Chapter 1 Medicare History

Medicare is a federal health insurance program intended to help protect the elderly by ensuring that they can get medical insurance coverage at an affordable rate after age 65. It also provides coverage for certain people younger than 65 who are disabled or suffer from end-stage renal disease. The federal government funds Medicare through payroll tax contributions, general tax revenues, and premiums paid by those who are enrolled in the program. Of all the great social programs, Medicare is arguably one of the most successful—it is the nation's largest single health insurance program and covers about 61 million Americans.

Medicare Act of 1965
The federal government's entry into the health care and health insurance arena came about in 1965 with the creation of the Medicare program. Though the program has undergone a number of adaptations over the years, its mission remains unchanged: to ensure that the elderly and disabled are provided with a way to obtain and pay for needed health care and health services. It is a basic entitlement program and a significant and core component of our nation's health care system.

When Medicare was created in 1965, it represented a troubled compromise, patched together, despite the incompatible goals of those who enacted the legislation. Its supporters, concerned about rapidly rising medical costs, wanted to create a plan that would protect older people on fixed incomes from a system that forced them to spend all of their personal resources on medical care before being eligible for funds from public assistance. Opponents of the program argued for a voluntary health insurance program that would be supported by government funds.

Even those who favored Medicare disagreed on many issues. For example, many of Medicare's advocates did not want older people to regard the program as charity and insisted that its benefits be identical for everyone regardless of income. Others feared that an attempt to provide comprehensive insurance to the entire elderly population would dilute the benefits, making it impossible to offer extensive coverage to those who were most in need.

What emerged from this heated congressional debate was the Medicare Act of 1965, which identified age as its principal eligibility requirement. Everyone age 65 and over could sign up for Medicare with no medical tests to determine need. To satisfy those in Congress who were concerned about funding such a sweeping program, the plan was designed to provide only partial coverage. At that time, medical costs were not nearly as high as now, and Medicare usually covered a large share, if not most of a beneficiary's bill.

Medicare - 1970s to Present
In 1972, Medicare was expanded to cover the severely disabled and people with end-stage renal disease. Also in the 1970s, responsibility for administering the Medicare program was given to the Health Care Financing Agency. In 2001, the name of this agency was changed to Centers for Medicare and Medicaid Services (CMS). (CMS is part of the Department of Health and Human Services.) The change included more than a name change. This agency was given control of several government medical care programs, including Medicare and Medicaid, and the Children's Health Insurance Program (CHIP). CMS's mission is to control health care costs associated with the programs assigned to it. The agency makes the rules and regulations that standardize payments for services, defines what type of care is reasonable for various health care needs, and supervises the certification of Medicare providers. CMS effectively controls all Medicare operations, including the four parts of Medicare:

-Part A—Hospital Insurance
-Part B—Medical Insurance
-Part C—Medicare Advantage
-Part D—Prescription Drug coverage

Some of the most significant changes to the Medicare program occurred in 2003 and 2008. In 2003, the Medicare Prescription Drug Improvement and Modernization Act (MMA 2003) was enacted; in 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA 2008). The former introduced prescription drug coverage to the Medicare program and established new Medicare Advantage (MA) plans. The latter provided for a number of changes with respect to low-income subsidy qualification, Private Fee for Service plan restructuring, special needs plans redefinition, physician payments, Medicare Advantage marketing guidelines, and Medicare Advantage plan payment reductions.

The Patient Protection and Affordability Care Act of 2010

The Patient Protection and Affordability Care Act of 2010 (PPACA) created the first large-scale reorganization of health care coverage and delivery in the United States. The act has come to be known simply as "ACA." While most of the act dealt with health care changes for those under age 65, some provisions included minor changes in Original Medicare and more particularly in Medicare Advantage and Medicare Part D. Of significance is the fact that ACA called for a $116 million reduction in Medicare Advantage spending and presumably would cut another $500 billion from Medicare spending over ten years by reducing the growth of payments to providers.

ACA Changes to Original Medicare

There were two important changes in Original Medicare, both of which became effective January 1, 2011. First was the elimination of the deductible and coinsurance for most preventive services under Part B, which covers physician services. The second major change was to provide coverage for annual no-charge wellness visits, during which the beneficiary receives a personalized plan prevention service (PPPS). This annual wellness doctor visit is available every year after a Medicare beneficiary has been in the program for one year and has received his or her original "Welcome to Medicare" physical.

ACA Changes to Medicare Advantage

The changes to Medicare Advantage dealt primarily with a cutback in Medicare payments to MA plans. The objective was to bring MA spending in line with Original Medicare's fee-for-service payment structure. The cuts began in 2012 and may result in higher MA plan premiums and a reduction in the benefits offered by most plans, although the plans must retain the same statutory benefits as Original Medicare. Also, a limitation on out-of-pocket costs for MA plan enrollees was set at $6,700 per year for "in-network" services, or $10,000 per year for "out-of-network" services.

ACA Changes to Part D

ACA made a very significant change to the Medicare Part D (Prescription Drug) program. Part of the act called for less plan availability to reduce confusion for both enrollees and agents. (Currently in 2020, there are over 946 plans.) However, the biggest change was a reduction in the "donut hole," which was the point at which a plan participant had to pay 35 percent of his or her prescription drug costs for brand-name drugs and 44 percent for generic drugs.

The ACA called for a complete elimination of the donut hole over a span of ten years. Incremental reductions started in 2011 with a 50 percent discount on brand-name drugs and a 7 percent discount on generic drugs. (As of 2020, both of those discounts had increased to 75 percent.) Because the full retail price of the drugs (including the discount and plan participation) is credited to the donut hole expense, the enrollee arrives sooner at the catastrophic benefit level (when Part D coverage pays for almost all listed prescription drug costs, with only a small co-pay—$3.60 for generics or $8.95 for all other drugs—or at a 5 percent expense to the enrollee, whichever is higher). Income-based Part D premiums were also introduced, and high-income enrollees are now charged more in a manner similar to Part B high-income premiums.

Skyrocketing Costs
As medical costs have increased, the federal government's outlays for Medicare have soared. Costs to Medicare beneficiaries have also skyrocketed. Along with the rising costs of physician fees, other expenses have risen far in excess of general inflation. In 1966, for example, the Medicare Part A deductible for hospitalization was set at $40, which represented the average cost of a day in the hospital. By 1990, this deductible had soared to $592, and in 2020, it had reached $1,408. History indicates that it will continue upwards under the present Medicare system.

Soaring Enrollment Numbers
The number of people enrolled in the Medicare program has increased by almost 170 percent since it began. As we move further into the twenty-first century with the arrival of more and more baby boomers into the Medicare system, and as the population continues to age, these numbers will soar because of improvements in health care techniques and increases in longevity. The Census Bureau has predicted that 20 percent of the population will be 65 or older by 2030—an estimated 78 million people who will be eligible for Medicare. In 2020, there were roughly 65 million people on Medicare.

And because older people account for over a third of all hospital stays, everyone may face the possibility of some substantial medical bills while covered by Medicare, thus increasing the cost of Medicare delivery.

Recent Changes
The Medicare Part B premium became somewhat of an issue in mid-2015, when MedPAC, a governmental agency designed to keep an eye on Medicare expenses, determined that the Part B premium needed to be raised for 2016. However, because federal law states that increases in Part B premiums are limited to cost-of-living (COLA) increases in Social Security benefits and because there was no COLA increase in Social Security benefits for 2016, the Part B premium could not be raised for most Medicare beneficiaries (about 70 percent). These beneficiaries were "held harmless" against any premium increase. The remaining 30 percent of enrollees were required to shoulder a premium increase of $121.80 per month in 2016.

In 2017, another anomaly was created, again due to a very small COLA increase of .3 percent in Social Security benefits. The solution was to create a three-tiered schedule of Part B premium payments for 2017:

-Tier 1–the "hold harmless" enrollees paid a premium of $109 per month
-Tier 2–those who were new to Medicare in 2016 paid a premium of $127 per month
-Tier 3–those new to Medicare in 2017 paid a premium of $134 per month

Those in these tiers amount to about 70 percent of enrollees. The remaining 30 percent of enrollees paid an even higher monthly Part B premium. Among the 30 percent are:

-Those who do not collect Social Security benefits (and do not have Medicare premium deductions taken from their benefits)
-Dual eligible beneficiaries whose premiums are paid by Medicaid
-Those beneficiaries who pay an additional income-related premium (IRMAA)

Employing different tiers for Medicare Part B premiums is not a new concept; Part B premium differences had been in force a few years before 2013.

The annual Part B deductible, in the meantime, rose to $198 for 2020.

Services Medicare Does Not Cover
Medicare Part A does not pay for convenience items such as telephones and televisions provided by hospitals or skilled nursing facilities, nor does it pay for private rooms (unless medically

necessary) or private duty nurses.

The only type of nursing home care Medicare pays for is skilled care in a skilled nursing facility (SNF) for rehabilitation, such as recovery time after a hospital discharge. Medicare does not pay if an insured needs only custodial services (help with daily living activities like bathing, eating, or getting dressed).

With only a few exceptions, Original Medicare does not pay for prescription drugs outside of the hospital or a doctor's office. MMA 2003 enacted Part D to cover prescription medications. Also, with the exception of the annual wellness visits, routine physical examinations or services not related to treating illness or injury are not covered. Part B does not pay for dental care or dentures, cosmetic surgery, routine foot care, hearing aids, eye examinations, or eyeglasses (except for one pair after eye surgery). Except for certain limited cases in Canada and Mexico, Medicare does not pay for treatment outside the United States.