MEDICARE BENEFIT DESIGN

*Medicare***basics**

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The Medicare benefit package is generally limited to acute care services and prescription drugs that are needed for the diagnosis or treatment of illness or injury. Medicare beneficiaries may receive coverage through the traditional program or they may enroll in a private health insurance plan under the Medicare Advantage (MA) program (Part C). Traditional Medicare covers health care services through three parts (Table 1):

- the hospital insurance program (Part A),
- the supplemental insurance program (Part B), and
- the prescription drug benefit (Part D).

Individuals who receive cash benefits from Social Security on the basis of age or disability are automatically entitled to Part A benefits, including hospital inpatient care, short-term care in skilled nursing facilities, post-institutional home care, and hospice services.

Part B enrollment is voluntary, although the vast majority of beneficiaries choose to enroll and pay a monthly premium. The premium changes annually, and the 2007 premium is $93.50 if beneficiaries' income is below $80,000 if single or $160,000 if married. The premium increases on a sliding scale for beneficiaries with incomes above $80,000 if single and above $160,000 if married. The maximum 2007 premium is $161.40 per month for beneficiaries with incomes above $200,000 if single and above $400,000 if married. Part B covers physicians' and other practitioners' services, hospital outpatient and other outpatient facility services, home health services not covered under Part A, and a variety of other services such as diagnostic tests, durable medical equipment, ambulance services, and limited preventive services and outpatient prescription drugs.

Enrollment in Part D, which covers outpatient prescription drugs not covered under Part B, is also voluntary. By law, beneficiaries must have at least two prescription drug plans to choose from in their region, and they are responsible for a premium that depends on the plan they choose. However, beneficiaries have their premiums fully subsidized if their income is below 135 percent of the federal poverty level (FPL) and their assets are less than $7,620 if single or $12,190 if married. Also, premiums are partially subsidized on a sliding scale for beneficiaries who have incomes above 135 percent and below 150 percent of the FPL and assets less than $11,710 if single or $23,410 if married.

Under the MA program, beneficiaries may receive Medicare benefits by enrolling in participating private plans, such as health maintenance organizations, preferred provider organizations, or private fee-for-service plans. Private plans must cover the same services as Part A and Part B of traditional Medicare, but the cost-sharing requirements may differ as long as they are at least actuarially equivalent—the average projected cost-sharing liability per person must be the same or smaller. Beneficiaries can also receive Part D benefits through an MA plan. Finally, beneficiaries who enroll in MA plans also may receive other benefits, such as reduced cost-sharing requirements or other products and services not covered by traditional Medicare.

Medicare benefits are financed primarily by payroll taxes, general tax revenues, and beneficiary premiums. In addition, beneficiaries are responsible for paying a portion of the cost for most covered services in the form of deductibles and coinsurance. ■

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Table 1 Medicare benefits and cost-sharing requirements, 2007

Services	Beneficiary cost sharing
Part A	
Inpatient hospital (up to 90 days per benefit period plus 60 lifetime reserve days)	$992 for the first stay in a benefit period Days 1–60: Fully covered Days 61–90: $248 per day 60 lifetime reserve days: $496 per day
Skilled nursing facility (up to 100 days per benefit period)	Days 1–20: fully covered Days 21–100: $124 per day
Hospice care for terminally ill beneficiaries	Nominal coinsurance for drugs and respite care
Part B	
Premium	$93.50–$161.40, per month, depending on income
Deductible	$131 annually
Physician and other medical services (including supplies, durable medical equipment, and physical and speech therapy)	20 percent of Medicare-approved amount
Outpatient hospital care	Greater of 20 percent of Medicare-approved amount or 20 percent of 1996 national median charge updated to 2000*
Ambulatory surgical services	20 percent of Medicare-approved amount
Laboratory services	None
Outpatient mental health services	50 percent of Medicare-approved amount
Both Part A and B	
Home health care for homebound beneficiaries needing skilled care	None
Part D	
Premium	Depends on plan choice
Deductible	$265
Coinsurance	25 percent on costs from $265 to $2,400, 100 percent from $2,400 to $3,850, and nominal cost sharing above $3,850

Note: The Part B premium increases from $93.50 to $161.40 per month based on a sliding scale for individuals with incomes above $80,000 and below $200,000 and for couples with incomes above $160,000 and below $400,000.
* Because hospital charges are typically much higher than costs, 1996 charges updated to 2000 are still often higher than hospital costs. Therefore, beneficiaries' coinsurance rates are often well above 20 percent of costs. For example, the average coinsurance rate among imaging services was 42 percent of costs in 2005.