SOCIETY OF ACTUARIES

Article from:

In The Public Interest

January 2014 – Issue 9

AN INTRODUCTION TO MEDICARE

By Zach Davis

Words like Social Security, Medicare, and entitlement programs from the press and politicians receive a lot of attention when the country's economic position and federal deficit are discussed. Many Americans know that Medicare is a government health insurance program; however, they are not always sure who and what it covers. This article is intended to provide an introductory summary of the Medicare program; including its history, who it covers, what it covers, and how it is financed.

HISTORY OF MEDICARE

Medicare was enacted by President Lyndon B. Johnson on July 30, 1965. The program was designed to extend health coverage to all Americans over the age of 65, low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. Medicare was implemented on July 1, 1966, with 19 million Americans enrolling. Over the next 48 years there were many expansions to the program. Some of the key expansions include[1]:

- 1972—Extending coverage to long-term disabled individuals under 65 and individuals with end stage renal disease (ESRD);
- 1973—The HMO Act provided grants and loans along with preferential treatment to federally qualified HMOs;
- 1988—The Medicare Catastrophic Coverage Act improved coverage for inpatient, skilled nursing facilities, and included an outpatient prescription drug benefit;
- 1997—The Balanced Budget Act established private Medicare options that have evolved into what is known today as Medicare Advantage or Medicare Part C;
- 1998—www.Medicare.gov launched to help provide information on Medicare and answer Medicare related questions;
- 2003—The Medicare Modernization Act established a prescription drug benefit under Medicare Part D.

BENEFIT ELIGIBILITY AND STRUCTURE

Individuals must be 65 years old or older to be eligible for Medicare benefits and have paid into the Medicare system by paying the Medicare payroll tax for 10 or more years. Individuals who are under age 65 may also be eligible for Medicare, if they have been collecting Social Security disability for 24 months, have ESRD, or have amyotrophic lateral sclerosis (ALS).

Medicare health coverage is broken down into three parts[2]:

- Part A—Hospital Insurance (HI) covers inpatient hospital care, skilled nursing facility (SNF) care, hospice, and home health services;
- Part B—Medical insurance covers physician services, outpatient services, home health services, durable medical equipment, and other medical services/screenings; and
- Part D—Prescription Drug Insurance, offered through private carriers, provides coverage to individuals enrolled in standard Medicare and Medicare Advantage.

Part A

There is no Medicare Part A premium for individuals that have paid into the HI fund for 10 or more years. There is a Medicare Part A premium (up to $441 monthly for 2013) for individuals who have paid into the HI fund for less than 10 years. There is also patient cost sharing (i.e., deductibles, coinsurance, and/or copays) for individuals regardless of whether they pay the Part A premium or not.

Hospital Inpatient Cost Sharing

- Care is reimbursed based on each benefit period. A benefit period starts when the patient is admitted to the hospital for inpatient care and ends when the patient has been discharged from the hospital or SNF for 60 days without being re-admitted (Note: It

CONTINUED ON PAGE 20

Zach Davis, FSA, MAAA, is an associate actuary at Milliman, Inc. in Atlanta, Ga. He can be reached at *zach.davis@milliman.com.*

Patients that are eligible for Medicare are not required to enroll in Medicare Part B, but those that choose to enroll are subject to a monthly Part B premium. . . .

counts as a single benefit period even if the patient is admitted to the hospital for a different disease/illness within 60 days of being discharged).

- The patient pays the following deductible and copays for each benefit period:
  - First dollar deductible ($1,184 in 2013);
  - $0 copay per day for days 0–60;
  - Per day copay (25 percent of first dollar deductible) for days 61–90;
  - Per day copay (50 percent of first dollar deductible) for each day above 90 for up to 60 additional "lifetime reserve days"; and
  - After the lifetime reserve days have been exhausted, the patient is responsible for 100 percent of the continuing cost of care.

SNF Cost Sharing

- The patient must have been admitted to the hospital for at least three days before Medicare begins covering the costs of a SNF.
- The patient pays the following deductible and copays for each benefit period:
  - $0 copay for days 1–20;
  - Copay (12.5 percent of inpatient first dollar deductible) for days 21–100;
  - 100 percent of cost after day 100 for each benefit period; and
  - Patients may not use lifetime reserve days to extend the coverage of care in SNFs.

Hospice Cost Sharing

- A doctor must certify that the patient is terminally ill with a life expectancy of less than six months to qualify for hospice care.
- There is no cost sharing for in-home hospice care.
- $5 copay for outpatient prescription drugs for pain and symptom management.
- Patient pays 5 percent of costs for Medicare approved inpatient respite care.

Home Health Cost Sharing

- Home health coverage includes in-home skilled nursing care, pathology services and physical/speech/occupational therapy.
- There is no cost sharing for in-home care.

Part B

Medicare Part B provides medical insurance for physician and outpatient services. Patients that are eligible for Medicare are not required to enroll in Medicare Part B, but those that choose to enroll are subject to a monthly Part B premium, which varies by annual income level ($104.90 to $335.70 in 2013). Part B services are also subject to an annual Part B deductible ($147 in 2013) and a 20 percent coinsurance for most services. Patients do not have to pay cost sharing for preventive services.

Part D

Medicare Part D is the most recent expansion of the Medicare program. President George W. Bush signed the Medicare Modernization Act in 2003 establishing, for the first time, a Medicare prescription drug benefit. Medicare eligible individuals have the option to enroll in two types of Part D plans; a stand-alone Part D plan (PDP) or a Medicare Advantage Prescription drug plan (MAPD). The PDP plan only offers prescription drug coverage. The MAPD combines a private MA plan along with a PDP plan, so the individual has both medical and prescription drug coverage. The PDP and the MAPD plans are private prescription drug options and involve an annual competitive bidding process. The federal government pays the private health insurance company a fixed premium each month for each individual. The private insurance company is responsible for payment and administration of Part D services. Any gain/(loss) from covering and administering these services is the responsibility of the private

insurance company, subject to risk sharing provisions with the federal government.

CURRENT AND FUTURE MEDICARE FUNDING STATUS

Medicare Part A (HI) is funded primarily by payroll taxes assessed on employees and employers. Both the employee and the employer pay 1.45 percent of the employee's wage toward the HI fund. There is no wage limit for the Medicare payroll tax. Starting in 2013, high income wage earners are required to pay an additional 0.9 percent tax for wages above $200,000. The HI fund also receives a small amount of funds from taxes on social security benefits, interest earned in the HI fund, and Part A premiums for those individuals who did not meet the Part A qualification standard.

The Supplemental Medical Insurance fund (SMI) funds both Part B and Part D coverage. The SMI's primary source of funding is an authorization by Congress each year. This funding is paid out of the federal government's general revenue. The second main source of funding is the monthly Medicare Part B and Part D premiums. The monthly Medicare Part B premium is established each year to fund approximately 25 percent of the annual Part B costs. The monthly Medicare Part D premium is established each year to fund approximately 25.5 percent of the annual Part D cost. The SMI also receives a small amount of additional funding from interest earned on fund investments.

According to the 2012 Social Security and Medicare trust fund report,[3] both the HI Fund and the SMI Fund paid out more in benefits than they received in income. The HI fund is projected to be depleted by 2026. Starting in 2026, the revenue is projected to fund only 87 percent of benefits paid out in 2026, and only 73 percent of benefits by 2087.

ADDITIONAL MEDICARE PRODUCTS

In addition to Medicare Part A and Part B, there are other options for Medicare eligible individuals. Medicare Advantage "MA," also known as Medicare Part C, is an alternative to Part A and Part B. Under MA, private health insurance companies enroll and cover Medicare eligible individuals in lieu of standard Medicare. In exchange for taking the risk of these individuals, the private health insurance companies receive a monthly payment for each enrollee from the Centers for Medicare and Medicaid Services (CMS) along with a member premium, if any. The CMS payment is adjusted for several factors including age, area and risk score, but the member premium does not vary. The health insurance company is then responsible for the payment and administration of Medicare covered services along with any additional services promised in the MA plan. Any gain/(loss) from covering and administering these services is the responsibility of the private insurance company. Each year there is a bidding process that establishes the next year's payment from CMS to the health insurance company and any premium to be paid by the individual.

The HI fund is projected to be depleted by 2026.

Medigap policies, also known as Medicare Supplemental policies, are another option for Medicare eligible individuals. Medigap polices are sold to supplement Medicare Part A and Part B benefits. These plans are designed to cover out-of-pocket expenses created by the standard Medi-

CONTINUED ON PAGE 22

Although few Americans believe that the Medicare program will be terminated, many believe that changes will be needed to make the program sustainable in the future.

care plan design. An individual must be enrolled in Medicare before they are allowed to purchase a Medigap policy. The Medigap policy requires a monthly premium that is age adjusted in addition to any premiums required for Medicare Parts A, B and D. Currently, there are 10 standardized Medigap policies.[4] Since 2004, there have been changes to the standardized Medigap plans, ranging from eliminating prescription drug coverage (due to Part D), to adding high-deductible options, to adding coinsurance, copays and out-of-pocket maximums. Depending on the policy chosen, the Medigap plan may cover some or all of the Medicare deductibles, copays and coinsurance required by standard Medicare plans.

MEDICARE IN THE FUTURE

Currently, the Medicare HI and SMI funds are paying out more in benefits than they are receiving in revenue each year. This funding issue creates an uncertainty about the future of Medicare. Although few Americans believe that the Medicare program will be terminated, many believe that changes will be needed to make the program sustainable in the future. Some of the potential changes include raising the eligibility age, increasing the Medicare payroll tax, and modernizing the benefit design to simplify cost sharing, steer utilization, and provide more comprehensive catastrophic coverage.