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Health Law Fundamentals: Medicare Coverage and Reimbursement

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FUNDAMENTALS OF MEDICARE

I. OVERVIEW

Medicare is getting older! On July 30, 1965, the Compromise Social Security Amendments of 1965 (Pub.L.No. 89-87), adding Title XVIII (Medicare) and Title XIX (Medicaid) to the Social Security Act, was signed into law by President Lyndon B. Johnson. Medicare is a social health insurance program that provides universal hospital coverage for Americans 65 years of age or older. The nation's largest health insurance program, Medicare covers over 57 million beneficiaries and processes over 1 billion claims per year. The number of beneficiaries is expected to rise to more than 81 million by 2030.[1] In 2000, Medicare expenditures exceeded $215 billion and accounted for about 17.7% of total federal outlays. By 2015, Medicare expenditures exceeded $646 billion and accounted for about 20% of total national health expenditures. Originally established as a health insurance program for the aging, Medicare now also insures the long-term disabled, those who require renal dialysis, and certain other eligible persons who can buy into the program regardless of age.

II. MEDICARE STRUCTURE

Medicare is organized into four separate programs, Part A (hospital insurance); Part B (supplementary medical insurance); Part C (Medicare Advantage); and Part D (prescription drugs). The term "Part" refers to divisions within Title XVIII of the Social Security Act. Each Part is financed differently and offers a distinct type of beneficiary coverage.

A. Part A

Medicare Part A covers inpatient hospital and critical access hospital (CAH) care, post-hospital skilled nursing facility (SNF) care, some home health services and hospice care. Medicare Part A is financed through the federal Hospital Insurance (HI) Trust Fund which is funded through payroll tax contributions from workers and employers. No premium payments are required for those automatically eligible for Part A.[2] When you hear experts discuss the dangerously low levels in the Medicare Trust Fund, they are referring to Medicare Part A.

B. Part B

Medicare Part B covers "medical and other health services", including physicians' services, outpatient hospital department care, laboratory services, some home health care, physical and occupational therapy, durable medical equipment (DME) and supplies, diagnostic imaging, x-ray therapy and radiation therapy, medical supplies, ambulance services, rural health clinic services, home dialysis

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1 SOURCE: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

2 See 42 C.F.R. Part 406.

supplies and equipment, vaccines, screening mammography, clinical psychologists and clinical social workers. [3] Medicare Part B, also known as Supplementary Medical Insurance (SMI), is a voluntary program. Medicare Part B is financed through the SMI Trust Fund which in turn is funded by individual premiums and general tax revenues. Premium payments for Part B enrollees are automatically deducted from the individual's social security checks. For persons not yet receiving social security or railroad retirement benefits, Medicare will send a bill for the Part B premium every 3 months.[4]

C. Part C

Formerly known as Medicare+Choice, the "Medicare Advantage" or "MA" program offers Medicare beneficiaries a range of managed care coverage choices. Beneficiaries with traditional Part A and Part B coverage may continue to receive such traditional fee-for-service coverage, or may elect MA coverage through a Medicare-approved private managed care organization or fee-for-service plan, for a monthly premium. At a minimum, every MA plan must provide beneficiaries with all of the items and services offered by Parts A and B, with limited exceptions. Most offer additional benefits to encourage enrollment, such as vision, dental, hearing, and wellness programs. Payments to MA organizations are financed through the HI and SMI Trust Funds.[5] About one in every three Medicare enrollees participates in an MA Plan.

D. Part D

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 established a voluntary outpatient prescription drug benefit for Part A eligible or Part B enrolled beneficiaries that became operational in 2006. Part D covered drugs include Medicaid-covered prescription drugs, biologicals, and vaccines. The goal of the program is to provide beneficiaries access to prescription drugs at lower cost due to CMS negotiated prices. The Part D benefit, which is provided through prescription drug plans (PDPs) and MA plans that offer drug coverage, is financed through a separate account in the SMI Trust Fund and is administered by CMS.[6]

E. Medicare Supplements

Medicare Supplements are not a program benefit, but Medicare-approved voluntary private insurance policies. They cover Medicare deductibles, copayments, and some additional services. Medicare Supplements are outside of traditional Medicare, and are fully funded by participants

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3 See generally 42 C.F.R. § 410.10.

4 See generally 42 C.F.R. Part 407.

5 See generally 42 C.F.R. Part 422.

6 See generally 42 C.F.R. Part 423.

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