

# Medicare Overview

James Cosgrove, Director  
U.S. Government Accountability  
Office (GAO)  
February 6, 2015

---



# Presentation Outline

- General Structure, Eligibility, and Beneficiaries
- Medicare Providers
- Medicare Benefits
- Medicare Financing
- Medicare Administration
- Dual-Eligible Beneficiaries

# GENERAL STRUCTURE, ELIGIBILITY, AND BENEFICIARIES

# The “Parts” of Medicare

- **Part A** – Hospital Insurance (HI)
- **Part B** – Supplementary Medical Insurance (SMI)
- **Part C** – Medicare Advantage (MA)
- **Part D** – Prescription Drug Benefits

# Who Is Eligible?

- U.S. citizens and permanent legal residents who are:
  - Age 65 and older
    - Automatically entitled if they or their spouse paid Medicare payroll taxes for at least 10 years on earnings covered by the Social Security or the Railroad Retirement systems
    - If not automatically entitled, may obtain coverage by paying a monthly premium
  - Adults under age 65 with permanent disabilities
    - Eligible after receiving Social Security Disability Insurance (SSDI) benefits or disability benefits from the Railroad Retirement System for 24 months
  - Anyone with end-stage renal disease (ESRD) or Lou Gehrig's disease
    - Eligible as soon as they begin receiving SSDI benefits (Lou Gehrig's disease) or after 3 months of dialysis treatments (ESRD)
- Approximately 54 million Medicare beneficiaries in 2014

# Selected Medicare Demographics and Health Status (2010)

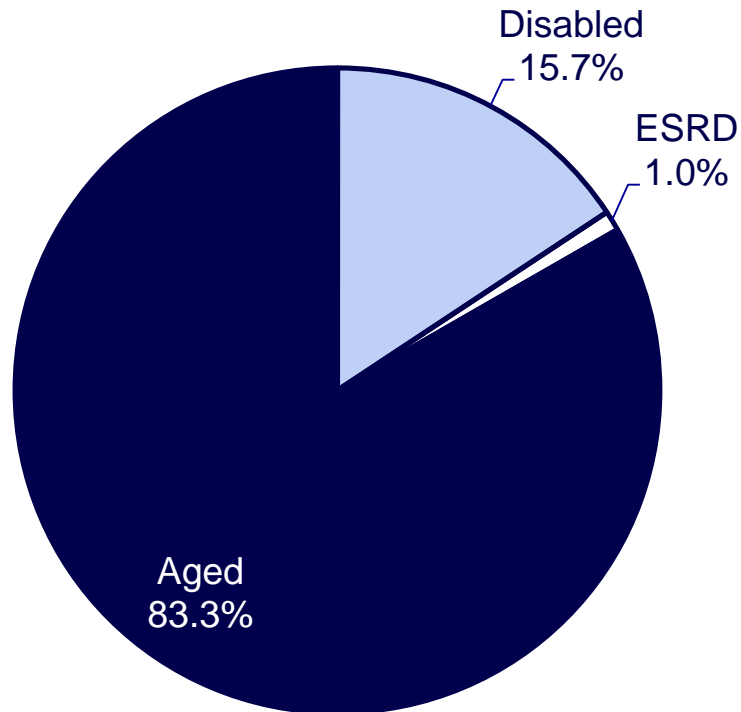
<u>Characteristic</u>	<u>Percent of the Medicare Population</u>
Living Arrangement	
Institution	5
Alone	29
Income Status	
Below 125% of poverty	23
Over 400% of poverty	27
Supplemental Insurance Status	
Medicare only	10
Medicaid	14
Employer, medigap, other	76
Health Status	
3+ chronic conditions	65
Fair/ poor health	27
Cognitive/ mental impairment	31
2+ ADL limitations	20

Note: ADL = activity of daily living.

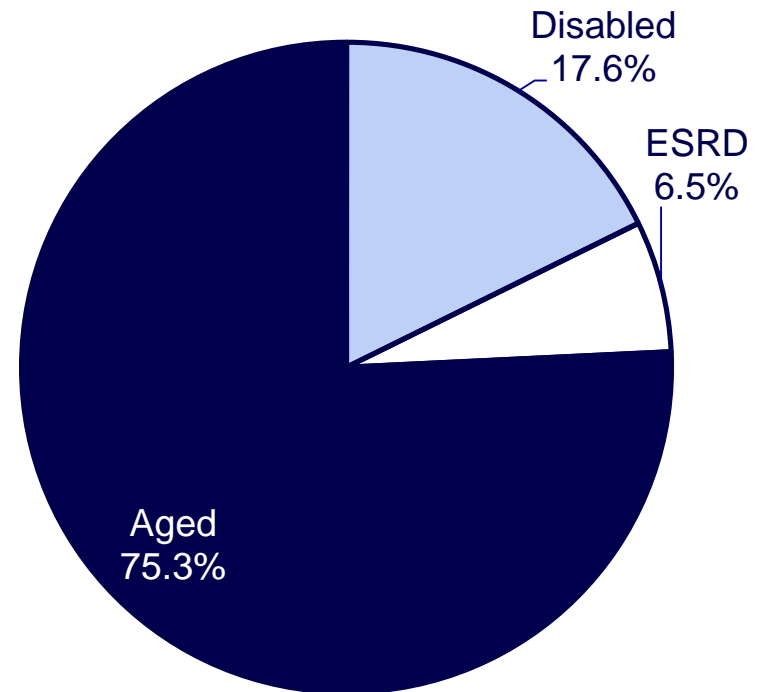
Sources: Adapted from MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2010; Urban Institute and Kaiser Family Foundation analysis, 2013; and Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2010.

# Aged Beneficiaries Account for the Greatest Share of the Medicare Population and Program Spending (2010)

**Percent of Beneficiaries**



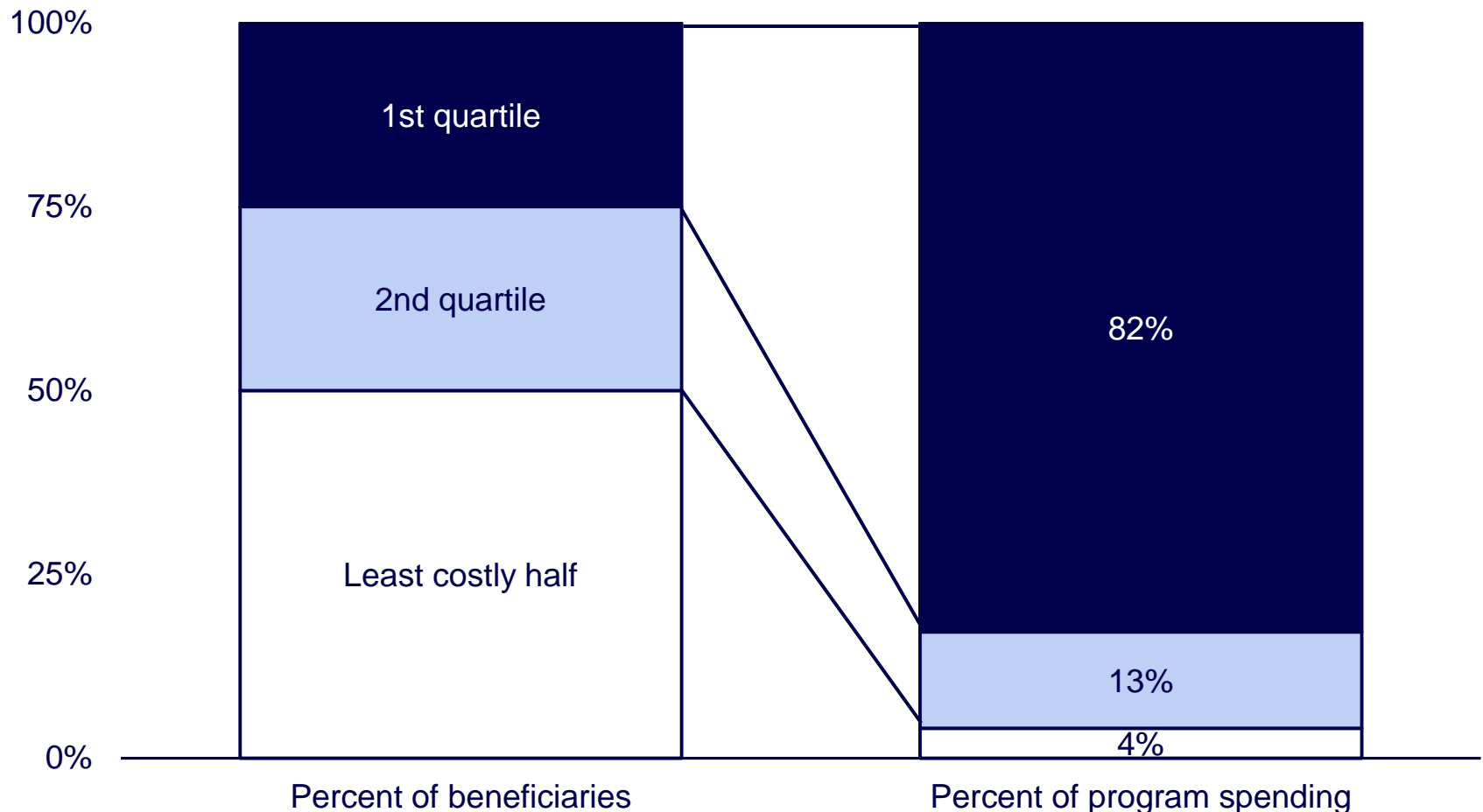
**Percent of Spending**



Note: ESRD = end-stage renal disease. The aged category refers to beneficiaries age 65 or older without ESRD. The disabled category refers to beneficiaries under age 65 without ESRD. The ESRD category refers to beneficiaries with ESRD, regardless of age. Results include fee-for-service, Medicare Advantage, community-dwelling, and institutionalized beneficiaries. Totals may not sum to 100 percent due to rounding and exclusion of an "other" category.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2010.

# Medicare FFS Program Spending Is Highly Concentrated in A small Group of Beneficiaries (2010)

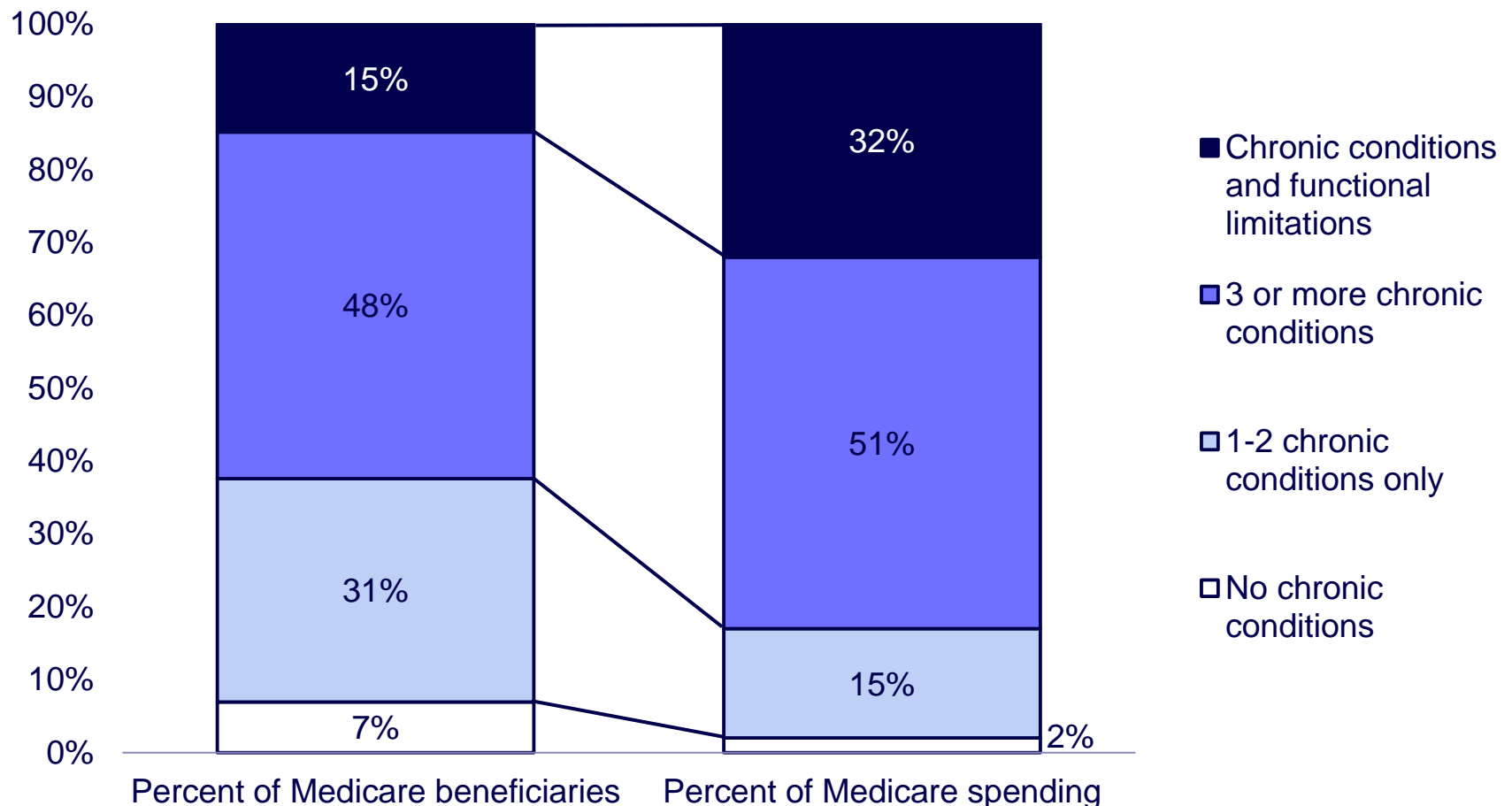


Note: FFS = fee-for-service. Excludes beneficiaries with any group health enrollment during the year.

Source: Adapted from MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files, 2010.



# Beneficiaries with Chronic Conditions and Functional Limitations Account for Almost One-third of Medicare Spending (2006)



Note: Analysis is based on Medicare beneficiaries enrolled in the traditional FFS Medicare program and therefore excludes beneficiaries enrolled in Medicare Advantage plans.

Source: Avalere Health, LLC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2006.

# MEDICARE PROVIDERS

# Selected Providers and Suppliers under Parts A & B (2013)

## Medicare Institutional and Physician/Supplier Providers

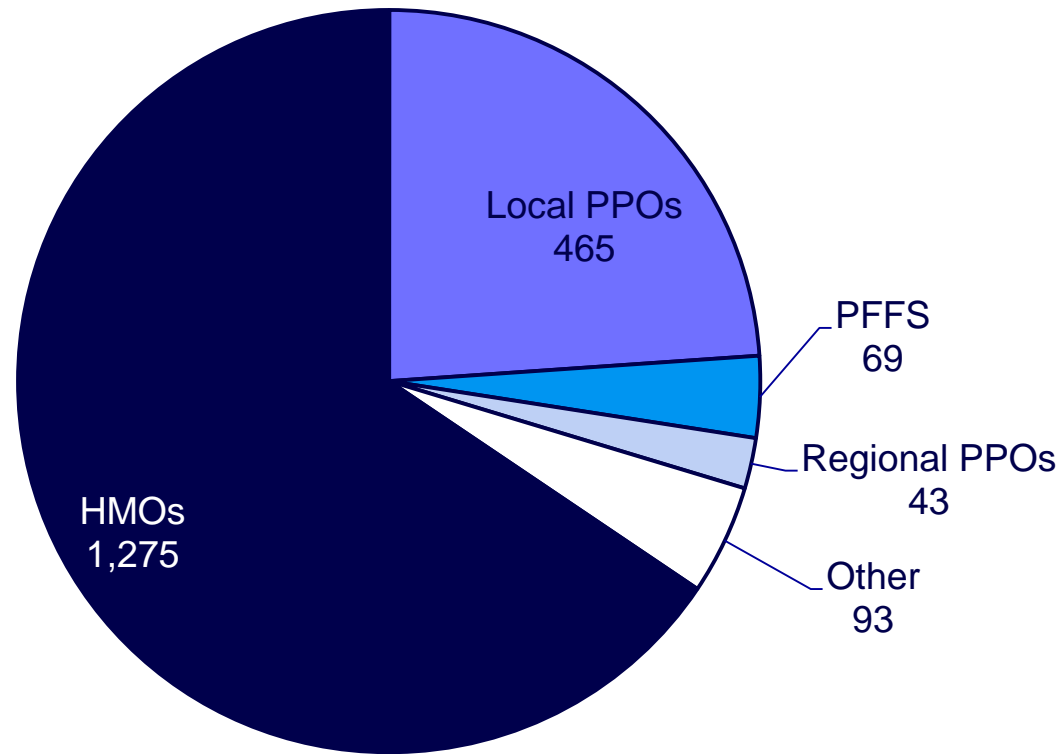
Total Hospitals	6,164
Home Health Agencies	12,459
Skilled Nursing Facilities	15,156
Labs	244,427
Ambulatory Surgical Centers	5,368
Hospices	3,941
Physicians	662,155
Other Practitioners	473,234
Durable Medical Equipment Suppliers	91,339

# Providers under Part C (MA)

- Approximately 1,950 Medicare Advantage and other Part C plans in 2015
  - Coordinated Care Plans (CCP)
    - Local Preferred Provider Organizations (PPO) or Health Maintenance Organizations (HMO)
    - Regional PPOs
    - Special Needs Plans (SNP)
  - Private Fee-for-service (PFFS)
  - Cost plans
- The average beneficiary can choose from 18 plans

# Providers under Part C (MA)

**Distribution of Medicare Advantage and Other Part C Plans, by Plan Type (2015)**



Note: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations. Other category includes cost plans and Medicare MSAs.

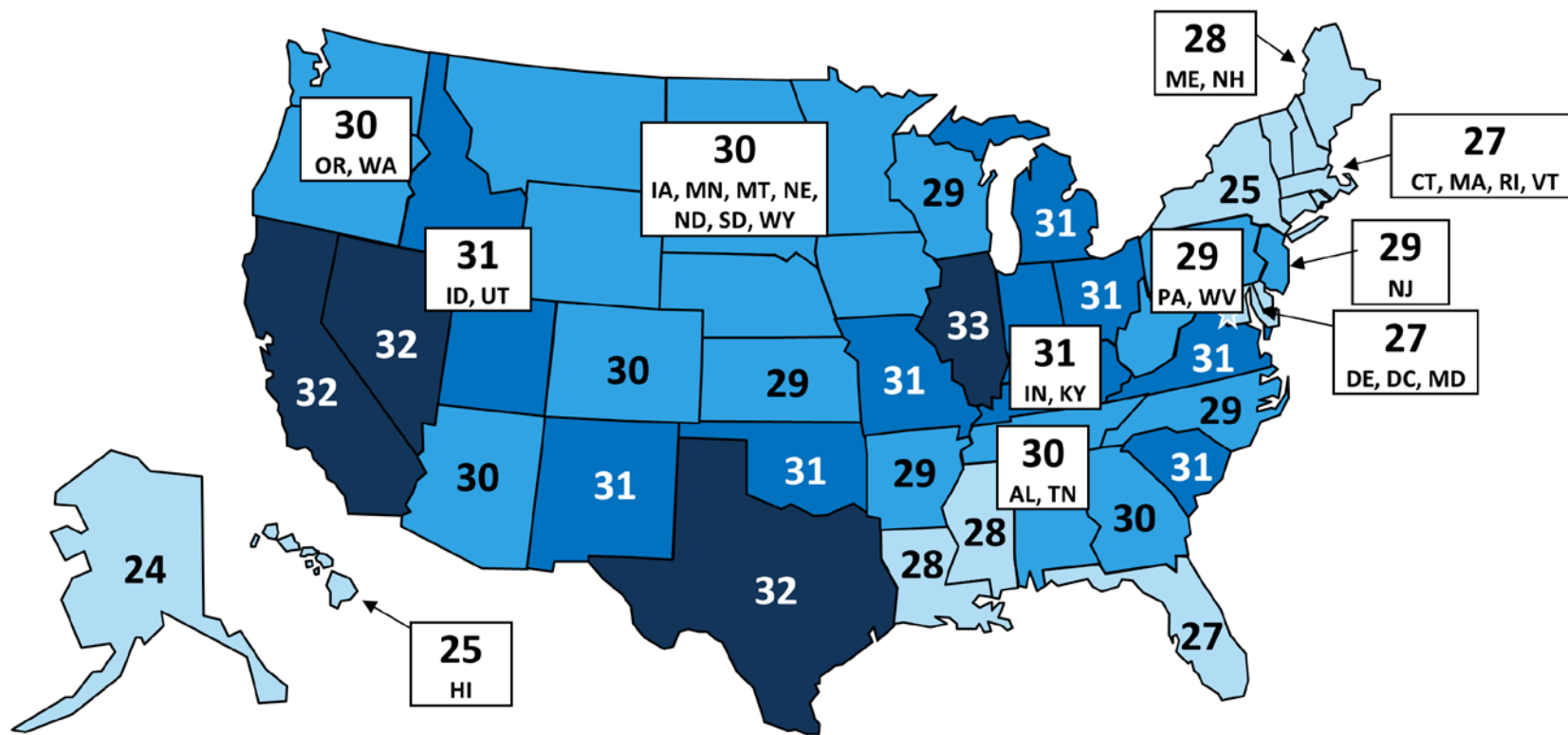
Source: Adapted from Mathematica Policy Research/ Kaiser Family Foundation analysis of CMS's Landscape Files for 2015.

# Providers under Part D

- Approximately 1,000 stand-alone Prescription Drug Plans (PDP) provide additional drug coverage to traditional Medicare in 2015
- The average beneficiary can choose from 30 PDPs
- Many MA plans offer Part D prescription drug coverage to their enrollees through MA Prescription Drug (MA-PD) plans that cover both services and drugs

# Providers under Part D

## Number of Medicare Part D Stand-Alone Prescription Drug Plans, by Region (2015)



Note: Excludes plans in the territories. Includes 36 plans under CMS sanction and closed to new enrollees as of September 2014.

Source: Georgetown/ NORC/ Kaiser Family Foundation analysis of CMS 2015 PDP Landscape Source File.

# MEDICARE BENEFITS



# Medicare Benefits

- Medicare covers services that are reasonable and necessary for the diagnosis or treatment of an illness or injury
- Congress has added coverage for certain preventive services, such as annual wellness visits and flu shots
- Medicare does not cover most long-term care
- Medicare does not have a catastrophic cap on cost-sharing charges
- By original statute, the Medicare program must not interfere with the practice of medicine

# Part A Benefits (2015)

- **Inpatient hospital stays** (coverage up to 150 days/ spell of illness)
  - Days 1-60: \$1,260 total deductible
  - Days 61-90: \$315 coinsurance per day
  - Days 91 and beyond: \$630 coinsurance per each “lifetime reserve day” (up to 60 days over lifetime)
- **Skilled nursing stays** (100 day maximum/ benefit period)
  - Requires 3-day prior hospital stay
  - Days 1-20: No cost
  - Days 21-100: \$157.50 coinsurance per day
- **Home health visits** (must be homebound) (also covered under Part B)
  - Level of care requirements
  - No charge for home health care services
- **Hospice care** (no coverage for curative services)
  - Terminal illness with less than 6 months to live
  - No charge for hospice services

# Part B Benefits (2015)

- Covers outpatient services, including
  - Physician visits
  - Outpatient hospital services
  - Preventive services, such as a “Welcome to Medicare” physical exam and mammography and colorectal screening
  - Home health visits (also covered under Part A)
  - Ambulance services
  - Clinical laboratory services
  - Durable medical equipment, such as wheelchairs and oxygen
  - Mental health services
  - Diagnostic tests, such as X-rays and MRIs
  - Certain prescription drugs, such as injections in a physician’s office and some oral cancer drugs

# Part B Benefits (2015)

- Costs
  - Standard monthly premium = \$104.90 and higher
  - Annual deductible = \$147
  - 20 percent coinsurance on most services (after deductible is met)
  - No coinsurance for most preventive services and some other services such as home health services

# Part B Premiums (2015)

**Standard premium (paid by over 95 percent of Part B enrollees) =  
\$104.90/month**

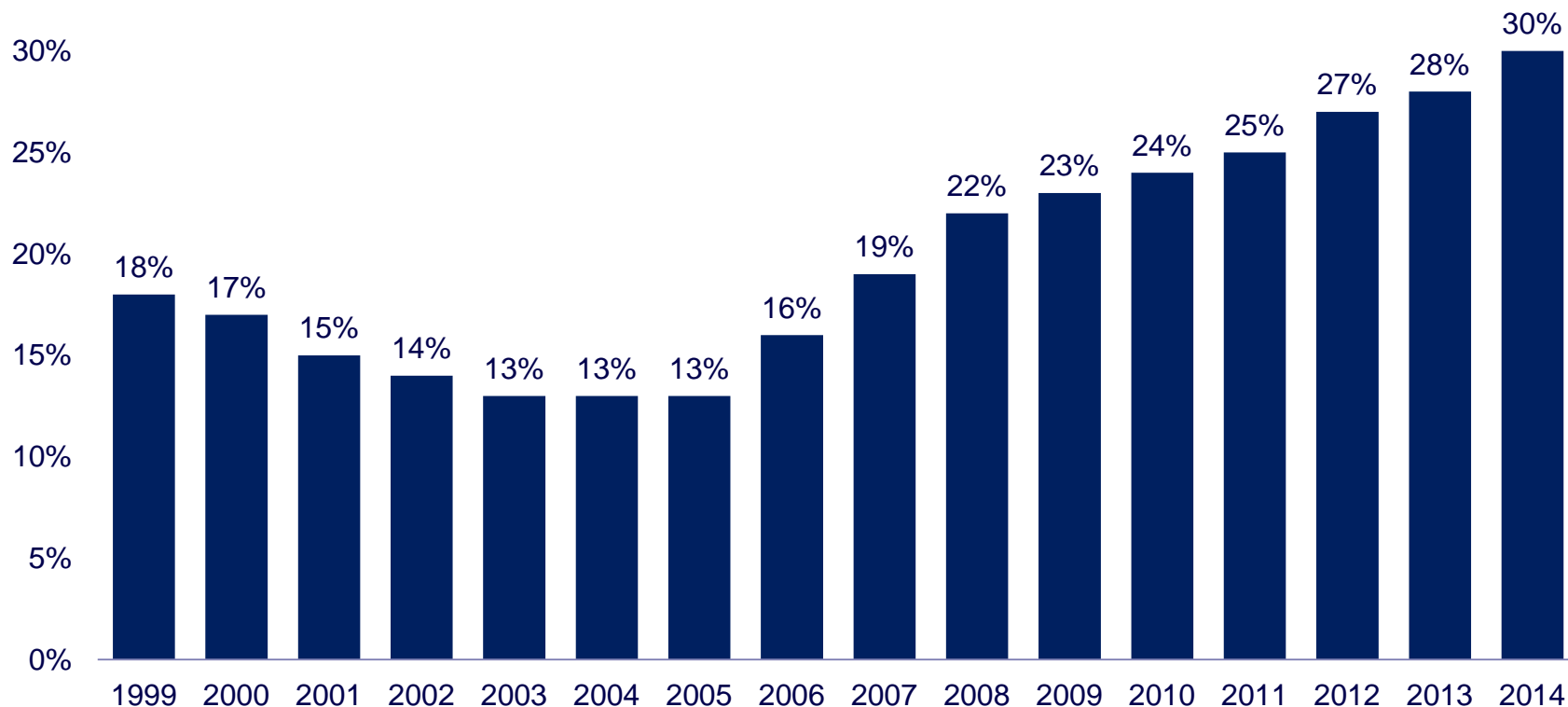
If your yearly income in 2013 was		In 2015, you pay
<i>Individual tax return</i>	<i>Joint tax return</i>	
\$85,000 or less	\$170,000 or less	\$104.90/month
Above \$85,000 up to \$107,000	Above \$170,000 up to \$214,000	\$146.90/month
Above \$107,000 up to \$160,000	Above \$214,000 up to \$320,000	\$209.80/month
Above \$160,000 up to \$214,000	Above \$320,000 up to \$428,000	\$272.70/month
Above \$214,000	Above \$428,000	\$335.70/month

# Part C Benefits

- MA plans
  - must cover all Part A & B services, except hospice
  - may offer coverage for additional items and services, such as vision or dental, or reduced cost sharing
  - may charge a monthly premium (in addition to Part B premium)
  - may offer Part D prescription drug coverage to their enrollees
  - have flexibility in setting cost-sharing requirements with some limitations

# Medicare Advantage Enrollment

## Percentage of Medicare Beneficiaries Enrolled in Medicare Private Health Plans (1999-2014)



Note: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.

Source: Adapted from Mathematica Policy Research/ Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2014, and Mathematica Policy Research, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

# Part D Benefits

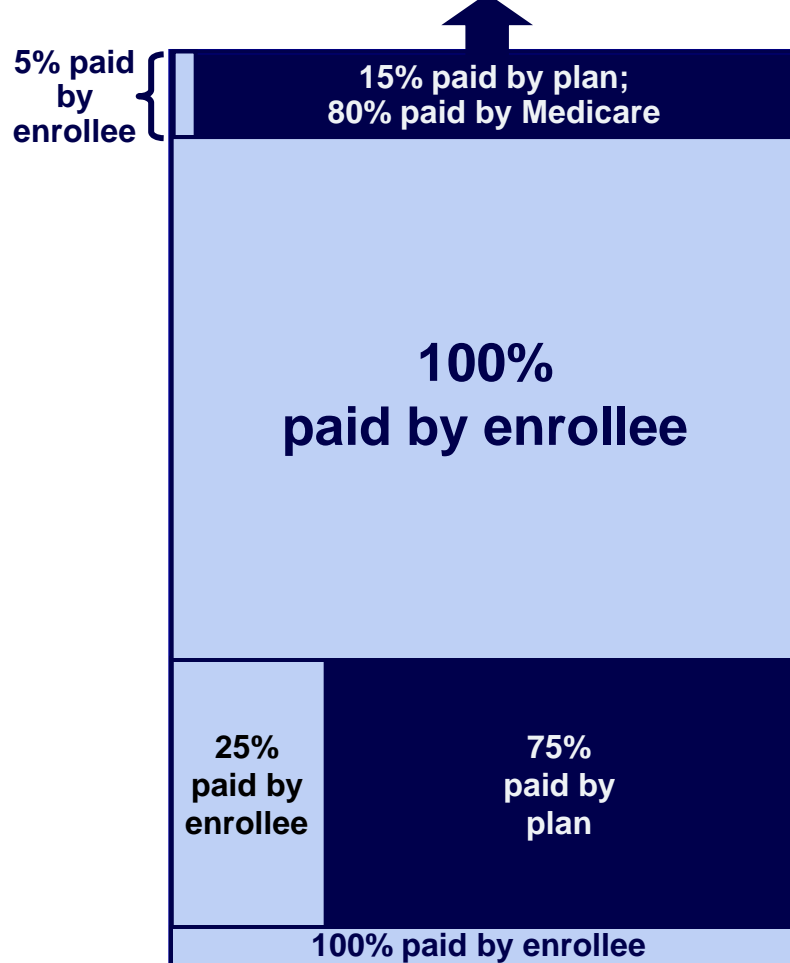
- 2015 standard benefits and coverage
  - Annual deductible = \$320
  - Up to \$2,960 in total drug spending = 75 percent coverage (25 percent out of pocket)
  - Coverage gap: from \$2,960 in total drug spending to \$4,700 in total out-of-pocket costs (or \$7,062 in total drug spending under standard benefit)
    - Plans required to cover 65 percent of generic drugs and 45 percent of brand name drugs
  - After \$4,750 in total out-of-pocket costs = about 95 percent coverage (5 percent out of pocket)
- Plans can, and often do, offer alternative coverage structures
  - Projected annual average premium for 2015 = \$466 (varies by plan)



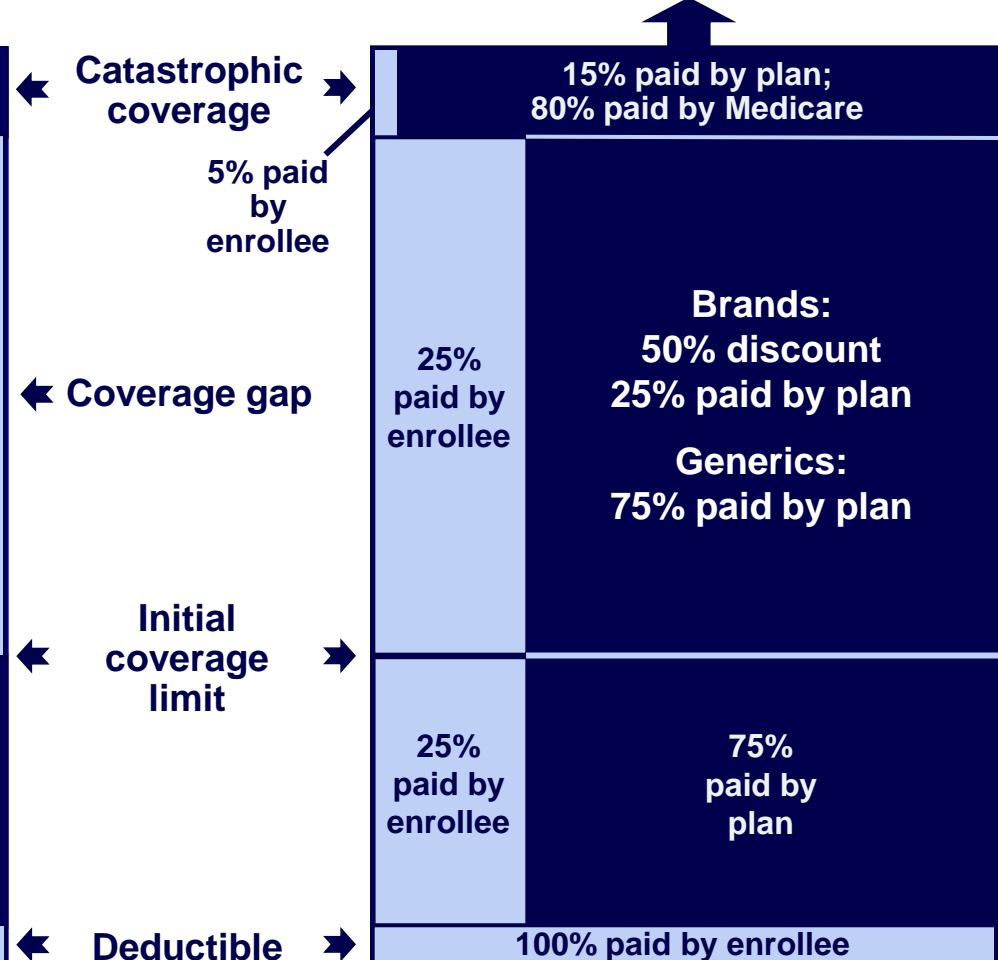
# Standard Medicare Prescription Drug Benefit (2020)

## *Before and After Health Reform*

### Before Health Reform



### After Health Reform

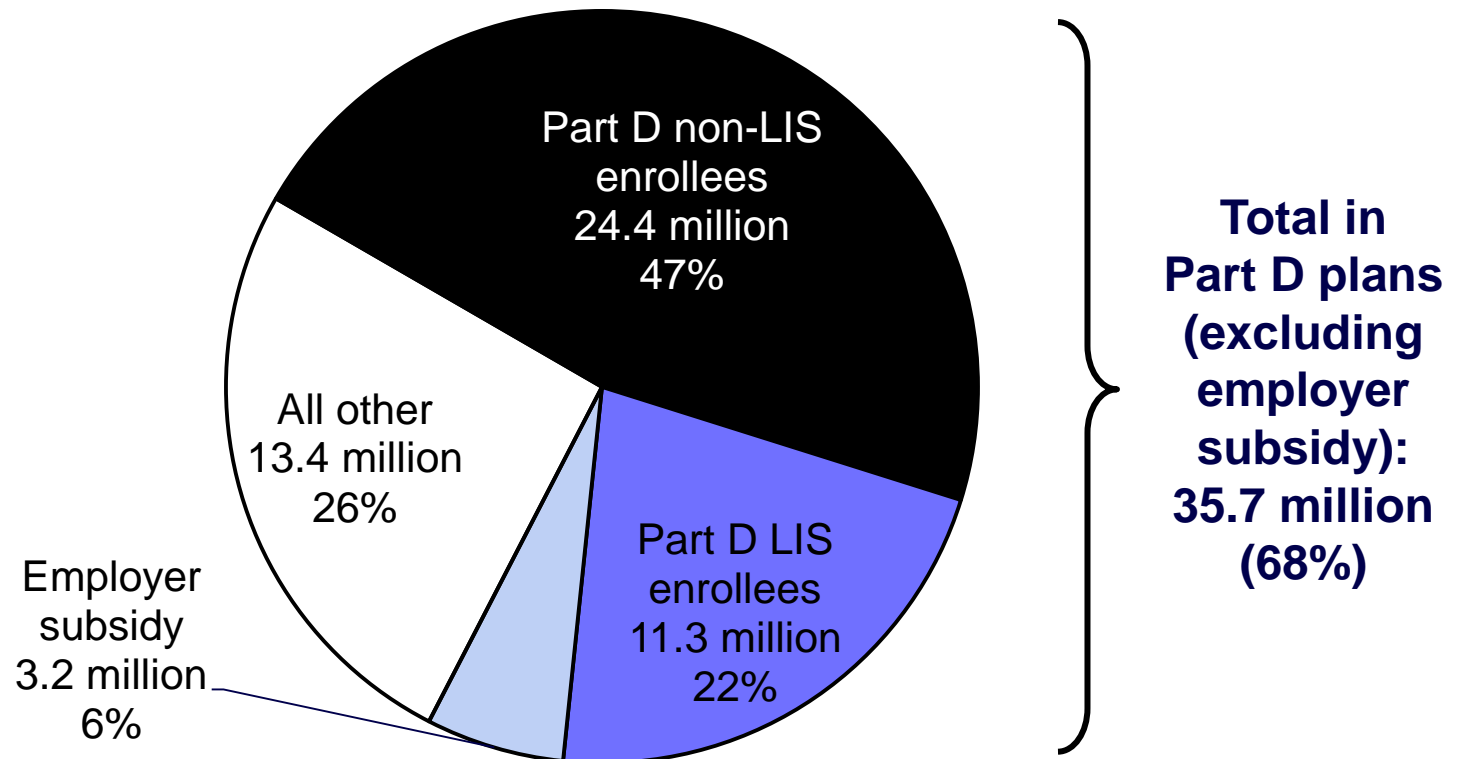


Source: Adapted from Kaiser Family Foundation.

# Part D Low-Income Subsidy (LIS)

- Substantial premium and cost-sharing assistance for beneficiaries with low incomes and modest assets
- Individuals with both Medicare and Medicaid are deemed eligible for assistance
  - Automatically assigned to qualifying plans if beneficiary does not choose a plan
- Individuals with slightly higher incomes and assets qualify, but pay a deductible and monthly premiums
- About 11.4 million beneficiaries received the LIS in 2014
  - CMS has estimated that many other low-income beneficiaries are eligible for but not receiving these subsidies

# Prescription Drug Coverage Among Medicare Beneficiaries (2013)



**Total Number of Medicare Beneficiaries = 52.3 million**

**Estimated 10% of beneficiaries lack creditable drug coverage (2010)**

Note: Numbers do not sum to 100 percent due to rounding. LIS = low-income subsidy. Total Part D and Medicare enrollment based on 2012 intermediate estimates.

Source: Kaiser Family Foundation analysis of 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

# MEDICARE FINANCING

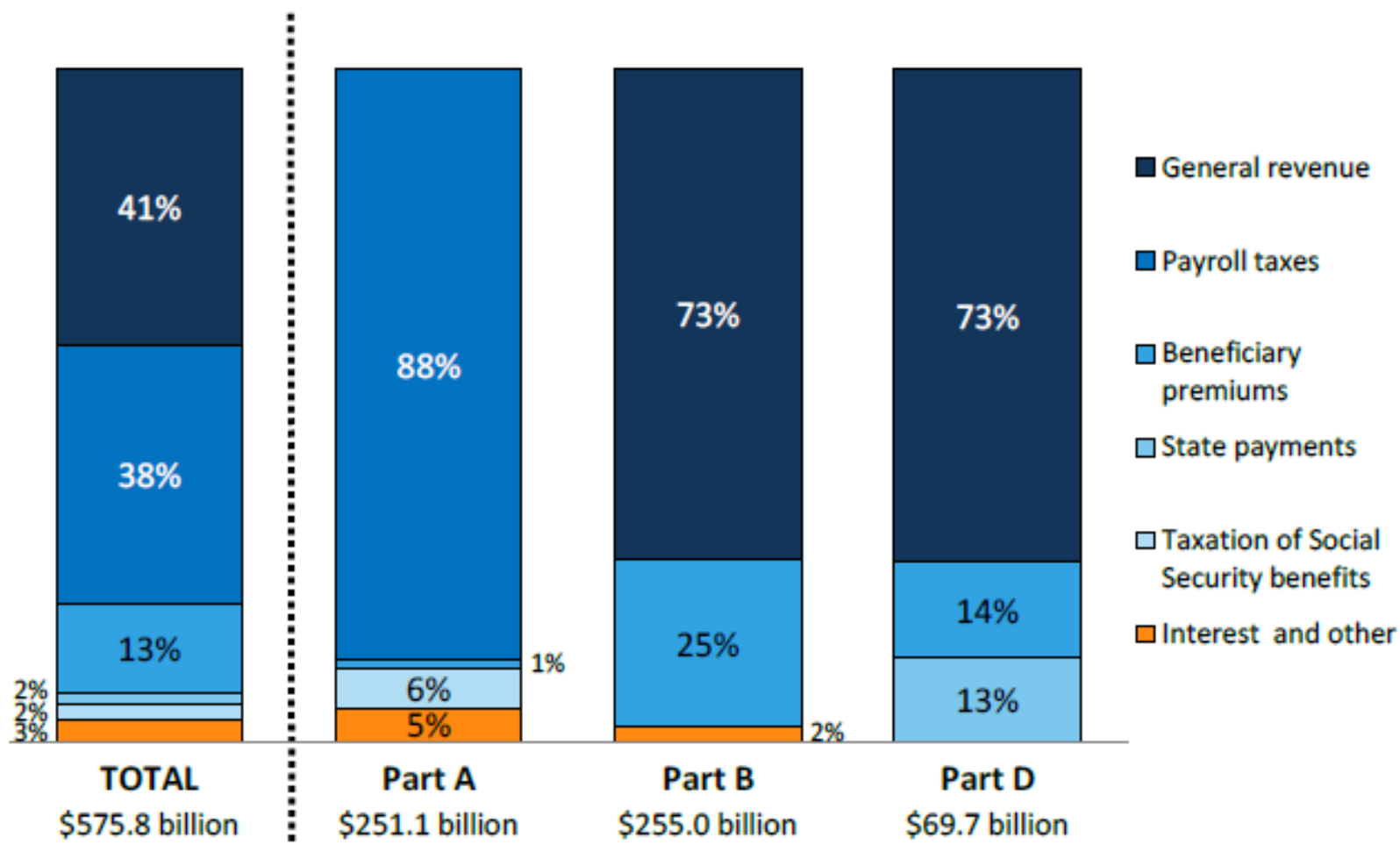
# Medicare Financing and Trust Funds

- **Hospital Insurance (HI) Trust Fund (Part A)**
  - Payroll taxes
    - Employers and employees each pay 1.45 percent of wages
    - Self-employed workers pay 2.9 percent of their net income
    - As of 2013, high-income workers pay an additional
      - 0.9 percent tax on their earnings above \$200,000 (individual) or \$250,000 (couples)
      - 3.8 percent tax on “unearned” income—such as dividends, rents, royalties
  - Interest
  - Tax on Social Security benefits

# Medicare Financing and Trust Funds

- Supplementary Medical Insurance (SMI) Trust Fund
  - **Part B**
    - General revenues
    - Beneficiary premiums
  - **Part D**
    - General revenues
    - Beneficiary premiums
    - Payments from states

# Sources of Medicare Revenue (2013)

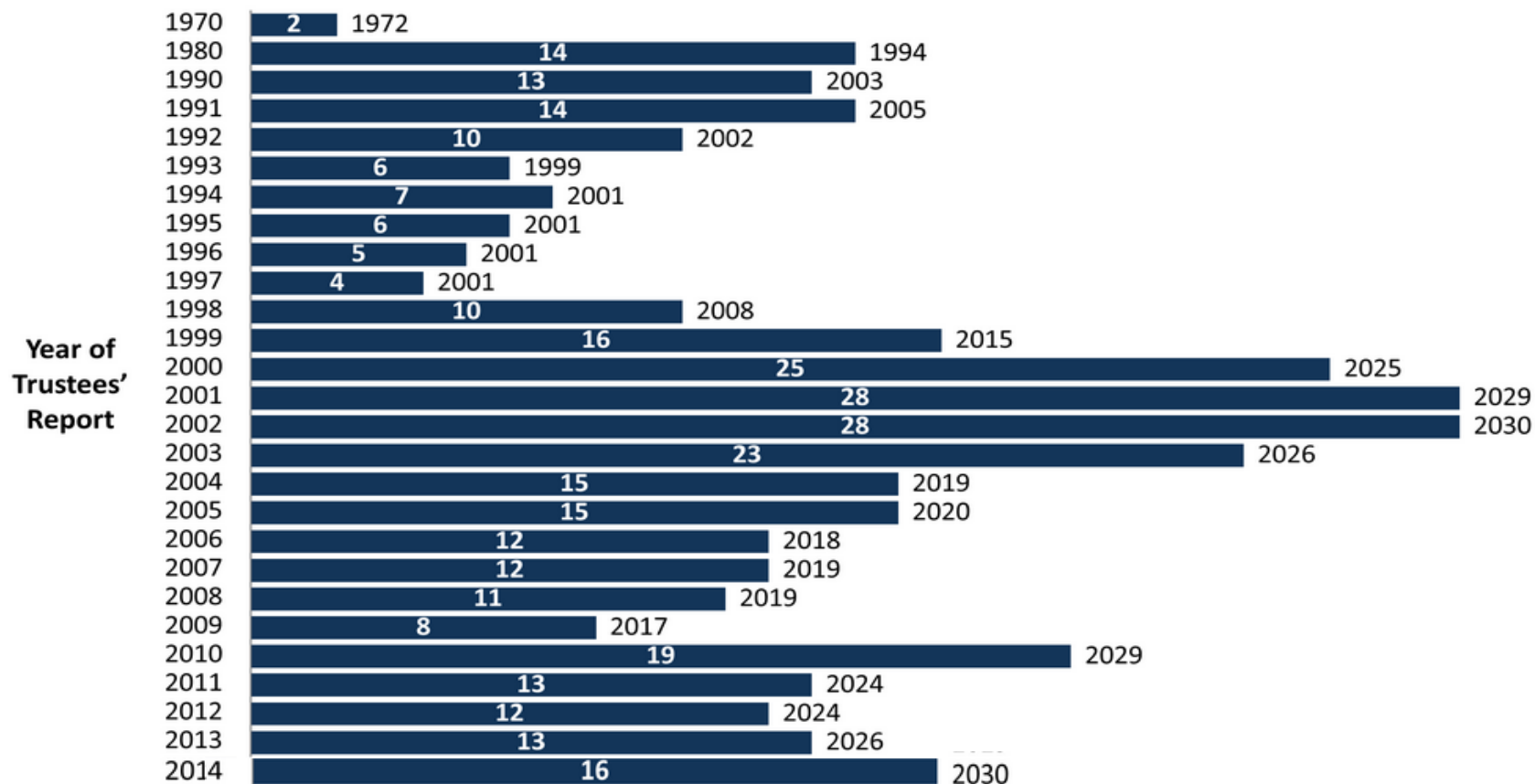


Note: Numbers may not sum to 100 percent due to rounding.

Source: Kaiser Family Foundation, based on 2014 Annual Report of the Boards of Trustees of the Federal HI and Federal SMI Trust Funds.

# Solvency Projections of the Medicare Part A Trust Fund (1970-2014)

*Projected Number of Years to Insolvency and Projected Year of Insolvency:*

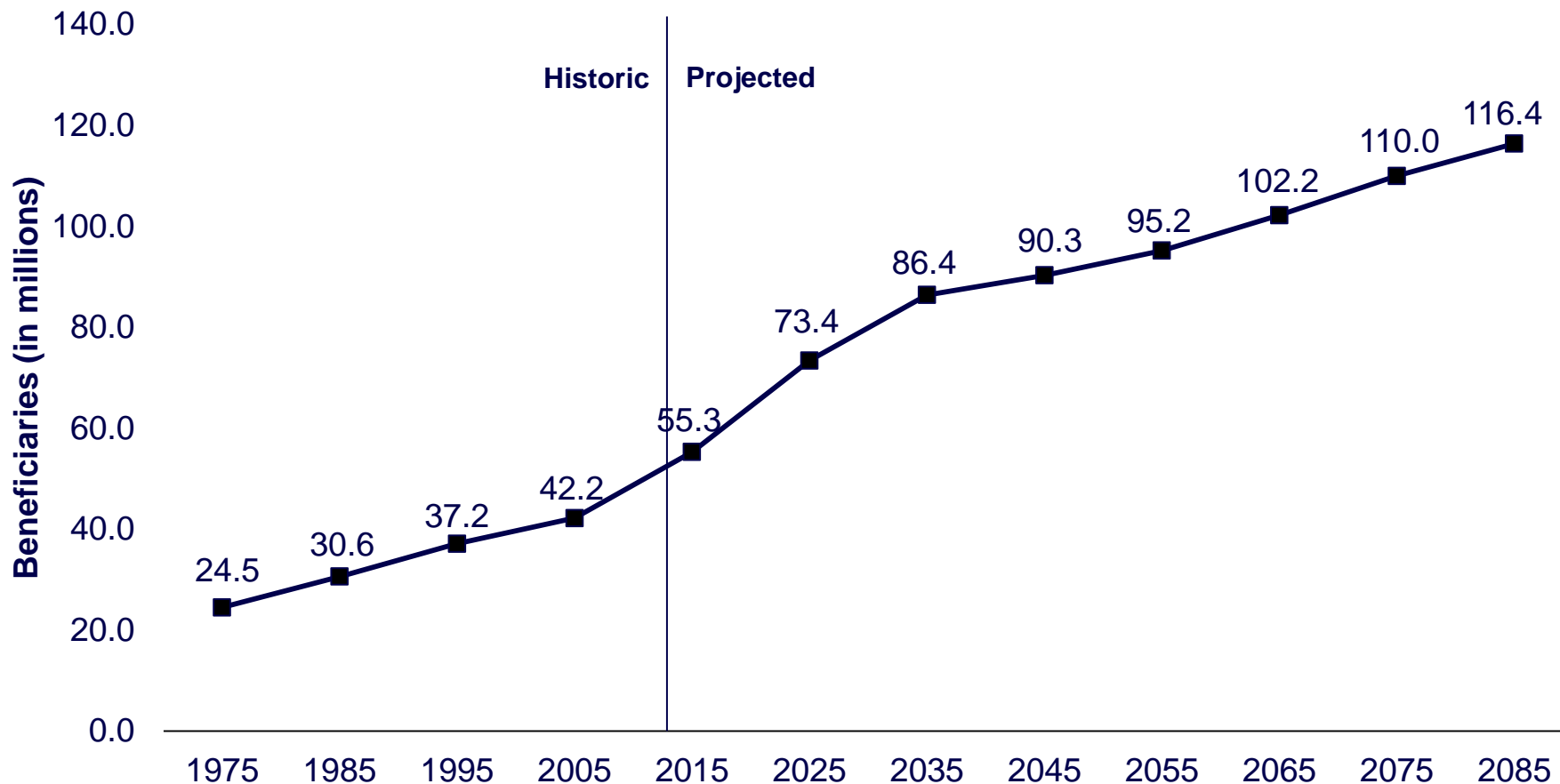


Note: Insolvency refers to the depletion of the trust fund. No insolvency projections were made for 1973-1975 and 1989. For all other years not displayed, the Hospital Insurance Trust Fund was projected to remain solvent for 17 or fewer years.

Source: Kaiser Family Foundation (1970-2013) and GAO (2014), based on intermediate projections from 1970-2014 Annual Reports of the Boards of Trustees of the Medicare Trust Funds.



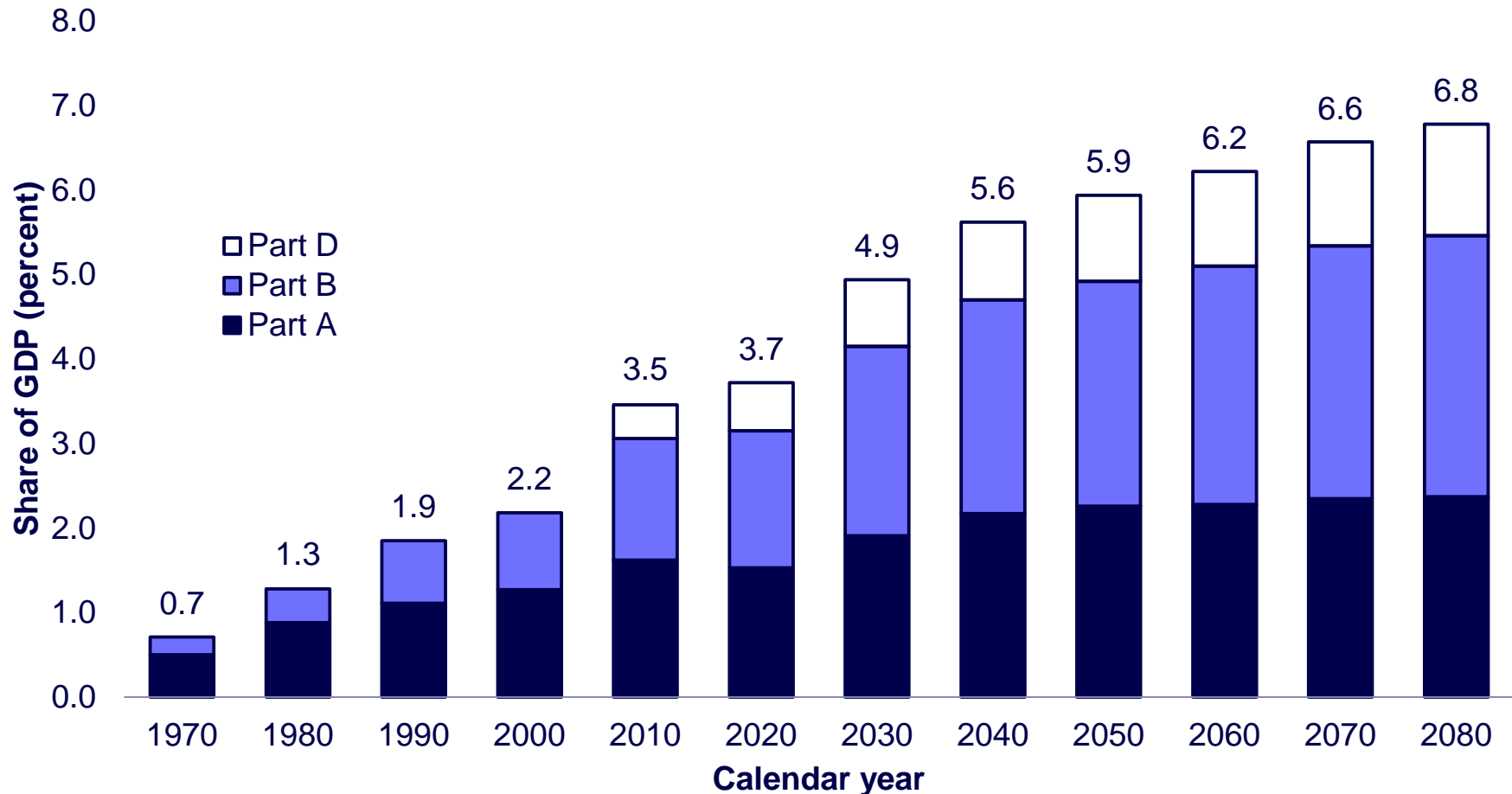
# Enrollment in the Medicare Program is Projected to Grow Rapidly in the Next 20 years



Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.

Source: GAO, based on 2014 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

# Medicare Trustees Project Medicare Spending to Increase as a Share of GDP



Note: GDP = gross domestic product. These projections are based on the Trustees' intermediate set of assumptions.  
Source: GAO, based on 2014 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

# MEDICARE ADMINISTRATION

# Medicare Administration

- The Centers for Medicare & Medicaid Services (CMS) uses Medicare Administrative Contractors (MAC) to process and pay claims in the traditional program (Parts A & B)
- For Part C (Medicare Advantage), CMS contracts with health plans to manage program benefits
- For Part D, CMS contracts with plan sponsors

# Contractors Conduct Integrity Activities

- The Recovery Auditors (RA) examine claims and other documentation to determine if improper payments have been made
- The Zone Program Integrity Contractors (ZPIC) investigate potential fraud in the traditional program
- The Medicare Drug Integrity Contractor (MEDIC) investigates potential fraud in Parts C & D

# Coverage Determinations

- CMS decides what it will cover nationally through National Coverage Determinations (NCD)
  - evidence-based processes
  - may include input from the public
- However, MACs can develop local coverage determinations (LCD) in their jurisdictions, as long as they do not conflict with national policy
  - When there is no NCD for a given service
  - For instance, some MACs made LCDs for allergy testing
  - LCDs may include specific requirements for the medical necessity of the service

# DUAL-ELIGIBLE BENEFICIAIRES

# Dual-Eligible Beneficiaries

- Over 10 million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs
  - Medicare is the primary source of health insurance coverage
- “Full Dual Eligibles” qualify for full Medicaid benefits
  - Medicaid supplements Medicare, paying for services not covered by Medicare, such as dental care and long-term care, and by helping to cover Medicare’s premiums and cost-sharing
- “Partial Dual Eligibles” qualify for limited assistance
  - Medicaid helps cover some of Medicare premiums or cost-sharing, but does not provide other Medicaid benefits

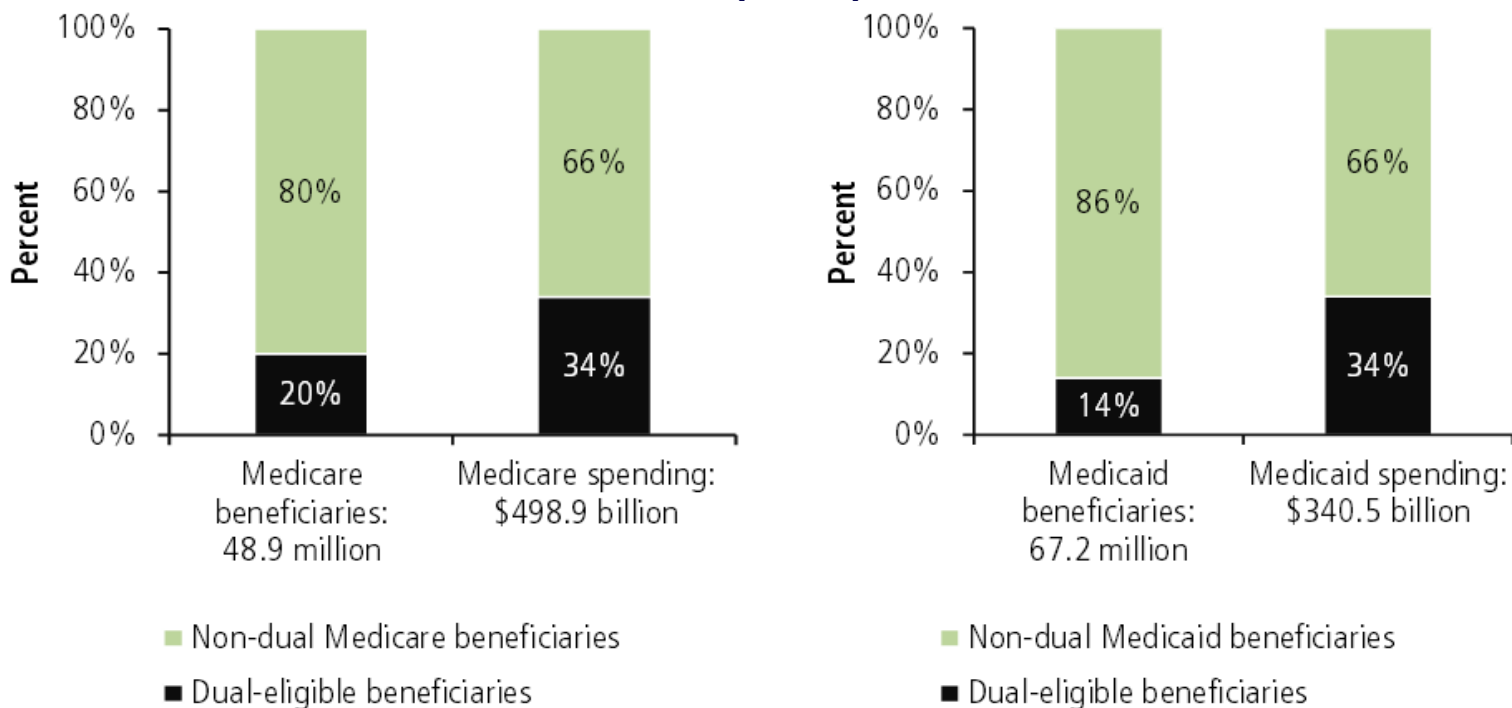


# Dual-Eligible Beneficiaries

- Overall, dual-eligible beneficiaries are more likely than other Medicare beneficiaries to
  - Report poor health, and have multiple chronic conditions
  - Have cognitive impairments and mental disorders
  - Report limitations in activities of daily living (ADL), such as bathing and toileting
  - Be disabled beneficiaries less than 65 years old
- However, dual-eligible beneficiaries have diverse health care needs
  - For example, over 25 percent report limitations in 3+ ADLs, but close to half report no such limitations

# Dual-Eligible Beneficiaries Account for a Disproportionate Share of Medicare and Medicaid Expenditures

**Duals as a Share of Medicare and Medicaid Enrollment and Spending (2010)**



# Full Duals—Two Programs, No Coordination

- Full-benefit duals must navigate two programs with separate services—Medicare and Medicaid
  - Neither program assumes full responsibility for coordinating all of a beneficiary's care
  - Neither program has any incentive to align policies with the other (e.g., quality measures, grievance and appeal procedures)
  - Each program wants to minimize its costs, which can mean increased costs for the other

# Special Needs Plans for Dual Eligibles (D-SNP)

- D-SNPs are
  - Medicare Advantage plans that are open only to dual-eligible beneficiaries
  - required to provide specialized services targeted to the needs of their beneficiaries, including a health risk assessment and an interdisciplinary care team
- In 2014
  - 1.6 million dual-eligible beneficiaries in 353 D-SNPs in 39 states and the District of Columbia
  - 36 D-SNPs provided access to both Medicare and Medicaid services (fully integrated)

# Special Needs Plans for Dual Eligibles (D-SNP)

- D-SNPs designed for disabled duals were found by GAO to have
  - moderately better health outcomes compared to traditional Medicare Advantage
  - no reduction in use of costly Medicare services
- Results suggest that expectations regarding the extent to which integration of benefits will produce savings may be optimistic



U.S. GOVERNMENT  
ACCOUNTABILITY OFFICE

[www.gao.gov](http://www.gao.gov)