our society, but it also equals greater demand for Medicare benefits. The fact is, though, that no one quite knows what would happen if the Medicare trust fund actually ran out of money. According to the Congressional Research Service (CRS), "There are no provisions in the Social Security Act governing what would happen in such an event."

## SOLUTIONS AND REFORM PROPOSALS

The bottom line is that the government is running out of money. Medicare is facing an unprecedented fiscal challenge. Unless some reforms are made, Medicare will eventually become insolvent. The need for reform is undeniable and with the first wave of baby-boom generations retiring last year in 2011, the number of beneficiaries is projected to skyrocket beyond what it has ever been in the history of the program. Medicare costs will crush current and future taxpayers. As with other largely unsustainable federal programs out there, there are several reform proposals being tossed around. But, there are no easy answers.

As this chapter detailed, over the years of Medicare's history, there have been numerous changes, reforms and tweaks enacted to attempt to keep the program solvent and functioning. But, there have also been changes made to it to repeatedly expand benefits, expand coverage and expand eligibility, effectively contributing, at least in some part, to its current dire status.

It is neither responsible, nor is it accurate, to characterize the Democrats' health care overhaul law enacted in the 111th Congress as containing reforms to Medicare. As of the time of this writing, the Democrats have yet to offer any real, viable solutions to the crisis Medicare is currently facing.

***Editor's Note:** For more information regarding the Democrats' health care overhaul law, please refer to the Health Care chapter of the 2012 NRCC Issues Book.*

### FY 2013 House Budget Resolution

Most recently in the current 112th Congress, H. Con. Res. 112, the FY 2013 House Republican Budget Resolution, proposed changes in the structure of Medicare. The reforms proposed are very closely based on a plan put forth at the beginning of 2012 by Congressman Paul Ryan (R-Wis.) and Senator Ron Wyden (D-Ore.), effectively referred to as the Wyden-Ryan plan.

One of the most important things to keep in mind regarding the Medicare reform proposals in the FY 2013 budget resolution is that **nothing proposed would affect current seniors or those nearing retirement (those who turn 55 in 2012). Current Medicare beneficiaries and individuals who became eligible for Medicare prior to 2023 (i.e. those who turn 55 in 2012), would remain in the current Medicare program.**

According to a report on the FY 2013 budget resolution's changes to Medicare, the Congressional Research Service (CRS) states:

“Age of Medicare Eligibility: The budget proposal would gradually increase the Medicare eligibility age to 67. Beginning in 2023, the age of eligibility for Medicare would increase by two months each year until it reached 67 in 2034. Younger individuals could still qualify on the basis of disability.

“Conversion of Medicare to a Premium Support System: Under the Ryan budget proposal, current Medicare beneficiaries and individuals who become eligible for Medicare prior to 2023 (i.e. those who turn 55 in 2012), would remain in the current Medicare program (described earlier). Individuals who become eligible (based either on age or disability) for Medicare beginning in 2023 would be given the option of enrolling in a private insurance

plan or a traditional fee-for-service option through a newly established Medicare exchange.<sup>1</sup> These plans would be required to offer standard benefits that are at least actuarially equivalent to traditional fee-for-service benefits, and to accept all people eligible for Medicare who apply regardless of age or health status.

“All of the plans, including the traditional fee-for-service option, would engage in an annual competitive bidding process. The lower of the second-lowest approved plan bid or fee-for-service Medicare would be used to establish the amount of the subsidy (premium support) provided by Medicare and the base premium paid by Medicare beneficiaries.<sup>2</sup> The amount of the subsidy would generally be the same regardless of the cost of the plan; so, for instance, if a beneficiary selects a plan whose bid is higher than the second lowest bid, the beneficiary would pay a higher premium to make up the difference between the subsidy and the base premium. Similarly, if the beneficiary enrolls in a plan that bid lower than the second-lowest approved bid, the beneficiary would be provided a rebate in the amount of the difference. The payments to plans would be geography-rated and risk-adjusted for health status. Additionally, based on annual risk reviews conducted by the Centers for Medicare and Medicaid Services (CMS), fees would be imposed on plans that enrolled a higher-than-average number of low-risk beneficiaries; those that enrolled a higher-than-average number of high-risk (expensive) enrollees would receive incentive payments funded by the fees from the low-risk plans.

“In 2023, the premium subsidy would be set at \$7,500, on average.<sup>3</sup> The amount of premium support provided to high-income individuals would be reduced.<sup>4</sup> Low-income beneficiaries would be provided a dedicated savings account to be used to pay premiums, co-pays and other out-of-pocket costs. The proposal suggests that program cost growth would be mitigated through the competitive bidding process; however, should that not occur, the proposal would limit annual per capita premium support increases to nominal GDP growth plus 0.5%.<sup>5</sup> Should actual costs exceed this amount, Medicare beneficiaries would pay increased premiums to make up the difference. The proposal would limit the impact of these increases for low-income enrollees, with Medicaid continuing to pay for the out-of-pocket expenses for dual-eligibles (those who qualify for both Medicare and Medicaid), and additional funding would be provided in savings accounts for those who meet certain low-income limits but do not qualify for Medicaid.

“Under this premium support model, CBO estimates that by 2030, 39% of Medicare beneficiaries would be enrolled in this new system and thus subject to these new spending constraints, and by 2050, this number would increase to 91%. While average spending per Medicare beneficiary is still expected to increase through time, it would do so at a slower rate. For example, in 2050, under the new system, spending for new enrollees (67 years old) would be \$11,100 per year (in 2011 dollars) compared with \$17,000 under CBO’s baseline

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<sup>1</sup> “Those who qualify for Medicare prior to 2023 would also be given the option of switching to the new system.”

<sup>2</sup> “By comparison, competitive bidding under Medicare Part D bases plan subsidies and beneficiary premiums on the national weighted average bid.”

<sup>3</sup> “This is approximately the same amount as projected net federal spending per capita for 65-year-olds in traditional Medicare that year.”

<sup>4</sup> “The means-testing thresholds currently used to establish Medicare Parts B and D premiums would apply.”

<sup>5</sup> “By contrast, the Ryan-Wyden proposal would limit annual premium support increases to GDP+1, <http://paulryan.house.gov/UploadedFiles/WydenRyan.pdf>.”

scenario.<sup>6</sup> Under this proposal, net federal Medicare spending as a share of GDP would be expected to grow from 3.25% in 2011 to 4.75% in 2050, compared with 6.50% in 2050 under CBO’s baseline scenario.”

Candidates may also find it helpful to take a look at what the House Budget Committee Republicans published on the Medicare reform proposal in the FY 2013 budget resolution. This information can be found [here](#) in the Committee’s report that accompanied the resolution and the Committee’s publication entitled, “The Path to Prosperity,” which can be found [here](#). According to the Committee’s report that accompanied the budget resolution:

“For future retirees, the budget supports an approach known as ‘premium support.’

“Starting in 2023, seniors (those who first become eligible by turning 65 on or after January 1, 2023) would be given a choice of private plans competing alongside the traditional fee-for-service Medicare program on a newly created Medicare Exchange. Medicare would provide a premium-support payment either to pay for or offset the premium of the plan chosen by the senior, depending on the plan’s cost.

“The Medicare recipient of the future would choose, from a list of guaranteed coverage options, a health plan that best suits his or her needs. This is not a voucher program; a Medicare premium-support payment would be paid, by Medicare, directly to the plan or the fee-for-service program to subsidize its cost. The program would operate in a manner similar to that of the Medicare prescription drug benefit. The Medicare premium-support payment would be adjusted so that the sick would receive higher payments if their conditions worsened; lower-income seniors would receive additional assistance to help cover out-of-pocket costs; and wealthier seniors would assume responsibility for a greater share of their premiums. Also starting in 2023, the age of eligibility for Medicare would begin to rise gradually to correspond with Social Security’s retirement age.

“This approach to strengthening the Medicare program—which is based on a long history of bipartisan reform plans—would ensure security and affordability for seniors now and into the future. It would set up a carefully monitored exchange for Medicare plans. Health plans that chose to participate in the Medicare Exchange would agree to offer insurance to all Medicare beneficiaries, to avoid cherry-picking and ensure that Medicare’s sickest and highest-cost beneficiaries receive coverage.

“While there would be no disruptions in the current Medicare fee-for-service program for those currently enrolled or becoming eligible in the next 10 years, all seniors would have the choice to opt-in to the new Medicare program once it began in 2023. This budget envisions giving seniors the freedom to choose a plan best suited for them, guaranteeing health security throughout their retirement years. It would also expand that freedom to non-retirees by giving certain employers the option to offer their employees a free choice

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<sup>6</sup> “CBO based its projections on figures of Medicare spending amounts (through 2022) and growth rates (years 2023 and beyond) provided by Chairman Ryan and his staff. CBO did not analyze the policies that might be implemented to produce these levels of Medicare spending over time.”

option, smoothing the transition from their working years to when seniors become Medicare-eligible. This would enable workers to devote their employer's health coverage contribution to the purchase a health insurance plan that works best for them.

“This reform also ensures affordability by fixing the currently broken subsidy system and letting market competition work as a real check on widespread waste and skyrocketing health care costs. Putting patients in charge of how their health care dollars are spent will force providers to compete against each other on price and quality.”

On March 29, 2012, H. Con. Res. 112 was passed by the House by a vote of 228 to 191 (R: 228-10; D: 0-181). You can see how they voted [here](#).

***Editor's Note:** For more information regarding the other provisions of the FY 2013 House budget resolution, please refer to the Budget and Federal Spending chapter of the 2012 NRCC Issues Book.*

**IMPLEMENTATION FOR KEY MEDICARE PROVISIONS OF THE 2010 HEALTH CARE REFORM LAW, 2010-2015**

*Editor's Note: The following information is provided by The Henry J. Kaiser Family Foundation and is available [here](#).*

2010	
<b>Cost containment</b>	<ul style="list-style-type: none"> <li>• Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust payments for productivity</li> <li>• Ban new physician-owned hospitals in Medicare</li> </ul>
<b>Delivery system reforms</b>	<ul style="list-style-type: none"> <li>• Establish a new office within the Centers for Medicare &amp; Medicaid Services (CMS), the Federal Coordinated Health Care Office, to improve care coordination for dual eligibles</li> </ul>
<b>Part D</b>	<ul style="list-style-type: none"> <li>• Provide a \$250 rebate for beneficiaries who reach the Part D coverage gap</li> </ul>
2011	
<b>Cost containment</b>	<ul style="list-style-type: none"> <li>• Establish a new Center for Medicare and Medicaid Innovation within CMS</li> <li>• Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels (\$85,000/individual and \$170,000/couple), and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple</li> <li>• Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012</li> </ul>
<b>Medicare Advantage</b>	<ul style="list-style-type: none"> <li>• Prohibit Medicare Advantage plans from imposing higher cost sharing for some Medicare-covered benefits than is required under the traditional fee-for-service program</li> <li>• Restructure payments to Medicare Advantage (MA) plans by phasing payments to different percentages of Medicare fee-for-service rates; freezes payments for 2011 and 2010 levels</li> </ul>
<b>Physician payment</b>	<ul style="list-style-type: none"> <li>• Provide a 10 percent Medicare bonus payment to primary care physicians and general surgeons practicing in health professional shortage areas</li> </ul>
<b>Part D</b>	<ul style="list-style-type: none"> <li>• Begin phasing in federal subsidies for generic drugs in the Medicare Part D coverage gap (reducing coinsurance from 100 percent in 2010 to 25 percent by 2020)</li> <li>• Require pharmaceutical manufacturers to provide a 50 percent discount on brand-name prescriptions filled in the coverage gap (reducing coinsurance from 100 percent in 2010 to 50 percent in 2011)</li> </ul>
<b>Preventive services</b>	<ul style="list-style-type: none"> <li>• Eliminate Medicare cost sharing for some preventive services</li> <li>• Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan</li> </ul>
2012	
<b>Cost containment</b>	<ul style="list-style-type: none"> <li>• Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the savings they achieve for the Medicare program</li> <li>• Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions</li> </ul>
<b>Delivery system reforms</b>	<ul style="list-style-type: none"> <li>• Create the Medicare Independence at Home demonstration program</li> <li>• Establish a hospital value-based purchasing program and develop plans to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory surgical centers</li> </ul>
<b>Medicare Advantage</b>	<ul style="list-style-type: none"> <li>• Reduce rebates for Medicare Advantage plans</li> <li>• High-quality Medicare Advantage plans begin receiving bonus payments</li> </ul>
<b>Part D</b>	<ul style="list-style-type: none"> <li>• Make Part D cost sharing for dual eligible beneficiaries receiving home and community-based care services equal to the cost sharing for those who receive institutional care</li> </ul>

2013	
<b>Delivery system reforms</b>	<ul style="list-style-type: none"> <li>Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care</li> </ul>
<b>Part D</b>	<ul style="list-style-type: none"> <li>Begin phasing in federal subsidies for brand-name drugs in the Part D coverage gap (reducing coinsurance from 100 percent in 2010 to 25 percent in 2020, in addition to the 50 percent manufacturer brand discount)</li> </ul>
<b>Tax changes</b>	<ul style="list-style-type: none"> <li>Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9 percent (from 1.45 percent to 2.35 percent) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly</li> <li>Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments</li> </ul>
2014	
<b>Cost containment</b>	<ul style="list-style-type: none"> <li>Independent Payment Advisory Board comprised of 15 members begins submitting legislative proposals containing recommendations to reduce Medicare spending if spending exceeds a target growth rate</li> <li>Reduce Disproportionate Share Hospital (DSH) payments initially by 75 percent and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care</li> </ul>
<b>Medicare Advantage</b>	<ul style="list-style-type: none"> <li>Require Medicare Advantage plans to have medical loss ratios no lower than 85 percent</li> </ul>
<b>Part D</b>	<ul style="list-style-type: none"> <li>Reduce the out-of-pocket amount that qualifies for Part D catastrophic coverage (through 2019)</li> </ul>
2015	
<b>Cost containment</b>	<ul style="list-style-type: none"> <li>Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1 percent</li> </ul>

## MEDICARE BENEFICIARIES BY TYPE OF COVERAGE, BY STATE

*Editor's Note: The following information is from February 2010 and is provided [here](#) by The Henry J. Kaiser Family Foundation.*

State	Medicare Part D Eligible	Beneficiaries in Stand-Alone PDPs	Beneficiaries in Medicare Advantage Drug Plans (MA-PDs)	Beneficiaries in Employer Plans Taking Retiree Drug Subsidies	Beneficiaries with Other Prescription Drug Coverage	Beneficiaries with Known Creditable Drug Coverage
Alabama	832913	308664	167080	123321	137468	736533
Alaska	63974	24443	192	15840	11581	52056
Arizona	909557	237703	318004	97231	138282	791220
Arkansas	524907	256970	61669	46982	88424	454045
California	4669125	1644563	1591617	407878	482758	4126816
Colorado	609849	172479	185504	76444	97028	531455
Connecticut	560340	216559	92469	113314	62969	485311
Delaware	145842	69620	3648	34388	20097	127753
District of Columbia	77028	29288	7204	3968	20455	60915
Florida	3314477	1050077	951418	420476	473481	2895452
Georgia	1211860	510355	225787	108444	194628	1039214
Hawaii	202750	59741	74309	7450	33437	174937
Idaho	224133	81561	49714	20770	36798	188843
Illinois	1818883	869253	136696	338312	204737	1548998
Indiana	991222	440397	118289	173838	122239	854763
Iowa	513404	291857	50466	47412	68884	458619
Kansas	428471	224475	40270	28409	71301	364455
Kentucky	748151	374241	79137	97132	98478	648988
Louisiana	677365	272965	147206	86316	81300	587787
Maine	260686	135141	27503	20173	36367	219184
Maryland	771790	283811	54585	140565	159810	638771
Massachusetts	1045371	417431	186393	185030	121305	910159
Michigan	1625605	559630	207298	443378	141463	1351769
Minnesota	774433	279692	249461	69284	95661	694098
Mississippi	489980	281013	37336	27012	78136	423497
Missouri	991772	427868	191583	108817	137854	866122
Montana	166315	73836	20877	14712	28659	138084
Nebraska	276731	152223	26481	21804	44002	244510
Nevada	347112	90178	103242	43463	62750	299633
New Hampshire	213449	90630	10524	30428	35483	167065

New Jersey	1310966	557956	132035	281326	153942	1125259
New Mexico	307056	117464	72263	22613	50912	263252
New York	2954341	969735	786071	531331	296525	2583662
North Carolina	1460593	644904	221015	222652	195932	1284503
North Dakota	107765	68717	5803	4308	16645	95473
Ohio	1876347	637915	386024	441595	193032	1658566
Oklahoma	596181	279253	75913	44371	102569	502106
Oregon	608330	183666	210515	42753	84211	521145
Pennsylvania	2259681	718543	700506	280292	274560	1973901
Residence Unknown	661940	48170	427504	13642	63575	552891
Rhode Island	180984	62597	59853	11738	25518	159706
South Carolina	755843	315083	94709	120503	126951	657246
South Dakota	135136	78656	9120	6478	25532	119786
Tennessee	1038035	439679	226964	104285	140976	911904
Texas	2938054	1154183	517797	423385	438032	2533397
United States	46492853	17676819	9933173	6369330	6218190	40197512
Utah	277162	80839	74584	28203	50324	233950
Vermont	109156	58002	2925	17692	15499	94118
Virginia	1122504	460599	126947	112563	246507	946616
Washington	950097	335699	171035	118948	155331	781013
West Virginia	378108	195885	33639	51500	51728	332752
Wisconsin	898374	303591	178472	130053	108736	720852
Wyoming	78705	39019	3517	6508	15318	64362

## MEDICAID BASICS

Medicaid was enacted in 1965 in the same legislation that created the Medicare program. Medicaid is a health insurance program jointly funded by the federal government and the states. Despite this cost sharing, the Medicaid program is the third largest entitlement spending item in the federal budget behind Social Security and Medicare. For state budgets, it is either the largest or second largest spending item after education.

In FY 2011, a total of 69.4 million people were estimated to be enrolled in Medicaid at some time during the year. One-half of these beneficiaries (35.3 million) were children and 17.8 million were adults in families with dependent children. There were also 10.7 million individuals with disabilities and 5.7 million people over the age of 65 enrolled in Medicaid in FY 2011. Compared to both Medicare and employer-sponsored health care plans, Medicaid offers the broadest array of medical care and related services available in the United States today. In FY 2009, while the majority of enrollees in Medicaid were children without disabilities (roughly half), such children accounted for only about 19 percent of Medicaid's total expenditures on benefits. The next largest beneficiary group, adults in families with dependent children, accounted for about 25 percent of all enrollees, but only about 13 percent of benefit expenditures. Disabled people represented about 15 percent of Medicaid enrollees, but this group accounted for the largest share of Medicaid benefit expenditures – about 41 percent – of all groups. Finally, the elderly represented about eight percent of Medicaid enrollees, but about 20 percent of all benefit expenditures.

Unlike Medicare and Social Security, federal funding for Medicaid comes entirely from general revenues, rather than a dedicated account or trust fund within the U.S. Treasury. Federal spending levels for Medicaid are largely determined by the states, which generally receive open-ended funding as long as they operate their programs in compliance with federal law. Therefore, it represents a growing portion of the federal budget, having increased from two percent of federal outlays in FY 1975 to an estimated seven percent in FY 2008. According to the Congressional Budget Office's (CBO's) March 2012 baseline report, Medicaid outlays are projected to rise an average annual rate of 9.0 percent during the 2012 to 2022 period due to both demographic changes and an increase in enrollment beginning in 2014 as a result of significant program changes under the Democrats' health care overhaul law. That enrollment increase is estimated to be roughly 17 million individuals by 2021.

***Editor's Note:** For more information regarding changes made to Medicaid in the Democrats' health care overhaul law, please refer to the Health Care chapter of the 2012 NRCC Issues Book.*

States generally control their own Medicaid spending levels by altering eligibility, covered services, cost-sharing and premiums paid by beneficiaries, health care provider reimbursement rates and other aspects of the program within broad federal guidelines.

Generally, eligibility for Medicaid is limited to low-income children, pregnant women, parents of dependent children, the elderly and people with disabilities. Some eligibility groups are mandatory, meaning that all states with a Medicaid program (which is all 50 states) must cover them; others are optional. Examples of groups that states **must provide** Medicaid to include:

- poor families that meet the financial requirements (based on family size) of the former Aid to Families with Dependent Children (AFDC) cash assistance program

- families losing Medicaid eligibility due to increased earnings from work who receive up to 12 months of Medicaid coverage
- pregnant women and children through age six with family income at or below 133 percent of the federal poverty level (FPL)
  - for example: in 2012, the FPL for a family of four is \$23,050 – 133 percent of FPL for such a family would equal \$30,656.50
- children ages six through 18 with family income at or below 100 percent FPL, rising to 133 percent FPL beginning in 2014 (or sooner at state option)
- low-income individuals who are age 65 and older, or blind, or under age 65 and disabled who qualify for cash assistance under the Social Security Income (SSI) program
- certain groups of legal permanent resident immigrants (e.g. refugees for the first seven years after entry into the U.S.; asylees for the first seven years after asylum is granted; lawful permanent aliens with 40 quarters of creditable coverage under Social Security; immigrants who are honorably discharged U.S. military veterans) who meet all other financial and categorical Medicaid eligibility requirements
- beginning in 2014, certain individuals who age out of foster care, up to age 26, and do not qualify under one of the other mandatory groups noted above
- beginning in 2014, or sooner at state option, all non-elderly, non-pregnant adults with modified adjusted gross income (MAGI) at or below 133 percent FPL who do not qualify under one of the other mandatory groups noted above

Examples of groups that states **may choose** to cover under Medicaid include:

- parents with income above AFDC financial levels
- pregnant women and infants with family income exceeding 133 percent FPL up to and including 185 percent FPL
- individuals who are ages 65 and over, or blind, or under age 65 and disabled whose income exceeds the SSI level (about 75 percent FPL nationwide) up to and including 100 percent FPL
- certain children with disabilities who live at home but need the level of care provided in an institution; in these cases, children whose income meets the SSI level may qualify for Medicaid, and parental income and assets are ignored for the purposes of determining eligibility
- individuals who are living in institutions (e.g. nursing facilities or other medical institutions) with income up to and including 300 percent of the maximum SSI benefit (about 220 percent FPL)
- the “medically needy” who are individuals in categories selected by the state (e.g. age 65 and above, the disabled, families with dependent children) whose income is too high to qualify as categorically needy; for states that elect the “medically needy” option, coverage must be provided to certain

pregnant women and children under age 18; “medically needy” coverage is particularly important for the elderly and persons with disabilities, since this pathway allows deductions for medical expenses that lower the amount of income counted in the determination of financial eligibility for Medicaid

- legal immigrants after their first five years (or earlier for children and pregnant women) in this country; and
- beginning in 2014, all non-elderly, non-pregnant individuals with MAGI above 133 percent FPL

States are required to cover certain mandatory services for these eligible beneficiaries, which are listed in federal statute. Examples of those include:

- inpatient and outpatient hospital services (excluding services for mental disease)
- federally qualified health center (FQHC) services
- free-standing birthing center services
- lab and x-ray services
- physician services
- certain nurse practitioner services
- smoking cessation services for pregnant women (i.e. counseling and pharmacotherapy) with no beneficiary cost-sharing
- pregnancy-related services (including postpartum care)
- early and periodic screenings, diagnosis and treatment (EPSDT) for children under age 21
- nursing facility care for persons age 21 and over
- home health care for persons entitled to nursing facility care.

The statute also lists additional services that are optional – that is, states can choose to include them in their state Medicaid plans. Some of these optional benefits include eyeglasses and prosthetic devices, routine dental care, physician-directed clinic services, services of other licensed practitioners (e.g. optometrists, podiatrists, psychologists), consumer-directed personal care attendant services for people with income up to 150 percent FPL (or higher when certain conditions are met), physical therapy and prescription drugs.

Both the optional traditional benefits offered and the breadth of coverage for a given benefit can and does vary from state to state, even for mandatory services. For example, states may place different limits on the amount of inpatient hospital services a beneficiary can receive in a year – as long as applicable requirements are met regarding comparability, state-wideness and sufficiency of amount, duration and scope with the state.

The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP). Determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per-capita income relative to the national average (and vice versa for states with higher per-capita incomes). States incur Medicaid costs by making payments to health care providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations). They then submit quarterly expense reports in order to receive federal reimbursement for a share of these costs.

## **BALLOONING COSTS AND THE NEED FOR REFORM**

Despite its rapid cost growth and large budget, Medicaid in a “vacuum” is viewed as a cost-efficient program. For Medicaid’s non-disabled populations, per person costs are no higher than private health insurance. Because Medicaid covers high-cost populations, primarily people with disabilities and those needing long-term care services, insurance costs are held down for all others who are covered under private plans. Many of the people who are on Medicaid, however, would be rejected from private coverage if they were to seek private health insurance coverage on their own. Nonetheless, the breathtakingly rapid increase in cost and growth makes Medicaid a significant current and future burden on the government’s finances.

Medicaid has become too costly and complex for states to effectively manage. It is already the biggest item in state budgets and is projected to absorb as much as 80 to 100 percent of all state revenues if left unreformed. The effects of the escalating costs of Medicaid are currently being felt by these states. Many states are limiting Medicaid eligibility and reducing benefits.

Medicaid is also confounded by the same demographic problems facing Medicare and Social Security. Medicaid is currently the largest single source of funding for long-term care services nationally, covering nearly half of all long-term care expenditures and the anticipated costs for long-term care services in this country threaten the future sustainability of the Medicaid program.

Another recent area of concern with Medicaid is the recent economic downturn, which has the potential to increase Medicaid enrollment at a time when state revenues might be stagnant or falling, putting pressure on the federal government to increase its cost share to help states make up the gap. Obviously, this is also an unsustainable situation.

Those that hold the above concerns believe that fundamental reform is needed in order to ensure the long-term fiscal sustainability of the Medicaid program while continuing to provide quality care to promoting the best possible health for all beneficiaries.

Finally, the Democrats’ recent health care overhaul law contained a further expansion of the Medicaid program with massive costs that will ultimately be borne by the states. Specifically, the health care overhaul expands eligibility to Medicaid by as many as 15 million additional Americans, which will place billions in new costs onto states to administer. Medicaid is the most significant, most visible and most costly part of the law for states, which fully expect to see increases in their spending. The costs to hire staff and plan for the average 25 percent increase in Medicaid rolls may swamp state budgets, which has led several states to enter into a lawsuit against the federal government over these provisions.

- In a March 23, 2010, article, Bloomberg.com reported, “President Barack Obama faces a fight over the health-care overhaul from states that sued today because the legislation’s expansion of Medicaid imposes a fiscal strain on their cash-strapped budgets.

“Florida, Texas and Pennsylvania are among 14 states that filed suit after the president signed the bill over the constitutionality of the burden imposed by the legislation. The health-care overhaul will make as many as 15 million more Americans eligible for Medicaid nationwide starting in 2014 and will cost the states billions to administer.

“States faced with unprecedented declines in tax collections are cutting benefits and payments to hospitals and doctors in Medicaid, the health program for the poor paid jointly

by state and U.S. governments. The costs to hire staff and plan for the average 25 percent increase in Medicaid rolls may swamp budgets, said Toby Douglas, who manages the Medicaid program for California, which hasn't joined the lawsuits.

“‘The states are coming through the worst fiscal period in the history of record keeping,’ said Vernon Smith, a former Medicaid director for Michigan and now a principal at the research and consulting firm Health Management Associates in Lansing, Michigan. ‘Medicaid is the most significant, most visible and most costly part of this expansion and states fully expect to see increases in their spending.’”<sup>7</sup>

### **FY 2013 House Budget Resolution**

Most recently in the current 112th Congress, H. Con. Res. 112, the FY 2013 House Republican Budget Resolution, proposed changes to Medicaid. First of all, the FY 2013 House budget resolution would repeal the Medicaid expansion included in the 2010 Democrats' health care overhaul law. Also, it proposes to restructure Medicaid from an individual entitlement program to a block grant program. Few details are provided regarding the specific design of the proposed block grant, but the budget resolution does indicate that:

- federal funding to states would increase annually according to inflation (CPI-U) and population growth, and
- states would be provided additional flexibility to design and administer their Medicaid programs.

The purpose of this type of reform of Medicaid is to make federal Medicaid spending more predictable and provide states with stronger incentives to control the cost of their Medicaid programs.

***Editor's Note:*** For more information regarding the other provisions of the FY 2013 House budget resolution, please refer to the Budget and Federal Spending chapter of the 2012 NRCC Issues Book.

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<sup>7</sup> Pat Wechsler, “States sue over overhaul that will bust state budgets,” Bloomberg.com, March 23, 2010

## IMPLEMENTATION TIMELINE OF KEY MEDICAID PROVISIONS OF THE 2010 HEALTH CARE REFORM LAW, 2010-2015

*Editor's Note: The following information is provided by The Henry J. Kaiser Family Foundation and is available [here](#).*

### 2010

- Creates a state option to cover childless adults through a Medicaid State Plan Amendment (April 1).
- Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women (March 23).
- Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met (March 23).
- Requires coverage for smoking cessation for pregnant women without cost sharing (October 1).
- Requires coverage for free standing birth center services (March 23 except if state legislation is required).
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans (January 1 except for rebates for managed care which are effective March 23, 2010).
- Provides funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid) (January 1 except for managed care rebates which is effective upon enactment).
- Provides states with new options for offering home and community-based services through a Medicaid State Plan Amendment rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and a higher level of need and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan (October 1).
- Establishes a global payments demonstration project for up to 5 states from 2010 to 2012 for large safety-net hospital systems (October 1).
- Authorizes a demonstration for stabilization of emergency medical conditions by Institutions for Mental Disease for individuals 21 to 65 who require stabilization in these settings as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). Today, these hospitals are denied payment for care that is required under the EMTALA rules with \$75 million in funding (Available October 1, 2010 through December 31, 2015).
- Establishes the CMS Innovation Center designed to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth. Payment reform models that improve quality and reduce the rate of costs could be expanded throughout the Medicare, Medicaid, and CHIP programs (By December 31).
- Establishes the Federal Coordinated Health Care Office (CHCO) within CMS to align Medicare and Medicaid financing, benefits, administration, oversight rules, and policies for dual eligibles (By March 1).
- Requires the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP (Regulations by September 19).
- Extends the 60 days that states have to repay the federal share of a Medicaid overpayment to one year or 30 days after an amount is determined through the judicial processes (March 23). Requires data reporting to MMIS to detect waste, fraud and abuse; mandates states' use of national correct coding initiative (January 1).
- Requires states to implement fraud, waste, and abuse programs by January 1, 2011 and increases funding for health care fraud and abuse control funding by \$10 million per year for fiscal year 2011 through 2020.

### 2011

- Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program) (Effective January 1, 2011 and payout of benefits starting 2016).
- Prohibits federal payments to states for Medicaid services related to health care acquired conditions (July 1).
- Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion (January 1).
- Authorizes \$100 million in grant funding for states to establish programs for Medicaid beneficiaries to cease tobacco use, control weight, lower cholesterol, lower blood pressure and/or avoid or improve management of diabetes (Appropriates funds available January 1 available for 5 years).
- Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services (October 1, 2011 through September 30, 2015).
- Establishes the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities (October 1).

#### 2011 (continued)

- Establishes procedures for screening, oversight, and reporting requirements for providers and suppliers that participate in Medicaid, Medicare, and CHIP; imposes a fee on providers and suppliers for screening purposes; requires additional requires billing agents, clearinghouses and alternative payees to register under Medicaid (January 1).
- Increase spending caps for the territories (July 1, 2011 through September 30, 2019).

#### 2012

- Establishes a bundled payment demonstration project for up to 8 states for acute and post-acute care (January 1, 2012 to December 31, 2016).
- Establishes demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (January 1, 2012 – December 31, 2016).

#### 2013

- Extends authorization and funding for CHIP through 2015 (2 years beyond the current authorization which is until 2013).
- Extends and increases funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities from \$100 million in 2013 to \$140 million in 2015.
- Increase Medicaid payments for primary care services provided by primary care doctors with 100% federal funding (For services provided from January 1, 2013 through December 31, 2014).
- Provides states with a 1 percentage point increase in the FMAP for preventive services recommended by the US Preventive Services Task Force with a grade of A or B and recommended immunization for adults if offered with no cost sharing (January 1).

#### 2014

- Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) and provides enhanced federal matching for new eligibles (January 1).
- Establishes Medicaid coverage (with EPSDT benefits) for children under age 26 who were in foster care when they turned 18 (January 1).
- Eliminates smoking cessation drugs, barbiturates, and benzodiazepines from excluded drug list (January 1).
- Permits all hospitals participating in Medicaid (with state verification of capability) to make presumptive eligibility determinations and allows hospitals and other providers to make presumptive eligibility determinations for all Medicaid eligible populations (January 1).
- Requires states to: enable individuals to apply or renew Medicaid coverage through a website with electronic signature; establish procedures to enable individuals to apply for Medicaid, CHIP or the Exchange through a State-run website that must be in operation by January 1, 2014; conduct outreach to enroll vulnerable and underserved populations in Medicaid and CHIP. Enrollment website must be operational by January 1, 2014.
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments (Beginning in FY 2014).
- Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.

#### 2015 and later

- Requires states to report annually beginning January 2015 on changes in Medicaid enrollment by population, outreach and enrollment processes and other data to monitor enrollment and retention of Medicaid eligible individuals. Then HHS would report findings to Congress beginning in April 2015 annually on a state-by-state basis.
- Requires that CHIP eligible children who cannot enroll in CHIP due to federal allotment caps must be screened to determine if they are eligible for Medicaid and if not would be eligible for tax credits in a plan that is certified by the Secretary by April 2015 to be comparable to CHIP in the exchange.
- Provides for a 23 percentage point increase in the CHIP match rate up to a cap of 100% beginning in October 1, 2015.

## **MEDICAID ENROLLMENT, BY STATE**

**Editor's Note:** The following information is from FY 2009 and is provided [here](#) by The Henry J. Kaiser Family Foundation.

<b>State</b>	<b>Total Medicaid Enrollment, FY 2009</b>
Alabama	954793
Alaska	121290
Arizona	1721265
Arkansas	698819
California	11027600
Colorado	618334
Connecticut	586713
Delaware	207243
District of Columbia	170184
Florida	3420858
Georgia	1818714
Hawaii	247246
Idaho	227849
Illinois	2698787
Indiana	1145569
Iowa	522746
Kansas	372522
Kentucky	884981
Louisiana	1148863
Maine	358004
Maryland	862385
Massachusetts	1521766
Michigan	2018597
Minnesota	879145
Mississippi	754333
Missouri	1065266
Montana	114958
Nebraska	253474
Nevada	290435
New Hampshire	159262
New Jersey	1010077
New Mexico	546532
New York	5208135
North Carolina	1813298
North Dakota	75328
Ohio	2180552

Oklahoma	799885
Oregon	564470
Pennsylvania	2199371
Rhode Island	204829
South Carolina	892583
South Dakota	128063
Tennessee	1502364
Texas	4488188
United States	62594979
Utah	294903
Vermont	182045
Virginia	945527
Washington	1159333
West Virginia	416858
Wisconsin	1028272
Wyoming	82365

## **MEDICARE AND MEDICAID TALKING POINTS**

- Republicans have the only plan to preserve and protect Medicare while the Democrats' government takeover of healthcare cuts \$500 billion from Medicare.
- The Democrats' big-government healthcare overhaul gives control over Medicare to 15 unelected bureaucrats, while the Republican bipartisan plan empowers 50 million seniors to make decisions on what type of care is best for them.
- The Republican plan does not affect anyone 55 years of age or older. Those 54 and younger would have the ability to choose from competing plans that fit their needs best, offering the same kinds of choices Members of Congress currently enjoy.
- Medicaid for the poor and elderly is critical and must be improved by making it less bureaucratic and more innovative.

## **ADDITIONAL INFORMATION AND RESOURCES**

- Boards of Trustees for Medicare – <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html>
- Center for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/>
- FY 2013 Budget Resolution, House Budget Committee – <http://budget.house.gov/fy2013Prosperity//>
- The Henry J. Kaiser Family Foundation – <http://www.kff.org/>
- National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) – <http://www.cdc.gov/nchs/>
- The Official U.S. Government Site for Medicaid – <http://www.medicaid.gov/>
- The Official U.S. Government Site for Medicare – <http://www.medicare.gov/>