Medicare Finances 101

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Despite Medicare being the major payor of medical services in the United States, many Medicare providers remain unaware of how Medicare is funded. With over a billion dollars a day being spent by Medicare, providers owe it to themselves to have a basic understanding of this omnipresent force. Obviously, the way in which Medicare is funded has a significant effect on how Medicare providers are reimbursed. The purpose of this article is to demystify this poorly understood, yet major force in the lives of Medicare providers and the patients who they treat. As such, definitions of key terms and a list of resources pertaining to Medicare financing are provided in this article.

Although Medicare currently has 4 programs or parts—Medicare Parts A, B, C, and D—technically, it only has 2 funds to pay providers for serving beneficiaries in each of these programs (Figure 1). Medicare Part A is funded under the Hospital Insurance (HI) Trust Fund, while Medicare Parts B and D are funded from the Supplementary Medical Insurance (SMI) Trust Fund.

Medicare Part A

The HI Trust Fund is financed primarily by payroll taxes from the current work force. Presently, the payroll tax is 2.9% of earned income. Interest on government securities held as assets in the HI Trust Fund accounts for the next largest portion of funds, followed by interest on government securities held as assets. A small share of funding comes from taxes on a portion of certain high-income earners' Social Security Administration (SSA) checks. It is anticipated that by the year 2020, the HI Trust Fund will be exhausted, requiring additional sources to finance Medicare Part A.

Medicare Part A currently comprises the largest portion of the total Medicare budget, accounting for around $318 billion in 2004. This program funds acute care in the hospital, home care, and skilled stay in a nursing facility. Medicare Part A also provides funding to hospices for end-of-life care. Each organization participating in Part A is responsible for the medications related to their program.

In 2006, Medicare beneficiaries who have paid into the HI Trust Fund for a period of time will not pay a premium. Patients are eligible for premium-free (no-cost) Medicare Part A if:

- they are 65 or older and are receiving, or are eligible for, retirement benefits from the Railroad Retirement Board or SSA;

Figure 1.
Sources of Medicare Funding for Provider Reimbursement

Hospital Insurance Trust Fund	Supplementary Medical Insurance Trust Fund	
Part A	**Part B**	**Part D**
Payroll Taxes	Beneficiary Premiums	Beneficiary Premiums
Interest on Government Securities	Interest on Government Securities	Interest on Government Securities
Taxes on High-income Earners' SSA checks	General Tax Revenues	Clawback Funds
		General Tax Revenues

Resources

MedLearn
The Medicare Learning Network (MLN) uses a variety of mechanisms, such as the Internet, national educational articles, brochures, fact sheets, web-based training courses, and videos, to deliver a planned and coordinated provider education program. The MedLearn program aims to provide health care providers with timely, easy-to-understand, educational materials to accompany the release of new or revised Medicare Program policies. For more information, visit: http://www.cms.hhs.gov/MLNMattersArticles/.

***Medicare and You 2006* Handbook**
The *Medicare and You* handbook is developed annually by CMS and delivered to every Medicare beneficiary. The handbook describes important changes in Medicare. It also provides basic information about the Medicare program, as well as specific information about each type of Medicare Advantage Plan or other Medicare health plan and prescription drug coverage choices. The handbook is an excellent resource to have throughout the year, but the information is valid only for 2006. For a copy, visit: http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

American Medical Association (AMA)
The AMA helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues. One such area that the AMA has invested a great deal of physician education resources focuses on reimbursement, including Medicare participation options. Visit: http://www.ama-assn.org/ama/pub/category/1815.html.

Centers for Medicare and Medicaid Services (CMS)
Formerly known as the Health Care Financing Administration (HCFA), CMS is the federal agency responsible for administering Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), the Health Insurance Portability and Accountability Act (HIPAA), Clinical Laboratory Improvement Amendments (CLIA), and several other health-related programs. Additional information regarding CMS and its programs is available at: http://new.cms.hhs.gov/home/aboutcms.asp.

Local Medicare Carriers
Local Medicare carriers are private insurance companies with which CMS contracts to perform local provider enrollment and claims-processing and adjudication functions on behalf of Medicare.

MedPAC
The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise Congress on issues affecting Medicare. MedPAC's statutory mandate is quite broad. In addition to advising Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC also is tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

- they are under 65, have received Railroad Retirement disability benefits for the prescribed time, and meet SSA disability requirements;
- they or their spouse had Medicare-covered government employment; or
- they are under 65 and have end-stage renal disease (ESRD).

If patients are not eligible for premium-free Medicare Part A, they can purchase Part A coverage by paying a monthly premium of $393 if:

- they are age 65 or older;
- they are enrolled in Part B; and
- they are a resident of the United States or are either a citizen or alien lawfully admitted for permanent residence, who has lived in the United States continuously during the 5 years immediately before the month in which they apply for Part A.

Currently, only 1% of beneficiaries pay a premium for Medicare Part A. In addition to the monthly Part A premium, Medicare beneficiaries are required to pay an annual deductible of $952. During each benefit period, this deductible includes:

- $952 for a hospital stay of 1 to 60 days;
- $238 per day for Days 61 to 90 of a hospital stay;
- $476 per day for Days 91 to 150 of a hospital stay;
- all costs for each day of a hospital stay over 150 days;
- $0 for the first 20 days of a skilled nursing facility (SNF) stay;
- $119 per day for Days 21 to 100 of a SNF stay; and
- all costs for each day of a SNF stay after Day 100.

Medicare Parts B and D

The SMI Trust Fund is financed by a combination of beneficiary premiums and general tax revenues. General revenues are federal tax

dollars that are not dedicated to a particular use and come from taxes generated from individuals and corporations. Currently, the SMI Trust Fund consumes 10% of all personal and corporate income tax revenue.

Funding for the SMI Trust Fund is set at approximately 25% from beneficiary premiums and 75% from general tax revenues. As a result of the Medicare Modernization Act (MMA), a separate account was created within the SMI Trust Fund for Medicare Part D. This portion of the SMI Trust Fund will be financed in a similar manner as Medicare Part B, with 25% coming from beneficiary premiums and 75% from general tax revenues. However, within this portion, additional funding will be financed in part by state transfers for Medicare beneficiaries who are also covered by the state's Medicaid program.

Medicare Part B

In the year 2004, payments for Medicare Part B services were about $54 billion. This represented a significant increase over previous years, in part due to an 11.5% increase in spending on physician services. The payment from Medicare to physicians is based on a fee schedule that lists services and their associated payment rates. The fee schedule assigns each service a set of 3 relative weights, intended to reflect the resources needed to provide the service. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount, known as the conversion factor, in order to determine payments. Medicare adjusts this conversion factor each year on

Table 1.

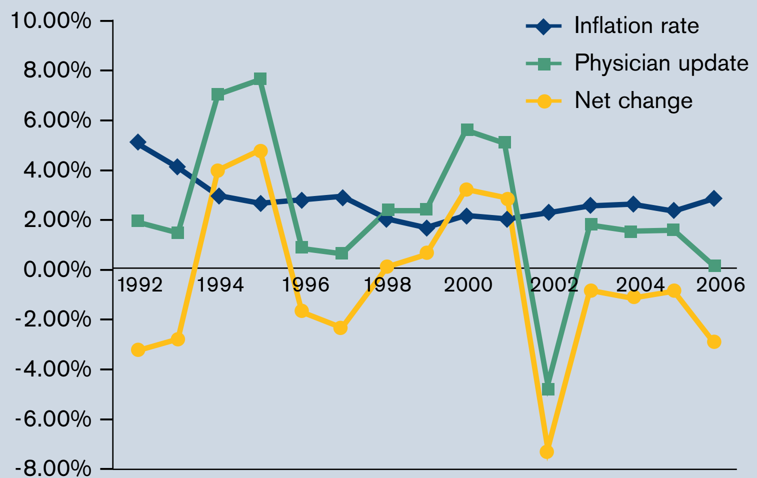
SGR Formula Factors

- Growth in input costs
- Growth in fee-for-service enrollment
- Growth in the volume of physician services relative to growth in the national economy

Table 2.

Inflation Rate/Physician Payment Update Trends: 1992 to 2006

Year	Inflation Rate	Physician Payment Update	Net Change
2006	2.9%	0.0%	-2.9%
2005	2.4%	1.5%	-0.9%
2004	2.6%	1.5%	-1.1%
2003	2.5%	1.7%	-0.8%
2002	2.3%	-4.8%	-7.1%
2001	2.1%	5.0%	2.9%
2000	2.2%	5.5%	3.3%
1999	1.7%	2.3%	0.6%
1998	2.1%	2.3%	0.2%
1997	2.9%	0.6%	-2.3%
1996	2.8%	0.8%	-2.0%
1995	2.7%	7.5%	4.8%
1994	3.0%	7.0%	4.0%
1993	4.1%	1.4%	-2.7%
1992	5.1%	1.9%	-3.1%



the basis of the sustainable growth rate (SGR) formula, although Congress can act on MedPAC's recommendations or at its own choosing to utilize a different conversion factor. In fact, the latter is what has occurred over the last several years.

Patients are automatically eligible for Part B if they are eligible for premium-free Part A. They are also eligible for Part B if they are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or alien lawfully admitted for permanent residence. In such cases, they must have lived in the United States continuously during the 5 years immediately before the month in which they apply for Part B. Medicare Part B has a current monthly premium of $88.50 plus a deductible of $124. These deductibles include 20% of the Medicare-approved amount for most physician services, outpatient therapy, preventive services, and durable medical equipment.

Although Medicare currently has 4 programs, it has only 2 funds to pay for provider services.

Sustainable Growth Rate (SGR) Formula

Physician charges are subject to the SGR formula. This formula ties physician payment updates to a number of factors listed in Table 1.

As a result of the SGR formula, there will be a substantial negative payment update from 2006 to at least the year 2011. Despite the SGR formula, MedPAC reimbursement recommendations to Congress are based on other factors, such as beneficiary access to services. Table 2 demonstrates the trends of the physician payment updates against inflation rates over the last 15 years.

The net effect on physician practice profitability is the difference between physician reimbursement and input costs. This net difference for a practice is actually greater than the difference using a general inflation number, since physician practice costs are increasing at a rate greater than inflation. Professional liability insurance continues to lead as the fastest growing input cost. However, even using the lower general inflation number, which has averaged 2.76% each year for the last 15 years, physician payment updates have averaged only 2.28% during this same period, resulting in a net average decrease of 0.047%. It's important to note that physician practice profitability may be used to increase physician income, but is also an important source of capital to reinvest back into the practice for electronic systems, additional care team members, and other resources to narrow the quality gap.

For 2006, the Medicare fee schedule is detailed in Table 3.

Table 3.
2006 Medicare Fee Schedule

CPT Code	Service	Complexity	Work RVU	Practice Expense RVU	Malpractice RVU	RVS	Medicare Fee Schedule
99205	Comprehensive history and exam	High	2.67	1.78	0.15	4.60	$166.41
99204	Comprehensive history and exam	Moderate	2.00	1.50	0.12	3.62	$130.96
99203	Detailed history and exam	Low	1.34	1.13	0.09	2.56	$92.61
99202	Expanded problem-focused history and exam	Straightforward	0.88	0.79	0.05	1.72	$62.22
99201	Problem-focused history and exam	Straightforward	0.45	0.49	0.03	0.97	$35.09

RVU=relative value scale; RVS=revenue value scale.

Definitions of Key Terms

Benefit Period
The benefit period is the way that the original Medicare plan measures a beneficiary's use of hospital and SNF services. A benefit period begins the day a patient enters a hospital or SNF. The benefit period ends when the beneficiary has not received any hospital care (or skilled care in a SNF) for 60 consecutive days. If the beneficiary goes into the hospital or SNF after a benefit period has ended, a new benefit period begins. Medicare beneficiaries must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods a Medicare beneficiary can have.

Conversion Factor
The conversion factor is the dollar amount that, when multiplied by the RVS for a specific service, produces the Medicare fee schedule. The conversion factor is adjusted annually as a result of the SGR formula.

Inflation Rate
Commonly referred to as the inflation rate, the consumer price index (CPI) is a measure of the average change in prices paid by consumers for a fixed market basket of goods and services.

MediGAP
Also known as Medicare supplemental insurance, MediGAP is specifically designed to supplement Medicare's benefits by paying a portion of the costs that Medicare does not pay for covered services and may pay for certain services not covered by Medicare.

Moral Hazard
A moral hazard is the risk that the presence of a contract will affect the behavior of 1 or more parties, resulting in a greater use of resources. The classic example is in the insurance industry, where coverage against a loss might increase the risk-taking behavior of the insured or encourage the overuse of services since out-of-pocket expenses are lowered.

Pay-for-Performance (P4P)
Pay-for-performance is a CMS initiative that supports quality-improvement rewards to physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. One current P4P demonstration, the Physician Group Practice Demonstration, seeks to encourage coordination of Part A and Part B services, promote efficiency through investment in administrative structure and process, and reward physicians for improving health outcomes. For more information about Medicare P4P initiatives, visit: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1343.

Relative Value Scale (RVS)
An RVS is an index that assigns various weights to specific medical services. Each weight represents a relative amount to be paid for each service. An RVS provides the basis for the Medicare fee schedule for physicians.

Relative Value Unit (RVU)
Relative value scales feature units of measure called relative value units. These are often used by plans to compare performance among providers. RVUs apply to 3 components of a service:

- The amount of physician work needed for a service (relative time, effort, stress, and skill);
- The practice expense related to the service; and
- The malpractice liability expense associated with the service.

Sustainable Growth Rate (SGR) Formula
The sustainable growth rate formula is based on a CMS estimate of the change in each of 4 factors:

- The estimated percentage change in fees for physicians' services;
- The estimated change in the average number of Medicare fee-for-service beneficiaries;
- The estimated 10-year average annual growth in real gross domestic product (GDP) per capita; and
- The estimated change in expenditures due to changes in law or regulations.

For more information, visit: http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2006p.pdf.

Medicare Part D

Medicare Part D is the new Medicare prescription drug benefit introduced on January 1, 2006. Like Medicare Part B, the funding is the same—that is, the funding comes from the SMI Trust Fund and is financed through beneficiary premiums and general tax revenues. Given the likelihood that expenditures for prescription drugs will continue to climb with the introduction of new expensive prescription drugs (eg, oral cancer agents) and the greater utilization of medications through increased needs and moral hazard, aggressive fund management of this program is inevitable.

Medicare Funding Warning

Left unchanged, the Medicare program will require major new

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Take-Away Message

- The HI Trust Fund funds Medicare Part A. Its funding is from payroll taxes and interest on government securities.
- The SMI Trust Fund funds Medicare Part B through funds received from beneficiary premiums and general tax revenue primarily.
- For 2006, physicians received a 0% increase in Medicare reimbursement, which is consistent with the trend.
- The Medicare Funding Warning goes into effect if the requirement from the general tax revenue exceeds a certain amount. At this point Congress is likely to cut provider reimbursement, raise beneficiary cost sharing, and reduce benefits, as well as make attempts to increase system efficiencies.

ROI

- Understanding Medicare financing is required to optimize outcomes for patients and practices.
- Practices should utilize the trend patterns of Medicare reimbursement to best develop an appropriate business plan strategy.

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sources of financing for Part A, as well as a much more significant share of funds from general tax revenues for Parts B and D. Because of this likely event and the need to make changes to the program or arrange for additional funding, the MMA created the requirement that the Medicare Trustees issue a "Medicare funding warning" when the general revenue funding is projected to account for 45% or more of total Medicare expenditures for any 1 year within the 7-year projection period. If a Medicare funding warning occurs in 2 consecutive fiscal years, the MMA directs the President to propose legislation to Congress, intended to prevent general revenue funding from actually accounting for 45% of Medicare expenditures.

For Medicare Part A, current projections call for the Medicare payroll tax to increase from its current level of 2.9% to 6.0% to cover the projected deficit by the year 2080. Further, the increased funds from the general tax revenue needed to cover increasing gaps in Medicare Part B funding will move from 10% today to 29% by the year 2030 and by more than 50% by the year 2070. Given that the larger burden will be applied to working class Americans through increased taxes and payroll taxes needed to accomplish this, it is unlikely to be acceptable at the required funding level. Medicare's long-term financing likely will involve moves toward a more equitable distribution of the burden or cutting of the benefit. Additionally, a greater burden will be placed on Medicare beneficiaries through increased premiums, since the amount of the premiums is set as a percentage of the total program's expenditures. This has already occurred, with an increase of nearly 15% during 2005, causing monthly premiums for Medicare Part B to rise to $88.50. These increases will continue to outpace the growth in SSA income.

Possible strategies to reduce the burden on beneficiaries and workers include reducing provider payments, limiting benefits, and raising the age of Medicare eligibility. Another option already introduced through the MMA is requiring higher premiums from wealthier seniors. This is a significant change given that in the 40 years since Medicare's inception, all Americans, regardless of income, have paid the same premiums. This was based on the belief that all Americans paid into the program based on a percentage of their wages so that continued payment through premiums should not be higher for wealthier individuals. This appropriation is sure to be applied to the Medicare Part D premiums.

Of course, the least painful solution would be a move to improve the efficiency of our health care delivery system. Some believe that this would be possible by improving incentives within the fee-for-service payment system, through pay-for-performance measures, the use of private plans to deliver Medicare benefits, and the use of technology and coordinated care models.

Clearly, Medicare financing will be changing from its current approach. Equally clear is that providers and beneficiaries will be affected directly. What is not as clear is to what degree? However, knowing the possibilities will best prepare all of those affected. MPM

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