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Learning Objectives

After completing this chapter, the reader should be able to answer the following questions:

- What is Medicare and who qualifies for it?
- What are the origins of the Medicare Program?
- What benefits were originally available under Medicare?
- How has Medicare changed up to 2011?
- What are the major challenges facing Medicare beyond 2011?

Introduction

In 1965, the United States Congress created Medicare under Title XVIII of the Social Security Act. The aim of the program was to provide health insurance coverage to all Americans aged 65 years and older. This chapter describes the evolution of Medicare from passage in 1965 to 2011. It is useful for both health-care practitioners and practitioners-in-training to understand the history of Medicare. Medicare has been in constant evolution and will continue to face serious challenges

as health-care spending outpaces inflation and as the US elderly population increases.

Passage of Medicare

The Elderly as a Priority

Medicare was passed during an era that was best known for large-scale social programs aimed at combating poverty in the United States. The elderly segment of the population became a target for social intervention when it became apparent that older Americans were significantly poorer than the rest of the population. In the 1960s, the poverty rate for households headed by someone aged 25–54 years was 13 % while the poverty rate for households headed by an elderly head of household was 47 % [1]. This level of impoverishment was thought to be largely due to disproportionate health-care expenditures by the elderly. The elderly faced disproportionately

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higher health-care expenditures in the 1950s and 1960s because health-care insurance at that time was predominantly employer-based. Therefore, as most Americans retired, they could no longer afford coverage and were forced to personally cover medical expenditures.

Support of health-care assistance for the elderly began to gain momentum among politicians in the 1950s. An important first step toward Medicare came in 1960 with the passage of the Kerr-Mills bill which provided federal matching funds to states for health-care provider payments in the treatment of the indigent aged. The program defined indigence as financial hardship causing a person's inability to pay for health-care services [2]. Thus, through federal assistance, the poor elderly could for the first time afford health-care coverage.

Medicare Passes

Despite passage of the Kerr-Mills bill, there was growing support for universal coverage for Americans 65 years and older. In 1962, what would be a precursor bill to the eventual Medicare bill was narrowly defeated (12–11) in committee. The defeated bill, the King-Anderson Bill, proposed coverage of *some* hospital and nursing home costs for patients 65 years and older. The election of Lyndon B. Johnson in 1964, however, proved to be pivotal in the eventual passage of Medicare. With Johnson's election, the Democrats controlled both the Presidency and the Congress with a 2:1 ratio in the House and 32 more seats than Republicans in the Senate. The King-Anderson Bill was revisited and rewritten as Medicare to provide coverage to individuals over the age of 65 for limited hospitalization and nursing home insurance benefits. Johnson proclaimed the new bill as an integral piece to his Great Society program. The new bill was not without opposition, however. Groups previously opposing the original King-Anderson Bill proposed their own versions of Medicare such that three forms of the bill emerged. One of the two opposing bills was outright rejected, and the

Medicare bill that was eventually sent to Congress in March 1965 included several provisions from the other remaining bill.

The final Medicare bill went through more than 500 amendments but was eventually passed on July 28, 1965, as an amendment to the Social Security Act of 1935. The bill, which was known as Title XVIII, included a Part A that provided for hospital insurance for the aged and a Part B that provided supplementary medical insurance.

Of note (and discussed in Chap. 3), Title XIX, also passed at the same time, was known as Medicaid and provided federal matching funds to states in order to assist Americans at or near the poverty line with health-care coverage.

Not Just the Elderly

Over the past five decades, the eligibility of Medicare has been expanded to include specific subsets of Americans younger than 65 years of age. In 1972, Congress expanded the eligibility to include younger Americans who (1) have permanent disabilities or blindness and are eligible for Social Security Disability Insurance (SSDI) or (2) have end-stage renal disease (ESRD). In 2001, coverage was again extended by Congress to include Americans with amyotrophic lateral sclerosis (ALS).

Overview of Medicare

One year after its passage, Medicare was an active program for the 65-and-older population, and by that point, the program already had an enrollment of 19.5 million [3]. By 2008, Medicare had an enrollment of 45 million and was projected to reach 78 million by 2030 [4].

In this section, we provide an overview of the fundamentals and benefit structures within Medicare. In proceeding sections, we chronologically describe the evolution of the program and how the fundamentals have been changed and/or supplemented.

Funding

Medicare benefits are financed primarily by two trust funds. The Part A trust fund is funded through mandatory payroll deductions. 1.45 % of taxable earnings paid by employees and 1.45 % paid by their employers (totaling 2.9 %) accrue to the Part A trust fund. Self-employed individuals pay 2.9 % to the fund [5]. Under this system, these taxes paid each year are used to fund the expenses of current beneficiaries, and those not needed are invested in US Treasury securities. This funding approach thus relies on the current work force to pay for the health-care costs of the elderly, most of who are no longer active members of the work force. This payment structure is noteworthy because Medicare's financial stability thus becomes dependent on preventing health-care expenses incurred by the elderly from exceeding the revenues provided through taxes on the current work force.

Part B (and also Part D which is discussed later in this chapter) is funded through premiums paid by program enrollees and contributions from the general revenue of the US Treasury. The latter revenue source is a significant proportion (approximately 75 %) of the Part B budget.

Eligibility

Age over 65, disability, and end-stage illness are generally the eligibility criteria for Medicare. However, within these major eligibility groups, there are nuanced eligibility requirements.

Age Over 65

Persons over the age of 65 may qualify for Medicare if they are US citizens or have been permanent legal US residents for 5 years *continuously*, and either they or their spouse has paid Medicare taxes for at least 10 years.

Disability

To become eligible to enroll in Medicare, disabled Americans must have received either SSDI benefits or Railroad Retirement Board disability benefits for at least 24 months.

End-Stage Disease/ALS

Patients with ESRD must be getting continuing dialysis for their ESRD or require a kidney transplant. Patients with ALS are eligible for Medicare if they are declared disabled by the Social Security Administration (SSA) and are eligible for SSDI benefits.

Benefits

Part A: Hospital Insurance

Under Medicare Part A, participating institutions (e.g., hospitals, skilled nursing facilities, home health-care services, and hospice services) are reimbursed for a variety of services to the elderly. We briefly review these services.

Inpatient hospital stays are covered under Medicare Part A. Service coverage includes the cost of a semiprivate room, meals, regular nursing services, operating and recovery room, intensive care, and other medically necessary services.

Skilled nursing facility care is also covered under Medicare Part A; however, certain criteria must be met: (1) preceding hospital stay of at least 3 days, (2) admission to nursing home facility for a condition diagnosed during main hospital stay or condition that was cause for hospital stay, and (3) need for skilled nursing care (i.e., custodial and long-term care activities are not covered). Medicare also limits the nursing facility stay to 100 days per benefit period (i.e., per ailment). Medicare covers the first 20 days in full, while the remaining 80 days requires a co-payment.

Medicare Part A also provides coverage for home health agency (HHA) care and hospice care. HHAs may provide health aides for a home-bound beneficiary if some form of skilled nursing is required. Similarly to the skilled nursing facility criteria, Medicare covers the first 100 visits after a 3-day hospital stay (or a skilled nursing facility stay); however, there must be a plan of treatment reviewed by a physician. Part A also provides hospice care to terminally ill persons with life expectancy less than 6 months.

Part B: Supplementary Medical Insurance

Part B (supplementary medical insurance) is often viewed as a means to pay for services not covered under Part A. Traditional Part B services include outpatient physician and nursing services, diagnostic imaging and testing, outpatient hospital procedures, vaccinations, and a variety of services provided by physicians on an outpatient basis. However, to be covered under Part B, services have to be deemed medically necessary. Some services, such as physical and occupational therapy, while covered by Part B, typically require higher cost sharing on the part of the beneficiary.

Coverage under Part B is optional and must be secured by paying monthly premiums. Most people deemed eligible for Medicare Part A simultaneously elect for enrollment in Part B. The large proportion of simultaneous enrollees in Part B is partially due to a lifetime penalty (10 % annual premium per year) imposed for not enrolling. Those eligible for Part A who are still working *and* have health coverage through their employer may defer enrollment in Part B without penalty.

Of note, Part B has a deductible feature. As part of this feature, patients pay up to a certain amount for the cost of their care (hence deductible). After this amount has been reached, Medicare then pays for 80 % of the cost for approved services, while the beneficiary is responsible for the remaining 20 %. The Part B deductible was \$140 in 2012 [6].

Evolution of Medicare

Changes to Program Administration

Upon passage of the Medicare law, implementation of the program was originally headed by the Department of Health and Human Services (HHS). However, in 1976, administration of Medicare passed to a newly created special purpose Federal Program—the Health Care Financing Administration (HCFA). This organization was in charge of administering both Medicare and Medicaid. HCFA would eventually

become in 2001 the Centers for Medicare and Medicaid Services (CMS). Primary responsibilities of the CMS in overseeing Medicare include program policy and guidelines, contracts with intermediaries and carriers, monitoring of utilization, and general financing of Medicare.

The board is also mandated to report annually to the US Congress on the financial operations and actuarial status of the Medicare Program. The information reported to Congress is included in an annual report entitled “Medicare Trustees Report” [7].

In the 2012 report, the Trustees concluded that in 2011 Medicare costs were 3.7 % of GDP, and these costs exceeded Medicare’s Trust Fund revenues by more than \$27 billion for that year. The Trustees projected that Medicare expenditures would grow to 5.7 % of GDP by 2035 and would increase gradually thereafter to about 6.7 % of GDP by 2086. The reports warned that Medicare fiscal stability would be reliant on policy changes to increase revenues, decrease expenditures, or both.

Introduction of Managed Care

Soon after Medicare was passed, the government looked to Health Maintenance Organizations (HMOs) as a means to reduce escalating Medicare costs. The goal was to reduce the downstream costs of care by promoting preventative (upstream) care. In 1971, the Nixon administration announced a new health strategy that would establish planning grants and loan guarantees for HMOs. Following this announcement, in December 1973 President Richard Nixon signed the Health Maintenance Organization and Resources Development Act. This Act authorized \$375 million in federal funds to aid in developing HMOs and also mandated that employers with businesses of more than 25 employees offer HMOs as a health-care option.

Prior to signing the 1973 Act, a 1972 amendment to the Social Security Act introduced HMO enrollment and contracting as an option *within* Medicare [8]. HMOs had to meet Medicare-mandated standards and also had to provide the full range of Medicare services.

Diagnosis Related Group

Diagnosis Related Groups (DRGs) were originally introduced in 1983 as a payment system that classified hospital services into one of 467 groups. It was assumed that patient care episodes falling into each group would be clinically similar, would utilize hospital resources to the same extent, and thus could be reimbursed the same amount. Prior to the introduction of DRGs, Medicare institutional reimbursements were based on a fee for service model in which institutions were reimbursed based on their stated daily costs. As part of the overall compensation, hospitals were also permitted to factor in their overall operating costs into each patient bill. Thus, there was an incentive toward overbilling and overutilization of medical resources. DRGs were introduced to curb this trend in overutilization by paying a preset average cost to treat a patient with a particular diagnosis.

Since its introduction in 1983, DRGs have evolved, and today there are several systems of patient classification that were developed to refine disease classification and include risk adjustment for important cost drivers such as disease severity. Medical Severity (MS)-DRGs have since been widely adopted as the standard beyond the Medicare system and today are the focal point of many health-care industry reimbursement models.

Medicare Advantage

Throughout the 1990s, escalating costs continued to be a source of major concern for Medicare. To address escalating costs in health care, in 1997, the US Congress passed the Balanced Budget Act of 1997—a legislative package designed to balance the federal budget by 2002. As part of the package, the Congressional Budget Office promised \$112 billion in Medicare spending reduction [9]. As part of the Act's efforts to control costs and reduce spending, Medicare worked with private insurers to provide beneficiaries with an alternate avenue to access medical services. Medicare hoped to incent more beneficiaries to participate under privately run and lower cost-

managed care contracts rather than in the original fee for service plan created through Parts A and B.

Following passage of the Balanced Budget Act, the Medicare + Choice (M+C) Program (now known as Medicare "Part C") was introduced in 1997. Under M+C, new plans were introduced which were approved by Medicare but run by private insurance entities. Initially M+C was only available to Medicare eligible beneficiaries already enrolled in Parts A and B. M+C plans were required by Medicare to offer benefit packages with similar or better coverage than the original Medicare program. M+C plans did this and a little more. The newly created programs offered choice through diversification in how benefits were covered. For example, under one plan, a beneficiary could pay less for nursing facility stay but might then pay more for a regular doctor's visit. Under another plan, this relationship might be reversed. In general, in absolute terms, M+C plans offered more benefits (such as added dental and vision coverage) than the original Medicare program, and they also offered more attractive financing terms.

For those choosing to enroll in M+C, Medicare would pay the selected M+C plan's private insurance company a set amount every month for each member (payment amount was determined by Medicare based on beneficiary comorbidity and likely health-care use per month). The Medicare member enrolling in M+C would then still have to pay the Medicare Part B premium directly to Medicare—the rationale being that beneficiaries should still retain their original primary care physician who would oversee and coordinate the various benefits of the M+C plan.

By 1998, 17 % of Medicare enrollees (6.9 million) were enrolled in one of 346 M+C plans available nationwide [10]. However, between 1999 and 2001 nearly half of the plans participating in M+C program cancelled their contracts with Medicare. Medicare payment levels and poor profitability (as a result of rising input costs) were thought to be the major impetus for cancelled contracts. During the same time period, there were virtually no new M+C plan entrants. The withdrawals affected 1.6 million beneficiaries and M+C enrollment dropped to 5.5 million [11].

Medicare Prescription Drug, Improvement, and Modernization Act 2003 (Part D)

To stimulate more robust health-care insurance industry participation in Medicare and also to provide even greater coverage and more options to beneficiaries, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was enacted in 2003. MMA added a prescription drug benefit (Medicare Part D) and introduced several changes to M+C (M+C was renamed Medicare Advantage [MA] with the new changes). At that time, the changes introduced as part of MMA were the most significant changes introduced into Medicare since its inception.

Upon introduction of MMA, there was explosive growth in the number of participating Medicare Advantage organizations providing benefits. Several key Medicare changes spurred the growth in participating programs. Firstly, payment levels were increased on a per county basis to each county's traditional Medicare costs (some counties realized payment increases up to 20 % from pre-MMA levels). Further, risk-adjusted payments were incorporated into the payment model such that Medicare would pay a premium to the private plan providers for enrollees with greater comorbidities. MMA also introduced a regional preferred provider organization (PPO) option. Benefit providers could offer PPO-style benefits in which a beneficiary signing up for a program could have their care limited to a network of physicians. Finally, MMA also allowed Medicare Advantage programs to target dual eligible (those qualifying for Medicare and Medicaid) beneficiaries via the Special Needs Plan (SNP) option. Medicare Advantage organizations could offer benefit plans targeted to special needs populations—i.e., those with chronic diseases qualifying for Medicaid coverage (see Chap. 3).

MMA also introduced prescription drug coverage. In light of increasingly unaffordable prescription drug costs for the elderly, the most significant change (and thus the genesis of the Act's name) that stemmed from the introduction of MMA was Medicare Part D—a prescription

drug benefit program that subsidized the costs of prescription drugs for Medicare beneficiaries. This program went into effect on January 1, 2006.

Beneficiaries were eligible for prescription drug coverage under Part D if they were entitled to benefits under Part A and/or enrolled in Part B. Plans under Part D came in two varieties. The first was a Prescription Drug Plan (PDP), which provided drug coverage *only*. Under PDPs, not all drugs are covered at the same level; thus beneficiaries have the option of picking a PDP that best suits their prescribing patterns. The second option was a Medicare Advantage Prescription Drug plan (MA-PD). MA-PDs were plans that provided medical coverage under Medicare Advantage while *also* providing prescription drug coverage.

The MMA established a standard benefit package for Part D plans. Packages were standardized based on beneficiary contributions as opposed to drug coverage. In 2010, the standard benefit consisted of a \$310 initial deductible with a coverage limit of \$2,830. Once beneficiaries reach their coverage limit, he/she then pays the full cost for their drugs out of pocket (OOP) up until they have spent a total of \$4,550. Once OOP expenses exceed \$4,550, beneficiaries become eligible for catastrophic coverage that involves minimal cost sharing—beneficiary pays the greater of 5 % coinsurance or \$2.50 for generic drugs and \$6.30 for brand-named drugs. The coverage gap (OOP expenses) existing between initial and catastrophic coverage is referred to as the “donut hole” in Part D (Fig. 2.1).

Although the benefit package as described is considered the standard, programs vary widely in the formularies used. For example, some plans may remove the deductible and instead offer stratified co-payments in which cheaper drugs have lower co-pays, whereas costlier medications have a higher co-pay.

Medicare Improvements for Patients and Providers Act 2008

In the wake of Medicare reforms under MMA, the costs associated with payments to MA

Medicare Part D Standard Prescription Drug Benefit, 2010

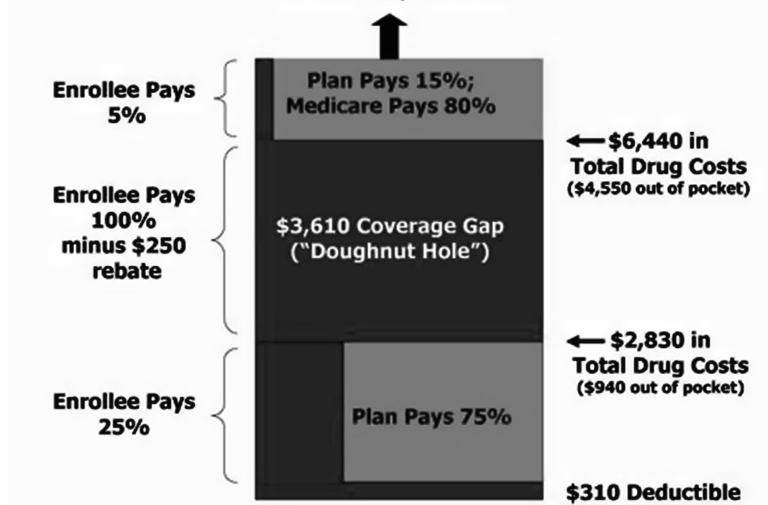


Fig. 2.1 Medicare donut hole (Note: Amounts rounded to nearest whole dollar) (Accessed at <http://facts.kff.org/chart.aspx?cb=58&sctn=164&ch=1748>; The Henry J. Kaiser Family Foundation illustration of Medicare Part D Standard Prescription Drug Benefit, 2010, Fast Facts. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family

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plans began to escalate. The Medicare Improvement for Patients and Providers Act (MIPPA) took preliminary steps to curb increases in payment to MA plans. MIPPA measures aimed at cutting MA plan costs included controlling the proliferation of skilled nursing facilities (SNPs) and private fee for service plans, as well as cutting MA payments for indirect medical education. MIPPA also sought to protect patients from aggressive brokers and agents by codifying consumer protections. Restrictions on program marketing efforts included no door-to-door sales, unsolicited calls, and a restricted marketing locale.

Legislating in favor of providers, MIPPA blocked a 10.6 % cut in Medicare payments to physicians in 2008 and instead increased the physician fee schedule by 1.1 % in 2009. Through the Act, providers were also given pecuniary incentive toward quality reporting and e-prescribing.

Patient Protection and Affordable Care Act 2010 and Medicare

For a detailed discussion on the Patient Protection and Affordable Care Act (PPACA), please see Chap. 19. The following discussion focuses on the law as it pertains to Medicare. With continually escalating health-care costs and beneficiary cost sharing throughout the first decade of the twenty-first century, the government looked to enact health-care reforms that would again drastically restructure Medicare. In 2010, President Barack Obama passed the Patient Protection and Affordable Care Act (PPACA). The legislature is best known by the public for introducing an individual mandate for health insurance and expanding access to insurance for Americans. The program however has profound implications for the Medicare Program. The goal of Medicare provisions under PPACA was both to prolong the time frame of Medicare financial solvency and to reduce beneficiary expenses.

In describing the relationship between PPACA and Medicare, President Obama said:

This new law recognizes that Medicare isn't just something that you're entitled to when you reach 65; it's something that you've earned. It's something that you've worked a lifetime for, having the security of knowing that Medicare will be there when you need it. It's a sacred and inviolable trust between you and your country. And those of us in elected office have a commitment to uphold that trust—and as long as I'm President, I will. And that's why this new law gives seniors and their families greater savings, better benefits and higher-quality health care. That's why it ensures accountability throughout the system so that seniors have greater control over the care that they receive. And that's why it keeps Medicare strong and solvent—today and tomorrow. [12]

Programs introduced under PPACA aimed to reduce costs via improving the quality of care, reforming the system of care delivery, appropriately pricing/financing health-care systems, and reducing waste within the system. We briefly elaborate on these measures next.

Improving the Quality of Care in Medicare

The PPACA introduced a number of measures seeking to improve quality of care through value-based purchasing (VBP) programs within the Medicare program. VBP programs were introduced as a means to change how health-care providers are paid. The goal is to align payments with performance measures in order to improve the quality of care. For example, the Hospital VBP program is an example of new VBP measures under PPACA. As part of the Hospital VBP, starting fiscal year 2013, incentive payments are made to hospitals that meet (or exceed) Medicare performance standards. Target performance standards focus on efficiently managing high-volume medical conditions (e.g., acute myocardial infarction and heart failure) and limiting hospital-associated complications (e.g., health-care-associated infections).

Further, in an attempt to create even greater accountability, transparency, and incentive toward quality, the PPACA created multiple tools for the public dissemination of health-care provider performance. On the website www.healthcare.gov/compare, the public is readily

able to compare a variety of quality measures for health care and service providers. Specifically, quality information on hospitals, medical practices, physicians, nursing homes, home health agencies, and dialysis facilities are available through the website.

PPACA also enacted a “hospital readmissions reduction program,” which rewards hospitals for reducing avoidable readmissions and is projected by the CMS Office of the Actuary to reduce Medicare costs by \$8.2 billion through 2019 [13].

Reforming the System of Care Delivery and Medicare

PPACA introduced the concept of Accountable Care Organizations (ACOs). ACOs are health care delivery systems in which preassigned teams of physicians, hospitals, or other health-care providers collaborate to manage and coordinate the care of Medicare beneficiaries. Under the Medicare shared savings program, if providers meet certain quality/efficiency benchmarks, they receive a share of any savings resultant from reducing duplicative work. Although budget neutral in principle, the program has been projected to cumulatively reduce Medicare expenditures by \$5 billion within 10 years [12].

To provide further oversight of Medicare fiscal health, the PPACA established the Independent Payment Advisory Board (IPAB)—the board's primary goal being to monitor Medicare fiscal health and recommend policy revisions to Congress on how to keep pace with cost growth. Cost projections suggest that IPAB could reduce Medicare costs by almost \$24 billion by 2019 [12]. However, IPAB has been highly criticized by many stakeholders for its lack of accountability to publicly elected officials and the fact that practicing physicians are prohibited from serving on IPAB.

Improving Pricing/Financing of Medicare

Cost estimates of payments to new MA plans suggested that Medicare grossly overpaid these plans. It was estimated by the Medicare Payment Advisory Commission (MedPAC) that Medicare paid MA plans 14 % (~\$1,000 per person more on average) more for health services than they

did under traditional Medicare. The additional payments could not be explained by health differences among service recipients [12]. Although there is no clear explanation for the MA plan overpayments, it can be speculated that MA plans are a more costly way to deliver care given that they require higher marketing/administrative costs than traditional fee for service plans. Further, it has also been suggested that the Medicare disease severity coding formula inappropriately allows MA plans to claim a patient as “sicker” than would be possible under a fee for service plan. PPACA introduced cost-cutting measures aimed at equalizing costs between MA plans and traditional Medicare benefits.

PPACA also introduced the concept of market-based adjustments to provider payments, the goal of these adjustments being to take health-care provider location into consideration and to appropriately adjust provider annual payment based upon region.

Two other smaller-scale financing measures also introduced as part of PPACA include competitive bidding for durable medical equipment (DME) and modified equipment utilization factor for advanced imaging. Under competitive bidding, suppliers submit bids to become Medicare contract suppliers. In competitive bidding areas, the bidding process de facto drives down the price at which the suppliers provide DME. Competitive bidding was already under consideration prior to PPACA; however, the Act accelerated its enactment. The program is projected to reduce Medicare spending by more than \$17 billion [12]. Under the modified equipment utilization factor for advanced imaging provisions, the PPACA applied a discount to physician fee schedules for performing advanced imaging services. In essence, the PPACA altered the physician payment schedule such that physicians would be paid less for using advanced imaging modalities. This provision represents a projected \$2 billion over 10 years cost savings [12].

Reducing Medicare Fraud and Abuse

PPACA also introduced measures aimed at preventing fraud and abuse within the Medicare system. Screening processes were implemented to verify and validate providers making

Medicare claims. More resources were allocated to anti-fraud activities such as prepayment reviews and “boots on the ground” to conduct site visits. The PPACA specifically looked to reduce fraudulent billing in two areas in which Medicare had been historically vulnerable: home health and DME. PPACA imposed tighter restrictions on providers’ ability to refer for home health or DME.

The PPACA also expanded the Recovery Auditor Contractor (RAC) program, which had been created in 2003 under the MMA. RACs were independent collection agencies that worked in collaboration with Medicare to implement “claw-backs” through retrospective reviews of claims, thereby reclaiming improper payments. Since the passage of the PPACA, there have been several attempts to implement RAC related demonstrations so that recovery auditors could review hospital claims before they are paid, thereby prospectively identifying improper payments. In 2011, the CMS announced a list of 15 procedures that would be subject to prepayment review. All 15 procedures related to cardiovascular and orthopedic services.

Medicare Beneficiary Provisions Under PPACA

PPACA attempts to enhance Medicare prescription coverage. The Act phased down coinsurance rates in the Medicare Part D donut hole from 100 % to 25 % by 2020. This was accomplished via federal subsidies and Medicare-mandated pharmaceutical manufacturer discounts. These reduced cost-sharing initiatives are projected to save beneficiaries about \$43 billion within 10 years [14]. PPACA also removed beneficiary cost sharing for Medicare-covered preventative services such as colorectal screenings.

PPACA measures did not, however, result in across-the-board positive impacts for beneficiaries. PPACA introduced income-related Medicare Part B premiums such that higher-income beneficiaries began to pay higher premiums. Beneficiaries enrolled in MA plans also saw their number of benefits reduced. With a scaling down of government subsidies to MA programs, the programs responded by reducing the array of additional benefits offered to plan enrollees.

Evolution Beyond 2011?

The biggest challenge facing Medicare remains controlling costs in order to ensure the financial health and long-term sustainability of the program. With increased life expectancy and the aging of the baby boom generation, the 65 and older population in the USA is expected to double by 2030 [4]. This phenomenon, in addition to increased health-care utilization, rise in prices, and adoption of new technologies, is expected to place an unbearable strain on the Medicare budget.

Many of the programs and measures described in this chapter have taken aim at improving Medicare's long-term fiscal viability. More steps must be taken, however. Much of the future debate will center upon which shareholder group should bear the fiscal burden of the Medicare program. Some policymakers suggest that seniors should begin to play a greater role in the cost sharing and that they should be made financially responsible for the benefits that they receive. Others argue, however, that limiting payments to providers would effectively decrease costs and could encourage more judicious use of resources.

The medical profession has an obligation to remain abreast of the constantly evolving Medicare landscape and to provide leadership and input into strategies to ensure the viability of the Medicare program. As such, we may better understand the impact of Medicare policy changes on our profession and the health-care accessibility options for those under our care.

Conclusion

In this chapter, we presented an overview of the Medicare program. Medicare is a social security program passed in 1965 that since passage has provided health insurance coverage to Americans aged 65 years and older. We described the evolution of Medicare from its original format - Part A and B - to the addition of Medicare Advantage plans and prescription drug benefits. Given how closely Medicare history is tied to legislative acts of Congress, we outlined and presented the key

pieces of legislature that have shaped Medicare since 1965. Most recently, such acts have included the Balanced Budget Act of 1997; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and the Patient Protection and Affordable Care Act of 2010. Medicare has evolved to provide US seniors with choice and access to care unparalleled in American history. Going forward, the program will inevitably continue to evolve as necessitated by the financial strains of an aging population and escalating medical costs.

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