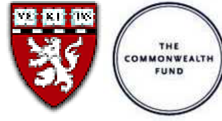
HMS/COMMONWEALTH HEALTH POLICY EDUCATION INITIATIVE



Health Care Access Series Case II

A SMOKING LUNG: A STORY OF MEDICARE AND THE ELDERLY

Case Author:
Cindy Lin
MD Candidate, Harvard Medical School

Case Consultants:

Deborah Stone, PhD
Research Professor of Government,
Dartmouth College

Carl O'Donnell, PhD
Assistant Professor of Medicine
Beth Israel Deaconess Medical Center

December 2004

Disclaimer
All events described in this case are fictional but meant to discuss real problems in medical practice. Any resemblance to any real life cases is purely coincidental.

Acknowledgements
We would like to acknowledge Richard Schwartzstein, MD, Associate Professor of Medicine, Beth Israel Deaconess Medical Center, for his assistance as a clinical consultant to this case.

Case 2-1: December 7, 2000

Greg Lantos is a 67-year-old widower and retired building contractor. Six months ago, he moved to Palm Springs, Florida for his retirement and used his life savings to purchase a small condo. New to the area, he chooses you to be his new primary care physician. He arrives at your clinic today for his first visit accompanied by his 40-year old daughter, Ada.

Mr. Lantos' chief complaint is worsening shortness of breath, cough, and fatigue. He attributes these symptoms to his long-standing chronic obstructive pulmonary disease (COPD). He reports having smoked a pack of cigarettes every day for the past 50 years.

After the physical exam, you tell Mr. Lantos that his smoking is making his symptoms worse, and you offer to refer him to a smoking cessation program.

He tells you that there is no way he can quit now because he's been smoking since he was seventeen years old. He adds that his symptoms have been relieved by inhalers in the past, but that he hasn't used these medications as directed for some time because his Medicare insurance does not adequately cover their cost. Inspecting the medications that he has brought in a brown bag, you find that he has a long and short-acting bronchodilator and an inhaled corticosteroid. You glance at the clock on the wall and realize that you don't have the time to continue talking to him about the importance of quitting smoking. You provide him with a prescription for the same medications and advise him that the long-acting bronchodilator is the most important of the medications for him to use consistently.

You conclude the visit, and Ada and Mr. Lantos leave the exam room. As you are about to knock on the door of another exam room to see your next patient, Ada stops you in the hallway to express her concern about recent changes she has noticed in her father's behavior. She tells you that her father has been having a hard time remembering whether or not he paid his bills and that last week he forgot how to get home from the grocery store. She is particularly concerned because her paternal grandfather developed Alzheimer's disease in his early sixties. Based on this information, you suggest that she talk to her father about making a follow-up appointment for a neuropsychological evaluation.

Guiding Questions: *What is Medicare? Who is eligible for Medicare and how do these individuals enroll? What does it cover? What doesn't it cover? Given Mr. Lantos' inability to pay for the drugs that you prescribed, how can you help him to better manage his disease?*

Case 2-2: April 14, 2001

Four months after Mr. Lantos' office visit, you receive a call from Stoneham General Hospital Emergency Department notifying you that Mr. Lantos was admitted the night before. You flip through his chart to refresh your memory of this patient and realize that Mr. Lantos never followed up after his initial visit. You are concerned that his ER visit may be related to his COPD or to the early signs of dementia that his daughter suspected.

You learn that Mr. Lantos arrived in the emergency room with respiratory distress, fever, chills, and sharp inspiratory pain in his right lower chest. In the few days before his ER visit, he developed fatigue, worsening shortness of breath, a fever, and a productive cough. In the emergency room, his low arterial oxygen saturation and his continued respiratory distress despite supplemental oxygen prompted the physicians to sedate, intubate, and place Mr. Lantos on a mechanical ventilator. The ER physician ordered a chest X-ray, which confirmed a diagnosis of pneumonia in the right lower lobe, and subsequently administered bronchodilators and IV antibiotics.

Mr. Lantos is admitted to the ICU to stabilize his acute respiratory failure. During the next several days as the respiratory care team monitors his condition, several considerations weigh on your mind. Discussions at hospital administration meetings over the years have made you and the other consulting ICU physicians keenly aware of the hospital's Medicare reimbursement structure, the DRG (Diagnosis Related Group), which provides a strong incentive for hospitals not to keep Medicare patients on mechanical ventilation in the ICU for any longer than absolutely necessary. The result has been an implicit pressure to move patients who may still need time to wean from mechanical ventilation but are otherwise medically stable from the ICU to lower-cost rehabilitation.

The financial situation of Stoneham General Hospital has been tenuous in recent years because Medicare reimbursements the hospital receives in general have been lower than the costs for care. Thus, the hospital "loses money" for each additional day that Mr. Lantos stays in the ICU. You also recognize, however, that if Mr. Lantos is discharged from the ICU to the rehabilitation unit or from the respiratory rehabilitation unit to his home too soon his respiratory condition may not have stabilized adequately, and he may relapse into respiratory failure.

In light of these considerations, after Mr. Lantos' condition improves sufficiently, he receives a tracheostomy and is transferred to a specialized respiratory rehabilitation unit in Stoneham. During his three-week stay in the unit, Mr. Lantos receives counseling on smoking cessation options and is given a neuropsychological evaluation that reveals early signs of Alzheimer's disease. Now that Mr. Lantos is feeling better, you gently inquire about why he did not follow up after his first visit with you. Mr. Lantos tells you that he was concerned about incurring more drug expenses, and also admits that he was afraid to find out whether or not he had Alzheimer's.

Guiding Questions: *What could have been done to prevent Mr. Lantos' ER admission? To what extent are physicians responsible for ensuring that patients follow up on visits?*

Given his current condition, what are Mr. Lantos' options for care after he leaves the hospital? How will his health insurance status influence his care? How are hospitals paid for the services they provide to Medicare patients and what is the DRG system?

Case 2-3: May 30, 2001

You discuss the options for Mr. Lantos' post-discharge care with Ada. Mr. Lantos is in need of extensive respiratory care including chest physiotherapy, daily nebulizer treatments, IV medications, and nocturnal ventilation. Clearly, he will not be able to live alone in his condo anymore.

Ada tells you that she doesn't want to put her father in a nursing home, but that between working full-time and taking care of her children, she doesn't know if she and her husband will be able to properly care for her father if he comes to live with them.

Medicare provides some coverage for home health care services, and you give Ada a list of home health care agencies in her community that accept Medicare insurance and that provide part-time skilled nursing care and home health aides. Ada is overwhelmed by the prospect of figuring out which of the many providers would be best, so you refer her to a social worker in the hospital who can assist her in negotiating the maze of home health agencies.

You determine that Mr. Lantos needs a nurse and a home health aide to provide care for a few hours each weekday and that he also needs durable medical equipment including a nocturnal ventilator, O_2 tank, pulse oximeter, nebulizer, oxygen concentrator, power source, and a humidifier. Medicare Part B will cover the cost of this durable medical equipment after you submit testing results and certification forms. Mr. Lantos also needs to begin taking a cholinesterase inhibitor medication to delay his Alzheimer's symptoms as well as to continue taking his bronchodilators. The full cost of these medications is not covered by his Medicare insurance. To his great disappointment, Mr. Lantos and his family make the difficult decision to sell his condominium in order to pay for his medical bills and prescription drug co-payments.

Following the sale of his condominium, Mr. Lantos moves into his daughter's home. You see him regularly in your clinic, and he seems to be doing well. His emphysema has stabilized with the help of the medications and respiratory therapy. Although he has cut down on his smoking, he continues to smoke a few cigarettes a day.

Guiding Questions: *What are the major coverage differences between Medicare Part A and Part B? What are home health services and what extent of coverage for home health services does Medicare provide? What are some common examples of durable medical equipment that patients might need and what does Medicare cover?*

Case 2-4: June 8, 2002

A year after Mr. Lantos moves into his daughter's home, you receive a phone call from Ada. She sounds tired and worried. She explains that her father's cognitive function has progressively declined, and he needs more assistance with activities of daily living. She recently became pregnant, and she and her husband are increasingly concerned about their ability to provide adequate care for her father in their home.

"I didn't want it to come to this, but I think we may have to put dad in a nursing home," Ada explains to you, tearfully.

You explain to her that Medicare does not cover nursing home care. She informs you that Mr. Lantos did not purchase long-term care insurance because he never thought he would need it and that it would be a waste of money. After some research, Ada learns that nursing home care will cost $175 per day—more than $60,000 per year. Despite the cost, she feels that given her father's condition and her family's inability to adequately care for him she has no choice but to place him in a nursing home.

Mr. Lantos has some money left over from the sale of his condo which can be used to help pay for nursing home care. The family selects a nursing facility close to their home, and Mr. Lantos receives around-the-clock monitoring of his respiratory condition and his dementia. After two years in the nursing home, Mr. Lantos meets both the income and asset test for Medicaid coverage of his nursing home costs.

Guiding Questions: *To what extent does Medicare provide coverage for nursing home care? How low does one's income and assets have to be before qualifying for Medicaid coverage of nursing home care? How do most American families meet the high costs of nursing home care?*

POST-CASE DISCUSSION

The case of Greg Lantos, a 67 year old man with insurance coverage by Medicare, a government health insurance program for the elderly or disabled, introduces us to the following topics:

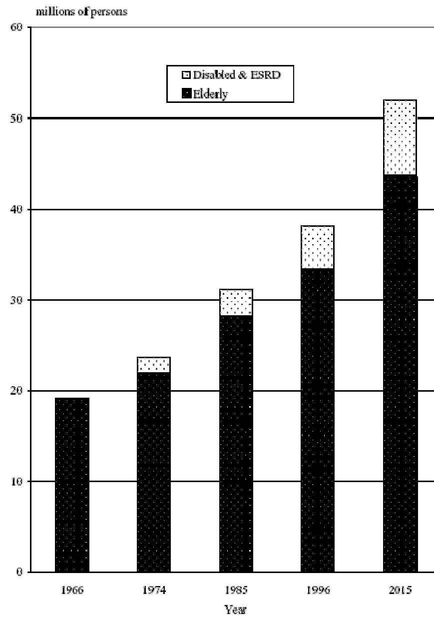
1. Eligibility and enrollment
2. Coverage under Part A and Part B
3. Gaps in coverage
4. The impact of rising costs on patients, the government, and providers

The Basics & Eligibility

Medicare is a federal program administered by the Centers for Medicare & Medicaid Services (CMS), which is part of the U.S. Department of Health and Human Services. Medicare provides health insurance coverage for individuals age 65 and older and for disabled individuals under the age of 65 who qualify for Social Security Disability Income (SSDI) benefits. It also provides coverage for two specific diagnoses regardless of age: end-stage renal disease (permanent kidney failure treated by dialysis or transplant) and amyotrophic lateral sclerosis (AML) disease (See Appendix A).

Medicare currently covers over 45 million Americans, which is about one in every seven Americans, and the number continues to grow (See Figure 1). By 2030, Medicare is projected to serve 77 million people—more than one out of every five Americans—and to account for 4.4 percent of the gross domestic product (Board of Trustees of the Federal Hospital Insurance Trust Fund, 2000).

Figure 1: Medicare Enrollment: Elderly, Disabled, and End-Stage Renal Disease, 1966-2015



Source: Figured prepared by CRS based on HCFA, Profiles of Medicare, 1996

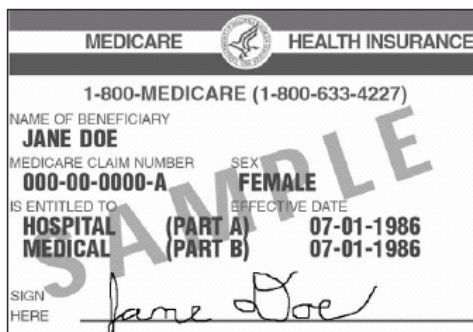
Enrollment

An individual's Medicare eligibility and enrollment is determined by the Social Security Administration. Only citizens and lawfully admitted aliens or legal residents who have lived in the U.S. continuously for at least a five-year period qualify for Medicare benefits. Individuals who receive benefits from Social Security or the Railroad Retirement Board are automatically enrolled in Medicare Part A and Part B starting the first day of the month they turn 65. The initial enrollment period for Medicare Part A and B starts 3 months before an individual turns 65 and lasts for 7 months. A Medicare card (See Figure 2) is mailed to new insurees three months before their 65th birthday. People can sign up anytime during the year for Part A coverage.

If a potential beneficiary does not currently receive Social Security or Railroad Retirement Board benefits, he must apply for Medicare and other retirement benefits through the Social Security Administration website or over the phone. Enrollment in Part B is voluntary, but requires a monthly premium payment. If an individual does not enroll in Medicare Part B during the initial enrollment period but then later decides to enroll, he will have wait until the next General Enrollment Period to enroll in Part B. The General Enrollment Periods run from January 1 and March 31 of each year.

Patients who want to enroll in Medicare can contact the Social Security Administration at 1-800-772-1213 or find information online at www.cms.hhs.gov/medicare/.

Figure 2: Sample Medicare Card



Source Medicare & You 2004, CMS

Medicare Part A and Part B

Medicare Part A: Hospital Insurance Program helps pay for in-patient care at hospitals, short-term stays at skilled nursing facilities, post-institutional home health care services up to 100 visits (following a hospital or an inpatient skilled nursing facility stay), and hospice care. Most people over the age of 65 qualify for Part A coverage without owing a premium as long as they or their spouses contributed to 40 or more quarters of Medicare-covered employment and as long as they receive or are eligible for retirement benefits from Social Security or the Railroad Retirement Board.

Part A is financed by Social Security payroll taxes, and most individuals do not pay any premium for Part A coverage. Individuals who only contributed to 30-39 quarters of Medicare covered employment, however, must pay a Part A premium of $206.00 per month (in 2005). Individuals who are not eligible for premium-free Part A hospital insurance or who contributed to less than 30 quarters of Medicare-covered employment pay a premium of $375.00 per month (in 2005) for Part A coverage.

Medicare Part B: Supplementary Medicare Insurance Program covers outpatient physicians' services and outpatient hospital care. It also covers some medical services that Part A does not cover such as physical and occupational therapy, home health care services beyond the first 100 visits covered under Part A, and durable medical equipment such as wheelchairs, home oxygen equipment, diabetic supplies, and prosthetics.

Part B is financed by general revenues and premiums paid by beneficiaries. To receive Part B coverage, beneficiaries pay a Medicare Part B premium of $78.20 per month (in 2005). In some cases, the premium is higher if the individual signed up for Part B after the initial enrollment period.

Gaps in Coverage

The major gaps in Medicare coverage are:

- Large deductibles for inpatient hospital care and limits on the number of covered hospital days
- Prescription drug costs
- Nursing home care

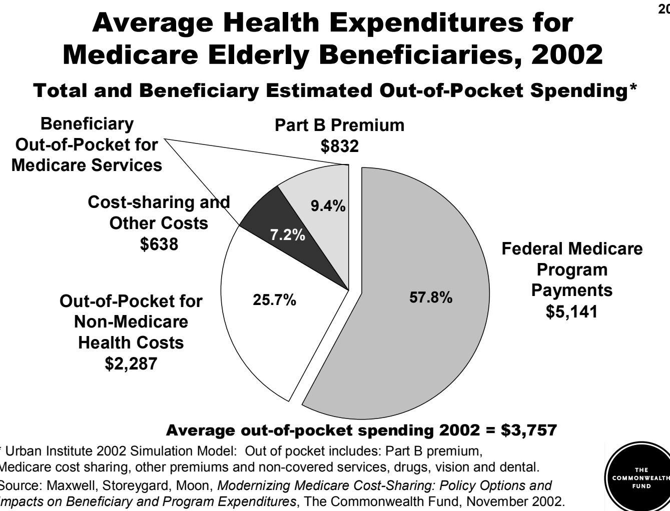
Deductibles and Co-payments for Medical Services

One major gap in Medicare coverage is the deductibles and co-payments for physician office visits and other health care services. Medicare beneficiaries owe 20% of the Medicare approved amount for each physician office visit. Medicare beneficiaries must also pay an annual $110 deductible for Part B services first before Medicare begins to pay for any Part B services incurred for the year. When Mr. Lantos was seen for an outpatient visit in your internal medicine office, his visit was covered by Medicare Part B. (See Appendix B for a "Cost of Care Breakdown for Mr. Lantos"). In 2002, the average out-of-pocket spending by Medicare beneficiaries was $3,757 (See Figure 3).

Inpatient hospital care is covered under Medicare Part A. The inpatient hospital care deductible and per diem charges apply to a benefit period that begins the first day a patient is admitted to a hospital or skilled nursing facility. The benefit period ends when the patient has not received inpatient hospital care for 60 consecutive days. If the same patient enters a hospital after the benefit period has ended, a new benefit period begins.

Mr. Lantos received post-institutional home health care, which is covered under Medicare Part A for the first 100 visits. He did not owe a co-payment for these services. Durable medical equipment, like the equipment Mr. Lantos used during his post-institutional home health care, is covered under Part B. There is, however, a co-payment for durable medical equipment, which varies depending on the beneficiary's state of residence and the type of equipment rented or purchased.

Figure 3: Health Expenditures by Medicare Beneficiaries [20]



What Medicare Does Not Cover

Medicare does not cover nursing home care, eyeglasses (except after cataract surgery), dental care, hearing aids, or health care services provided in foreign countries. Recent Medicare reform added drug coverage that will phase in over the coming years and will include a drug discount card that will expire in 2006, an option to enroll in private insurance plans that provide limited prescription drug coverage, and a new Medicare Part D, all commencing in 2006.

Mr. Lantos did not use his medications as directed because of the high cost of paying for the medications out-of-pocket. This is a reality for many Medicare recipients since prescription drugs comprise a significant portion of out-of-pocket expenditures for beneficiaries (See Figure 4). Recent Medicare prescription drug coverage reform is described in more detail in Access Case III *Ms. Patterson's Pills: Prescription Drug Costs and the Medicare Prescription Drug Benefit*.

Nursing home care is not covered by Medicare, although Medicaid covers the cost of nursing home care when an individual meets income and asset tests and other requirements determined by individual states. Mr. Lantos had to pay all of his nursing home care costs out-of-pocket until he qualified for Medicaid coverage by spending down his assets to a very low level. The cost of nursing home care presents a significant burden to many families (See Figure 5).

Figure 4: Out-of-Pocket Expenditures by Medicare Beneficiaries

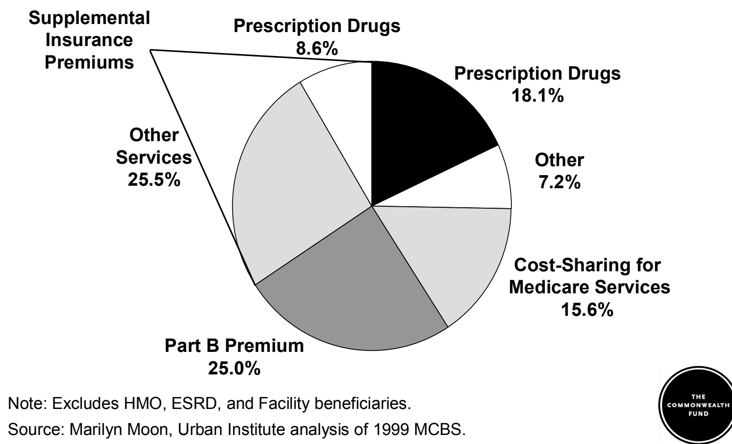
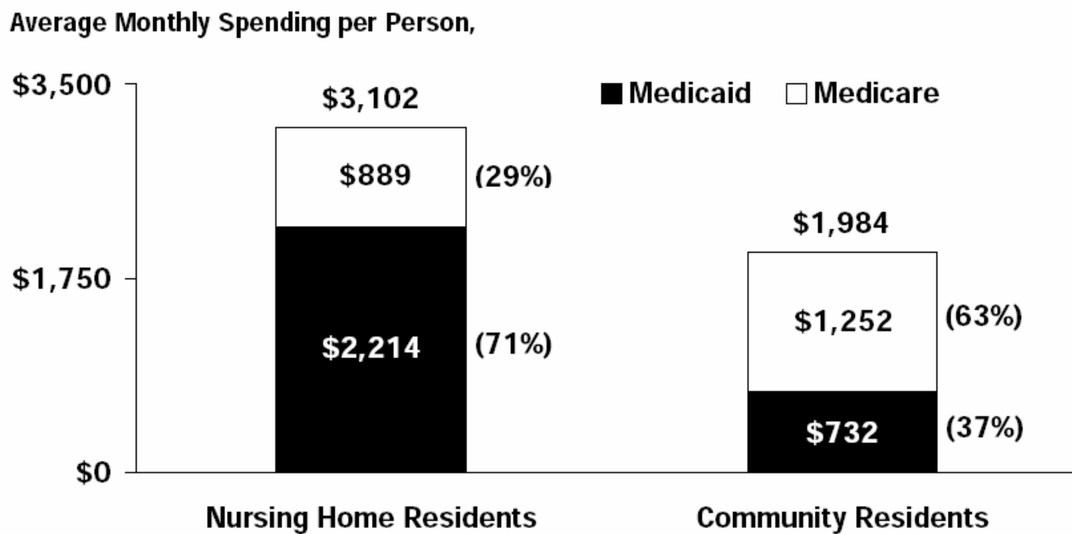


Figure 5: Medicare and Medicaid Spending for Elderly Medicare-Medicaid Long-Term Care Users by Nursing Home and Community Residence



Source: Analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin. Komisar, Feder, and Gilden. The Roles of Medicare and Medicaid in Financing Health and Long-Term Care for Low-Income Seniors, September 2000.

Supplemental Insurance for Medicare Coverage Gaps

The Medicare benefits package is inadequate to meet acute care costs. Supplemental insurance policies called Medigap (also known as Medisup) that partially fill the gaps in Medicare coverage can be purchased by beneficiaries from private insurance companies for a monthly premium. There are 10 standardized policies categorized A through J, and they each offer a different set of standard benefits (See Figure 6). Benefits may also vary by the geographic location of the plan. Most Medigap policies cover out-of-pocket hospital and outpatient visit deductibles as well as some home health care not covered by Medicare. Medigap coverage of deductibles results in reduced cost sharing by beneficiaries. This has raised concerns that these supplemental policies may encourage over-utilization of health care services.

Figure 6: Medigap Plans at a Glance

Medigap benefits	A	B	C	D	E	F	G	H	I	J
basic benefits: coinsurance for hospital days 61–150 and payment in full for 365 additional days; 20% coinsurance for physician and other Part B services after Part B deductible has been met; first three pints of blood.	★	★	★	★	★	★	★	★	★	★
hospital deductible: $840 in 2003		★	★	★	★	★	★	★	★	★
skilled nursing facility: coinsurance of $101.50 for days 21–100			★	★	★	★	★	★	★	★
part b deductible: $100 in 2003			★			★				★
part b excess charges: up to 115% of Medicare's approved amount						★ 100%	★ 80%		★ 100%	★ 100%
emergency care outside the United States: 80% during the first two months of the trip, with $250 deductible and lifetime up to $50,000			★	★	★	★	★	★	★	★
annual at-home recovery benefit: up to $40 a visit for 40 visits—$1,600 per year				★			★		★	★
preventive services: up to $120 a year if ordered by doctor					★					★
prescription drug costs: up to 50% of $2,500, after a yearly $250 deductible (up to $1,250)								★	★	
prescription drug costs: up to 50% of $6,000, after a yearly $250 deductible (up to $3,000)										★

Source *Talking with your Parents about Medicare and Health Coverage*, *Kaiser Family Foundation, 2003*

The Future of Medigap Under Prescription Drug Reform

Although some Medigap policies currently provide limited prescription drug coverage, these plans will be affected by recent reform. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), no Medigap policies providing drug coverage may be sold, issued, or renewed after January 1, 2006.

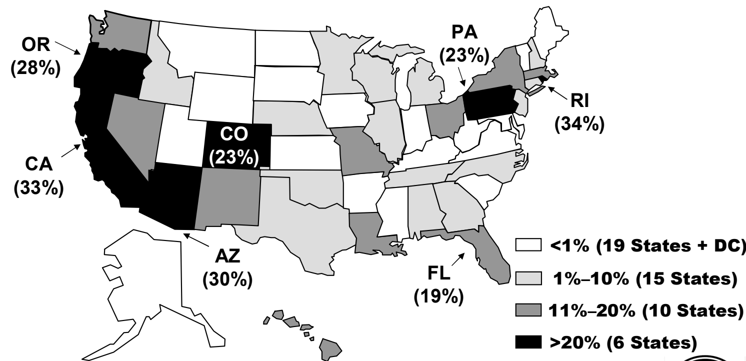
This new law will not affect people currently enrolled in a Medigap plan without a drug benefit, and their Medigap plan (if they choose to keep it) will continue to cover co-payments and deductibles for physician and hospital services.

People currently enrolled in a Medigap plan with drug coverage will have two choices: 1) they may keep their current Medigap plan with drug benefits, but if they later decide to switch to a Medicare Part D plan, they may have to pay a late enrollment penalty fee; or 2) they may enroll in the Medicare Part D plan and either enroll in another Medigap plan without drug coverage or keep their current Medigap plan but drop its drug benefits. People who turn 65 after January 1, 2006 will only be able to enroll in Medigap policies that do not offer drug coverage.

Medicare + Choice

Depending on the geographic location of a Medicare beneficiary, he may have the option of joining a Medicare managed care plan called Medicare+Choice (renamed Medicare Advantage), also known as Medicare Part C. Medicare+Choice coverage takes the place of Medicare Part A and B coverage for enrollees. There is wide geographic variation in premiums, benefit packages, and the availability of Medicare Part C plans, as shown by the percentage of Medicare beneficiaries in each state enrolled in Medicare+Choice (See Figure 7). Medicare+Choice plans tend not to be offered in rural and low population density areas.

Figure 7: Medicare+Choice Enrollees as a Percent of Medicare Beneficiaries by State (2003)



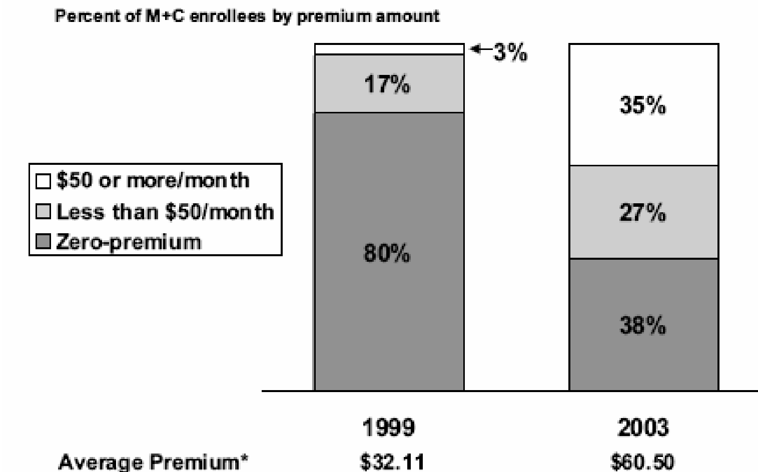
Source: Geraldine Dallek, Brian Biles, and Lauren Nicholas, *Lessons from Medicare+Choice for Medicare Reform*, The Commonwealth Fund, June 2003. From *Medicare+Choice, Fact Sheet*, Kaiser Family Foundation, April 2003.

Types of Medicare+Choice Plans

HMOs are one type of Medicare+Choice managed care plan. Medicare+Choice HMOs cover the same benefits as Medicare and sometimes offer additional benefits such as eye exams, hearing aids, or routine physicals. Beneficiaries must pay a co-payment each time services are used. If an individual is in a Medicare HMO, he must use physicians and hospitals within the HMO network to receive full coverage of medical services. Out-of-network visits are not covered by Medicare+Choice plans except in emergencies or urgent care settings. The average monthly premium for Medicare+Choice plan members in 2003 was $60.50 (See Figure 8).

In addition to HMOs, additional Medicare Part C plans include Provider Sponsored Organizations (PSOs), Preferred Provider Organizations (PPOs) and other certified public or private coordinated care plans that meet Medicare standards.

Figure 8: Monthly Premiums for Medicare+Choice Enrollees, 1999 and 2003



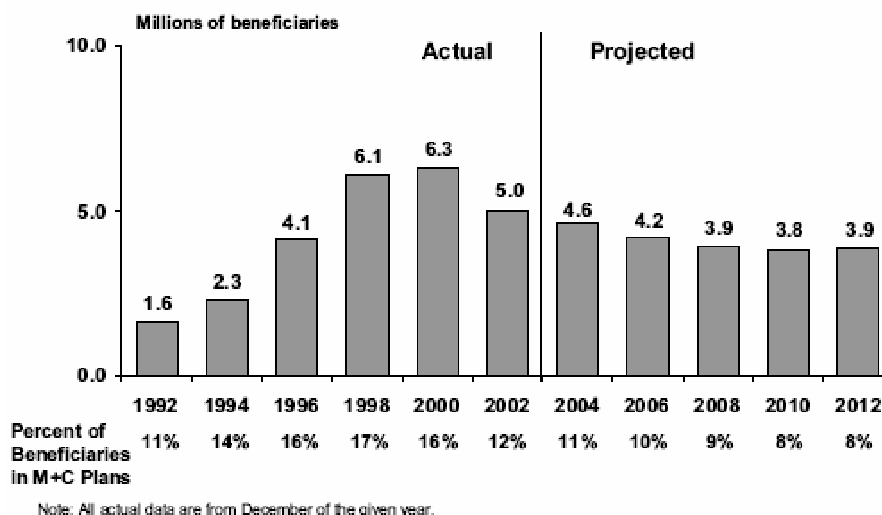
Source: Mathematica Policy Research, Inc. analysis of Medicare Compare database for the Commonwealth Fund, April 2003

Challenges Facing the Medicare+Choice Program

About 12 percent of current Medicare beneficiaries are enrolled in Medicare+Choice plans. One of the major problems with the Medicare+Choice program is the incentive for health plans to "cream skim," or select for healthier enrollees by screening insurance applicants for demographic characteristics and medical history. Another problem is that even for individuals who have Medicare+Choice coverage, acute and chronic care costs are still a high out-of-pocket burden.

Medicare+Choice plans are also troubled by the fact that in recent years many insurance companies have withdrawn from the program citing the government's payments to partially support these plans as inadequate. While the number of Medicare+Choice plans rose from 96 in 1990 to 346 plans in 1998, the number of plans dropped by more than half to 148 between 1998 and 2003 (Medicare+Choice Fact Sheet, 2003) (See Figure 9). The decision of many insurance companies to withdraw from the Medicare+Choice program forced millions of Medicare+Choice beneficiaries to return to traditional Medicare coverage. During the development of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, both the American Association of Health Plans and the Health Insurance Association of America strongly lobbied to increase payments from the federal government to managed care companies that enroll Medicare beneficiaries.

Figure 9: Trends in Enrollment in Medicare+Choice Plans

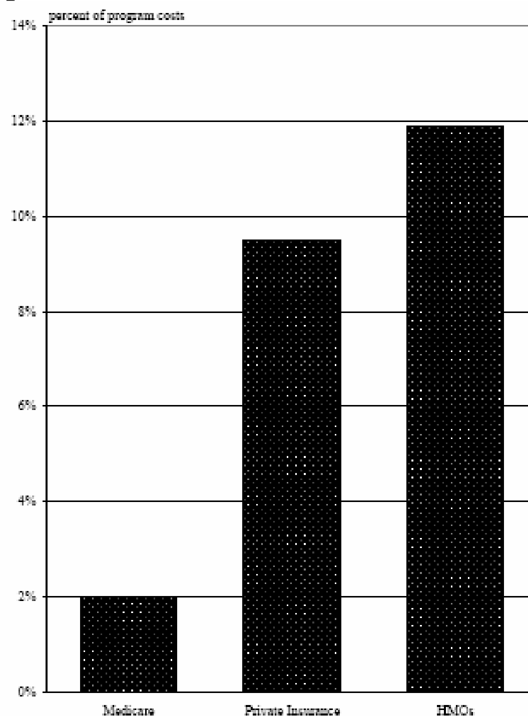


Source: Actual: HCFA/Center for Health Plans and Providers, 2002;
Projections: CBO, Medicare Baseline, March 2003

Medicare Versus Private Insurers: The Administrative Costs Differ

Medicare is the single biggest payer of health care services in the U.S., and it does so with lower administrative costs than private insurance plans. In 1993, administrative costs represented 2% of Medicare's total program costs, while administrative costs represented 9.5% of private insurers' costs and 11.9% of HMOs' total program costs (See Figure 10). Higher administrative costs mean less money going toward the care of patients enrolled in a plan. The administrative cost difference can be largely attributed to the inclusion of marketing costs and shareholders profits in the administrative costs of private insurers and HMOs (Medicare and Health Care Chartbook, 1997).

Figure 10: Administrative Costs: Medicare Compared to Private Insurance and HMOs, 1993



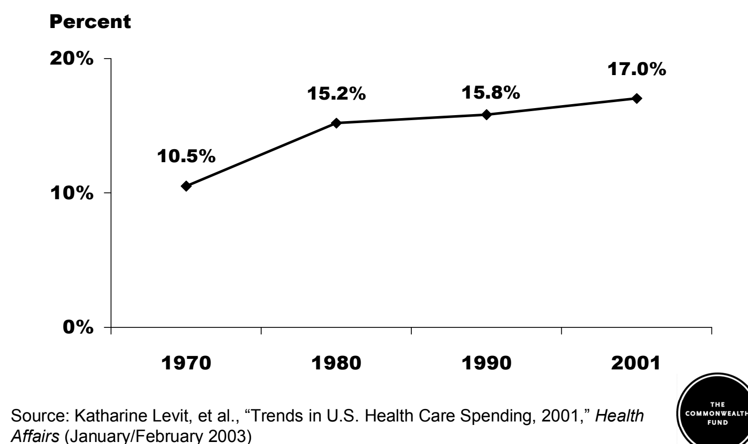
Source: Figure prepared by CRS based on HCFA, Profiles of Medicare, 1996

Rising Costs for the Federal Government

Medicare spending by the federal government has increased substantially in recent decades. In 1970, Medicare accounted for 3% of the federal budget. Today, it accounts for 12% of the federal budget. In 2001, Medicare accounted for 17% of total national health expenditures (See Figure 11).

The distribution of health care spending by Medicare beneficiaries is not uniform, and this plays an important part in the rising cost of care. Health care expenditures are highly concentrated among a minority of beneficiaries. In 1998, six percent of beneficiaries incurred expenses of $25,000 or more, accounting for half of all Medicare payments while 41% of beneficiaries incurred health care expenses of less than $500 (Kaiser Medicare Chartbook, 2001). Policy analysts and news reporters often take this "skewing" of health care spending as a sign of a problem in the distribution of health care resources. But the purpose of health insurance *is to* redistribute resources from the healthy to the sick. Unfortunately, hospitals and physicians may sometimes find themselves under pressure to reduce expenditures on the very sick. As health care providers, they should remember their mission when faced with such pressures.

Figure 11: Medicare Spending as a Percent of Total Health Expenditures, 1970-2001



Source: Katharine Levit, et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003)

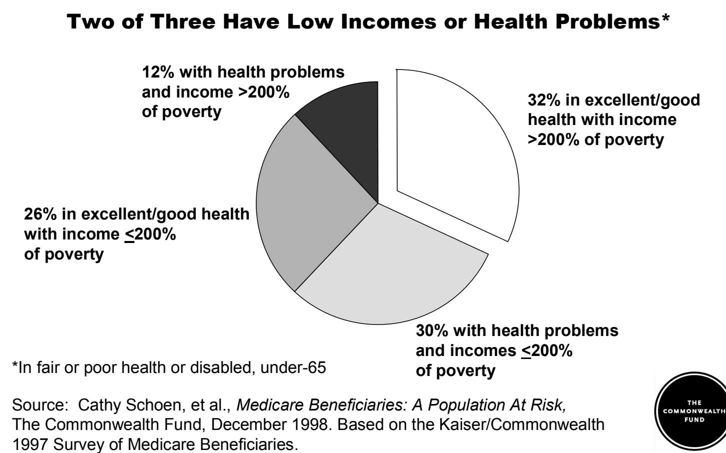
Reform Efforts to Control Costs

Since the late 1970s, national health care reform has focused on slowing the growth in federal expenditures on Medicare. Methods for cutting federal spending on Medicare have included cutting payments to physicians and hospitals, cutting contributions to graduate medical education, increasing deductibles and co-payments by beneficiaries, and limiting Medicare's benefits. Raising the eligibility age for Medicare has also been considered but has not been instituted as a method of controlling costs.

In 1998, Medicare accounted for almost 40 percent of total hospital revenues, including payments for patient care, capital costs, and medical education. As a result, reform efforts have a significant impact on the financial solvency of hospitals.

Beneficiaries are being asked to pay a growing share of health care costs. Currently, the average Medicare beneficiary pays more than $3,000 out-of-pocket each year for health care, including premiums, medical services, and prescription drugs, but excluding long term care (Maxwell, Moon, Segal, 2001). By 2025, these costs are expected to rise to $5,248 (in 2000 dollars). These high out-of-pocket costs will present a substantial burden since 56% of Medicare beneficiaries have incomes less than 200% of the federal poverty level (See Figure 12).

Figure 12: Profile of Medicare Beneficiaries, by Poverty and Health Status



Shift from Fee-for-Service to a Diagnostic Related Group Payment System

Federal reimbursements to hospitals and physicians for Medicare patients have also declined, and in several states, some physicians are limiting or dropping the number of Medicare patients they care for.

Until 1983, Medicare reimbursed physicians and hospitals on a fee-for-service basis that allowed for “usual, customary, and reasonable costs.” But in 1983 Congress adopted the Prospective Payment System (PPS) to reimburse hospitals with a capitated payment system called the diagnostic-related group fee schedule (DRG), and in 1989 Congress extended prospective payment to physicians by establishing a fee schedule for their

services based on a resource-based relative value scale (RBRVS), designed to account for the complexity and time required for physicians to provide different services.

DRG is a flat rate per admission paid to hospitals to cover the average acute care costs associated with providing a specific disease treatment. Payment rates are based on national averages for resource consumption and length of stay for a particular disease. For many cases, however, the DRG rates do not meet the costs incurred by hospitals for providing care.

Mr. Lantos was admitted with a DRG of 475, the code for respiratory system diagnosis with ventilator support. Even after Medicare reimbursed the hospital for his care, having Mr. Lantos on the ventilator may have caused the hospital to incur a deficit (estimates have approximated $10,000 for patients on long-term ventilatory support) (Sullivan et al, 2000). As illustrated in the case, there is implicit pressure to discharge patients who are otherwise stable medically but who require a prolonged time for weaning from mechanical ventilation to rehabilitation units where care can be provided at a lower cost. Research by Gracey (2002) has identified Medicare Part A's low reimbursement of hospitals for patients receiving mechanical ventilation with a DRG of 475 as contributing to serious financial problems for many hospitals serving this patient population. Specifically, a multicenter study conducted by Gracey revealed that 150 Medicare patients in 53 different DRGs who received mechanical ventilation for more than 48 hours had a mean Part A cost of $31,896. However, mean reimbursement for these patients under the PPS system was $10,981. This reflected a loss of $20,915 per patient or $3,137,250 for the group of 150 patients (2002).

History of Medicare

Medicare was created in 1965 by the federal government with the goal of reducing the financial burden of illness on the elderly and their families and ensuring that Social Security beneficiaries had adequate access to and coverage of acute medical care. President Johnson signed the Medicare program into law on July 30, 1965, and Medicare was fully implemented on July 1, 1966. The architects of Medicare did not develop the program with the intention of providing comprehensive health care coverage; rather, they viewed the program as a framework toward someday creating a system of universal health care coverage in the United States (Lee and Estes, 2003).

The establishment of Medicare's original payment system to hospitals was also a means of enforcing the 1964 Civil Rights Act. In this way, Medicare helped to end racial segregation in a majority of hospitals throughout the United States.

Since the founding of Medicare nearly 40 years ago, policy reform, medical advances, and economic and demographic changes have greatly affected the health care coverage of the elderly. The original Medicare program covered only those individuals over the age of 65 who were eligible for Social Security retirement benefits. Legislation passed in 1972 extended Medicare coverage to the permanently disabled who had received Social Security benefits for two years and to individuals with end-stage renal disease. Later

legislation extended coverage to individuals with Lou Gerhig's disease (See Appendix A). The Balanced Budget Act of 1997 established Medicare Part C, the Medicare+Choice program, modified the financing of home health services and graduate medical education, and established medical savings accounts.

The history of the Medicare program and its prospects for the future are best understood in light of the health care policymaking process and as a polarized struggle between those who believe that medical care is a public good and those who believe that medical care should be treated as a market good. While some believe that Medicare should expand benefits under a single payer plan provided by the government, others believe that Medicare should be fundamentally restructured and that it would best serve the population if there were private competition among health plans for all elderly beneficiaries.

President Johnson signing the Medicare program into law, July 30, 1965. Shown with the President (on the right in the photo) are (left to right) Mrs. Johnson; former President Harry Truman; Vice-President Hubert Humphrey; and Mrs. Truman. *Photo courtesy of LBJ Presidential Library.* **http://www.ssa.gov/history/lbjsm.html**

Conclusion

What the Medicare program covers and does not cover plays a far reaching role in setting the direction of health policy reform in America. Medicare has evolved tremendously since its inception, and it will continue to change during your career as a physician. The gaps in Medicare coverage will greatly impact your patients' ability to afford health care and to receive the treatment that you recommend. A fundamental understanding of the benefits and the limitations of Medicare coverage is important to providing the best possible care for your future Medicare patients. Furthermore, continued restructuring of the DRG system and reimbursement fee schedules will greatly affect the salaries of physicians and the financial viability of hospitals.

Appendix A: Medicare Coverage of End-stage Renal Failure and Lou Gerhig's Disease

End-stage renal failure and Lou Gerhig's disease, also known as amyotrophic lateral sclerosis (ALS), are the two specific diseases covered under Medicare for individuals under the age of 65. Coverage of dialysis and kidney transplant to individuals with end-stage renal disease was added by the Social Security Amendments of 1972 following strong lobbying from transplant surgeons, patients, and kidney transplant recipients.

The Amyotrophic Lateral Sclerosis Treatment and Assistance Act of 1999 (H.R. 353) waived the 24-month waiting period for Medicare coverage for individuals with ALS and provided coverage of drugs used for treatment of the disease. ALS is a progressive neuromuscular disease characterized by a degeneration of the nerve cells of the brain and spinal cord leading to the wasting of muscles, paralysis, and eventual death. The life expectancy of individuals with ALS is 3 to 5 years from the time of diagnosis.

Appendix B: Cost of Care Breakdown for Mr. Lantos

In Part 1, if you charged $150 for Mr. Lantos' initial office visit, Medicare would agree to pay you $110 for the visit based on its physician fee schedule, and Mr. Lantos would owe you 20% of $110, which is a $22 co-payment. If Mr. Lantos' office visit was his first health care utilization of the year, he would pay you $110, which would count toward his Part B annual deductible of $110. After this visit, he would pay a $22 co-payment for each subsequent physician office visit.

In Part 2, if Mr. Lantos was discharged immediately after being seen in the ER, he would pay a 20% co-payment for the ER visit. However, because he was admitted to the hospital, the charges for the ER visit would be combined with the charges for inpatient hospital care.

Since Mr. Lantos was in the hospital for five weeks, he would owe an initial deductible of $912.00 (in 2005) for his hospital stay covered by Medicare Part A. If he were in the hospital for longer than 60 days, he would owe $228.00 per day for each subsequent day; for days 91-150 in the hospital he would owe $456 per day.

Eligibility for Medicaid coverage of nursing home care varies by state because Medicaid is a joint state and federally-funded program. For example, in Florida, where Mr. Lantos' lives, eligibility for nursing home benefits under the Medicaid program is determined by the Florida Medicaid Institutional Care Program, which imposes a three-pronged test for qualification for nursing home benefits. The assessment first determines whether or not the individual seeking Medicaid benefits requires the level of care provided in a skilled nursing facility. If a person passes this test, the Medicaid Agency assesses the individual's income stream and assets. Florida is an "income cap" state, so if a person's gross income exceeds $1,692 per month, that person is ineligible for Medicaid benefits. Florida allows individuals to retain $2,000 in non-exempt assets, in addition to certain exempt assets

such as a car, limited life insurance, and a burial contract while still being able to qualify for Medicaid nursing home coverage.

Physicians should familiarize themselves with Medicaid coverage in their own states www.cms.hhs.gov/medicaid/statemap.asp

Appendix C: Burden of COPD & Dementia on the Medicare Population

This case also illustrates some of the health care needs associated with chronic obstructive pulmonary disease (COPD) and dementia, two conditions that have a significant burden on the Medicare population. Total per capita expenditures for Medicare beneficiaries with COPD are nearly 2.5 times higher than expenditures of those without COPD ($8,482 v. $3,511). As with other serious chronic conditions affecting the elderly, severely ill individuals who represent a minority of the Medicare population incur the largest share of total costs. Nearly 50% of the total Medicare payments for COPD were incurred by approximately 10% of the Medicare beneficiaries with COPD.

Hospitalization-related costs, the largest portion of all expenditures for patients with COPD, commonly occur in the later stages of the disease, as seen when Mr. Lantos was placed on a mechanical ventilator after contracting pneumonia. The National Medical Expenditure Survey study estimated that per capita expenditures for inpatient hospitalizations in the COPD cohort were 2.7 times the per capita expenditures of the non-COPD cohort ($5,409 v. $2,001). Appropriate primary care management and treatment of COPD could help to prevent or limit hospitalizations for patients with COPD and could substantially reduce the burden of this disease (Sullivan et al, 2000).

Most people who have Alzheimer's and related dementias are Medicare beneficiaries. A study published in 2001 by the Lewin Group and funded by the Alzheimer's Association projected that the cost to Medicare of treating people with Alzheimer's disease will soar 54.5% from $31.9 billion in 2000 to $49.3 billion in 2010. Currently, approximately 4 million Americans have been diagnosed with Alzheimer's disease. Nearly one in 10 Americans over the age of 65 and nearly half of those over 85 are affected. Between 2010 and 2050, as the baby boom cohort enters the age of highest risk, the number of people with Alzheimer's will increase from an estimated 5.5 million to 14 million.

Nearly half of Medicare beneficiaries with Alzheimer's disease also qualify for Medicaid because they have exhausted their own financial resources paying for long term care. At least half of all nursing home residents have dementia. These patients are the residents with the longest stays and the ones most likely to spend down to Medicaid. Furthermore, about 28% of Alzheimer's patients also have congestive heart failure, 27% have chronic obstructive pulmonary disease, 22% have diabetes, and 20% have cancer. According to the Alzheimer's Association, patients with dementia stay an average of four days longer in the hospital than other patients of the same age at the average added cost of $4,000 per patient. Alzheimer's patients often have preventable medical crises brought on by impaired memory and the inability to care for themselves. Their health often declines

because they cannot follow medical instructions and do not recognize signs of health problems (Lewin Group, 2001).

MULTIPLE CHOICE QUIZ

1. The Medicare program covers the following populations (Mark all that apply)

A. Individuals age 65 and over receiving Social Security Benefits
B. All permanently disabled individuals
C. Individuals with end stage renal disease or amyotrophic lateral sclerosis
D. Only individuals who have worked for the federal government

Answer: A and C. Individuals who receive Social Security Benefits or Railroad Retirement Board benefits are eligible for Medicare. Medicare covers two specific diagnoses regardless of the age of the individual: end stage renal disease and amyotrophic lateral sclerosis. B is not a correct answer because only disabled people who also receive Social Security Disability Income (SSDI) benefits are eligible. D is not correct because individuals need not have worked for the federal government to qualify for Medicare. Only American citizens and lawfully admitted aliens or legal residents who have lived in the U.S. continuously for five years qualify for Medicare benefits.

2. Medicare Part A covers (Check all that apply)

A. Prescription drugs
B. Nursing home care
C. In-hospital care
D. Outpatient physician office visits

Answer: C. Medicare Part A covers in-hospital care and short-term stays at skilled nursing facilities, post institutional home health care services up to 100 visits, and hospice care. Part B covers outpatient physicians' services and outpatient hospital care. It also covers some home health care services and durable medical equipment.

3. Medicare+Choice (Medicare Advantage) plans (Check all that apply)

A. Are available uniformly across the country
B. Can be HMO, PPO, or PSO plans
C. Have been increasingly steadily in number in recent years
D. Offer the same benefits as Medicare and sometimes also cover eye exams, hearing aids, and annual physicals

Answer: B and D. A is not correct because the availability of Medicare+Choice plans varies widely by geographic location. C is not correct because many Medicare+Choice plans have terminated their coverage of beneficiaries in recent years citing inadequate reimbursements and payments for these beneficiaries.

4. Medicare currently accounts for approximately what percentage of the total national health expenditures?

A. 2%
B. 7%
C. 18%
D. 29%

Answer: C.

5. Reform efforts to control the rising costs of Medicare have included (mark all that apply)

A. Raising the eligibility age for Medicare beneficiaries
B. Instituting the Prospective Payment System DRGs
C. Increasing co-payments and deductibles paid by beneficiaries
D. Mandating that all Medicare beneficiaries enter private health insurance plans i.e. HMOs

Answer: B and C.

REFERENCES

Board of Trustees of the Federal Hospital Insurance Trust Fund. *Annual Report of the Federal Hospital Insurance Trust Fund*. Washington, DC: United States Government Printing Office, 2000.

Committee on Ways and Means, US House of Representatives. *Medicare and Health Care Chartbook*. February 27, 1996. 105th Congress. Washington, DC: United States Government Printing Office, 1997.

Gracey, D.R. "The Problem with Diagnosis Related Group 475." *Chest.* July 2002. 122(1): 299-301.

Lee, P.R. and Estes, C. *The Nation's Health*. 7th ed. Sudbury: Jones and Bartlett, 2003.

Maxwell, S., Moon, M., Segal, M. *Growth in Medicare and Out-of-pocket Spending: Impact on Vulnerable Beneficiaries*. New York: Commonwealth Fund, January 2001.

Medicare+Choice Fact Sheet. Fact sheet #2052-06. Kaiser Family Foundation, April 2003.

Medicare and Medicaid Costs for People with Alzheimer's Disease. Washington, DC: The Lewin Group, April 2001.

Schoen, C. and Cooper, B. *Medicare's Future: Current Picture, Trends, and Prescription Drug Policy Debate*. Commonwealth Fund. June 2003. Updated October 2003.

Stone, Deborah. “The Struggle for the Soul of Health Insurance.” *Journal of Health Politics, Policy and Law*, Vol. 18, No. 2, 1993: 287-317.

Sullivan, S.D., Ramsey, S.D., and Lee, T.A. “The Economic Burden of COPD.” *Chest*. Feb 2000. 117(2 Suppl):5S-9S.

Further Resources on Medicare

Centers for Medicare and Medicaid Services (CMS) **http://www.cms.gov**

Medicare Payment Advisory Commission **http://www.medpac.gov**

Medicare Rights Center www.medicarerights.org

Gluck, M. and Hanson, K. *Medicare Chartbook*. Kaiser Family Foundation. 2nd ed. Fall 2001. http://www.kff.org/medicare/1622-index.cfm

Medicare at a Glace Fact Sheet. Kaiser Family Foundation, March 2004. http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=33319

Moon, M. *Medicare and Markets: Separating Fact from Fiction*. Testimony for the Senate Committee on Aging. May 6, 2003. #650. http://www.cmwf.org/publist/publist2.asp?CategoryID=9

Report to Congress: Medicare Payment Policy. Medicare Payment Advisory Commission. March 2003. **http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1&sid=2&subid=0**